United States v. State of Texas

Monitoring Team Report

Brenham State Supported Living Center
January 16-20, 2012

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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.

Substantial Compliance Ratings and Progress

Across the state's 13 facilities, there was variability in the progress being made by each facility towards substantial compliance in the 20 sections of the Settlement Agreement. The reader should understand that the intent, and expectation, of the parties who crafted the Settlement Agreement was for there to be systemic changes and improvements at the SSLCs that would result in long-term, lasting change.

The parties foresaw that this would take a number of years to complete. For example, in the Settlement Agreement the parties set forth a goal for compliance, when they stated: "The Parties anticipate that the State will have implemented all provisions of the Agreement at each Facility within four years of the Agreement's Effective Date and sustained compliance with each such provision for at least one year." Even then, the parties recognized that in some areas, compliance might take longer than four years, and provided for this possibility in the Settlement Agreement.

To this end, large-scale change processes are required. These take time to develop, implement, and modify. The goal is for these processes to be sustainable in providing long-term improvements at the facility that will last when independent monitoring is no longer required. This requires a response that is much different than when addressing ICF/DD regulatory deficiencies. For these deficiencies, facilities typically develop a short-term plan of correction to immediately solve the identified problem.

It is important to note that the Settlement Agreement requires that the Monitor rate each provision item as being in substantial compliance or in noncompliance. It does not allow for intermediate ratings, such as partial compliance, progressing, or improving. Thus, a facility will receive a rating of noncompliance even though progress and improvements might have occurred. Therefore, it is important to read the Monitor's entire report for detail regarding the facility's progress or lack of progress.

Furthermore, merely counting the number of substantial compliance ratings to determine if the facility is making progress is problematic for a number of reasons. First, the number of substantial compliance ratings generally is not a good indicator of progress. Second, not all provision items are equal in weight or complexity; some require significant systemic change to a number of processes, whereas others require only implementation of a single action. For example, provision item L.1 addresses the total system of the provision of medical care at the facility. Contrast this with provision item T.1c.3., which requires that a document, the Community Living Discharge Plan, be reviewed with the individual and Legally Authorized Representative (LAR).

Third, it is incorrect to assume that each facility will obtain substantial compliance ratings in a mathematically straight-line manner. For example, it is incorrect to assume that the facility will obtain substantial compliance with 25% of the provision items in each of the four years. More likely, most substantial compliance ratings will be obtained in the fourth year of the Settlement Agreement because of the amount of change required, the need for systemic processes to be implemented and modified, and because so many of the provision items require a great deal of collaboration and integration of clinical and operational services at the facility (as was the intent of the parties).

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 greatly appreciates all this assistance from staff throughout the Facility. The Monitoring Team was especially appreciative of the efforts of the Settlement Agreement Coordinator, Susie Johnson, and the staff who assisted her to keep up with all our requests, especially Leah Cook, Caitlyn Connor, Juanita Taylor, Jacquelyn Gertman, Tammie Pavlu, and Brandy Todd. They ensured the documents requested were available before, during, and after the visit, and they ably coordinated arrangements for all the meetings and observations.

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. The following report provides brief highlights of areas in which the Facility is doing well or had made significant improvements and other areas in which improvements are needed.

General Comments

Population. Population of the Facility at the beginning of the compliance visit was 310.

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. The Action Plans specified the action to be taken, what evidence would be used to confirm status, start and projected completion dates, and the current status. 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 might use its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes.

Specific Findings

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

Restraints

Statement of Status: The Facility was in compliance with one provision but may not have provided documentation that could have led to a finding of compliance with one or more other provisions. Restraint use was trending up, but it was unclear what led to the increased frequency.

- Positive Practices and Improvements Made
    - Individuals, when restrained, received the required checks and supervision.
- Improvements Needed

- The Monitoring Team observed little evidence that training and behavior programs were carried out by direct care staff. In fact, when queried by the Monitoring Team, none of the Direct Care staff could describe an Individual's behavior program.
- The quality and accuracy of the documentation associated with episodes of crisis intervention restraint, which was noted to have improved in the last review, remains problematic.
- The Facility's overall management of use of protective restraints, and related documentation, needs to significantly improve to achieve substantial compliance with the SA. The Facility has formed a special work group to develop policies and procedures associated with this topic.

Abuse, Neglect and Incident Management

Statement of Status: To achieve full compliance with Section D of the Settlement Agreement the Facility needs to achieve compliance with only five addition components of two provisions. The Facility has a new Incident Management Coordinator (IMC) and he has a new supervisor, the new Quality Assurance Director. Additionally the Facility has two new investigators.

- Positive Practices and Improvements Made
  - 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. Recommendations are tracked and recording in a database until satisfactory evidence is provided to the IMC and reviewed by the Incident Management Review Team.
  - The scope of the tracking and trending of incidents has been expanded.
- Improvements Needed
  - The process, and related documentation, of Facility investigations of serious discovered injuries needs improvement.
  - The process of reviewing investigations of non-serious discovered injuries to rule out abuse and neglect needs enhancement.

Quality Assurance

Statement of Status: A new QA Director had started and presented plans for improvements to the QA process. Although there are many initiatives in place, no significant changes to the QA process had been fully put into place since the last compliance visit.

- Positive Practices and Improvements Made
  - BSSLC tracks most data required in the SA.
  - BSSLC produces a number of trend reports.
- Improvements Needed

- The integrity of some data has not been assessed, and some data are inconsistent across reports.
- The Facility had an informal Quality Enhancement Plan which delineated the monitoring/audit tools used at the Facility, the frequency of review, sample sizes, and other relevant information necessary for carrying out QA activity. Much of the plan had not yet been implemented and the components that had did not result in substantive analysis and review leading to decision-making.

Integrated Protections, Services, Treatments and Supports

Statement of Status The Facility continued to implement the "Supporting Visions" ISP process, which was intended to reinforce the concept that planning is intended to support the individuals' vision for the future. A somewhat revised ISP format and process had been recently introduced. This ISP process was still meeting with limited success specific to the requirements of this section of the SA.

- Positive Practices and Improvements Made
  - The quality of participation by IDT members had improved in some instances, with more interdisciplinary discussion and a willingness to challenge each other as to the conventional wisdom.
  - The Facility continued to devote considerable resources to training, monitoring, and coaching for QDDPs, both new and current, an effort the Monitoring Team commends. This training included completion of Q Construction facilitation training, as well as other training initiatives.
- Improvements Needed
  - IDT members sometimes came to planning meetings without a basic knowledge or awareness of an individual's current status or needs.
  - There was still no meaningful preparation provided to ensure the PFA and/or ISP processes were conducted in a manner that facilitated real participation by the individuals.
  - ISPs 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 barriers to living in the most integrated setting always lead to goals, objectives, or service strategies.
  - ISP strategies did not reflect encouragement of community participation in any meaningful or purposeful manner.
  - There was a troubling trend toward elimination of many skill acquisition programs and the replacement of these with service objectives in individuals' ISPs. Service objectives were not routinely implemented, possibly because they were seen as informal and/or optional. In addition, the data that was kept merely indicated participation and provided very little to no information as to individuals' responses.

Integrated Clinical Services

Statement of Status: The Facility took important actions toward integrating clinical planning and services. Many of these actions are in early stages, and their effect on integrated planning and case coordination are not yet clear.

- Positive Practices and Improvements Made
  - Medical Services had become much more a part of the interdisciplinary process. Although participation in planning and review meetings is not yet fully consistent either in attendance or in integrated discussion, both show signs of improvement. The medical morning meeting is now an interdisciplinary meeting that addresses both individual and systemic issues, and the participants in the meeting engage in valuable integrated planning.
  - The office of the Infection Control Nurse was moved into the Health Center Building to increase access to infection control information and enhance integration/communication with other clinical staff.
  - Psychiatrists attend IDT meetings to review services for individuals who have experienced frequent restraint.
  - Involvement of Communication staff in the PBSP process was expanded.
  - Interdisciplinary involvement in the Medication Variance Committee was expanded.
  - Clinicians routinely documented review of recommendations by non-Facility clinicians.
- Improvements Needed
  - Participation in ISP planning meetings and in the ISP process was mixed, with examples of good participation and examples in which it was lacking or of a multidisciplinary rather than interdisciplinary integrated approach.
  - Plans to address identified risks did not consistently show evidence of integrated planning or coordinated implementation.
  - Health Management Plans (HMPs) rarely contained integrated intervention in collaboration with other relevant disciplines.
  - The Facility developed guidelines for reviewing consultations; these focused entirely on review by physicians but should address all clinicians. The guidelines require that the Nurse Case Manager present the recommendations to the morning unit meeting but do not explain the role of the IDT in reviewing and acting on recommendations.

<u>Minimum Common Elements of Clinical Care</u>
Statement of Status: Although no provisions of this Section were found to be in compliance, the Monitoring Team recognizes progress in several areas.

- Positive Practices and Improvements Made
  - The Facility had made progress on communicating and tracking health status of individuals through the Morning Medical Debriefing and reporting to the Incident Management Review Team.
  - Focused nursing assessments when an individual experienced a change in health status and improvements in the comprehensiveness of communication assessments had been initiated and become routine.
  - Diagnoses were consistent with current classifications.

- The Facility had implemented training for direct care staff on how to observe and recognize indicators of health status change. The training included guidelines for reporting and documentation.

- Improvements Needed
  - There was not yet an organized system to track health status of individuals or health status of the population of the Facility, although there had been a beginning of identifying and measuring health status issues such as falls and injuries.
  - Adequacy, comprehensiveness, and timeliness of evaluations and assessments remained problematic.
  - More assertive follow-up assessments were needed when indicated, and documentation of the rationales for diagnoses needs improvement.
  - Development and use of clinical indicators of health status for both individuals and for the population as a whole needs to occur. Some initial steps have taken place.

<u>At-Risk Individuals</u>

Statement of Status: The BSSLC processes to demonstrate compliance with this section of the SA had improved since the last review. This was especially noted for risk assessment planning that occurred since November, 2011.

- Positive Practices and Improvements Made
  - Use of these tools, initiated in November 2011, and additional training provided to IDTs, was leading to improved risk assessments and risk action plans.
  - The risk screening, assessment and management system observed by the Monitoring Team was adequate.
  - Interdisciplinary discussion required to properly assess risk and develop risk mitigation strategies had improved significantly.
- Improvements Needed
  - Although the risk system was adequate, and interdisciplinary discussion had improved, the effective use of the process remains problematic, and risk ratings and actions to address risks were not always accurate or effective.

<u>Psychiatric Care and Services</u>

Statement of Status: Psychiatric services had continued to improve, but there was still much more that needed to be done. Addition of psychiatrist time as a contract psychiatrist has joined staff full-time should help.

- Positive Practices and Improvements Made
  - Psychiatrists were all board certified, and they actively and appropriately participated in the interdisciplinary process.
  - Psychiatrists appropriately participated in the interdisciplinary process.

- All individuals who were prescribed psychotropic medication had treatment plans, and all had working psychiatric diagnoses.
- Information about the FDA approval for the specified use of the medication was a recent addition to the consent form. If the medication was proposed for use for an "off label" indication, this was specified, along with information about the proposed use of the medication.
- Psychiatrists participated in the Morning Medical Debriefing meeting and had excellent clinical discussion with the Primary Care Physicians and other participants about side effects of medication.
- Psychiatric Treatment Plans for new medications have just started to be deployed.
- Overall, the level of integrated care for use of "dual purpose" medications was impressive.

- Improvements Needed
  - There was some progress in nurse monitoring for safety during medical restraints, but many individuals did not have treatment plans to minimize or eliminate the need for the pre-treatment sedation, and there was no process in place to evaluate the effectiveness of the plans.
  - Eighty-six psychiatric evaluations (58%) of the needed Appendix B format had been completed. However, they lacked evidence to justify the psychiatric diagnoses, and NOS diagnoses needed to be resolved. In addition, 42% of individuals who need evaluations still did not have them.
  - Combined case formulations are now part of the Functional Behavioral Assessment (FBA) document. However, this process is new, and further progress is needed at the level of the behavioral healthcare planning (FA and PBSP), and at the level of the ISP.
  - The Facility had not demonstrated that individuals received the least intrusive and most integrated care.
  - Overall rates of polypharmacy had not changed. The Monitoring Team noted that a basic structure for polypharmacy review was in place in the form of PMOC, and valuable data on polypharmacy was collected. However, these data were not well analyzed, tabulated or presented.

<u>Psychological services</u>

Statement of Status: The Facility had achieved considerable progress in many areas, but there were areas that the Facility self-assessed as in compliance that were not yet.

- Positive Practices and Improvements Made
  - Progress was evident in relation to the Structural and Functional Assessments (SFAs), Positive Behavior Support Plans (PBSPs), and psychological evaluations. Many components of the SFAs and PBSPs were accordant with accepted standards of practice. The PBSPs, in particular, were lacking in only a few areas, which reflected substantial improvement from previous site visits.
  - Peer review had also been enhanced by the addition of a review of difficult cases by the Facility BCBAs. .Since the initiation of the BCBA Review meeting in August 2011, the group had completed a review of 18 cases. Of the 18

cases reviewed, eight resulted in revisions to the PBSP and two more produced cooperation with other disciplines, such as psychiatry and dentistry.
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- Improvements Needed
    - There was regression in efforts to ensure that adequate numbers of BCBAs were employed by the Facility. At the time of the site visit, the Facility had lost two BCBAs and a substantial number of existing staff had reduced participation in classes required to earn board certification.
    - Although the content of the PBSPs had greatly improved, the implementation and monitoring of plans remained inadequate.
    - PBSPs included in the sample lacked adequate criteria for success, did not provide clear instructions for data collection, and did not ensure that treatment targets were analyzed appropriately.
    - Data graphs indicated that treatment decisions at times lacked the support of objective evidence.
    - Some individuals were noted to have experienced increases in problem behavior over several months without a review or revision of the PBSP.
    - Progress had been reported in regard to behavioral/psychiatric case formulations, but none of the cases reviewed, including samples provided by the Facility of "best work", included a case formulation. As this process is new, not enough had been completed to be found in the sample.
    - BSSLC demonstrated substantial progress in developing a sound peer review process. The documentation presented by the Facility reflected, however, that lapses in implementation were present in a sizable portion of the sampled records.
    - Although there had been progress, a large number of individuals residing at the Facility, however, had not yet been provided the required psychological assessments.

<u>Medical Care</u>

Statement of Status: The Monitoring Team was most impressed with the significant reorganization of the Facility's Medical Staff, including the appointment of a new Medical Director. Unlike previous reviews, the entire Medical Staff was noted to be well engaged in the Settlement Agreement process, and with the Facility's Plan of Improvement.

- Positive Practices and Improvements Made
    - A robust, multidisciplinary morning clinical meeting, the Morning Medical Debriefing, was established.
    - Physicians are now documenting clinical notes in a SOAP format, and documenting a clinical impression and plan.
    - Annual Medical Assessments are being updated to better reflect the Individuals condition.
- Improvements Needed
    - The Facility must significantly enhance its provision of medical services to Individuals served by the Facility. Ensuring that syndromal conditions, and manifestations are addressed, ensuring the treatment of chronic

conditions are at the level of community standard of care, and that they are assessed regularly, are important areas that must be addressed
  - The Facility must ensure that medical audits include a robust mechanism to evaluate physician's clinical performance.
  - The Facility must enhance its Death Review Process to include a meaningful Root Cause Analysis, and ensure that leadership at the Facility regularly reviews longitudinal trends analysis.
  - A process to assess clinical indicators has not been developed. The Facility is aware that this process must be developed in the near future, and that quality indicators must reflect clinical practice at the Facility, include an interdisciplinary methodology, include longitudinal trends analysis, implement corrective action, and evoke a mechanism to ensure remedies are effective.

<u>Nursing Care</u>
Statement of Status: Nursing Services continues to make progress in staffing, assessment, and documentation.

- Positive Practices and Improvements Made
  - 100% of the nursing positions were filled.
  - The realignment of nursing positions in appointing a Skin Integrity Nurse, another Nurse Educator and an Administrative Assistant the Infection Control Program to enter data should further aid in improving nursing services.
  - The Emergency Response System continued to move forward with the addition of new emergency equipment and the establishment of the CPR Committee and Special Code Committee.
  - The Nursing Department had continued to conduct an excellent process for reviewing and taking corrective actions for medication errors committed by the nursing staff.
- Improvements Needed
  - Although much effort had been put forth to improve the quality of the Annual/Quarterly Comprehensive Nursing Assessments, the overall nursing summaries need to be improved to clearly and concisely summarize clinical data for each of individuals' nursing problems/diagnoses in order to determine the individuals' progress toward their established goals and objectives.
  - It was positive to find that the Nursing Administration recognized the need to further improve the quality and to individualize the Acute Care Plans and Health Maintenance Plans.
  - Although the Nursing Education Department had continued to maintain an excellent system to track all nursing training which demonstrated that at least 95% of the nursing staff were trained on the various policies, procedures, and protocol developed and implemented to date, that alone does not constitute compliance with this provision. In order for this provision to meet compliance, not only must the nursing assessments and reporting protocols be established and implemented, they must be demonstrated through actual clinical practice sufficient to address the

health status of individuals served. As was found throughout the other provisions, the assessments and protocols have not been adequately put into practice sufficient to meet individuals' health status needs.
  - Identification of risk indicators continues to need improvement.
  - The Nursing Department needs to refine the infrastructure to function efficiently and effectively, such as a collaborative system developed with the pharmacy regarding procedures/processes for prescribing, ordering, transcribing, preparation, dispensing, delivery and/or administration of medication, storage, security, and accountably of medication, and ensuring medication variances are reported by all relevant disciplines, e.g., nursing, pharmacy, and physicians.

<u>Pharmacy Services and Safe Medication Practices</u>
Statement of Status: The Monitoring Team noted enhanced effort on the part of pharmacy, as they work toward compliance with the requirements of this Section.

- Positive Practices and Improvements Made
  - The Facility maintains a database for all STAT and one-time orders. The data was presented in table form, and graphic representation that provided extensive insight into the use of STAT medications at the Facility.
  - The Facility has also significantly enhanced its efforts to monitor for metabolic syndrome.
  - The Facility continues to make significant improvements with the review process of QDRRs. QDRRs were completed timely in 100% of the sample reviewed.
  - The Facility has significantly improved many aspects of monitoring of polypharmacy and the use of STAT medications at the Facility. The Facility maintains a database for all STAT and one-time orders.
  - The pharmacy department had significantly enhanced methods to ensure appropriate completion of MOSES and DISCUS Assessments by developing a database tracking system and reporting compliance issues at P&T Committee.
  - The Facility continues to enhance its ADR process. The Facility had a meaningful process in place to address ADRs.
  - The Facility now offers excellent training on ADRs to direct care staff and nurse. The Facility collects data on all ADRs for trends analysis.
  - The Facility provides an excellent Drug Utilization Evaluation (DUE) process that is comprehensive and clinically meaningful.
- Improvements Needed
  - Pharmacy needs to ensure there is documentation supporting the pharmacist's review of all commonly required laboratory studies for each medication reviewed; ensure review, and documentation that all allergies, and side effects have been reviewed; provide clinically appropriate recommendations for each single patient intervention.
  - The Pharmacy Department must be aware of necessary clinical interventions, and monitoring specific for medications; ensure that there is documentation of the physician's action plan, and notation if the physician agrees

or disagrees with the pharmacy recommendation; ensure that pharmacy has a mechanism in place to assess compliance by physician with the pharmacists recommendations and action plan for each intervention.
  - The Facility should improve documentation to demonstrate meaningful review of risks associated with metabolic syndrome, polypharmacy, and the use of benzodiazepines.
  - Action plans were not consistently documented on the QDRR.
  - The Facility made significant efforts to assure that all required screens were administered and physician reviews completed. It was not clear, however, that all individuals who needed screens had received them, or that screens were provided at the required frequency.
  - The Facility does not have a well integrated medication variance process that includes oversight by the pharmacy department

<u>Physical and Nutritional Management</u>
Statement of Status: The Facility still needs to improve Physical and Nutritional Management (PNM) services. Although actions had been taken to improve these services, the pace of improvement needs to increase.

- Positive Practices and Improvements Made
  - Great strides had been made which included the appropriate membership and participation of all relevant disciplines, and implementation of 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.
  - PNMPs included detailed information regarding adaptive equipment, bathing/showering positioning, transfer information, mealtime strategies as well as communication strategies.
  - 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.
- Improvements Needed
  - There was still no evidence that data were collected and the IDT or PNM team was reviewing this data to better identify system issues or respond to recurrent issues on a regular basis.
  - 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 PNMPs had clear instructions and were readily available, 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.
- 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.
- Clinicians need to conduct routine, proactive review of PNMPs with frequency based on risk level.
- Not all individuals who receive enteral nutrition received an annual assessment that addressed the medical necessity of the tube and potential pathways to PO status.

Physical and Occupational Therapy

Statement of Status: The Facility has open positions for PT and OT that have not yet been filled. With the lack of resources, much improvement is needed to reach compliance.

- Positive Practices and Improvements Made
  - The OT/PT assessment format was revised so it focuses more on the areas of risk and what interventions are in place to mitigate the risk. Other positives included:
  - Annual assessments were completed timely.
  - There was evidence of communication and or collaboration in the OT/PT assessments.
- Improvements Needed
  - Assessments were not being consistently completed in response to a change in status and were not consistently comprehensive.
  - Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills.
  - Therapy services were not consistently integrated into the ISP.
  - 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 which included all necessary components.

Dental Services

Statement of Status: The Dental Director had started at the Facility just prior to the last compliance visit, and the department has undergone reorganization. Numerous improvements had begun during the interim between the visits, and dental services are moving forward towards developing meaningful processes that, if implemented, will help to ensure compliance. The Monitoring Team was delighted to see the dental office staff's enthusiasm and dedication while working towards compliance. .

- Positive Practices and Improvements Made
  - There was an increased number of direct care hours provided by dentists.

- There was progressive use of technology and programs, such as the procurement of a handheld mobile x-ray device.
- An oral hygiene monitoring program including biweekly visits to homes was initiated and appears to have had impact on improved oral hygiene.

- Improvements Needed
  - Tracking of dental services must improve so all needed information is available, including tracking of outcomes and adverse outcomes related to dental services.
  - Integration of dental services into the IDT process has begun but needs to improve.
  - Efforts must be taken to improve on use sedation, including TIVA; and address issues related to restraint and desensitization.

<u>Communication</u>
Statement of Status: BSSLC has filled all of their positions but remained not compliant due to lack of the Speech and Language Pathologists' (SLPs) presence in all facets of care in which their expertise was needed.

- Positive Practices and Improvements Made
  - Assessments were noted to be mostly comprehensive and provided clear details and strategies to improve the individuals' level of communicative functioning.
  - At the time of the review, 183 new assessments had been completed which accounted for 60% of the census. 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.
  - There were numerous individuals in need of AAC who were not consistently identified as being in need of AAC or were not provided with basic communication goals to improve expressive language.
  - While the comprehensive assessments were detailed and met all the requirements of the SA, the updates generally provided a review of consults provided over the past year and did not contain any information regarding how the individuals' present status differs from the previous assessment or updater. Failure to provide this analysis results in a risk of failure to identify the beginnings of functional decline.
  - BSSLC had a monitoring process to address the presence and working condition of the AAC devices but were not consistently 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.
  - DCPs interviewed were not knowledgeable of the communication programs and communication plans and how the individual communicates was not consistently included in the PSP.

Habilitation, Training, Education, and Skill Acquisition Programs

Statement of Status: Although efforts had been made to implement skill acquisition programs, they were not implemented in a manner that would move the Facility toward compliance. The Facility needs to review its initiatives and identify actions that would be more effective.

- Positive Practices and Improvements Made
  - BSSLC did provide a modest increase in Enclave employment opportunities
- Improvements Needed
  - Of considerable concern was the movement by the Facility away from both comprehensive assessment of personal skills and the use of specific skill acquisition programs that include objective and measureable goals. It was also noted that the skill acquisition plans that were developed lacked individualization and frequently did not address needs that were identified by the existing assessment process. BSSLC had substantially reduced the number of SPOs for each individual. In the place of SPOs, it was often noted that the individual was provided with Staff Service Objectives (SSOs).
  - There was a lack of formal skill acquisition training in community settings. Although individuals living at the Facility were provided the opportunity to engage in community activities, with very few exceptions these community activities did not include or support the development of skills necessary for living in the community.

Most Integrated Setting

Statement of Status: Significant deficits in the Facility's assessment processes continued to hamper these efforts to develop and implement adequate transition planning.

- Positive Practices and Improvements Made
  - Six individuals had transitioned to community living and there were 13 active referrals.
  - CLDPs were reviewed with the individual and LAR to facilitate their decision-making regarding supports and services needed for community living.
  - A new Post-Move Monitor had been hired on November 1, 2011, and was completing training with the APC. The Facility reported that a Program Auditor had been assigned to accompany the Post-Move Monitor on all PMM visits to review the accuracy of the Post-Move Monitor's monitoring of community placements.
- Improvements Needed
  - BSSLC still failed to adequately assess, plan for, and implement a plan for each person's needs for education and awareness about community living options.
  - Continuing deficits in assessments also translated to many instances in which the IDT failed to identify in each individual's ISP the protections, services, and supports that needed to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs, or the

major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences and the strategies intended to overcome such obstacles. ,These deficits were apparent in CLDPs that did not adequately reflect the protections, services and supports an individual would need to make a successful transition to community living.
    - PMM Checklists generally appeared to be completed in a timely manner, but there were questions about the actual completion date of at least one such document. Overall, the Monitoring Team remained very concerned that the PMM process had not been implemented in a sufficiently rigorous manner.

<u>Consent</u>
Statement of Status: Progress on this Section awaits completion of DADS statewide policies, procedures, and practices.

- Positive Practices and Improvements Made
    - The Monitoring Team commends early efforts by the HRO to help teams begin to engage in more thoughtful consideration of an individual's need for guardianship, including both training and hands-on technical assistance.
    - The HRO had undertaken several activities to enhance resources for individuals who may require assistance with decision-making.
    -
- Improvements Needed
    - BSSLC did maintain a list of individuals in need of a guardian that was updated regularly, but the list was not currently prioritized.
    - Statewide, and then local, policy must be established and implemented.

<u>Recordkeeping and General Plan Implementation</u>
Statement of Status: Recordkeeping practices, and the use of records for decision-making, continue to improve. Auditing is in place but needs improvement in tracking patterns of deficiency.

- Positive Practices and Improvements Made
    - The Facility maintained a Unified Record consisting of an Active Record, Master Record, and an Individual Notebook called the All About Me" book.
    - The Facility had increased the number of audits done and had a process to notify appropriate staff of the need for corrections, to require a report of completion of corrections, and to spot-check to determine whether reported corrections had actually been completed.
    - Staff interviewed could easily find documents and could describe how they used information from the record.
    - Observations showed documents used in meetings to ensure accurate information.

    - Communication through IPN documentation had improved.
- Improvements Needed
    - Although the condition of records continued to show improvement over records at the baseline review, there were still numerous errors and deficiencies in documentation, although there had been improvement.
    - Staff providing direct care could not state the interventions planned for individuals without checking the records.
    - Evaluations needed by the IDT were not posted timely to the Share Drive to permit review.

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. BSSLC Plan of Improvement (POI) dated 12/30/11 2. Section C Presentation Book (undated) 3. DADS Policy 001 Use of Restraint (8/31/09) 4. DADS SSLC Nursing Protocol: Pretreatment and Post-Sedation Monitoring (February 2011) 5. BSSLC Restraint for Behavioral Crisis Policy (6/8/11) 6. BSSLC Medical and Dental Restraint Policy (6/18/11) 7. List of all crisis intervention restraint use from 8/1/11 to 11/28/11 8. List of all protective restraint use from 8/1/11 to 11/28/11 9. List of all medical restraint use from 8/1/11 to 11/28/11 10. List of Individuals with more than three restraints in a rolling 30 day period from 8/1/11 to 12/7/11 11. List of Individuals with a Safety Plan (undated) 12. Sample of physical restraint records (Sample C.1): Individuals #490 (10/25, 10/21 7:36pm, 9/28 10:25am, 10/7 3:00pm, 10/7 3:17pm, and 9/26 2:20pm), #181 (8/18, 9/10 1:35pm, and 9/9 5:45pm), #173 (11/17, 10/25 10:42am, and 10/31, #185 (8/27 4:29pm, 10/30 5:30pm, and 10:20 9:53pm), Individual #381 (10/12 and 9/13), #11 (9/20 7:33am and 7:51am), Individual #367 (10/28), #12 (11/3), #425 (8/19 5:50pm), #321 (11/13), and #403 (9/20) 13. Sample of medical restraint records (Sample C.2): Individual #45 and Individual #349 (6/2/11) 14. Sample of protective restraints (Sample C.3): Individuals #332 and #392 15. BSSLC "Do Not Restrain" list (undated) 16. Data sheets to document implementation of IDT approved programs were put in place to minimize need for pre-treatment sedation for dental procedures 17. Sample of 25 direct care professionals' training records (Sample C.5) 18. Staff training records for sample of staff designated as restraint monitors 19. DADS report "Percent of All Employees Completing Courses of Training Programs" 12/9/11 20. DADS report "Course Due/Delinquent for BSSLC" for various required courses 12/8/11 21. Restraint Competency Exam (4/27/11) 22. Staff training material developed by BSSLC for restraint monitoring (Class RMT2011) 23. Minutes of Restraint Reduction Committee 10/27/11 and 12/1/11 24. Log of restraint related injuries to individuals since the last review. 25. Checklist for 3/30 Meetings/Reports (undated) 26. Form titled "Checklist for Implementing Restraint Medical/Physical" 12/9/11 27. Sedation Workgroup meeting minutes 9/22/11, 10/6/11, and 11/14/11 28. Dental Support Plans for Individuals #62, #118, #249, #380, #440, and #538 29. Medical Support Plans for Individuals #38, #113, #207, #377, #488, and #548 30. BSSLC Restraint Trend Report 12/31/11

	People Interviewed: 1. Terry Hancock, PhD, BCBA, Chief Psychologist 2. Shawn Cureton, M.S., Psychology Manager 3. Dr. Mary Brett, Medical Director 4. Dr. Jennifer Nguyen, Dentist **Meeting Attended/Observations:** 1. Facility Incident Management Team meeting 1/16/12 2. IDT meeting to review restraint of Individual #12 1/16/12 3. IDT meeting to review restraint of Individual #38 1/17/12 4. QA/QI Council meeting 1/18/12 5. Protective Restraint Workgroup 1/18/12 6. Restraint Reduction Committee meeting 1/19/12
	Facility Self-Assessment: The BSSLC Plan of Improvement reported substantial compliance with three of the eight provisions of Section C of the Settlement Agreement (SA) - Provisions C.3, C.6, and C.8. The Monitoring Team determined substantial compliance with only one provisions, C.6. In the last review the Monitoring Team found substantial compliance with provisions C.3, C.6, and C.8. In its self-assessment the Facility did not provide any rationale as to how it reached its self-assessment conclusions. At the last review it was noted that documentation had significantly improved compared to that observed at the earlier monitoring reviews. Documentation provided to the Monitoring Team during this review was incomplete in many instances, which was a significant factor in the reduced number of provisions determined to be in compliance.
	Summary of Monitor's Assessment: The BSSLC was in substantial compliance with Provision C.6 of the SA. Several other provisions were found to be not in substantial compliance primarily because the Facility did not provide the Monitoring Team with documentation it may have had. It is important that the Facility provide the Monitoring Team with documentation to validate compliance with each element of each provision of the SA. Restraint use at BSSLC was trending up. Crisis intervention restraint (physical and chemical) was used an average of 13 times/month in the second quarter of FY11, 25 times/month in the third quarter, 30 times/month in the fourth quarter, and 35 times/month in the first quarter of FY12. The Monitoring Team observed little evidence that training and behavior programs were carried out by direct care staff. In fact, when queried by the Monitoring Team, none of the Direct Care staff could describe an Individual's behavior program. This may be one factor in the increasing use of restraint. Lack of knowledge of an individual's PBSP (and the resultant inability to implement them) also calls into question the efficacy of restraint use in a "clinically justifiable" manner. The quality and accuracy of the documentation associated with episodes of crisis intervention restraint, which was noted to have improved in the last review, remains problematic. The psychology department reported it reviews 100% of restraint documentation to ensure accuracy and consistency. Nevertheless, the

	Monitoring Team found many examples of obvious errors. A lack of a systematic approach to the use of protective restraints is problematic. The Facility's overall management of use of protective restraints, and related documentation, needs to significantly improve to achieve substantial compliance with the SA. The Facility has formed a special work group to develop policies and procedures associated with this topic. A lack of a systematic approach to the use of medical restraints is also problematic. The Monitoring Team was unable to conduct a comprehensive compliance review of medical restraint because reviewable systems are not in place. The Facility has formed a special work group to develop policies and procedures associated with this topic. None of the Restraint Review forms reviewed addressed errors or incorrect procedures in documentation, application, or monitoring of the restraint. All restraints should be reviewed within three days of the restraint and documentation should reflect corrective action to be taken when errors are found in documentation or implementation.

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C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	BSSLC reported in its Plan of Improvement (POI) that it was not in substantial compliance with this provision of the Settlement Agreement (SA). The Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. The Monitoring Team determined this provision of the SA is not in substantial compliance as evidenced by the continued increase in use of restraint, the lack of program implementation that contributes to effective management of problem behavior, and the inconsistent documentation of restraint practices. BSSLC Restraint for Behavioral Crisis Policy (6/8/11) and BSSLC Medical and Dental Restraint Policy (6/18/11) 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. Restraint use at BSSLC was trending up. Crisis intervention restraint (physical and chemical) was used an average of 13 times/month in the second quarter of FY11, 25 times/month in the third quarter, 30 times/month in the fourth quarter, and 35 times/month in the first quarter of FY12. Two individuals accounted for approximately half the restraint episodes. <u>Prone Restraint</u> DADS and BSSLC policies clearly prohibit use of prone restraint. Employees were trained during New Employee Orientation and annual PMAB training, that prone restraint was	Noncompliance

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		prohibited. Based on review of other documentation, including a list of all restraints and a sample of restraint checklists, the use of prone restraint was not identified. <u>Restraint Samples</u> Three samples of restraint episodes from lists provided by the BSSLC were developed. These lists included restraints that had occurred since the last monitoring visit and were: • Sample C.1: Physical Restraint –20% of reported restraints were selected to sample. 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, bear-hug restraint, and chemical restraint. The sample included records for Individuals #490 (10/25, 10/21 7:36pm, 9/28 10:25am, 10/7 3:00pm, 10/7 3:17pm, and 9/26 2:20pm), #181 (8/18, 9/10 1:35pm, and 9/9 5:45pm), #173 (11/17, 10/25 10:42am, and 10/31), #185 (8/27 4:29pm, 10/30 5:30pm, and 10:20 9:53pm), Individual #381 (10/12 and 9/13), #11 (9/20 7:33am and 7:51am), #367 (10/28), #12 (11/3), #425 (8/19 5:50pm), #321 (11/13), and #403 (9/20). Seventeen restraints involved individuals with a Safety Plan. Files prepared by the Facility for these 24 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 Facility included four oral pre-treatment sedation restraints and 19 instances of use of total intravenous anesthesia (TIVA). Two instances of oral pre-treatment sedation were selected for review. These were for Individuals # 45 and #349. Four instances of TIVA (20%) were selected to review. These were for Individuals #45, #392, #443, and #588 and will be discussed separately in this report. Files prepared by the Facility for the medical restraints, including TIVA, were to include the restraint checklist, medical orders, physician specified monitoring schedule, standard facility protocol for monitoring medical restraint (if applicable), ISP 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. • Sample C.3: Protective Mechanical Restraint - the list provided by the BSSLC contained nine Individuals who were, or had been since the last review, in	

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		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. These were Individuals #332 and #392. <u>Other Restraint Requirements</u> Based on document review, the Facility policy states 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 24 records (92%), 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 (RC) and the debriefing form (FFAD). The two that did not document immediate and serious threat provided no description of events leading up to restraint use on the restraint checklist and merely noted, "was given chemical restraint." ▪ For 24 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 22 (92%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. The two that did not provide a description of events leading up to restraint use on the restraint checklist merely noted "was given chemical restraint." The RC did not contain sufficient information to rule out inappropriate use of restraint. ▪ In 16 of 24 of the records (67%), 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. Six Individuals had a Positive Behavior Support Plan (PBSP) which included a Safety Plan (SP). None of the RCs for these six individuals noted that interventions in the PBSP or SP were used. The RC for Individual #403, who received a chemical restraint, notes only that "staff redirection" was attempted prior to restraint. The RC for Individual #181, who received chemical restraint, notes only that "prompted replacement behavior" was attempted prior to restraint. The Individual's PBSP calls for a series of interventions to be attempted in order to avoid restraint. In seven instances the Restraint Monitor indicated on the FFAD that restraint was used in a clinically justifiable manner. In one instance the Facility did not produce the FFAD associated with the restraint episode. Sixteen restraint checklists (67%) indicated use of many pre-restraint interventions. including	

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		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. ▪ As described in Section K the Facility needs to improve in direct care staff knowledge of Positive Behavior Support Plans (PBSPs) and when, and how, to implement them. The Monitoring Team observed little evidence that training and behavior programs were carried out by direct care staff. In fact, when queried by the Monitoring Team, none of the Direct Care staff could describe an individual's behavior program. Lack of knowledge of an individual's PBSP (and the resultant inability to implement them) calls into question the efficacy of restraint use in a "clinically justifiable" manner. The lack of PBSP knowledge, or of PBSP implementation methods, could lead to unnecessary restraint. Similarly, as reported in Section S, more effort is needed in the delivery of training to Individuals. Monitoring Team observations and data review confirmed that staff was not consistently implementing training programs and individuals had too much time without formal or informal training. This can lead to unwanted behavior by an individual, which might be dangerous and can lead to restraint. ▪ As noted above, two instances (of four) chemical restraints contained insufficient documentation on the RC to establish that there was consideration of less restrictive measures in a clinically justifiable manner. In both instances a post restraint review conducted by a psychologist was completed. In one instance the review established that the individual's behavior, and attempted staff interventions that were unsuccessful, justified use of chemical restraint. The other was less clear. ▪ Facility policies identify a list of approved restraints. Based on the review of 24 restraints, involving 11 individuals, 24 (100%) were approved restraints. The quality and accuracy of the documentation associated with episodes of crisis intervention restraint, which was noted to have improved in the last review, remains problematic. The psychology department reported it reviews 100% of restraint documentation to ensure accuracy and consistency. Nevertheless, the Monitoring Team found many examples of obvious errors, for example: • The RC for Individual #381 does not indicate the type of restraint used or the level of supervision provided during the 21-minute restraint. • Very few RCs contained an entry noting the date of unit review. • The RC for Individual #181 reported chemical restraint but in the box on the RC to note the medication/dose "unknown" was reported. • There are many items on many FFADs checked "no" that should have been checked "N/A" such as medications given, meals offered, and shift change review when a restraint lasted one minute. This suggests Restraint Monitors need	

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		additional training, and/or need to pay closer attention when completing the document. • Most FFAD documents did not contain entries noting the date of unit review and the date of Incident Management meeting review. Although the Facility had made progress in ensuring restraint was used only in compliance with the requirements of the SA, the upward trend in use, along with the lack of implementation of behavioral interventions, leads the Monitoring Team to question whether restraint may be used in the absence of effective interventions. This 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 not in substantial compliance with this provision of the Settlement Agreement (SA). The Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. The Monitoring Team determined this provision of the SA is not in substantial compliance as evidenced by a lack of a systematic approach to the use of protective restraints. The 24 restraint records involving the 11 individuals in Sample C.1 were reviewed. Four were chemical restraint. Of the remaining 20, all (100%) reported the release code P "released immediately because no longer an immediate and serious risk of harm to self/others." or the release code N "released due to not able to maintain restraint correctly." When code "N" was used the post-restraint review conducted by the psychologist reported that upon release, in instances where the Individual continued to exhibit dangerous behavior, restraint was immediately (and appropriately) reinitiated. From the documentation presented, the Monitoring Team was able to determine that crisis intervention 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. Sample C.3 (protective mechanical restraint) reports on two Individuals. Both Individuals were in protective mechanical restraint for extended periods of time since the last review. In both instances, the Facility did not provide assessments that supported the need for protective restraint, the ISP documenting IDT approval, restraint checklists documenting restraint application, release, and monitoring, or other documents that would enable the Monitoring Team to determine if use of these restraints were compliant with the provisions of the SA. The Facility acknowledged multiple issues with the definition, use, and SA requirements associated with protective restraint at the BSSLC. The Facility had established a focused workgroup on this topic. The Monitoring Team met	Noncompliance

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		with the workgroup (as well as representatives from DADS) to review a variety of protective restraint related topics and to offer technical assistance. The Facility's overall management of use of protective restraints, and related documentation, needs to significantly 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 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.	BSSLC reported in its Plan of Improvement (POI) that it was in substantial compliance with this provision of the Settlement Agreement (SA). The Facility's Plan of Improvement (POI) did not report any rationale for its determination of compliance. While the Monitoring Team believes policies associated with crisis intervention and medical restraint are sufficient, the Monitoring Team reviewed sufficient documentation to determine the BSSLC has not achieved substantial compliance with this provision of the SA because all staff had not been trained as required by policy and the SA. Additionally, until the facility addresses appropriate policy to govern the use of protective restraints it will not achieve compliance with the 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 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. The BSSLC had sufficient policy's to govern restraint; however, as noted in Section C.1, the Facility faces some challenges in ensuring policies are effectively implemented. The Facility reported it had initiated several things to better manage restraint use, including the development of databases to track: • Restraint monitor training • Protective restraints • SFA date, PBSP date, IQ/adaptive testing data, HRC approval date, PBSP training dates • Treatment integrity including IOA • BCBA Referrals • Psychiatry related rating scales The Facility also reported it had initiated a number of forms/tools or revised existing forms to better manage restraint use, including: • 3 in 30 IDT Meeting Checklist • Revised the Considerations for Restraint form and began to develop a list of individuals for whom the PCP and the team believe there should be restrictions on restraint. • Dental Desensitization Assessment/Intervention Form	Noncompliance

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		• PBSP Initial Competency Training Checklist • Added a Case Formulation section and an Adaptive Behavior/Strengths section to the SFA Review of the Facility's training curricula revealed that it included adequate training and competency-based measures in the following areas: • Policies governing the use of restraint; • Approved verbal and redirection techniques; • Approved restraint techniques; and • Adequate supervision of any individual in restraint. The BSSLC Restraint for Behavioral Crisis policy identified specific classes required for all staff as follows: PMA320 (PMAB Intermediate Protection), PMA400 (PMAB Restraint), PMA700 (PMAB Prevent), and RES0105 (Restraint: Prevention and Rules for Use at MR Facilities). 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 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 staff to validate completion of the required courses. For each of the four required courses 23 of 25 (92%) staff had completed required training. The Monitoring Team also reviewed two DADS reports. The first reported a percentage of staff that had completed required training, by class number. This reports completion percentages as follows: • PMA0320 96% • PMA0400 95% • PMA0700 95% • RES0105 96% The second DADS report listed the names of staff that have not completed required training for specific course. The number of staff that had not completed courses is as follows:	

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		• PMA0320 42 • PMA0400 34 • PMA0700 34 • RES0105 29 Because the use of restraint at the BSSLC has been steadily increasing it is imperative that all staff receive required training. The three data sources noted above confirm deficiencies in the completion of required training and this precludes a determination of substantial compliance for this provision of the SA.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	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 Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. The Monitoring Team concurs with the self-assessment of noncompliance. Based on a review of 24 crisis intervention restraint records (Sample C.1), 24 (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 two protective mechanical restraint records (Sample #C.3), two (100%) contained no documentation that use of restraint was planned to respond to imminent risk of harm. Based on a review of 24 crisis intervention restraint records (Sample C.1), only one 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 included 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. This form was not present in 23 of 24 documentation files prepared for the Monitoring Team. Nevertheless, the Facility maintained a "Do Not Restrain" list. The Monitoring Team compared the names on the Do Not Restrain list with the log of restraints and determined no individuals were restrained who were on the Do Not Restrain list. The Facility reported four instances of use of oral pre-treatment sedation for dental procedures. Two were selected to review and the Facility was asked to prepare	Noncompliance

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		documentation files. Facility policy requires the completion of a Restraint Checklist to document the use of medical restraint. A RC was provided for one (50%) of two restraints reviewed. One (50%) of two restraints reviewed included a Dental Support Plan, This plan had been in place for a considerable period of time and called for trials once a week. The last four months of data was reviewed. Data sheets reported that trial occurred only four times over 16 weeks. An additional review of 12 randomly selected medical/dental support plans (from a list of 108 provided by the Facility) revealed many plans that were not individualized, were not implemented with the frequency called for, and did not capture data that could lead to assessment of progress and additional decision-making. For example, one plan reported unsuccessful trials for months with no apparent effort to modify the plan. The Facility reported 19 instances of use of TIVA. Four cases were selected for review. During the last review the section lead for Section C reported a great deal of work needed to be done to ensure medical restraint data was organized and accurately and regularly reported. It appears this still needs to occur. It is puzzling that the Facility provided a list of 108 individuals with support plans but reported that only four individuals received pre-treatment sedation and 19 received TIVA. The Facility has tasked a special workgroup to develop a work plan that can lead to compliance with the medical restraint aspects of the SA. The Monitoring Team looks forward to reviewing the outputs from this work group at its next review. Based on the limited data presented above, a list of medical restraints which may not be accurate, 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	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 Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. The Monitoring Team concurs with the self-assessment of noncompliance. 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. This course is RMT2011. 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 (crisis intervention restraint). This consisted of 24 Restraint Checklists. The staff person noted as the restraint monitor on the Restraint	Noncompliance

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	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.	Checklist matched the list of restraint monitors provided by the Facility in each instance (100%) where a restraint monitor name was provided on the RC. The Monitoring Team reviewed the training transcripts for the restraint monitors that monitored restraints in Sample C.1 in order to validate completion of the following classes: PMA320 (PMAB Basic) 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). In every case the Restraint Monitor had completed required training. To assess Restraint Monitor arrival times being within 15 minutes of a restraint initiation the Monitoring Team reviewed FFADs. The FFAD includes an entry for "time monitor arrived." The Monitoring Team views this as the time the assessment began. For 20 of 24 instances (83%) for Sample C.1 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. For two restraints (Individuals #173 and #381 – 9/13) an FFAD was not provided to the Monitoring Team. No Restraint Monitor was noted for restraint of Individuals #403 and #381 – 10/13. In 20 instances (83%), the documentation on the FFAD showed that an assessment was completed of the application of the restraint. In 24 instances (100%), the documentation on the FFAD, supplemented with the post-restraint review by the psychologist, showed that an assessment was completed of the circumstances of the restraint. None of the 24 non-medical restraint records in the sample indicated an alternative physician ordered monitoring schedule. Based on a review of 24 restraint records for restraints that occurred at the Facility (Sample #C.1), there was documentation that a licensed health care professional: ▪ Conducted monitoring at least every 30 minutes from the initiation of the restraint in 16 (67%) of the instance of restraint. Listed below are the Individuals and date of each restraint where this did not occur: o Individual #181: 8/18/11 at 8:45 a.m. The nurse did not monitor until 10:25 a.m. On 9/10/11 at 1:35 p.m., Individual #181 received a chemical restraint. There was no Physician Order's for monitoring. According to	

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		BSSLC Use of Restraint Policy, 001, H.2., "A licensed health care professional must monitor and document vital signs, respiration, circulation, and mental status (orientation to person, place, and time compared to what is normal for the individual, and level of consciousness) of the individual in physical and mechanical restraint at least every 30 minutes and chemical restraint at least every 15 minutes from the start of the restraint." Individual #181's vital signs were not monitored consistently every 15 minutes but were monitored at least every 30 minutes for two or more hours. o Individual #425: 8/19/11 at 5:20 a.m. The nurse did not document attempts to monitor every 30 minutes on the Restraint Checklist. o Individual 403: 9/20/11 at 6:30 p.m. Individual #403 received a chemical restraint. There was no Physician Order for monitoring. Individual #403 was monitored every 30 minutes as opposed to every 15 minutes for two or more hours. o Individual #185: 8/27/11 at 4:29 p.m. and 10/10/11 at 9:53 p.m. The nurse did not document attempts to monitor every 30 minutes on the Restraint Checklist. o Individual #11: 9/20/11 at 7:33 a.m. The nurse did not document attempts to monitor every 30 minutes on the Restraint Checklist. A nursing note on the Restraint Checklist stated to refer to the Restraint Checklist on 9/20/11 at 7:51 a.m. for monitoring assessments. However, on 9/20/11 at 7:51 a.m., the nurse did not begin to monitor every 30 minutes until 2:15 p.m. ▪ Monitored and documented vital signs in 21 (88%). Of the 21 restraints that were monitored and documented for vital signs, 15 (72%) of the restraints did not contain a full set of vital signs because of individuals' refusal. This did not mean that all vital signs were refused. The nurses did monitor and document some of the vital signs. This should not be considered a negative finding because the documentation on the Restraint Checklists indicated that the nurses made reasonable effort to obtain a full set of vital signs. Although, the nurse should be able to obtain respiration without individuals' cooperation. Records that did not contain documentation of this are listed below for Individuals and date of each restraint where this did not occur: o Individual #11: 9/20/11 at 7:33 a.m. The nurse did not document attempts to monitor vital signs every 30 minutes on the Restraint Checklist. A nursing note stated to refer to the Restraint Checklist on 9/20/11 at 7:51 a.m. for vital sign assessments. However, on 9/20/11 at 7:51 a.m., the nurse did not begin to monitor vital signs every 30 minutes until 2:15 p.m. o Individual #425: 8/19/11 at 5:50 p.m. The nurse did not document attempts to monitor vital signs every 30 minutes on the Restraint Checklist. ▪ Monitored and documented mental status in 21 (88%). Of the restraints that were monitored and documented for vital signs, five (24%) of the 21 restraints	

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		did not consistently contain mental status assessments because of individuals' refusal. This did not mean that all mental status assessments were refused. The nurses did monitor and document most of the mental status assessments. This should not be considered a negative finding because the documentation on the Restraint Checklists indicated that the nurses made reasonable effort to obtain all mental status assessments. Although the individuals refused the mental status assessment, it is not necessary to obtained individuals' cooperation. The nurse should be able to describe the individuals' mental status through observation, e.g., yelling, crying, engaging in combative behavior. Records that did not contain monitoring and documentation of mental status assessments are listed below for Individuals and date of each restraint where this did not occur: o Individual #11: 9/20/11 at 7:33 a.m. The nurse did not document attempts to monitor mental status on the Restraint Checklist. A nursing note on the Restraint Checklist stated to refer to the Restraint Checklist on 9/20/11 at 7:51 a.m. However, the nurse did not begin to monitor mental status every 30 minutes until 2:15 p.m. o Individual #425: 8/19/11 at 5:50 p.m. The nurse did not monitor mental status every 30 minutes or document on the Restraint Checklist that attempts were made to monitor. Based on documentation provided by the Facility, one restraint had occurred off the grounds of the Facility in the last six months. A sample of one was reviewed. A licensed health care professional: ▪ Conducted monitoring within 30 minutes of the individual's return to the Facility in one (100%). ▪ Monitored and documented vital signs in one (100%). ▪ Monitored and documented mental status in one (100%). The Monitoring Team noted numerous refusals by the Individuals to allow the nurse to complete the required monitoring. In the future, if an individual frequently refuses to allow the nurses to complete the required monitoring, this may indicate a need to do something different with the PBSP, skill acquisition plan, or safety plan. Sample C.2 included files for two medical restraints. Neither file was well organized making it difficult for the Monitoring Team to assess compliance. Files prepared by the Facility for review of these 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), ISP 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,	

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		and any other information the Facility felt would be helpful in understanding the circumstances associated with the restraint use to establish SA compliance. One (50%) file contained documentation of physician specified type of monitoring or schedule for monitoring. This consisted of a note accompanying the physician order which read "monitoring as per nursing protocol." It should be noted that DADS has an SSLC Nursing Protocol: Pretreatment and Post-Sedation Monitoring (February 2011) to serve as a guide to facility nurses.	
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 in substantial compliance with this provision of the Settlement Agreement (SA). The Facility's Plan of Improvement (POI) did not report any rationale for its determination of compliance. The Monitoring Team determined this provision is in substantial compliance with the SA. Sample C.1 of 24 crisis intervention 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: • In 22(92%), continuous one-to-one supervision was documented. Those that did not included Individual #381on 9/13/11 and again on 10/12/11. • In 24 (100%), the date and time restraint was begun was documented; • In 24 (100%), the location of the restraint was documented; • In 22 (92%), information about what happened before, including the change in the behavior that led to the use of restraint was documented. The two that did not included Individuals #403 and #181. In each case, in the section of the RC asking to "describe the events leading to behavior that resulted in restraint" the entry merely states "was given a chemical restraint." More information is 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; • In 22 (92%), the interventions taken by staff prior to the use of restraint were documented and are adequate for post restraint review. Documentation of staff intervention for the two chemical restraints described above was incomplete. • In 24(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. • In 23(96%), the names of staff involved in the restraint episode were	Substantial Compliance

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		indicated on the restraint checklist. There was no entry on the RC for Individual #425. • 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. Only one exceeded 15 minutes. 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. • In 23(96%), the level of supervision provided during the restraint episode was recorded on the restraint checklist. The restraint of Individual #381 on 9/13 did not record level of supervision. • In 24 (100%), the date and time the individual was released from restraint was recorded on the restraint checklist. In 18 of 24 (67%), 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 Individuals #185, # 425, #381, #181(2x), and #11. In 22 of 24 (92%) the FFAD restraint debriefing forms were present. This was not the case for Individuals #173 (10/31) and #381 (9/13). 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	

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		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? The files produced pursuant to Sample C.1 included this facility specific restraint review process in 23 of 24 (96%) files.	
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:	According to Facility documentation, during the six-month period prior to the on-site review, a total of seven individuals were placed in restraint more than three times in any rolling thirty-day period. A sample of seven of these individuals (100%) was selected for review to determine if the requirements of the Settlement Agreement were met. The following documents were reviewed • PSPs, • PST addenda, • PBSPs, • PBSP progress notes, • Restraint documentation • Psychological Evaluations and Updates The results of this review are discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement. For two of the individuals/instances reviewed (29%), the individuals' teams met to discuss the restraints.	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	For two of the individuals/instances reviewed (29%), individuals' teams reviewed the individual's adaptive skills, as well as biological, medical and psychosocial factors. The following is an example of an individual for whom this was done appropriately: • For Individual #173, a review of restraint applications was conducted on 8/17/2011. During this review, the IDT identified agitation and fear due to an upcoming ear exam as the probable reason for the need to apply restraints. The following are examples of where teams failed to do this adequately: • For individuals #11, #38, #185, #381, and #490, the record did not reflect any review by the IDT of the individual's adaptive skills and biological, medical, psychosocial factors.	Noncompliance

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		• On 9/15/2011, the IDT reviewed restraint applications for Individual #181. The results of this review suggested that the behavior resulting in restraint was likely due in part to psychosocial factors including the failure of the individual's mother to visit as scheduled. While this indicated a review of psychosocial factors, the documented review process did not address the additional areas in this Provision: Adaptive skills and biological factors.	
	(b) review possibly contributing environmental conditions;	For three of the individuals/instances reviewed (43%), individuals' teams reviewed the possibly contributing environmental conditions. The following are examples of individuals for whom this was done appropriately: • On 9/15/2011, the IDT reviewed restraint applications for Individual #181. The results of this review suggested that the behavior resulting in restraint was likely due in part to environmental factors including the crowding of the immediate environment. The following are examples of where teams failed to do this adequately: • For individuals #11, #38, #381, and #490, the record did not reflect any review by the IDT of the environmental conditions.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	For two of the individuals/instances reviewed (29%), individuals' teams reviewed and/or performed structural assessments of the behavior provoking restraints. The following are examples of individuals for whom this was done appropriately: • On 9/15/2011, the IDT reviewed restraint applications for Individual #181. The results of this review suggested that the behavior resulting in restraint was likely due in part to a history of reinforcement for similar behaviors. The following are examples of where teams failed to do this adequately: • For individuals #11, #38, #185, #381, and #490, the record did not reflect any review by the IDT of the structural assessments of the behavior provoking restraints.	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	For two of the individuals/instances reviewed (29%), individuals' teams reviewed and/or performed functional assessments of the behavior provoking restraints. The following are examples of individuals for whom this was done appropriately: • On 9/15/2011, the IDT reviewed restraint applications for Individual #181. The results of this review suggested that the behavior resulting in restraint was likely due in part to a history of reinforcement for similar behaviors. The following are examples of where teams failed to do this adequately: • For individuals #11, #38, #185, #381, and #490, the record did not reflect any	Noncompliance

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		review by the IDT of the functional assessments of the behavior provoking restraints.	
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	For seven of the individuals reviewed (100%), the individual had a PBSP. Of the seven individuals in the sample who had PBSPs, the following was found: • Five (71%) were based on the individual's strengths; • Seven (100%) specified the objectively defined behavior to be treated that led to the use of the restraint; • 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; and • Four (57%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. The following are examples of individuals for whom adequate PBSPs were in place: • Individuals #173, #181, #490 had PBSPs in place that included the components identified as necessary in Provision C7. The following are examples of individuals had inadequate PBSPs: • For Individual #185, the SFA available in the record was dated 10/10/2010 and did not address issues pertinent to the current use of restraint, such as behavioral responses to unexpected changes in routine or the failure of anticipated events to occur as scheduled. Furthermore, although the individual was diagnosed with a mental illness, the SFA did not reflect the assessment of behavioral aspects of the mental illness. Due to these limitations in the SFA, the PBSP was not based upon a full understanding of the individual, and strategies were not provided to address those circumstances. • For Individual #381, the record did not include a current SFA. Approval forms were noted in the record for an Analog Functional Analysis, but the findings of such an analysis were not included. As a result, the PBSP lacked the evidentiary support for effective intervention. The Safety Plans of the individuals in the sample were reviewed. The following represents the results: • In six out of seven of the Safety Plans reviewed (86%), the type of restraint authorized was delineated; • In six (86%), the maximum duration of restraint authorized was specified; • In six (86%), the designated approved restraint situation was specified; and • In six (10086%), the criteria for terminating the use of the restraint were specified.	Noncompliance

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		• Individual #185 did not have a Safety Plan in the record.	
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	For none of the individuals reviewed (0%), the individual's IDT reviewed the behavioral data and/or treatment integrity checks to determine that the PBSP was implemented with a high level of treatment integrity in relation to the application of restraint.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	In none of the records reviewed (0%), there was documentation that the individual's PBSP had been revised as appropriate. The following are examples of where teams failed to do this adequately: • During a review on 11/2/2011 of restraint involving Individual #173, the IDT indicated that the PBSP was effective and required no revision. During the same review, however, the IDT also agreed with the decision to require a helmet for self-injurious behavior. At a minimum, the PBSP would require revision to address the use of on-going restraint. The IDT also agreed with the decision to increase antipsychotic medication to address aggression and self-injury. As self-injury and aggression were not identified as symptoms of mental illness through comprehensive assessment, the increase in psychotropic medication suggests ineffective use of behavioral strategies.	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 Facility's Plan of Improvement (POI) did not report any rationale for its determination of compliance. The Monitoring Team does not concur with the Facility's self-assessment of compliance. Documentation provided did not validate the completion of restraint review specified in both DADS and BSSLC policy which require each instance of restraint to be reviewed in the unit morning meeting and in the facility-wide incident review meeting. In the last review the Monitoring Team determined this provision to be in Substantial Compliance because the documentation provided by the Facility demonstrated and documented both review at the Unit morning meeting and the facility-wide incident review meeting. As described by Facility staff, and in policy, there were many meetings held at the facility to address restraint incidents, including PST meetings for individuals involved in restraints, Restraint Reduction Committee meetings, Incident Management Review Team Meeting (IMRT) meetings, Daily Unit meetings, and Human Rights Committee (HRC)	Noncompliance

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		meetings. Restraint incidents were also referred to the IDT for follow-up. IDTs met following restraint incidents to review restraints. As reported in Provision C7, IDTs did not revise PBSPs for individuals who were restrained more than three times in a rolling 30-day period. Documentation to validate many of these processes was not presented to the Monitoring Team. The RC includes a data item for recording the date of Unit Review. The FFAD includes a data item for recording the date of the Unit Review and the date of the IMRT review. Referring to Sample C.1 (crisis intervention restraints) three of 24 RCs (13%) recorded the date of Unit Review. Four of 24 (16%) of FFADs recorded the date of Unit Review and none (0%) recorded the date of IMRT review. No other documentation, such as unit meeting minutes or IMRT meeting minutes was provided to document this requirement. Last review the documentation provided to the Monitoring Team showed a high level of compliance with this review requirement. It is possible that reviews occurred as called for but were not recorded on the RC or FFAD. The Monitoring Team must make compliance decisions from evidence presented by the Facility. None of the Restraint Review forms in the sample addressed errors or incorrect procedures in documentation, application, or monitoring of the restraint. All restraints should be reviewed within three days of the restraint and documentation should reflect corrective action to be taken when errors are found in documentation or implementation. 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. Much of the discussion was anecdotal with little evidence-based plans to investigate any 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)
5. Improve accuracy of restraint documentation (Provisions C.1 and C.2)

6. Ensure all requirements of the SA are reflected in policy and practice and are sufficiently documented (Provisions C.2, C.5, and C.8)
7. Ensure training and behavior programs are implemented routinely and consistently to ensure restraint use is clinically justified (Provisions C.4 and C.7)
8. Ensure all required staff training occurs (Provision C.3)

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 Plan of Improvement (POI) 12/30/11 2. BSSLC Presentation Book (undated) 3. DADS Policy 021 – Protection From Harm – Abuse, Neglect, and Exploitation (5/11/11) 4. DADS Policy 023 Incident Management dated (1/31/11) 5. BSSLC Policy Protection from Harm-Abuse, Neglect, and Incident Management (4/14/11) 6. BSSLC Draft Policy D2: Maintaining and Providing ANE Resource Guide (12/30/11) 7. BSSLC Draft Policy D3: Participating in and Completing Incident Management UIR Committee (12/30/11) 8. BSSLC Draft Policy DD2: Injury Reporting – Semi-Annual Under Reporting Audits (12/30/11) 9. Form 1020 for 25 employees 10. Your Rights and Zero Tolerance posters 11. Training materials used by BSSLC Abuse/Neglect classes 10/1/07 and 5/12/11 12. Abuse/Neglect/Exploitation Competency Exam dated 4/18/11 13. Log of Department of Family and Protective Services (DFPS) cases 8/1/11 to 12/12/11 14. Data Report prepared by the BSSLC summarizing Abuse & Neglect allegations, and case disposition, from 7/1/11 to 12/31/11 15. Log of Office of Inspector General (OIG) cases 8/1/11 to 12/14/11 16. Log of serious injuries 8/1/11 to 1/16/12 17. Log of serious incidents 8/1/11 to 1/16/12 18. Log of witnessed injuries 8/1/11 to 1/16/12 19. Log of discovered injuries 8/1/11 to 1/16/12 20. List of discovered injuries whose cause remained unknown after investigation 1/18/12 21. DFPS investigation reports and related materials selected for Sample D.1: 40685598, 40660170, 40572497, 40554397, 40538666, 40393696, 40387696, 40332085, 40305938, and 40297924 22. Other DFPS case reports: 40250564, 40286111, 40449238, 40291687, 40259917, 40277833, 40646817, 40287717, 40392223, 40304160, and 40210273 23. BSSLC investigations selected for Sample D.2: UIRs 11-257, 12-003, 12-025, and 12-028 24. Other BSSLC investigations: UIRs 11-258, 12-094, 12-038 25. BSSLC Investigator Recommendation Log 1/12/12 26. List of employees placed in No Direct Contact (NDC) status 8/1/11 to 12/13/11 27. OIG Case reports: UIR 12-058, 12-054, 12-055, and 12-014 28. Incident Management Team meeting minutes 1/13/12 and 1/16/12 29. List of the ten most injured individuals since the last review 12/13/11 30. List of peers who caused the most injuries since the last review 12/13/11 31. BSSLC Unusual Incident Reports Trend Report 12/31/11 32. BSSLC Abuse, Neglect, Exploitation Trend Report 12/31/11

	33. BSSLC Injury Trend Report 12/31/11 34. Training transcripts for Facility Investigators 35. Training transcripts for DFPS Investigators 36. Minutes of DFPS/OIG/BSSLC meetings 8/11/11 and 11/16/11 37. Minutes of Self-Advocacy group 8/29/11, 9/19/11, 10/24/11, 10/31/11, 11/21/11, and 11/28/11 38. List of BSSLC employees 12/8/11 39. DADS spreadsheet documenting background checks 12/22/11 40. DADS report MHMR0102 Percent of All Employees Completing Course of Training 12/9/11 41. Course/Due Delinquent reports for ABU0100 and UNU011 12/8/11 **People Interviewed:** 1. Natalie Montalvo, Facility Director 2. Kim Littleton, Assistant Director of Programs 3. Daniel Dickson, Quality Assurance (QA) Director 4. Michael Appling, Incident Management Coordinator **Meetings Attended/Observations**: 1. Facility Incident Management Team meeting 1/16/12 2. Driscoll Unit Incident Management Team meeting 1/19/12 3. QA/QI Council meeting 1/18/12 4. Restraint Reduction Committee meeting 1/19/12 5. Meeting with nine direct care staff 1/19/12
	Facility Self-Assessment: The BSSLC Plan of Improvement reported substantial compliance with three (D.1, D.4 and D.5) of the five provisions of Section D of the Settlement Agreement (SA). The Monitoring Team determined substantial compliance with these same three provisions. 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. The Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. Therefore, the Monitoring Team cannot assess the adequacy of the self-assessment process in place at the BSSLC.
	Summary of Monitor's Assessment: To achieve full compliance with Section D of the Settlement Agreement the Facility needs to achieve compliance with only five addition components of two provisions. These are D2.a, D2.e, D2.i, D3.e, and D3.f. Unfortunately, the Facility had not experienced observable movement towards compliance in these five components since the last review. This is most likely the result of staff changes. The Facility has a new Incident Management Coordinator (IMC) and he has a new supervisor, the new Quality Assurance Director. Additionally the Facility has two new investigators. The processes 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. Recommendations are tracked and recording in a database until satisfactory evidence is provided to the IMC and reviewed by the Incident Management

	Review Team. The scope of the tracking and trending of incidents has been expanded. The process, and related documentation, of Facility investigations of serious discovered injuries needs improvement in order to be compliant with the Settlement Agreement. The process of reviewing investigations of non-serious discovered injuries to rule out abuse and neglect needs enhancement. At the time of the review BSSLC presented three draft policies directed at SA compliance issues. These were: policy D2 Maintaining and Providing ANE Resource Guide, policy D.3 Participating in and Completing Incident Management UIR Committee, and policy DD2: Injury Reporting – Semi-Annual Under Reporting Audits. Subsequent to the onsite review all three draft policies were formally approved with an implementation date of February 8, 2012.

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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 Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. 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. The Monitoring Team met with nine direct care staff, five from the day shift and four from the afternoon shift. They were asked to complete the same five question Abuse/Neglect test they complete in training. Three answered all five questions correctly, three answered four questions correctly, and three answered three questions correctly. This was an overall aggregate score of 82% correct. This indicates a need for ongoing and continued "on-the-spot" competency testing to ensure staff retains the key requirements of abuse/neglect reporting.	Substantial Compliance

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D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:	BSSLC Policy Protection from Harm-Abuse, Neglect, and Incident Management dated 4/14/11 governs this provision of the Settlement Agreement (SA).	
	(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. The Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. 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. The new QA Director, in a presentation to the QA/QI Council on 1/18/12, reported that a process to review and update key facility policies had been initiated. The Monitoring Team looks forward to reviewing outcomes associated with this initiative. From a response to a document request asking for the total number of abuse allegations and disposition/status for the six month period from 7/1/11 through 12/31/11, the following data were provided by the Facility: Total Number of Abuse Allegations: 153 Substantiated 4 Unsubstantiated 82 Inconclusive 3 Administrative Referral 28 Disposition Pending 36	Noncompliance

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		Total Number of Neglect Allegations: 29 Substantiated 4 Unsubstantiated 4 Inconclusive 0 Administrative Referral 15 Disposition Pending 6 Total Number of Exploitation Allegations: 1 which was determined to be unfounded. BSSLC provided a log of serious injuries during the period from 8/1/11 to 12/13/11, essentially a 4.5-month period. From this report the Monitoring Team was able to determine the BSSLC had 19 serious injuries during this time period. This is an average of 4.2 per month, a decrease from the 6.2 serious injuries per month noted in the last review. Two samples of investigations were selected for review by the Monitoring Team. These included: • Sample D.1: DFPS Investigations. A sample of 10 (20% of the investigations from 8/1/11 to 12/13/11) investigations was selected from the list of DFPS cases provided by the Facility. This list included cases from the last review to 12/14/11. This sample included the following DFPS cases: 40685598, 40660170, 40572497, 40554397, 40538666, 40393696, 40387696, 40332085, 40305938, and 40297924. These 10 cases included six cases of unconfirmed abuse, one case of confirmed physical abuse and neglect, and three cases of physical abuse determined to be unfounded. • Sample D.2: Facility Investigations. A sample of four investigations (20%) was selected from the facility log of serious injuries. All were discovered injuries. The sample consisted of the following UIRs: 11-257, 12-003, 12-025, and 12-028. Based on a review of the 10 investigation reports included in Sample D.1, nine (90%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by Facility policy. The one that did not include such evidence was DFPS case 40660170. The DFPS investigation report notes this incident occurred on 7/22/11 and was reported to DFPS on 11/22/11. From the documentation provided it is not clear if the facility reported the allegation on 11/22/11 or if it was reported to DFPS by the individual's mother (or someone else) on 7/22/11 and was mislabeled by DFPS. Notations in the case report state "All notifications were late due to the fact SWI did not call out to the router until 4pm", and, "priority was changed by DFPS supervisor…on 11/22/11." From the documentation provided it appears no investigatory activity took place between 7/22 and 11/22.	

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		Serious injuries are not always reported to the Facility Director according to policy (within one hour). In reviewing the four serious injuries in Sample D.2 three (75%) were not reported timely, including: • UIR 11-257: an individual was sent to the hospital emergency room on 8/21 at 10am with a suspected fracture. This was not reported to the Facility Director until the next day. The injury report provided to the Monitoring Team did not report a severity determination as required by policy. • UIR 12-003: This injury occurred on 8/15 and was not reported until 9/2. The physician examined the individual on 9/2 at 9:50am. The Facility Director notification occurred at 6:35pm. The injury report provided to the Monitoring Team did not report a severity determination as required by policy. • UIR 12-028: This injury occurred on 10/4 and involved two lacerations. The physician examined the individual on 10/5 at 11:05am. The Facility Director notification occurred at 5:45pm. The injury report provided to the Monitoring Team did not report a severity determination as required by policy. The Facility had a standardized reporting format, the Unusual Incident Report (UIR). Based on a review of 14 investigation reports included in Sample D.1 and Sample D.2, 14 (100%) contained a copy of the report utilizing the required standardized format. An additional element of properly reporting allegations of abuse and neglect is the investigation of non-serious discovered injuries. These investigations are conducted to determine, among other things, whether abuse and neglect can be ruled out as a cause, or a contributing factor, of the injury. The Monitoring Team reviewed the forms used by the Facility to accomplish this review including: 1) Client Injury Report, 2) Client Injury Report Dept IR Team Review and Followup, 3) Discovered Client Injury Initial Investigation Checklist, 4) Discovered Client Injury Secondary Investigation, and 5) Probable Cause and Contributing Factors. These forms, along with witness statements, comprise what the Facility refers to as "injury packets." Injury packets do not undergo any formal review outside the residential unit from which they originate. In order to ensure non-serious discovered injuries are adequately reviewed to rule out abuse/neglect some type of review, external to the residential unit, should occur. Through the course of reviewing investigations the Monitoring Team noted that the video surveillance cameras have been helpful in ascertaining the facts associated with many allegations. The Facility had not experienced observable movement towards compliance in this and other provision components noted as in noncompliance in the last review. This is most	

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		likely the result of staff changes. The Facility has a new Incident Management Coordinator (IMC) and he has a new supervisor, the new Quality Assurance Director.	
	(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. The Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. 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 10 investigation reports in Sample D.1, alleged perpetrators (AP) were identified in all 10 investigations. Documentation shows that the alleged perpetrators were placed in non-direct care (NDC) status in each case; however, in four (40%) of these 10 investigations the Monitoring Team could not validate placement in NDC was timely. In case 40305938 and 40297924 the UIR did not note the time the staff person was placed in NDC status. For case 40393696, the date and time of the incident is reported as unknown, it was reported at 5:12pm, and the UIR reports an alleged perpetrator was placed on NDC at 4:25pm. This brings into question what time the incident was found and whether it was reported within one hour of discovery or allegation, as there is no way to determine whether the times are correct or how long before the AP was placed on NDC the incident was discovered. Data that on its face appears inconsistent should be explained in the UIR. For case 40660170 the Facility Director was notified of the allegation at 4:05pm. The alleged perpetrator was not placed in NDC status until 6:45pm. 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.	Substantial Compliance

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		In reviewing the 10 investigations in Sample D.1, there were not any instances in which 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. Based on a review of the 10 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 was done, and environmental conditions that could have created a safety hazard for other individuals were corrected. The Monitoring Team has determined this component to be in substantial compliance based on the evidence that alleged perpetrators were removed from direct contact and that action was taken to protect individuals; however, the Facility, through its review of DFPS reports and UIRs, should be more thorough in identifying data discrepancies such as those noted by the Monitoring Team.	
	(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. The Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. 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 24 (96%) of these staff had completed competency-based training on abuse and neglect and 23 (92%) had completed unusual incidents within the last 12 months.	Substantial Compliance

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		The Monitoring Team also reviewed DADS report MHMR0102 Percent of All Employees Completing Course of Training which reported a 100% completion rate for ABU0100 and a 98% completion rate for UNU0100. As an additional check of staff knowledge with respect to abuse/neglect, the Monitoring Team met with nine direct care staff, five from the day shift and four from the afternoon shift. They were asked to complete the same five question Abuse/Neglect test they complete in training. Three answered all five questions correctly, three answered four questions correctly, and three answered three questions correctly. This was an overall aggregate score of 82% correct. This indicates a need for ongoing and continued "on-the-spot" competency testing to ensure staff retains the key requirements of abuse/neglect reporting.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	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 Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. The BSSLC policy titled Protection from Harm – Abuse, Neglect, and Incident 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, 100% of staff hired during this time period had signed the DADS required acknowledgement form 1020. This is the form required by DADS policy to document compliance with this component of the SA. 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 did not report any instances of late reporting.	Substantial Compliance
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing	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. The Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance.	Noncompliance

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	involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	BSSLC engages in very limited activity directed at this component of the SA. To respond to this component of the SA the Facility has a draft policy entitled "Maintaining and Providing ANE Resource Guide." This draft describes a process directed at achieving compliance and includes a QA process to ensure intended activity occurs. The Facility had not experienced observable movement towards compliance in this and other provision components noted as in noncompliance in the last review. This is most likely the result of staff changes. The Facility has a new Incident Management Coordinator (IMC) and he has a new supervisor, the new Quality Assurance Director. The Monitoring Team looks forward to assessing progress at its next review.	
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	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 Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. A review was completed of the postings used at the Facility. 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.	Substantial Compliance
	(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 Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. 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 10 investigations completed by DFPS (Sample #D.1) DFPS had made law enforcement referrals in each case. It appears that the practice of the DFPS office servicing the BSSLC is to report every allegation to law enforcement, in this case the Office of Inspector General (OIG). Based on a review of four investigations completed by the Facility (Sample #D.2), law enforcement referral was not necessary or appropriate given the nature of the incident being investigated and the facts discovered during the course of the BSSLC investigation.	Substantial Compliance

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	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	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 Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. 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 V of the policy. Based on interviews with the Facility staff 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. 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.	Substantial Compliance
	(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. The Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. The Facility reported it had not as yet initiated any formal activity to address this component of the SA but had developed a draft policy entitled "Injury Reporting Semi-Annual Under Reporting Audits. This draft describes a process directed at achieving compliance and includes a QA process to ensure intended activity occurs. The Facility had not experienced observable movement towards compliance in this and other provision components noted as in noncompliance in the last review. The Monitoring Team looks forward to assessing progress at its next review.	Noncompliance
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and	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 Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance.	

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	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 Policy Protection from Harm-Abuse, Neglect, and Incident Management dated4/14/11 governs this provision of the Settlement Agreement (SA).	
	(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. The Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. 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 reviewed current material used by DFPS in training its investigators. The required class "MH&MR Investigations ILSD" consisted of the following modules: 1. Introduction and History of DFPS, APS, DADS, and DSHS 2. Laws, Rules, & Policies Governing APS MH&MR Investigations 3. Dynamics of Abuse, Neglect, and Exploitation 4. Psychiatric Terms 5. Client Rights 6. Prevention and Management of Aggressive Behavior 7. Evidence Collection 8. Basic Interviewing 9. Interviewing Persons with Developmental Disabilities 10. MH&MR IMPACT Technical Guide 11. Analysis of Evidence 12. Effective Writing 13. Disposition of Cases The required class MH&MR Investigations ILASD included the following modules: 1. Cross-Cultural Interviewing 2. Strengthening the Written Report 3. Deception and Confrontation of Deception	Substantial Compliance

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		4. Time and Stress Management In reviewing the materials associated with these modules, and in consideration that DFPS case investigations reviewed by the Monitoring Team were generally thorough and comprehensive and case reports were generally well written, the Monitoring Team is of the opinion that this training is competency-based and is 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 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 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.	

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	(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. The Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. 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. 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 10 of 10 investigations (100%), Facility staff cooperated with DFPS investigators.	Substantial Compliance
	(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 Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. 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."	Substantial Compliance

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		Review of the investigation files in Sample D.1 showed no indication of interference by one agency or the other in 10 of 10 investigations (100%).	
	(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. The Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. 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 (Sample D.1) and the Facility (Sample D.2) no issues related to the storage or integrity of evidence was noted. Additionally, the OIG 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.	Substantial Compliance
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	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. The Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. 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> DFPS had modified its report format to more clearly summarize investigatory activity undertaken by DFPS within 24 hours of an allegation being reported. Typical activity reported in case reports included telephone contact with the Facility's Incident Management Coordinator or Campus Coordinator to ensure the Individual who is the subject of the report is safe (and if injured has received appropriate medical care), that any known APs were placed in NDC status, the identification of any collateral witnesses, that the Facility has (or is) gathering all relevant documentation, that any physical evidence is secure, a determination if there is likely video surveillance evidence to review, and the development and review of a preliminary investigation plan. Eight (80%)	Noncompliance

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		of the ten cases in Sample D.1 documented these type of activities took place within the first 24 hours. The two that did not were cases 40332085 (allegation reported 10/18/11) and 40660170 (allegation reported 11/22/11). The Monitoring Team suggests that an additional measure to assess whether or not an investigation commenced within 24 hours of an incident being reported is to assess the date/time of the first substantive interview, which most typically would be of the reporter, a staff person, or an individual who can share information that is believed to be reliable. Only one (10%) of 10 cases in Sample D.1 met this criterion. This was case 40572497. Onsite interviews of collateral witnesses' and APs often do not begin until 5-10 days after the report of an incident. This is somewhat less of a concern in instances where the events surrounding an incident are recorded by the video surveillance cameras, although this surveillance does not record audio. Although other substantive investigatory activities can serve to establish initiation of an investigation, there are also cases in which outcomes of investigations may be affected by time lags before interviews are held. Efforts should be made within the first 24 hours to determine the importance to the investigatory process of face-to-face interviews with collateral witnesses and APs and to schedule those deemed high priority at the earliest possible time. Seven of the 10 (70%) investigations were completed within 10 calendar days of the incident. Those that were not contained a written Extension Request Form noting supervisor approval. In two cases the extension was requested because witnesses need to be re-interviewed. In the third case the extension was requested because new witnesses were identified. It is unclear if these reasons represent "extraordinary circumstances" as required by the SA. It is possible that if interviews had started earlier in the 10 day time period re-interviews could also have occurred within the 10 day time period. In case 40538666 the first witness interview occurred on day seven. In case 40554397 the first witness interview occurred on day five. All 14 (100%) investigations in Sample D.1 and D.2 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 four 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:	

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		In reviewing Sample D.2 (four serious injuries) the information in the UIR was insufficient to determine that the investigation began within 24 hours of the incident in all four (100%) investigations. The UIRs 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 typically 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. Note: the observations noted above were included in the last report by the Monitoring Team. It was apparent that no change in practice had occurred since the last review. Facility investigations are usually not completed within 10 calendar days of the incident. Three of four (75%) in the sample were not within 10 calendar days of the incident, including sign-off by the supervisor. Those that were not included UIRs 11-257, 12-003, and 12-028. Four of four (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 four (100%) of the investigations reviewed, recommendations for corrective action were included. In all four of the investigations (100%), the recommendations appeared adequate to address the findings of the investigation.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each	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. The Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. This component was rated noncompliance in the last review. Measures to correct the deficient practices noted in the last report had not been initiated. The following is taken from the previous report which describes these deficiencies:	Noncompliance

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	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.	"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 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." 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 below, and findings related to DFPS	

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		investigations and Facility investigations are discussed separately. DFPS Investigations The following summarizes the results of the review of DFPS investigations: ▪ In 10 of 10 investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. ▪ The DFPS case report utilized a standardized format that set forth explicitly and separately o In 10 (100%), each serious incident or allegations of wrongdoing; o In 10 (100%), the name(s) of all witnesses; o In 10 (100%), the name(s) of all alleged victims and perpetrators; o In 10 (100%), the names of all persons interviewed during the investigation; o In 10 (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 10 (100%), all documents reviewed during the investigation; o In 10 (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 10 (100%), the investigator's findings; and o In 10 (100%), the investigator's reasons for his/her conclusions. Facility Investigations The following summarizes the results of the review of Facility investigations: ▪ In four of four investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion; however, it is noted that none of the investigations included witness interviews by an investigator which, had they occurred, may have provided additional information and insight that could have led to different conclusions. ▪ The report utilized a standardized format that set forth explicitly and separately o In four(100%), each serious incident or allegations of wrongdoing; o In five (100%), the name(s) of all witnesses; 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 four(100%), all documents reviewed during the investigation; o In four (100%), all sources of evidence considered, including previous	

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		investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency o In four (100%), the investigator's findings; and o In four (100%), the investigator's reasons for his/her conclusions.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	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 Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. 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 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: ▪ Ten of 10 (100%) case files reviewed contained evidence that the DFPS supervisor had conducted a review of the investigation report. ▪ Ten of 10(100%) case files, contained evidence that the BSSLC Abuse/Neglect/Exploitation Review 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 four (100%) investigation files there was evidence that the supervisor had conducted a review of the investigation report. ▪ In all four (100%) there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. In the last report the Monitoring Team recommended that the Facility should consider including Facility investigations of discovered serious injuries within the scope of administrative review conducted by the Abuse/Neglect/Exploitation Review Committee. The Monitoring Team would like to reiterate this recommendation.	Substantial Compliance

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		To respond to this component of the SA the Facility had a draft policy entitled "Participating in and Completing Incident Management UIR Committee" This draft describes a process directed at achieving continued SA compliance.	
	(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. The Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. 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. The Facility had a process in place to record and track its recommendations to ensure they are acted upon.	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. The Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. 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. The IMC maintains a "BSSLC Investigator Recommendation Log" which tracks all recommendations through completion, including submittal to the IMC of evidence of completion. 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	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	Substantial Compliance

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	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.	Team concurs. The Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. 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.	
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 in substantial compliance with this provision of the Settlement Agreement (SA). The Monitoring Team concurs. While this provision is in substantial compliance there are many opportunities to improve the tracking and trending beyond that required in the SA. These are described below. The Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. 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. 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 numbers. 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	Substantial Compliance

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		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.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	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 Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. 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 history. A random sample of 25 employees confirmed that their background checks were completed. The information obtained about volunteers was similarly reviewed. 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. 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.	Substantial Compliance

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		In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. Posters reminding employees of this obligation were displayed throughout the Facility.	

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.

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, consider thoroughly the possibility for abuse and neglect being a causal factor (including review of appearance and recent frequency of injuries) 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 Plan of Improvement (POI) 12/30/11 2. DADS Policy 003 Quality Assurance 11/13/09 3. BSSLC Policy Quality Assurance Process 11/22/10 4. BSSLC Policy Quality Assurance/Quality Improvement Council (9/30/10) 5. BSSLC Quality Enhancement Plan (untitled and undated) 6. BSSLC Draft Policy E.2 – Quality Assurance Measuring Trends 12/30/11 7. Quality Assurance/Quality Improvement (QA/QI) Council meeting minutes 9/7/11, 9/15/11, 9/20/11, 11/16/11, 12/8/11, 12/21/11and 1/4/12 8. QA/QI meeting agenda and meeting handouts 1/18/12 9. Facility Trend Reports 12/31/11 10. Monitoring tools and related reports currently in use by the QA department **People Interviewed:** 1. Daniel Dickson, QA Director 2. Kim Littleton, Assistant Director of Programs **Meetings Attended/Observations**: 1. QA/QI Council meeting 1/18/12
	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 Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. Therefore, the Monitoring Team could not assess the adequacy of the self-assessment process in place at the BSSLC. When interviewed the new QA Director reported that the Facility was "just getting started" in getting QA activity organized in a manner which would lead to SA compliance.
	Summary of Monitor's Assessment: When interviewed the new QA Director reported that the Facility was "just getting started" in getting QA activity organized in a manner which would lead to SA compliance. The new QA Director served as the QA Director at another State Supported Living Center, is familiar with the QA requirements of the SA, and had developed compliance related systems at that facility. New policies, plans, and processes were in various stages of development and are described in Section E.1. Assurances were provided to the Monitoring Team that significant development of QA systems would be apparent at the next review. The Monitoring Team looks forward to reviewing substantial progress at its next review. Because no improvement from that observed at the last monitoring review had taken place the observations noted in the last report remain relevant, including: ▪ BSSLC tracks most data required in the SA although the integrity of those data was not always clear.

	▪ BSSLC produces the following monthly trend reports: o Abuse/Neglect/Exploitation Trend Report o Facility Restraint Trend Report o Facility Injury Trend Report o Facility UIR Monthly Trend Report ▪ 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.

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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 Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. According to the new QA Director the Facility was "just getting started" in getting QA activity organized in a manner which would lead to SA compliance. Consequently there was little substantive information/data presented to the Monitoring Team for review. The new QA Director served as the QA Director at another State Supported Living Center, is familiar with the QA requirements of the SA and had developed compliance related systems at that facility. Assurances were provided to the Monitoring Team that significant development of QA systems would be apparent at the next review. The QA Director reported on several recent initiatives including: • Revising the QA Plan to include two levels of inter-rater reliability formats to begin validating monitoring data. • The facility QA/QI Council meeting format had been revised to include two monthly meetings. The first of the monthly meetings would focus on data review and analysis. This would consist of: the QA department sends out the prior month's data collection results with data reports and trend analysis summaries. The section leads would prepare discussion topics and draft corrective action plans based on the data reports. The QA/QI Council would discuss, review, and approve corrective action plans. The Facility has also revised the QA/QI minutes to reflect these changes. The second meeting each month would focus on information sharing. This new process was not yet in place at the time of the review. • The Facility had developed a draft policy and procedure for the development of Corrective Action Plans to address problematic trends that arises from the various systemic monitoring processes. • The Facility had developed a draft policy and procedure to measure trends across all areas of care as identified in the POI. This draft policy is awaiting	Noncompliance

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		executive approval. • A tracking system that allows for the identification of issues across all components of protections, supports and services for the individuals at the Facility was in the developmental stage. • A reporting system and procedure for use with reporting trends both monthly and quarterly to provide analysis of issues identified from trends to the QA/QI Council was in the developmental stage. • The development of quality indicators of all quality assurance data to determine trends/issues to ensure there is sufficient tracking and development of corrective action plans had started. The Monitoring Team looks forward to reviewing progress resulting from these initiatives at its next review. Trend Reports required by DADS were prepared including: • Abuse/Neglect/Exploitation Trend Report • Facility Restraint Trend Report • Facility Injury Trend Report • Facility UIR Monthly Trend Report Issues related to the content of these reports that were noted in the last review by the Monitoring Team remain, for the most part, unaddressed. For example, the integrity of data on reports was not always clear. As noted in the last Monitoring Team report, 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 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. 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. The BSSLC also had an informal Quality Enhancement Plan which delineated the monitoring/audit tools used at the Facility, the frequency of review, sample sizes, and other relevant information necessary for carrying out QA activity. Much of the plan had not yet been implemented and the components that had did not result in substantive analysis and review leading to decision-making.	

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		As noted in the last report by the Monitoring Team, in some areas the reporting of trend data could be expanded to be more 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. It is important that the review of Trend Reports include not just a presentation of numbers but also analysis that leads to organizational understanding and performance improvement. Another example noted in the last report by the Monitoring Team and merits reiteration is the trend report for UIRs. This report 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 be many other topics that an inquisitive Quality Assurance/Quality Committee 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. The Monitoring Team looks forward to reviewing substantial progress at its next review.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	The BSSLC in its POI reported it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. The Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. A Quality Assurance process, and Corrective Action planning, should consist 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 (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.	Noncompliance

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		At the time of this review very limited activity was occurring related to the first point. Activity that was occurring was primarily in the incident management program, records audits, and nursing department. No activity related to the second point was detected by the Monitoring Team. As discussed in E.1 QA activity sufficient to address SA requirements is "just getting started." Because of the lack of the QA Director position being filled the Monitoring Team did not observe any appreciable improvement in processes and practices than that observed six months earlier although significant improvement initiatives were underway. The QA/QI Council, as observed by the Monitoring Team and confirmed by review of the minutes, was primarily a forum for presenting and sharing information. 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. The Monitoring Team looks forward to reviewing substantial progress at its next review.	
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. The Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. Per interview, the Monitoring Team determined that the BSSLC did not as yet have a Facility-based organized and uniform system for the development, assignment and dissemination, implementation, and tracking of corrective action plans. Exceptions were the follow-up tracking that is a part of the Incident Management Review Team process and QA activity within the nursing department. The Monitoring Team looks forward to reviewing substantial progress at its next review.	Noncompliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	The BSSLC in its POI reported it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. The Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. Refer to Provisions E.1, E.2, and E.3. As noted there was insufficient information presented to the Monitoring Team to assess compliance with this provision of the SA. With respect to action plans emanating from investigations the IMC and IMRT tracked	Noncompliance

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		completion, including the presentation and review of evidence of completion for each planned action. There did not appear to be any work activity directed at ensuring the plans met the desired outcome of remedying or reducing the problems originally identified, for example, analysis that indicated the same issues were not continually reappearing. The Monitoring Team looks forward to reviewing substantial progress at its next review.	
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. The Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. Refer to Provisions E.1, E.2, E.3, and E.4. The Monitoring Team looks forward to reviewing substantial progress at its next review.	Noncompliance

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

1. Develop and implement systems necessary to address the SA requirements associated with Section E (Provisions E.1, E.2, E.3, E.4, and E.5)

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. Brenham State Supported Living Center (BSSLC) Plan of Improvement (POI), updated 12/30/2012 2. Brenham State Supported Living Center Presentation for January 2012 for Settlement Agreement Monitoring Team Visit 3. Section F Presentation Book materials 4. DADS Policy 004: Personal Focus Assessment, dated 09/01/11 5. DADS Policy Number 004: Personal Support Plan Process (Integrated Protections, Services, Treatments and Supports), dated 7/30/10 6. BSSLC Policy III.4.b. on Peer Review of Risk Assessment 7. Revised ISP Template, dated Nov 11/11 8. Draft Guide for ISP Meeting, dated October 27, 2011 9. Personal Support Plan Notification – January 2012 10. Individual Support Plans/Personal Support Plans (ISPs/PSPs),Personal Focus Assessment (PFA) and related documentation for Individuals #1, #7, #8, #20, #21, #50, #130, #133, #367, #406, #474, and #481 11. Record Reviews for #1, #7, #8, #20, #21,#50, #130, #149, #308, #362, #460, #474, and #481 **People Interviewed:** 1. Janet Crane, QDDP Coordinator 2. Kim Littleton, Assistant Director of Programs 3. Grace Preston, QDDP 4. Kori Kelm, Director of Habilitation Therapies 5. Jim Sibley, DADS Consultant **Meeting Attended/Observations:** 1. PSPs for Individuals #20, #154, and #474 2. Third Quarterly Meeting for Individual #149 3. CLDP for Individual #7 4. Culture Change Committee
	Facility Self-Assessment: The Monitoring Team reviewed the BSSLC POI. BSSLC reported it was not in compliance with any of the provisions, or the components with each provision, of this section of the SA. The Monitoring Team concurs. With a few exceptions, 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 many details as to how the Facility had assessed its current status, but rather listed actions the Facility had taken since the last visit and provided a list of Action Steps and completion status. The POI described a number of actions the Facility had taken since the previous site visit and laid out a number of additional steps it planned it take in the future. The Monitoring Team observed that this was a more robust and detailed POI in this regard than previous editions and would likely provide an improved

	road map for achieving results. The Monitoring Team commends the thoughtful attention to detail that was evident in the Action Steps. There were no outcome measures by which the desired results could be assessed, however. The Facility should consider how it may more fully use its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes. There are many opportunities to set measurable performance goals for each of the provisions and to use these over time to self-assess progress. For example, the Facility stated in the POI its intention to train all IDT members on the Olmstead decision and ADA with the expectation that skill acquisition plans will be implemented in a community setting as much as possible. It should obtain baseline data to determine the current level at which plans are so implemented, set a target goal for improvement, and devise a measurement strategy to allow it to determine whether progress is actual being made. In the Monitoring Team's finding for this site visit, as described in Provision S3b, it was found that only two skill acquisition programs were being implemented in a community setting. The Facility should attempt to validate this data and use it for baseline.
	Summary of Monitor's Assessment: BSSLC indicated it was not in compliance with any of the components for these provisions and the Monitoring Team concurred. The assessment which follows represents a compilation and synthesis of the interdisciplinary findings of the Monitoring Team. **Provision F1:** The Facility continued to implement the "Supporting Visions" ISP process, which was intended to reinforce the concept that planning is intended to support the individuals' vision for the future. A somewhat revised ISP format and process had been recently introduced. This ISP process was still meeting with limited success specific to the requirements of this section of the SA. The Monitoring Team was pleased to see the quality of participation by IDT members had improved in some instances, with more interdisciplinary discussion and a willingness to challenge each other as to the conventional wisdom. There was still no meaningful preparation provided to ensure the PFA and/or ISP processes were conducted in a manner that facilitated real participation by the individuals. IDT members sometimes came to planning meetings without a basic knowledge or awareness of an individual's current status or needs. The Facility continued to devote considerable resources to training, monitoring, and coaching for QDDPs, both new and current, an effort the Monitoring Team commends. This training included completion of Q Construction facilitation training, as well as other training initiatives. As noted in its POI, BSSLC had undertaken some initiatives to improve the timeliness and strengthen the quality of its assessment practices. These had met with limited success thus far. IDTs 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. **Provision F2:** The Monitoring Team found there were some examples of improved integration observed in

	planning meetings and record reviews. Overall, however, ISPs lacked many of the criteria specified in the SA for this Provision. ISPs still 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 barriers to living in the most integrated setting always lead to goals, objectives, or service strategies. The Monitoring Team also found ISP strategies did not reflect encouragement of community participation in any meaningful or purposeful manner. The Monitoring Team noted a troubling trend toward elimination of many skill acquisition programs and the replacement of these with service objectives in individuals' ISPs. Service objectives were not routinely implemented, possibly because they were seen as informal and/or optional. In addition, the data that was kept merely indicated participation and provided very little to no information as to individuals' responses. This would make assessment of appropriateness of the objective impossible. This trend was compounded by the fact that, even when they existed, skill acquisition programs were not well-written or implemented correctly and/or routinely.

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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:		
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 Qualified Developmental Disabilities Professional (QDDP) was the one person assigned to each individual to facilitate the work of each IDT. The Facility reported that it had 22 QDDPs and a QDDP Coordinator. Seven of the QDDPs were recent hires since 9/1/11, and several had not yet taken sole responsibility for facilitation of the ISP. The Facility continued to devote considerable resources to training, monitoring, and coaching for QDDPs, both new and current, an effort the Monitoring Team commends. This training included completion of Q Construction facilitation training, as well as other training initiatives described in more detail in Provision F2e below. It was reported that only one QDDP had yet been certified as competent in facilitation skills. The assigned QDDP also remained responsible for monitoring and revising treatments, services, and supports. The Monitoring Team found the QDDP did not consistently ensure the team completed assessments or monitored and revised treatments, services, and supports as needed as described below under Provisions F2a6 and F2d. <u>Conclusion:</u> This provision was found to be not in compliance.	Noncompliance

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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.	Composition and Participation of IDT: The Monitoring Team found the quality of participation had improved in some instances. There was more interdisciplinary discussion observed during team meetings held during this monitoring visit. This included a willingness on the part of members to challenge each other as to the conventional wisdom. For example, for Individual #474, there was more participation with more substantive discussion by team members observed than in previous ISP and At Risk Screening Assessments Meetings attended at BSSLC. In other instances, participation by other team members was limited. For example, Individual #474's direct support professional was not present at the ISP meeting held during the site visit. This is a vital team member to have present, who might have contributed significant information to the team discussion. Extent of Individual participation in ISP: Meaningful participation by individuals themselves remained very limited, as reported in previous assessments by the Monitoring Team. 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. A newly revised PFA process, as described in DADS Policy 004: Personal Focus Assessment, dated 09/01/11, appeared to be a better design for developing an understanding of an individual's preferences, strengths and needs, but it was not robust enough to facilitate an individual's real understanding and participation. The Monitoring Team recommends that the Facility implement a 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 QDDPs 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 to begin the PFA process and meeting, making them much more meaningful to the individual, simply by having the visual cues. It would also provide a more meaningful way for the IDT to explore the PFA areas with the individual. The portfolio could then be revised for the ISP meeting based on the PFA results. This would make the ISP a much more comprehensible, participatory and positive experience.	Noncompliance

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		Conclusion: This provision was found to be not in compliance.	
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.	Extent to which assessments are conducted routinely: As noted in its POI, BSSLC had undertaken some initiatives to improve the timeliness of its assessment practices. Assessments for the ISP were often not completed on a timely basis. The expectations remained that 1) the PFA would be completed and posted 90 days prior to the ISP date, such that all disciplines could incorporate the individuals preferences and individual goals into their assessments and recommendations, and 2) the remaining assessments would be posted no later than ten days prior to the meeting, such that all team members could review the findings and recommendations in preparation for the meeting. The BSSLC system for tracking assessments necessary for upcoming IDT meetings reported significant issues. A grid entitled "Personal Support Plan Notification – January 2012" was provided to the Monitoring Team. The QDDP Coordinator reported that an "x" in any cell should be interpreted as meaning the assessment was required but was not done (as of the date of report preparation). If a cell contained a date that should be interpreted as the date the assessment was placed in the S drive and available for IDT members. In reviewing this document for three recent ISPs (Individuals # 34 - reports were due 12/28/11, #23 – reports were due 1/4/12, and #440 – reports were due 1/5/12), it was reported that in no instance were assessments provided in the following areas: 1. Psychological update 2. PS Program Monitor report 3. Audiology Evaluation 4. Considerations for Implementing Restraint 5. Personal Focus Assessment 6. QDDP Annual Report 7. Rights Assessment In addition for at least one of the three Individuals the following assessments (according to this report) had not been done: 1. S.A.M assessment 2. Physicians Annual Report 3. Nursing Report 4. OT/PT Evaluation Update 5. Nutritional Evaluation Update 6. Social Update The Monitoring Team also reviewed the assessments available on the shared drive for ISPs upcoming over the next ten days. Zero of five (0%) had all required assessments	Noncompliance

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		available. It was noted in this review and during the site visit as a whole that the PFAs were not consistently completed on a timely basis. For example, two of four (50%) were available on the shared drive for the upcoming ISPs. The PFA was to completed by the third quarterly meeting to allow the IDT members to complete their assessments and develop their recommendations in light of individual's identified preferences as required. The Facility had recently made changes to the process by which the PFA was to be completed, as described in F1b, and it was not clear that the IDTs fully understood the new practices. Finally, the Monitoring Team found that the process for posting the assessments to the shared drive was erratic and confusing. The process varied by IDT, but in all cases it was necessary to search through multiple folders in order to locate all the available assessments. It is recommended the process be reviewed, streamlined and standardized to be of more practical use to IDT members as they prepare for ISP meetings. <u>Extent to which to which assessments are conducted in response to significant changes:</u> The Monitoring Team found that there were some examples in which assessments were being updated in response to significant changes. In one such example for Individual #21, who had an ISP meeting during the monitoring visit, it was noted that the Integrated Risk Rating had been updated several times during the past two months in response to significant changes in health condition. This represented progress. There were still many instances, however, in which assessments were not updated when the need arose. Examples included: • As reported in Section O, zero out of four (0%) Sample #1 individuals who were diagnosed with a PNM issue were assessed by the PNMT or IDT. • For Individual #7, the PSP developed in July 2011 had recommended an evaluation for a stationary bike and an evaluation by dietary of the possibility for adding a variety of snack options to the individual's weight-loss diet. Neither of these had been completed. <u>Extent to which to which assessments are of sufficient quality to reliably identify the individual's strengths, preferences and needs:</u> Assessments were still not routinely of sufficient quality to reliably identify the individual's strengths, preferences and needs. IDT members did not always take personal responsibility for ensuring they were aware of information needed to complete an accurate and thorough assessment. This was true across a number of disciplines. Examples included: • As reported under Section U, IDTs still did not adequately assess decision-making capacities nor develop appropriate action plans to address deficits. • As reported in Section L, there were deficits in the medical assessment practices. Examples reported included one that demonstrated a lack of evidence that an	

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		individual's chronic medical conditions were regularly and systematically assessed throughout the year, as would be expected in the context of community standard of care. In another example, ISPs, Annual Medical Assessments, and other components of clinical records, did not demonstrate assertive evaluation or follow-up for neuromotor or musculoskeletal conditions for two individuals, and there was no evidence to support that Medical Staff routinely assessed for progression of their functional decline, or other manifestations. • As reported under Section O, the medication administration section of the PNMP lacked information regarding staff positioning, presentation techniques, and detailed information regarding the need for adaptive equipment (i.e., youth spoon, etc). This was noted to be a pervasive issue. • As reported in Section O, findings of an annual assessment would at times drastically change in a short time span when a specific consult was made by the IDT. In once such instance, Individual #7's oral assessment on 6/24/11 stated that a ground texture was appropriate for safe dining. On 7/27/11, at the request of the IDT, another assessment was done and stated that a chopped texture was sufficient. The significant change in recommendations without a significant change in status change draws into question the aggressiveness and comprehensiveness of the OT/PT updates and their ability to identify potential decline in a proactive manner. Per interview with the Director of Habilitation Therapies, emails and report of conversations were provided to explain the changes but none of the explanations were clearly documented in the record. <u>Conclusion:</u> This provision was found to be not in compliance. Assessments were not completed routinely in a timely manner nor were they of adequate quality to reliably identify the individual's strengths, preferences and needs.	
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.	<u>Extent to which assessment results are used to develop ISPs:</u> Current assessment practices at BSSLC, in terms of timeliness, accuracy and thoroughness, did not provide assessment results that could adequately be used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual. As described in Provision F1c, assessments required to develop an appropriate ISP meeting were frequently not done in time for IDT members to review each other's assessments prior to the ISP meeting, nor were assessments completed with sufficient thoroughness. Even when the results of this flawed assessment process were used in the development of the ISP, the IDTs did not consistently use the available results appropriately to develop, implement, and revise the ISP as necessary. Examples included: • Records reflected that each individual had been provided with skill assessment by means of the Functional Skill Assessment (FSA). Unfortunately, it was not	Noncompliance

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		clear from a review of individual records and program documentation that the findings of the FSA had been effectively used in the development of skill acquisition programs. Several examples may be found under Provision S1. • As reported in Section R, communication interventions were referenced in the assessment section of the ISP but there was limited evidence these were used to develop strategies for use by staff in programs such as day program, skills training on the home, or in leisure activity program plans. Conclusion: This provision was found to be not in compliance. The Monitoring Team found a lack of rigor in the assessment processes at BSSLC. This is particularly troubling since careful assessments must lay the groundwork for all protections, supports and services to be provided. The Monitoring Team found this to be a pervasive issue that merits immediate attention on the part of the Facility.	
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).	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 IDT as a whole, and the members individually, serve as the state's qualified professionals for this purpose. It was noted that team members at BSSLC had recently been provided clarification and training as to their individual responsibilities to make a specific recommendation about the most integrated setting. The State Office had provided a directive that each SSLC team member should include in his/her assessment/evaluation a recommendation regarding the individual's appropriateness for transition to a more integrated setting, and delineation of the supports the individual would need. The State and DOJ had determined that, in addition to assessors providing recommendations in each of their assessments, the determination of the professionals on the team should be documented clearly in the ISP. The professionals' recommendation should be presented to the entire team, including the individual and LAR, for consideration. Based on team discussion, including any opposition from the individual or his/her LAR, the entire team then should make a decision regarding any potential referral for community transition. This has not yet been fully implemented. As reported in Provision T1b1, zero of eight (0%) recent ISPs demonstrated overall compliance with this guidance. Compliance was more in evidence in the most recent ISPs, such as those completed since December, 2011, but even for these many assessments did not include the specific criteria related to most integrated setting. The Monitoring Team attended three ISPs and reviewed eight recent ISPs as measures of how this new process may have affected the IDTs' implementation of this requirement of the SA. Overall, the Monitoring Team found the IDTs still failed to fully understand their	Noncompliance

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		roles and responsibilities in making a professional determination as to the most integrated setting appropriate to an individual's needs. For example, in five of eight (63%) recent ISPs, the IDT determined that there were no barriers to the individual living in a community setting. In each of these instances, however, the IDT determined at the conclusion of the plan that the most integrated setting was BSSLC. In almost every case, this was because the family/LAR expressed a preference for the individual to remain living at the Facility. As described in Provision F2e below, the IDTs should indicate the most integrated setting appropriate to an individual's and, if they choose not to make a referral, indicate the reason(s) for that choice, Conclusion: This provision was found to be not in compliance. It appeared the IDTs had confused the determination of the most integrated setting with the decision to make a referral for community living. These issues should not be necessarily be seen as one and the same. It is incumbent on the IDT to make a professional determination of the most integrated setting that would be appropriate for an individual, and to identify what would be needed to adequately support the individual in that setting. Family/LAR input should be solicited and factored into that determination, in that they have invaluable perspectives on the support needs of individuals. Family/LAR preference should not be the sole determining factor for identifying the most integrated setting. Once the IDT has made that determination, however, the individual or LAR may choose not to allow or accept a referral for community living to be made. DADS had begun using a revised ISP format that more directly guides the IDT to consider living options determinations, which the Monitoring Team commends. It should consider taking this a step further and guide the IDT to first determine the most integrated setting appropriate to an individual's needs, and having accomplished that, make a determination whether a referral will be made. This latter decision would be when individual and/or LAR preference would take precedence.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		

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	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	The Facility had very recently begun to use a revised ISP template that was developed in collaboration with its statewide consultants. It was not yet incorporated into statewide or local policy, but training had been provided to QDDPs on its use. Only a few samples of ISPs were available for review. This was accompanied by a Draft Guide for ISP Meeting, which appeared to be a checklist of actions that corresponded to the sequence of the ISP template. Although it was clear that teams were trying to identify and incorporate individuals' preferences and work in a more integrated manner, the resulting ISPs still did not show an integrated plan that set forth the full array of protections, supports, and services individuals required. It was not yet clear whether the new template would be used effectively as a tool to assist the IDTs to achieve such integrated plans, or whether teams would simply use the new format without also adjusting their thought processes and problem-solving techniques. Additional and extensive training was likely to be needed to prepare teams to think creatively about the needs and preferences of individuals and how to address them on a person-by-person basis. Too often, the Monitoring Team has seen the IDTs merely adapt old processes such that they fit into the new tool. The Monitoring Team looks forward to reviewing the implementation of this process at its next visit. <u>Extent to which ISP builds on the individual's preferences and strengths and prioritized needs:</u> IDTs did not consistently address in the ISP each individual's prioritized needs. Teams were making efforts to identify individuals' preferences. Six recent ISPs reviewed and/or attended (Individuals #1, #7, #8, #20, #50, #481) generally included more information regarding the individual's preferences. However, the following concerns were noted with regard to the identification and incorporation of preferences and strengths into ISPs: • Although all six of the ISPs reviewed/attended included a listing of individuals' preferences, none (0%) had effectively incorporated their preferences into related action plans. Most of the preferences identified for individuals related to items, food, or activities. It will be important for teams to define what it is the individual prefers about such items, foods, or activities to be able to offer the individual new experiences based on this information. It also will be essential to expand the discussion to include preferences related to environments, work, relationships, past or future experiences, routines, interactions with others, etc. • Little, if any, information about individuals' specific strengths was discussed in ISP documents. Strengths were not regularly built upon to address other need areas. <u>Extent to which ISP provides an explanation for any need or barrier that is not addressed:</u> IDTs did not consistently provide an explanation for any need or barrier that was not addressed. In none of the eight ISPs reviewed/attended (0%) were priorities clearly defined, or barriers identified and addressed.	Noncompliance

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		Extent to which ISP encourages community participation: IDTs did not consistently encourage community participation. As reported in Provision S3b, overall vocational opportunities in community settings have remained stable. BSSLC did provide a modest increase in Enclave employment opportunities, which are jobs that are located at local business but do not involve participation with other employees without disabilities. This reduces to a degree the extent to which these opportunities encourage community participation. Data presented by BSSLC did reflect an increasing trend toward the provision of community outings, but most of these were provided as Specific Service Objectives (SSOs) rather than Specific Program Objectives (SPOs). As described further in Provision S3b, it was only possible to identify two individuals living at BSSLC who were provided with formal community implementation of SPOs. For those who had community outing SSOs, many were implemented on only a sporadic basis. In addition, most of the SSOs were not implemented in a manner that they could be said to promote actual community participation. For example, Individual #1 had an SSO to participate in community activities at least weekly, and the rationale indicated the individual enjoyed a variety of activities, including shopping, sightseeing and eating at different restaurants, all of which were intended to enrich his community experiences. Data sheets from August-December 2011 documented 14 outings. Of these, seven were van rides, which cannot be said to promote community participation, and two were vaguely referenced as having gone out into the community or having gone sightseeing, with no specific activity noted. In October, there were no community outings. As recommended in Provision T1b2, the Facility's IDTs should develop an individualized community participation strategy for each individual that takes in to account their specific learning needs. These plans could include, and integrate, purposeful community integration activities; community tours; self-advocacy; community work, job exploration, and volunteer activities; developing and/or maintaining relationships with people living and working in the community, and other approaches the Facility might explore and create. All of these provide opportunities for increasing awareness of community living and should be considered in developing an integrated and individualized strategy for each individual. Conclusion: This provision was found to be not in compliance.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies	Extent to which ISP 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: As described in Provision F2a4 and further in Section S, ISP programs were generally not individualized	Noncompliance

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	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;	to the individual's needs, nor did they contain the requisite essential components of skill acquisition programs such as operational definitions of teaching targets, discriminative stimuli, consequences, and teaching instructions cannot be adequately presented. The Monitoring Team also noted a troubling trend toward elimination of many skill acquisition programs and the replacement of these with service objectives in individuals' ISPs. This trend was particularly noticeable in the most recent ISPs reviewed and at least one of the ISP attended during this monitoring visit. Service objectives were not routinely implemented. <u>Extent to which ISP identifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to overcome identified barriers to living in the most integrated setting:</u> Barriers to living in the most integrated setting did not always lead to goals, objectives, or service strategies. The ISP did not consistently specify individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain outcomes related to identified barriers to living in the most integrated setting appropriate to his/her needs. For example: • The IDT for Individual #21 did not appropriately consider the most integrated setting for the individual nor address the supports that could be provided to the family to address barriers, even though the mother noted on several occasions that she would be interested in considering a community placement closer to the family home. The IDT noted that the individual was a minor and therefore not eligible for CLOIP tours. They did not further suggest developing any action plans for otherwise providing the individual and family with community living education or awareness, except to tell the mother she could contact the MRA. The IDT also suggested to the mother that she would not want to have the individual moved until graduation, since the mother was pleased with the school. Another alternative would have been to assist the mother to make contact with other schools and school districts that were in closer proximity to the family home to see if a program could be developed that would be acceptable. It was noted the IDT indicated it saw no barriers to community living, but then determined that BSSLCS was the most integrated setting based on the LAR's preferences. See Provision T1b2 for additional examples. The Monitoring Team found very few goals that would assist in living in a more integrated environment such as goals for independent travel, cooking, socialization, real use of money, independent self-care, or making medical appointments, whether these were in response to an identified barrier or not. As noted in Section S, only two individuals at BSSLC appeared to have any training programs that were actually implemented in a community setting,	

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		Conclusion: This provision was found to be not in compliance.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	Extent to which ISP integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions: The Facility demonstrated some progress toward integrated treatment. These include the initiation of a number of processes designed to support integration through interdisciplinary collaboration, including: • The Facility had recently implemented a peer review process for the Integrated Risk Rating assessment. A peer review team had been organized and thus far met twice and given feedback to the IDTs. • The Facility also reported that Psychiatry and Psychology had developed a case formulation process to support integration of the impact of environmental variables on mental illness. • A daily Medical Staff meeting is attended by multiple disciplines, including Habilitation Therapy, Pharmacy, Nursing, Psychiatry, PNMT Nurse and Hospital Liaison Nurse to aid in joint planning and case formulation across disciplines. This process included a mechanism by which information was to flow back and forth between the Medical meeting and IDTs. • Primary Care Physicians were beginning to attend Psychiatric Treatment Review meetings. Despite these efforts, which the Monitoring Team commends, ISPs still failed overall to consistently integrate all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for an individual. Examples included: • As reported in Section R, three of 40 records reviewed (0%) had a clear rationale and description of communication interventions integrated into the ISP or into an individual's daily schedule. • The Monitoring Team saw very little evidence of integration of the IEP with the services and supports being provided at the Facility. The Monitoring Team reviewed the ISP, IEP and record for three school-age individuals (Individuals #8, #20 and #21). For Individual #21, the Monitoring Team also attended the annual ISP meeting. There was no discussion at the ISP of the IEP and how it might be built upon until the Monitoring Team suggested this needed to occur. The IEP indicated the individual could engage in many higher level skills than the IDT thought possible, particularly as it related to pre-vocational skills. During the discussion, the individual's mother confirmed these findings. The IDT was also unfamiliar with the federal requirement that the individual have a school to work transition plan in place at school.	Noncompliance
	4. Identifies the methods for implementation, time frames	Extent to which ISP identifies: • Methods for implementation: As reported in Provision S1, BSSLC failed to	Noncompliance

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	for completion, and the staff responsible;	conduct individual task analyses; rather it used the Murdoch Center Program Library in an "off the shelf" manner such that SPOs were not tailored to the unique learning needs of each person. In most instances, each individual was started at step one of every SPO regardless of demonstrated ability. As a result, many individuals were required to participate in unnecessary instruction targeting skills they already possessed. The programs were found to lack essential components required for skill acquisition such as operational definitions of teaching targets, discriminative stimuli, consequences, and teaching instructions cannot be adequately presented. • Timeframes for completion: Timeframes for completion of programs were not individualized, but were generally projected to be one year. It was also found, as described in Section S, that individuals were frequently required to demonstrate mastery for extended durations. • Responsible Staff: SPOs and SSOs typically indicated one or more staff members by name and shift who would be responsible for data collection, as well as identifying the QDDP by position as the individual responsible for program review. Conclusion: This provision was found to be not in compliance.	
	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	Extent to which ISP interventions, strategies, and supports are provided as prescribed: The Monitoring Team found in many instances that the interventions, strategies, and supports were not provided as prescribed in the ISP. For one of eight records reviewed (13%) were the interventions, strategies, and supports consistently implemented For example: • Individual #474 had SSOs for community outings once per month, weekly call to a parent and wheelchair strolls. None of these were implemented as required. The community outing SSO was not implemented in October, November or December of 2011. The phone call SSO was not implemented in October or December and no data sheet was available for September 2011. No data sheets were provided for the wheelchair stroll SSO in September, October and December 2011. Extent to which interventions, strategies, and supports are practical and functional: In many instances, the interventions, strategies, and supports prescribed in the ISP were not practical or functional in the Facility nor in a community setting. As described above, many interventions, strategies, and supports were provided on a very intermittent and even random basis, which would render them to be not of any practical function in an individual's life. Other examples of the interventions, strategies, and supports that were not practical or functional included:	Noncompliance

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		• As reported in Section S, the Monitoring Team observed an individual was given a coloring book and asked to "color". No crayons were made available at that time or during the following 15 minute remainder of the observation. In another observation, a staff member was reading from a book on astronomy to five individuals with severe to profound intellectual disabilities. The passage being read included statements regarding comparative weights of a cubic foot of soil collected on various sized planets. There was no evidence that the activities were in any way related to the individual's needs for services and supports in a manner that would be practical or functional. • Individual #7 had been referred for community living. An SSO for a community outing once per week indicated the individual enjoyed going out into the community and social interactions with others. This presented many opportunities to work on skills she would be needing in the community, in addition to assisting the individual to establish goals and preferences for community living, thereby making the excursions practical and functional. Over the course of three months, from September through November 2011, the individual's data sheets documented only three community outings. The SSO also noted the individual should be assisted with using money, with "hand over hand" assistance if required. This was a generic program not individualized to the functional needs of this individual, who would not require hand over hand assistance. Regardless, there was no documentation, asked for nor kept, of opportunities to use money skills. • Individual #7 also had an SSO to be offered opportunities to call her family and boyfriend at least weekly. The instructions noted the call might be placed at any time, although Sundays were best. Data sheets for July, September, October, November and December documented five opportunities provided and only one instance in which the individual was able to speak to a specific person. In October, staff wrote the individual had gone on pre-selection visits during the time calls would usually be made. This indicated the approach to offering opportunities to call was not carried out in a manner that was practical to the individual's needs and lifestyle. This intermittent approach was also not functional in supporting the individual's contact with family. Given that the individual was going to be moving to the community, it would also have been more functional to provide her with opportunities to exercise this skill in a more independent manner that did not depend on staff offering the opportunity <u>Conclusion:</u> This provision was found to be not in compliance.	
	6. Identifies the data to be collected and/or	<u>Extent to which ISP identifies data and/or documentation and the frequency of data collection in order to permit the objective analysis of the individual's progress:</u> As noted	Noncompliance

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	documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	in Provision F2a2 above, the Facility was increasingly relying on SSOs rather than SPOs. In addition to concerns regarding the intensity of efforts to meet the habilitation needs of individuals, data required for SSOs typically only required an indication of participation and provided very little to no information as to individuals' responses. This would make assessment of appropriateness of the objective impossible. This trend was compounded by the fact that, even when they existed, skill acquisition programs were not well-written or implemented correctly and/or routinely. Extent to which ISP identifies the person(s) responsible for the data collection, and the person(s) responsible for the data review: SPOs and SSOs sometimes indicated one or more staff members by name and shift who would be responsible for data collection, but this was not consistent. More often, the SPOs indicated only that a specific shift would monitor. Likewise, some SSOs and SPOs identified the QDDP by position as the individual responsible for program review, while some did not make reference to program review. Conclusion: This provision was found to be not in compliance.	
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.	Extent to which goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP: Based on the current review of ISPs, this was an area that required substantial improvement. As is discussed in other sections of this report, the Monitoring Team found a lack of coordinated supports in a number of areas, including between dental/medical and behavior/psychology; nursing and habilitation therapies; nursing and medical; speech/communication and psychology; and between the disciplines responsible for the provision of physical and nutritional supports to individuals served. Review of the ISPs generally showed a multidisciplinary as opposed to interdisciplinary approach, in that various disciplines might address the same issues, but rarely in a manner that caused them to pool efforts or resources in a coordinated approach to the same issue, or to consider how the actions of one discipline may hamper or augment the actions of another. Such considerations are the hallmarks of a truly interdisciplinary approach. Examples included: • As described in Section O, even within the PNMP there was a failure to address needs in a coordinated fashion. Individual #318's PNMP stated that head of bed (HOB) should be elevated during enteral feedings under the positioning section but under the dining section it stated that the individual should be upright. • As described in F2a3 above, for Individual #21, there was no discussion at the ISP of the IEP and how it might be built upon. The IEP indicated the individual could engage in many higher level skills than the IDT thought possible, particularly as it related to pre-vocational skills, but none of these were	Noncompliance

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		incorporated into ISP assessments or goals for vocational development or other skills development. • As described in Section R, there was limited evidence of how an individual's methods for expressive or receptive communication, or the strategies to be used by staff were coordinated throughout the individual's programs such as day program, skills training on the home, or in leisure activity program plans. As an example, Individual #33's assessment stated that signs should be utilized to help improve cooperation and comprehension but there was no evidence of these strategies were coordinated with the individual's service objectives. Conclusion: This provision was found to be not in compliance.	
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.	Extent to which ISP is accessible to staff: Staff were consistently able to locate the record and the programs found in the ISP. Although the Monitoring Team found staff were not consistently able to describe the contents of the ISP or programs without referring to the documents, they were able to locate the information with relative ease when asked. Extent to which ISP is comprehensible to staff: As described in Provision F2a4 above, training objectives were not written in a manner that related to the specific skills and needs of an individual. None of five staff (0%) questioned in one training area were able to discuss aspects of SPOs or SSOs without referring to a copy of the document. Observations and review of program data indicated that, in terms of outcomes the ISP did not appear to be comprehensible to the staff responsible for implementing it, as there were many instances in which staff could not describe supports contained in the ISP or did not implement them as called for in the ISP. In addition to data collection issues described in Provision F2a6 above, examples included: • As reported under Provision S1, data provided by the Facility indicated an average level of engagement across all settings of 61.3% in January of 2012, with a range of 57.6% to 66.8% obtained across the previous six months. To develop a basis of comparison for the current site visit, the Monitoring Team conducted observations in a variety of settings across the BSSLC campus. The level of engagement noted during the site visit was substantially lower than that obtained by the Facility. Engagement across all settings, including meals where engagement was typically the highest, was 38%. When meals were eliminated from the sample data, the level of engagement fell to 17%. The level of engagement is a significant indicator, in that the purpose of the ISP is to provide a basis from which staff can provide a continuous, comprehensive, coordinated and ongoing program of activities and supports that address an individual's preferences and goals and meet their assessed needs, not simply	Noncompliance

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		list a series of training programs. Engagement - that is, personal interaction - with an individual is clearly a prerequisite to successfully providing any of these activities and supports, and is at the heart of an integrated ISP. ISPs that do not provide staff with clear methodologies as to how to engage individuals and to provide activities and supports on an ongoing basis and in an integrated fashion do not rise to the level of being comprehensible. The engagement data cited above clearly indicated staff did not comprehend such methodologies. • As reported in Section R, staff were not knowledgeable of the communication dictionary or its contents. • As reported in Provision K11, staff were unable to discuss a PBSP in detail without asking for assistance or reviewing the written PBSP. Conclusion: This provision was found to be not in compliance.	
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.	Monthly review of progress: The IDTs did not consistently ensure assessment of progress on a monthly basis, or more frequently as needed, or make revisions if there was a lack of expected progress. The Monitoring Team found that Quarterly Reviews were often not completed in a timely fashion nor in a way that provided for meaningful evaluation of progress or program revision. The Monitoring Team found Quarterly Reports were sometimes missing. More often, they provided little evaluative analysis; instead, they made general reports such as "service provided" or "no data provided." Extent to which ISPs are modified as appropriate: The Facility did not have adequate data for many programs or services prescribed in the ISP upon which to base decisions regarding continuation or modification. As documented in Provisions F2a2 and F2a6, the Facility had begun to rely heavily on SSOs in place of training objectives, and data for these merely indicated whether a service had been offered and/or whether the individual had participated. This did not lend itself to any meaningful analysis of the need for modification. The Monitoring Team reviewed SSO/SPO data sheets for seven individuals (Individuals #1, #7, #8, #20, #21, #50, #474, #481). For six of seven, program data were missing or incomplete. Conclusion: This provision was found to be not in compliance.	Noncompliance
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete	Extent and adequacy of competency-based training for staff responsible for development of ISPs: As reported in previous reports, training on PSPs had been standardized across the SSLCs. Supporting Visions: Personal Support Planning was the standard training curriculum for personal supports planning. As indicated above, since the last review, additional training sessions and resources had been initiated. These included:	Noncompliance

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	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.	• The current QDDP Coordinator and two others were certified trainers for the Q Construction: Facilitating for Success training. All QDDPs had participated in the initial training. This training included a written test that each participant completed at the end of the classroom training. It also included a competency checklist. The competency checklist generally provided a good format for reviewing a number of planning and facilitation skills. As the checklist is implemented, changes likely will need to be made to further define certain competencies, and to ensure reliability across reviewers. The Facility had trained seven Program Assessors in the Q-Construction training as one means toward ensuring inter-rater reliability. • Twelve Q-Construction assessments had been conducted since July, 2012, but at the time of the site visit, only one QDDP had been certified as competent in the Q-Construction facilitation skills. The Facility reported that further competency assessments were to begin on facilitating an IDT meeting, writing minutes from an IDT meeting, and developing Action Plans and SPOs. • The Facility had posted a position for a QDDP Educator to assist with training and competency-testing, with a projected start date of February 1, 2012. • The APC had provided training to QDDPs and Social Workers on identification of obstacles and on the community referral process. • The State had hired consultants to provide training, and work hands-on with teams on the ISP process. The consultants had provided some training to BSSLC IDTs. Additional training should be provided on how to develop integrated action plans, including how to draw together the information gathered in assessments, analyze that information, incorporate the individual's preferences, set priorities, provide clear directions to those working with the individual, and develop measurable objectives to track progress or lack thereof. It will be important to provide teams with the tools necessary to focus on individual's interests, priorities and vision for his/her living arrangements, while reconciling these with the individuals' medical and safety needs. <u>Extent and adequacy of competency-based training for staff responsible for implementation of ISPs:</u> The Monitoring Team found staff were not adequately provided with competency-based training. This finding was made by the lack of active treatment and engagement observed and by the lack of fluency with which staff were able to discuss the strategies, supports and interventions included in an individual's ISP without referring to the record. <u>Conclusion:</u> This provision was found to be not in compliance.	
F2f	Commencing within six months of	<u>Extent to which ISPs are developed within 30 days of admission:</u> BSSLC reported four	Noncompliance

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	the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	admissions in the last six months. Of the three that were past 30 days since admission, each of the three had an ISP dated within that 30 day period. Extent to which ISPs are revised annually and as needed: Many ISP meetings do not occur within one year of the prior ISP date and many ISPs are not "put into effect" within 30 days as required by the SA. The Facility provided a tracking log (dated 12/8/11) which noted the dates of the most recent ISP, the previous ISP, and the date the most recent ISP was put into effect. In reviewing this log the Monitoring Team determined: • Eighteen of 310 ISPs (6%) did not occur within one year of the previous ISP. • Eighty of 310 ISPs (26%) were not put into effect within 30 days following the preparation of the ISP • Thirteen of these 80 were not put into effect for at least 60 days after the ISP meeting. One ISP was held on 1/4/11 and not put into effect until 7/2/11. Another was held on 2/10/11 and not put into effect until 7/7/11. Yet another was held on 2/3/11 and not put into effect until 7/2/11. Conclusion: This provision was found to be not in compliance due to the failure to hold and/or implement annual ISPs within the require timeframes.	
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.	Quality assurance measures that identify and remediate problems to ensure that the ISPs are developed and implemented were limited. Some quality assurance activities were underway, however, but these were not yet organized into system that would assist BSSLC to that identify and remediate problems to ensure that the ISPs. The Quality Assurance Department provided no data as to these issues. Examples of activities that were taking place included: • The Facility had recently implemented a peer review process for the Integrated Risk Rating assessment. A peer review team had been organized and thus far met twice and given feedback to the IDTs. • Lead QDDPs were reported to be engaging in more frequent monitoring of monthly and quarterly reviews completed by the QDDPs. Conclusion: This provision was found to be not in compliance.	Noncompliance

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

1. The process for posting annual assessments to the shared drive should be reviewed, streamlined and standardized to be of more practical use to IDT members as they prepare for ISP meetings. (Provision F1c)
2. DADS should guide the IDT to first determine the most integrated setting appropriate to an individual's needs, and having accomplished that, then make a determination whether a referral will be made. This latter decision would be when individual and/or LAR preference would take

precedence. (Provision F1e)

3. IDTs should develop an individualized community participation plan for each individual that takes in to account their specific learning needs. These plans could include, and integrate, purposeful community integration activities; community tours; self-advocacy; community work, job exploration, and volunteer activities; developing and/or maintaining relationships with people living and working in the community, and other approaches the Facility might explore and create. All of these provide opportunities for increasing awareness of community living and should be considered in developing an integrated and individualized strategy for each individual. (Provision F2a1)
4. Additional training should be provided on how to develop integrated action plans, including how to draw together the information gathered in assessments, analyze that information, incorporate the individual's preferences, set priorities, provide clear directions to those working with the individual, and develop measurable objectives to track progress or lack thereof. It will be important to provide teams with the tools necessary to focus on individual's interests, priorities and vision for his/her living arrangements, while reconciling these with the individuals¡¦ medical and safety needs. (Provision F2e)

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) 12/30/11 2. BSSLC Presentation Book (undated) 3. DADS draft policy #005: Minimum and Integrated Clinical Services 1/12/10 4. BSSLC Policy III.2.f Physician Procedures and Best Practice Guidelines 4/14/11 5. Email from Alvin H. Jones, Jr. (dated 7/26/11) regarding new training on New Required Training: Observing and Reporting Clinical Indicators of Health Status Change, and the course materials including slides, course outline, and written competency test. 6. Statement from BSSLC in response to document request for policy or procedure guiding integrated clinical services: "No Evidence" 7. Minutes of Physician's Meeting 12/19/11, 12/20/11, 12/21/11, 12/22/11, 12/27/11, 12/28/11, 12/30/11, 1/2/12, 1/3/12, 1/4/12, 1/5/12 and attachments 8. Email of 12/22/11 from Penny Foerster regarding Medical Staff Meeting Changes 9. Statement from BSSLC in response to document request for forms used to document review and response to recommendations from non-Facility clinicians: "No Evidence" 10. Guidelines for reviewing non-SSLC clinician's recommendations 11/2/11 11. Training rosters for training nurses on the Guidelines for reviewing non-SSLC clinician's recommendations 12. Consultation Reports for Individuals #30, #59, #90, #102, #134, #398, #411, #434, #446, #536, #575, and #599 13. PSPs, CLDPs, and other documents reviewed by the Monitoring Team **People Interviewed:** 1. Group interview of Mary Anne Brett, MD, Medical Director, Adolfo Carvajal, MD, and Malcolm Lochiel, MD **Meeting Attended/Observations:** 1. Medical morning meetings 1/17/12, 1/18/12, and 1/19/12 2. Two morning unit meetings 3. Psychiatric Treatment Review 01/18/12 4. PSP Annual Planning meeting for Individual #154
	Facility Self-Assessment: The Facility provided a self assessment in its Plan of Improvement (POI). The Facility reported that Provision G1 is not in compliance but Provision G2 is. The Monitoring Team found that neither provision is in substantial compliance, but significant progress has been made in both provisions. The Plan of Improvement provided some narrative descriptions of actions the Facility had or was taking to move towards compliance within each of the provisions, but did not present a comprehensive assessment of compliance with each of the indicators. The steps reported in the POI went back to 2010 but also

	included actions taken since the last compliance visit. The Facility did not indicate the basis for the decisions on compliance for either provision. The Facility reported action plans for achieving compliance. The Action Plans specified the action to be taken, what evidence would be used to confirm status, start and projected completion dates, and the current status. Actions included conducting Morning Medical Debriefing (which the Monitoring Team observed in action) and developing an Integrated Clinical Care Policy (which the Facility states is t in process and which was not presented to the Monitoring Team).
	Summary of Monitor's Assessment: The Monitoring Team commends the Facility on taking important actions toward integrating clinical planning and services. Many of these actions are in early stages, and their effect on integrated planning and case coordination are not yet clear. A significant improvement was that medical services had become much more a part of the interdisciplinary process. Although participation in planning and review meetings is not yet fully consistent either in attendance or in integrated discussion, both show signs of improvement. The medical morning meeting is now an interdisciplinary meeting that addresses both individual and systemic issues, and the participants in the meeting engage in valuable integrated planning. Other actions to promote integrated services included moving the office of the Infection Control Nurse into the Health Center Building in order to increase access to infection control information and enhance integration/communication with other clinical staff, having psychiatrists attend IDT meetings to review services for individuals who have experienced frequent restraint, expanding the involvement of Communication staff in the PBSP process, and expanding interdisciplinary involvement in the Medication Variance Committee. Nevertheless, involvement of all needed clinicians in IDT planning still needs improvement, both in attendance and in integrated discussion. Policy relevant to integrated clinical services should be implemented, and quality of implementation should be monitored. Clinicians routinely documented review of recommendations by non-Facility clinicians. Policy requires that clinicians enter into an IPN if a recommendation is not to be followed; nevertheless, clinicians provided an IPN entry for most consultations, and the Monitoring Team recommends this be done for all consultations. The Facility developed guidelines for reviewing consultations; these focused entirely on review by physicians but should address all clinicians. The guidelines require that the Nurse Case Manager present the recommendations to the morning unit meeting but do not explain the role of the IDT in reviewing and acting on recommendations.

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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 reported not yet being in compliance with this provision; the Monitoring Team concurs but does recognize the significant steps taken by the Facility to move toward compliance. The Facility had made progress toward providing integrated clinical services. In particular, medical services had become much more a part of the interdisciplinary process. Although the Facility had experienced a lengthy period without a Medical Director, the three physicians had worked toward more interdisciplinary involvement and, in interview, expressed a greater appreciation for the value of integrated planning. Although there is much work to do, the Monitoring Team commends the Facility and, in particular, Medical Services, for this progress. One action taken was to initiate a morning meeting. This meeting serves as a medical debriefing but includes participation by all primary care physicians, psychiatrists, Director of Habilitation Therapy, PNMT Nurse, Hospital Liaison Nurse, CNE, dentist, pharmacist (usually both clinical pharmacists, and an RN who takes minutes. Review of the minutes of these meetings documented attendance by most of these staff. The minutes showed that meetings began with a review of all calls to the physician on call followed by additional concerns that included issues regarding specific individuals (such as status of individuals in the hospital or who just returned the prior day, seizures, and response to infectious diseases that could require action to prevent transmission) and systemic issues that needed to be addressed (such as problems with late administration of medications due to outings, need for timely provision of paperwork to nurses when someone returned from the hospital, and individualization of care plans). Observation of medical meetings confirmed that there was active interdisciplinary discussion of both individual and systemic issues. For example, at the meeting of 1/19/12: • The dentist reported on the oral hygiene monitoring on living units and the staff response to observations; the Director of Habilitation Services asked to have the PNM Coordinators observe the monitoring, and the dentist suggested the dental staff could also check whether the PNMP is being followed during oral hygiene. This discussion resulted in a plan for the dentist, Director of Habilitation Services, and PNMT nurse to work out how to accomplish these actions. • Discussion was held about one individual whose gastrointestinal issues could be exacerbated by a psychotropic medication; the psychotropic medication was being held. The primary care physician and psychiatrist discussed whether this person needed the medication and the staff response to attempts to avoid medication use. Another physician discussed the need for approaching the individual from a specific side and noted approach from the other side led to increased target behaviors, and the Director of Habilitation Services stated the correct approach would be added to the PNMP. Additional discussion was held about a systemic issue at the living unit. This was an excellent discussion that	Noncompliance

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		began with a report about an individual but led to integrated planning that may have significant effect on treatment programming for the individual and on staff training. The Monitoring Team also attended the 1/17/12 AM Medical Morning meeting. The medical group reviewed several individuals, and issues around psychotropic medication use were well integrated into the discussion of behavioral and general medical care. These included discussions of Individual #112 (the on-call physician responded to after-hours questions about an extra dose of medication taken while on pass), and Individual #169 (who had possible medical complications of treatment with anticholinergic medications). The discussions were examples of positive practice. Also, at that meeting, the pharmacist provided an excellent review on the use of Keppra, an anticonvulsant. The pharmacist commented on the fact one of the more common side effects of Keppra is anxiety, and the physician and psychiatrists who were at the meeting had an excellent clinical discussion about the use of Keppra with several individuals. That was an example of good practice of integrated care. The Psychiatric Treatment Review process was also modified to increase collaboration. As reported in Section J, PTR discussions were observed for 4 individuals: The clinical discussion for all four individuals was relevant, the discussion was clinically solid and it was integrated – there was substantive exchange of information. Nurses were key participants in the PTR process and attended the IDT review for new medications. Primary care physicians were frequently presented at PTRs, and they review and co-sign psychiatric treatment plans (PTPs). Psychiatrists attended quarterly and annual ISPs, and worked with other behavioral specialists (primarily psychology) for example through the combined psychology-psychiatry workshops. The introduction of the combined case analyses described under Provision J8 also contributed to the process of evaluation and diagnosis. Other actions taken to improve collaboration and integrated planning included: • The Infection Control Nurse's office had been moved to the Health Center Building in order to increase access to infection control information and enhance integration/communication with other clinical staff (e.g., physicians, pharmacy, dietitian, occupational and physical therapists, dental hygienists, and psychiatrist). • Psychiatrists now attend meetings held regarding individuals who have experience more than three restraints in a rolling 30-day period, and a clinical review of the circumstances provides an opportunity for the psychiatrist and team to reflect on the clinical formulation of the individual. This is in early	

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		stages, and improvement still is needed in coordinated and joint case formulation and planning, but it provides an opportunity to work collaboratively. • Since the last review, the Medication Error Committee was officially changed in 10/2011 to the Medication Variance Committee based on the recently adopted Medication Variance Policy, 053. This change expanded the scope of the committee, including all aspects of medication administration practices as defined by policy. The committee included a more integrated approach that included membership comprised of multidisciplinary clinical staff. • Annual physical therapy (PT) and occupational therapy (OT) evaluations were completed collaboratively. • Examples of two records reviewed for individuals with pressure ulcers showed some improvement in the integration and management of skin integrity treatment and care. • 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. Although this had not yet resulted in improved identification of communication-based replacement behaviors, it provides an avenue to explore communication-based strategies for PBSPs. Furthermore, when interviewed about use of the record in making decisions on treatment, supports, and services, staff interviewed each gave a specific example of using a report from another discipline when planning a treatment or intervention. Nevertheless, there remain areas of needed improvement. • Participation in ISP planning meetings and in the ISP process was mixed, with examples of good participation and examples in which it was lacking. o Numerous clinical disciplines participated actively in the annual ISP planning meeting for Individual #154, which the Monitoring Team observed. There was extensive discussion of when to have a swallowing assessment, about dentures, and about the individual's breathing. The discussion led to a decision for further observation and for criteria to determine whether the swallowing assessment must be expedited. o Review of the ISPs generally showed a multidisciplinary as opposed to interdisciplinary approach, in that various disciplines might address the	

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		same issues, but rarely in a manner that caused them to pool efforts or resources in a coordinated approach to the same issue, or to consider how the actions of one discipline may hamper or augment the actions of another. • The Monitoring Team also attended the 01/17/12 quarterly ISP reviews for Individuals, #149 and #187. In those, although psychiatry attended the meeting, the discussion was not integrated. • Although the physician was an active participant in the ISP meeting for Individual #154, physician representation at other ISP meetings was limited. o Of six ISP meetings for which documentation was reviewed for Individual #446, the individual's physician attended only 1 such meeting (16%). There was no evidence indicating that potentially serious medical issues, such as possible atherosclerosis, degenerative spine disease, and a significant change on recent breast ultrasound was well communicated to the IDT. o For Individual #335, there was no participation by physician staff at the past two ISP quarterly reviews, dated 8/31/11 and 12/14/11. Given the numerous, and serious medical conditions, robust physician input is essential. • Plans to address identified risks did not consistently show evidence of integrated planning or coordinated implementation. • Health Management Plans (HMPs) rarely contained integrated intervention in collaboration with other relevant disciplines. A draft DADS statewide policy had also been available for a number of months. It addressed both integrated clinical services (section G) and minimum common elements of clinical services (section H). The aspects of the policy that addressed section G were minimal and will not likely be helpful to the facility because the policy merely mimicked the wording of the Settlement Agreement without providing any direction to the facility, such as 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. The Facility was also in process of developing a policy. The Monitoring Team did not review a draft but expects that the Facility will wait until the DADS policy is final before implementation of a local policy. To further assist all of the facilities in achieving substantial compliance with this provision, the monitoring teams recently presented to DADS and DOJ a listing of activities in which the SSLCs might engage that would indicate the occurrence of the	

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		provision of integrated clinical services. This list (i.e., criteria) was being reviewed by DADS and it is expected that over the next several months, this list will be finalized and can be used by each facility. Conclusion: BSSLC was taking significant steps toward integrated planning. It will take continuing effort to maintain and expand these steps. Furthermore, there may be a need for training so that clinicians in varying disciplines can learn how their knowledge can be used to improve services within other disciplines. The structures are being established; for compliance, outcomes showing collaborative and effective coordination of services and supports will need to be in evidence.	
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.	BSSLC Policy III.2.f Physician Procedures and Best Practice Guidelines states that "Routine medical/surgical consultation recommendations will be addressed within five days after the consultation" and requires that there must be a clear explanation in the IPN if recommendations are not implemented or a statement on the consultation report that the recommendation was "agreed and implemented" and a signature of the facility physician and date, along with a corresponding progress note. The policy did not provide information on procedures for clinicians other than physicians to follow when reviewing recommendations from non-Facility clinicians. The Facility physicians reported that off campus consultation primarily involved medical and surgical treatment; the neurologist, ophthalmologist, and podiatrist came to campus; and gastroenterology services were provided both on and off campus. For all consultations, the Facility clinician is to write in the consultant note whether there is agreement or disagreement with the recommendations, and to put a note into the Integrated Progress Notes (IPN). At the morning meeting, the Nurse Case Manager is to share the information to inform the IDT and decide whether there needs to be action at the team level; in two morning meetings observed, there was no consultation reported at one, and the second (an ophthalmology consultation) included a report of "follow up in a year" but no IDT discussion. Although no discussion was observed, the Monitoring Team recognizes the potential of this process to involve the IDT when needed. The Monitoring Team reviewed 17 consultations by non-Facility clinicians for 12 individuals. Of the consultations reviewed by the Monitoring Team, the Monitoring Team found: • Documentation of review by the Facility clinicians on the consultation form for 17 (100%) • IPN entries by the Facility clinician for 12 (71%) • Agreement with recommendations of the non-Facility clinicians documented for 16 (94%)	Noncompliance

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		• Agreement on the 16 of the 16 documented (100%) The Monitoring Team notes that 71% of sampled consultations were followed by IPN entries, although the clinicians agreed with the non-Facility clinician's recommendations in each case, and the Facility only requires IPN entries when a recommendation is not implemented. The Monitoring Team recommends that the policy require that an IPN entry be made for each consultation in order to ensure communication to other clinicians (who may or may not be present at a specific morning unit meeting) and in order to ensure that any needed explanation or rationale is provided. The Facility developed guidelines for review by Facility clinicians of consultation recommendations from non-Facility clinicians. This procedure was provided to clinicians, and training was held for nurses. Although the guidelines include referral to the RN Case Manager, who is to present the recommendations to the daily morning meetings, it does not provide clear guidance about IDT involvement or procedures to address disagreements the IDT members may have about the recommendations. Furthermore, the guidelines require an IPN only when there is a change recommended. Finally, the guidelines refer only to medical, rather than other clinical, consultations and require only the Primary Care Physician to review and document; although most consultations are medical (assuming that swallowing studies and physical therapy consultations would be considered medical), other consultations might in the future be considered, so the guidelines should address that possibility. The guidelines, while a good initial step, should include more information on the documentation needed and on the role of the IDT in reviewing and acting on recommendations. The Facility had made notable progress towards compliance in this area. To achieve compliance, the Facility should implement and monitor policy, clarify the role of the IDT in reviewing and acting on recommendations, and ensure the process is carried through for consultations by any non-Facility clinician.	

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

1. DADS should address the requirements for integrated clinical services more fully as it finalizes policy. When DADS policy is implemented, BSSLC should operationalize it locally and implement in timely manner.
2. When policy is implemented, the Facility should develop means to measure and track integrated planning and review of consultant recommendations.
3. Guidelines for Facility clinician review of recommendations by non-Facility consultants should address the documentation needed, the role of the IDT, and the possibility of consultants other than medical consultations.
4. Policy should require that an IPN entry be made for each consultation in order to ensure communication to other clinicians (who may or may not be present at a specific morning unit meeting) and in order to ensure that any needed explanation or rationale is provided.

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) 12/30/11 2. BSSLC Presentation Book (undated) 3. DADS draft policy #005: Minimum and Integrated Clinical Services 1/12/10 4. BSSLC Policy III.2.f Physician Procedures and Best Practice Guidelines 4/14/11 5. Email from Alvin H. Jones, Jr. (dated 7/26/11) regarding new training on New Required Training: Observing and Reporting Clinical Indicators of Health Status Change, and the course materials including slides, course outline, and written competency test. 6. Minutes of Physician's Meeting 12/19/11, 12/20/11, 12/21/11, 12/22/11, 12/27/11, 12/28/11, 12/30/11, 1/2/12, 1/3/12, 1/4/12, 1/5/12 and attachments 7. New Employee Orientation (Preservice Training) and Competency Training and Development (CTD) training schedule for December 2011 8. PSPs, CLDPs, and other documents reviewed by the Monitoring Team **People Interviewed:** 1. Group interview of Mary Anne Brett, MD, Medical Director, Adolfo Carvajal, MD, and Malcolm Lochiel, MD **Meeting Attended/Observations:** 1. ISP annual planning meeting for Individual #154
	Facility Self-Assessment: The Facility provided a self-assessment in its Plan of Improvement (POI). The Facility reported that Provision H2 is in compliance but the other provisions are all not in compliance. The Monitoring Team found that no provision is in substantial compliance, but progress has been made in many provisions. The Plan of Improvement provided some narrative descriptions of actions the Facility had or was taking to move towards compliance within each of the provisions, but did not present a comprehensive assessment of compliance with each of the indicators. The steps reported in the POI went back to 2010 but also included actions taken since the last compliance visit. The Facility did not indicate the basis for the decisions on compliance. The Facility reported action plans for achieving compliance. The Action Plans specified the action to be taken, what evidence would be used to confirm status, start and projected completion dates, and the current status. Actions reported and planned included (as some provision assessments simply refer to other provisions or may not report significant actions, only some are described below): • For Provision H1, the Facility reported that assessments are tracked by individual departments as of 12/15/2012 (sic) and that a process of notification for primary care physicians (PCPs) for annual assessment was implemented 12/4/11. Both of these would be too recent to result in changes that would be evident at this visit. Plans included assessing department tracking systems.

	• For Provision H2, which was reported to be in compliance, the most significant action was that PCPs received the 2012 version of the CPT and ICD-9-CM manuals and training on 11/30/11. This does not indicate there was any review or revision of diagnoses to identify status of compliance. An action dated 12/1/11 refers to an action plan that "J2 addresses diagnostic review and development of QA processes to ensure the most appropriate DSM-IV TR diagnosis is used." Although this does address review of diagnoses, it does not provide information on the status or findings of such review. • For Provision H5, the Facility reported that medical quality audits were conducted and measures were taken to correct issues, but no information was provided on status including significant findings or verification of correction, nor were any plans for tracking findings or taking proactive actions listed. As of 12/1/11, the Facility reported a number of ways in which changes in health status are reported, but again provided no indication of status or effectiveness of these processes. The Facility reported as one reporting process the Morning Medical Debriefing, which (as noted above in Provision G1) was confirmed by the Monitoring Team as a promising approach. The Facility should develop processes and measures to evaluate status of compliance for each of the provisions.
	Summary of Monitor's Assessment: Although no provisions of this Section were found to be in compliance, the Monitoring Team recognizes progress in several areas. The Facility had made progress on communicating and tracking health status of individuals through the Morning Medical Debriefing and reporting to the Incident Management Review Team. There was not yet an organized system to track health status of individuals or health status of the population of the Facility, although there had been a beginning of identifying and measuring health status issues such as falls and injuries. Adequacy, comprehensiveness, and timeliness of evaluations and assessments remained problematic, but the Facility had made several improvements such as focused nursing assessments when an individual experienced a change in health status and improvements in the comprehensiveness of communication assessments. Diagnoses were consistent with current classifications, but more assertive follow-up assessments were needed when indicated, and documentation of the rationales for diagnoses needs improvement. Development and use of clinical indicators of health status for both individuals and for the population as a whole needs to occur. Some initial steps have taken place. The Facility had implemented training for direct care staff on how to observe and recognize indicators of health status change. The training included guidelines for reporting and documentation.

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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.	Adequacy of assessments and evaluations remained problematic at this visit. Throughout this report, there are examples in which assessments were not routinely completed on a timely basis. As reported in Provision F1d, current assessment practices at BSSLC, in terms of timeliness, accuracy and thoroughness, did not provide assessment results that could adequately be used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual. As described in Provision F1c, assessments required to develop an appropriate ISP meeting were frequently not done in time for IDT members to review each other's assessments prior to the ISP meeting, nor were assessments completed with sufficient thoroughness. The Monitoring Team noted improvements in timeliness and comprehensiveness of assessments in a number of areas, Including: • For people who experience acute change in health status and subsequent admission and discharge from the hospital, the Facility showed improvement in following the Hospitalization, Transfers, and Discharge Protocol and the development and implementation of ACPs for their respective nursing problems/diagnoses. There was documented evidence that when the above individuals experienced acute changes in condition the nurses completed a focused assessment regarding the presenting symptoms and promptly notified the physician. • For individuals receiving Occupational Therapy (OT) or Physical Therapy (PT) services, the individual was provided an OT and/or PT assessment every 3 years, with annual interim updates or as indicated by a change in status. • Communication assessments had shown significant improvement since November 2010, which is when the format of the assessment was revised. Assessments were noted to be mostly comprehensive and provided clear details and strategies to improve the individuals' level of communicative functioning. At the time of the review, 183 new assessments had been completed which accounted for 60% of the census. Additionally, BSSLC presented a plan that would ensure all individuals would receive the new comprehensive assessments by the end of 2013. Assessments for newly admitted individuals were generally timely. • Psychiatric evaluations were done within 30 days following admission. • OT/PT assessments/screenings completed for those individuals who were newly admitted were completed within 30 days of admission. Need for improvement still remained in a number of areas:	Noncompliance

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		• There was need to improve psychiatric evaluations in the areas of diagnostic specificity and diagnostic justification. • As reported in Provision L1, there were examples of individuals who were reported to have been ambulatory in the past, but lost their ability to ambulate over time. Personal support plans, the Annual Medical Assessments, and other components of their clinical records, did not demonstrate assertive evaluation or follow-up of their neuromotor or musculoskeletal condition. The etiology of their loss of function was not documented in the Clinical Record. There was no evidence to support that Medical Staff routinely assessed for progression of their functional decline, or other manifestations. • Physicians reported that they recognize that past assessments were not always as comprehensive and thorough as they needed to be. They reported they are making a concerted effort to prioritize individuals and find or develop the information needed for improved assessments, but time limitations make this difficult. The Monitoring Team recognizes that the Medical Department is making efforts to improve assessments but that this will take time to accomplish. • As reported in Provision P1, there were individuals for whom there was not an assessment or review as indicated by a change in the individual's status or as dictated by monitoring results. • Records reflected that each individual had been provided with skill assessment by means of the Functional Skill Assessment (FSA). Unfortunately, it was not clear from a review of individual records and program documentation that the findings of the FSA had been effectively used in the development of skill acquisition programs or that the FSA was revised as indicated by data from training. • The oral motor section of the assessments for individuals who needed physical nutrition and management (PNM) supports continued to show improvement from the previous review but still did not provide clear objective information regarding swallow status and cannot be considered an assessment. Furthermore, it was not clear that the Facility had adequate processes to track assessments, diagnoses, and diagnostic updates to ensure assessments and evaluations are done both regularly and in response to changes in an individual's status. • As reported in Provision F1c, a grid entitled "Personal Support Plan Notification" reported dates of new evaluations and assessments. However, the consistent lack of posting of certain assessments as well as the variability in posting of other assessments made it appear that the Facility does not take action to review this grid and take corrective action on a systemic basis. • The Psychiatry Department database was up to date and was consistent with the diagnoses reported in psychiatric evaluations and diagnostic revisions. The	

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		database showed there were frequent differences between the database and the Active Problem List, even though both reported information in the DSM/ICD format.	
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 were consistent with the current versions of the DSM and ICD classification systems. For both medical and psychiatric diagnoses, there was not always the supporting information to verify and substantiate the diagnoses. • As reported in Provision J6, in many cases, specific diagnoses were provided, but not the documentation needed to fully substantiate the psychiatric diagnosis in terms of all of the symptoms that would be required to fulfill the complete diagnostic criteria set forth in the *DSM-IV-TR* or the *Diagnostic Manual of Intellectual Disability (DM-ID*). Furthermore, 33% of a sample reviewed had Not Otherwise Specified (NOS) diagnoses. • As reported in Provision L1, there remained a number of examples in which etiology of conditions was not investigated or indicated follow-up to assessment results was not done, either of which could affect the diagnosis. Thus, although diagnoses clinically fit the assessments and evaluations that had been done, further assessment might have led to differences in diagnosis. The Monitoring Team recognized that diagnoses were consistent with the required classifications but, for compliance, will need to ensure that adequate assessment is done to substantiate and verify diagnoses and that documentation of such assessment and of clinical rationales is clear.	Noncompliance
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.	The Facility did not have a plan or procedure in place to ensure or monitor that treatments and interventions were implemented timely. Several examples were provided in Provision L.1 showing lack of adequate and timely follow-up to diagnostic findings. As reported in Provision L1, there were numerous examples in which assessments that were identified as needed to follow up on conditions were not done in a timely manner; therefore, treatment could not be based on updated or complete assessments. As reported in Section O, instructions for Physical and Nutritional Management Plans (PNMPs) were improved but not yet comprehensive (and BSSLC was in the process of including additional information in PNMPs. Staff did not consistently implement interventions outlined in the PNMP.	Noncompliance

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		As reported in Provision K4, many records did not reflect that behavioral treatment decisions were based on available data and/or were revised timely based on data on efficacy of intervention. The Facility should develop an organized process to identify and track clinical indicators of individuals' status and to ensure treatments and interventions are implemented and revised timely.	
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.	The development and use of clinical indicators of efficacy of treatments and interventions had resulted in improvements in some areas but needed continuing improvement. The Facility initiated training developed by DADS to improve reporting of clinical indicators. This course was targeted to non-clinical professional and paraprofessional direct contact staff. The course outline and materials for this one-hour training included coverage of when to report (whenever there are changes from baseline health for an individual), to whom to report (nurses and physicians/nurse practitioners), examples of changes that should be reported, and how to document both the change in health status and that the report was made. Training schedules for December 2011 showed this training was scheduled for the preservice training held during the month and one time for incumbent staff. As reported in Provision K4, it was apparent that some areas of behavior data collection at BSSLC had improved substantially. For example, data collection practices on target behaviors would allow for adequate measurement of progress in most cases. However, only a minority of records reviewed included adequate data collection and tracking of replacement behaviors. In only slightly more than half the records reviewed were there indications that treatment decisions were based upon available data. In the remaining records, either no changes in the PBSP were attempted despite indications of poor program efficacy, or reviews of the PBSP only coincided with the annual ISP. Some individuals were noted to have experienced increases in problem behavior over several months without a review or revision of the PBSP. Provision O7 reported that PNMPs are reviewed at the ISP annual planning meeting, but 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 risk and using that data to drive the further individualization of triggers or provision of care. The Facility reported having a vision of identifying and tracking specific conditions and has begun to develop a database. At this time, the Facility is tracking falls, fractures, and injuries.	Noncompliance

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		In addition, DADS has begun the development of clinical pathways for medical conditions. These may provide clinical indicators useful for tracking both the status of individuals and the delivery of healthcare in general. The Facility should develop and organized process to identify and track clinical indicators, to evaluate data to determine status of systems of care and identify improvements to be made, and to ensure efficacy of treatment and intervention is assessed.	
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.	The Facility reported that several actions had been taken to monitor health status of individuals. • The Morning Medical Debriefing discusses hospitalizations and returns, calls received by the covering physician, and status of any individual when the PCP or other participant in the meeting determines the need for consultation or communication with the other participants. • The Incident Management Review Team (IMRT) agenda includes review of injuries and causes, reports from the hospital liaison nurse, and restraints. • A peer review process has been initiated to "ensure appropriate identification of risks(.)" In addition, the Facility reported that the Psychiatric Treatment Review monitors status of individuals, and the nursing audits provide a quantitative tool for quality improvement (although the Facility did not present any quantitative information to document status of compliance with this provision). These steps should be useful and should be part of a system to monitor health status of individuals; such a system should include clinical indicators and should involve reporting of resolution of acute conditions and measures of improvement or decline for chronic conditions. At this review, the Monitoring Team identified in several sections of this report examples in which risk was not re-evaluated following risk incidents (for example, on return from hospital) or where risk levels were not assigned accurately as well as changes in health status that were not clearly identified or addressed. The Facility will need to develop processes to identify when these occur and track corrective actions. In addition, the Facility needs to review and analyze data relevant to PNMPs and status of individuals who are at risk, to identify trends both in terms of health status of individuals (for example, changes in occurrence of aspiration triggers) and of the population of the Facility as a whole, and to analyze trends in an effort to prevent future occurrences.	Noncompliance

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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.	This section will require demonstration of a functional system that is both integrated and provides the full spectrum of all elements of clinical care. The various protocols developed by the State Office represent an initial framework for this section, but there needs to be evidence that these are put into action, and that treatment reflects ongoing interventions and changes in interventions based on identified clinical criteria/clinical indicators that are appropriate for the individual. 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, the clinical pathways that DADS is working on should include such guidance. Examples in which treatments and interventions were not modified when indicated were noted in several sections of this report.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	A draft DADS state policy 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). In addition, the Facility had implemented training for direct care staff on how to observe and recognize indicators of health status change. The training included guidelines for reporting and documentation. The Monitoring Team encourages the Facility to ensure that it is periodically provided as a refresher. The Facility reported in the POI that "Each Clinical Department as indicated has a policy and procedure that indicates the need and timelines for assessment," but as noted in several sections of this compliance report, assessments were not always done timely. The Facility should develop tracking mechanisms to ensure its policy is implemented accurately.	Noncompliance

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

1. Develop and implement processes to track assessments, diagnoses, and diagnostic updates to ensure assessments and evaluations are done both

regularly and in response to changes in an individual's status. (Provision H1)
2. Ensure assessments are completed and posted to the records and Shared Drive as required by policy. (Provision H1)
3. Complete and implement comprehensive policy to cover the requirements of this provision at both State and local levels. (Provisions H1 and H7)
4. Develop an organized process to identify and track clinical indicators of individuals' status and to ensure treatments and interventions are implemented and revised timely.
5. Develop processes to identify when risk is not re-evaluated following risk incidents or where risk levels were not assigned accurately as well as changes in health status that were not clearly identified or addressed and to track corrective actions. (Provision H5)
6. Develop a system to monitor health status of individuals; such a system should include clinical indicators and should involve reporting of resolution of acute conditions and measures of improvement or decline for chronic conditions. (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. BSSLC Plan of Improvement (12/30/11) 2. Section I Presentation Book 3. DADS Policy 006.1 At Risk Individuals (2/18/11) 4. Resource material: "Examples of things to consider during PSO meetings risk analysis/action plan discussions" (undated) 5. Resource material: "Suggestions to add to the risk action plans for each risk factor" (undated) 6. Resource material: "Integrated Risk Rating Discussion Form" (11/7/11) 7. Record reviews of Individuals #11, #13, #30, #51, #138, #151, #173, #242, #273, #291, #303, #408, and #411 **People Interviewed:** 1. Kori Kelm, Director of Habilitation Therapies **Meetings Attended/Observations**: 1. Facility Incident Management Team 1/16/12 2. Quality Assurance/Quality Improvement Council 1/18/12 3. Restraint Reduction Committee 1/19/12 4. Section I Team 1/19/12 5. ISP meeting for Individual #474 1/16/12
	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's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. The Facility reported it had initiated improved processes in November, 2011. These resulted from the incorporation of additional resource tools used by IDTs. These included "Examples of things to consider during PST meetings risk analysis/action plan discussions," "Integrated Risk Rating Discussion Form," and "Suggestions to add to the risk action plans for each risk factor." The Monitoring Team's review substantiated the Facility's self-assessment of noncompliance.
	Summary of Monitor's Assessment: The BSSLC processes to demonstrate compliance with this section of the SA had improved since the last review. This was especially noted for risk assessment planning that occurred since November, 2011. The Facility reported it had initiated improved processes in November, 2011. These resulted from the incorporation of additional resource tools used by IDTs. These included "Examples of things to consider during PST meetings risk analysis/action plan discussions", "Integrated Risk Rating Discussion Form" and "Suggestions to add to the risk action plans for each risk factor". It was apparent use of these tools, and additional training provided to IDTs, was leading to improved risk assessments and risk action plans.

	The risk screening, assessment and management system observed by the Monitoring Team was adequate to demonstrate compliance with Provision I.1 of the SA. This was especially evident with the processes observed or reviewed from November, 2011 forward. While the Facility demonstrated an adequate process, the effective use of the process remains problematic, and risk ratings and actions to address risks were not always accurate or effective, leading to noncompliance with Provision I.2 and I.3. Interdisciplinary discussion required to properly assess risk and develop risk mitigation strategies had improved significantly since the last review. Noticeably absent from most Risk Action Plans were clinical indicators to be monitored and the frequency of monitoring.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The BSSLC reported in its POI it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. The Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. The Monitoring Team observed one ISP meeting specifically to assess the risk assessment process. Staff present at the ISP was the actual staff who worked with the individual and was very knowledgeable about the Individual. Noticeably absent from the meeting were Direct Care Professionals (DCPs). The individual was present at the meeting but only for a few minutes before choosing to leave. The IDT used the Risk Level Guidelines required by State policy. The ISP meeting observed by the Monitoring Team included a full and open discussion among IDT members including presentation and discussion of clinical data when appropriate. The risk levels assigned to the individual during the meeting were, for the most part, appropriate to the circumstances and data presented at the meeting. Through discussion the team members made corrections and additions to the risk levels and rationale. Risk levels were changed appropriately based on discussion and clinical data supporting the change in levels. The Risk Action Plan for each risk level was revised as indicated based on discussion and supporting data. Although there was improved team participation, discussion, and rationale, there remained the need for continued improvement to ensure that all relevant risk levels and plans are thoroughly considered and addressed. Refer to Section M.5 for further details regarding Individual #474's At Risk Screening Assessment and Risk Action Plan. No information was provided about procedures to re-assess risk on a periodic schedule or following changes in status. In fact, examples were evident that risks were reviewed at other times in some cases and also that risks were not reviewed following changes in health status in other cases.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• As reported in Provision J2, quarterly reviews of the ISPs for individuals who were under psychiatric care included review of psychiatric risk, which is a positive finding. • As reported in Provision O1 regarding individuals who had been hospitalized with aspiration pneumonia, although three of four individuals were discussed at the PNMT, there was a lack of detailed discussion regarding the onset of the event as well as details regarding steps to mitigate future risk. Furthermore, risk levels assigned prior to November 2011 were recognized by the Facility as inaccurate but there was no process in place to revisit them. Please refer to Provision O2 for examples in which re-assessment should occur. o Ratings of risk for Individuals #318, #403, and #547 were inaccurate. • The Monitoring Team was told that risk categories completed prior to November were not consistently accurate but there was no process in place to revisit these individuals until their annual ISP review. An example was Individual #425 who had a diagnosis of pica and was observed multiple times during meals grabbing items that were not in agreement with his recommended texture and shoving the grabbed food item in his mouth to prevent retrieval from staff. The IDT was aware of this behavior but there was no attempt to revisit the risk rating. Another example was Individual #34; the Integrated Risk Rating Form, dated January 27, 2011, rated the individual to have a low risk rating for GI problems, despite well-documented GI conditions known. Regardless of the fact that the risk rating was completed in January 2011, given the individual's significant health care issues, the risks should have been updated. Risk screening, assessment and management system observed by the Monitoring Team had improved and might be adequate to demonstrate compliance with this provision of the SA if there was both facility-level policy or procedure that defines the system and a facility process to ensure implementation is consistent (and to take corrective action when implementation does not occur or is inaccurate) . This was especially evident with the processes observed or reviewed from November, 2011 forward. Furthermore, the effective use of the process remains problematic as described in Provision I.2 and I.3.	
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	BSSLC reported in its POI it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. The Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. Review of 13 records (Individuals #11, #13, #30, #51, #138, #151, #173, #242, #273, #291, #303, #408, and #411) showed there was documentation that the IDT started the assessment process as soon as possible but within five working days of the individual being identified as at risk for six (46%) individuals. Records that did not contain	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	documentation of this requirement included: Individuals #11, #51, #173, #242, #291, #303, and #411. This was a substantial improvement from what was reported (24% compliant) in the last monitoring report. The records of these 13 individuals were reviewed to determine if changes in circumstance should have resulted in changes to an at-risk assessment, rating, and plan. There were seven examples of risk events or changes in status. There was documentation that the IDT started the assessment process as soon as possible but within five working days of the individual changes in an at-risk condition for five of the seven (71%) individuals. Records that did not contain documentation of this requirement included: Individuals #242 and #291. Based on a review of records of six individuals (Individuals #13, #138, #151, #242, #273, and #408) for whom assessments had been completed to address the individuals' at risk conditions, four (67 %) 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#13 and #242. The following provides an example of an assessment that was not comprehensive: Individual #13's Risk Action Plan did not include preventive measures for medium risks for aspiration, cardiac disease, gastrointestinal (GI) problems, and urinary tract infections. Individual #13's Medium risks identified for aspiration, GI problems, and urinary tract infection were assigned to the QDDP. Responsibility for Risk Action Plans for these risks should have been assigned to the appropriate clinical disciplines, such as nursing and PNMT, who had the knowledge needed to develop, train, and monitor implementation of the plans. Actions should then have been established through interdisciplinary and integrated planning. The risk plans should have included, at minimum, for aspiration, GI problems, and urinary tract infection the nursing discipline with a health maintenance plan for each of these risks; and habilitation therapy with a PNMP for aspiration risk. The following provides an example of an assessment that was comprehensive: Individual #138 had the most complete Risk Action Plan of the six risk plans reviewed. The plan included functional and measurable objectives, more specificity in the risk actions steps, specific monitoring frequency for each risk, and identification of disciplines(s) responsible for each action step. Based on a review of records of four individuals (Individuals #30, #291, #303, and #411) for whom assessments had been completed to address the individuals' at risk conditions, one (Individual #30) included an adequate physical and nutritional management and/or	

#	Provision	Assessment of Status	Compliance
		OT/PT assessment to assist the team in developing an appropriate plan. The following provide examples of assessments that were not comprehensive: • Individual #291had aspiration pneumonia on 7/11/11. There was no documentation that the PNMT discussed this issue nor was there any evidence that this Individual's clinical issues were reassessed in response to this event. • The Integrated Risk Rating Form for Individual #34, dated January 27, 2011, rated the individual to have a low risk rating for GI problems, despite the well documented GI conditions known. Incidentally, the individual was also determined to be low risk for cardiovascular disease, despite an echocardiogram report demonstrating marked concerns, and also a low risk for fracture, despite the diagnosis of "severe osteoporosis" with a history of hip fracture. The following provides an example of an assessment that was comprehensive: Individual #30 had aspiration pneumonia on 11/29/11. The IDT met on 12/14/11 and conducted a risk screening assessment that resulted in the development of a new feeding program. Based on a review of records of three individuals (Individuals #11, #51, and #173) for whom assessments had been completed to address the individuals' at risk conditions, three (100%) included an adequate psychiatric assessment to assist the team in developing an appropriate plan. Other risk issues identified by the Monitoring Team are noted in Sections J, L, M, O, and P of this report.	
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	BSSLC reported in its POI it was not yet in compliance with this provision of the SA. The Monitoring Team concurs. The Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance. Based on a review of 13 records for individuals determined to be at risk (Individuals #11, #13, #30, #51, #138, #151, #173, #242, #273, #291, #303, #408, and #411), 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 five (38%)) cases. Records that did not contain documentation of this included Individuals #11, #51, #173 #242, #291, #303, #408 and #411. ▪ Implemented a plan that met the needs identified by the PST assessment in 5(38%) cases. Records that did not contain documentation of this included Individuals #11, #13, #151, #242, #291, #303, #408, and #411.	Noncompliance

#	Provision	Assessment of Status	Compliance
	plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	▪ Included preventative interventions in the plan to minimize the condition of risk in six (46%) cases. Records that did not contain documentation of this included Individuals #11, #13, #242, #291, #303, #408, and #411. When the risk to the individual warranted (seven cases), the Facility took immediate action in five (71%) cases. ▪ Integrated the plans into the PSPs in eight (62%) cases. Records that did not contain documentation of this included Individuals #13, #151, #242, #303, and #411. ▪ In three (23%), the risk plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. Records that did not contain documentation of this included Individuals #11, #13, #51, #138, #151, #242, #273, #303, #408, and #411. ▪ In five (39%) 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 #11, #13, #151, #242, #291, #303, #408, and #411. ▪ Included the clinical indicators to be monitored and the frequency of monitoring in three (23%) cases. Records that did not contain documentation of this included Individuals #11, #13, #51, #138, #151, #242, #291, #303, #408, and #411. Compliance rates from a low of 23% to a high of 71% are insufficient to demonstrate substantial compliance with this provision of the SA.	

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

1. The Facility should assure all IDTs are provided with training and ongoing technical assistance on implementation of the At Risk policy and its incorporation into the ISP process. QQDDPs/Team leaders should be provided with continuing competency based training and job coaching on implementation of the At Risk policy and its incorporation into the ISP process.
2. Ensure that appropriate and timely assessment and revision of the ISP 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: 1. BSSLC Plan of Improvement (POI) 12/30/2011 2. DADS Policy and Procedures 007.2 Psychiatry Services (08/30/11) 3. DADS Nursing Protocol Post Anesthesia Care (06/2010) 4. DADS Nursing Protocol Pre-treatment and Post Sedation Monitoring (06/2010) 5. Facility Presentation Book for Section J 6. A list of all individuals who received psychiatric care, including the current psychiatric diagnoses, the name of the treating psychiatrist, the psychotropic medications given to the individual, and the date of the Appendix B psychiatric evaluation 7. A list of any individuals for whom the psychiatric diagnoses have been revised since the last compliance visit, 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) 8. Minutes of the Pharmacy and Therapeutics Committee (P&TC) and the Psychotropic Medication Oversight Committee (PMOC), since the last compliance visit 9. A list of individuals prescribed intraclass polypharmacy and interclass polypharmacy, including the names of medications prescribed and each medication's start date 10. A tabulation that compared rates of Facility use of polypharmacy over the period from January 2010 until the present 11. A separate list of individual, for whom each of the following is prescribed: a. Anticonvulsant medications being used only for psychiatric indications b. Anticonvulsant medications being used only for neurological indications c. Anticonvulsant medications being used for both neurological and psychiatric indications d. Lithium e. Tricyclic antidepressants f. Trazodone g. Beta blockers being used as a psychotropic medication h. Clozaril/clozapine i. Mellaril j. Reglan k. Anticholinergic medications l. Benzodiazepines 12. A list of individuals who have medical support plans and dental support plans, to reduce the need for pre-treatment sedation 13. The number and percentage of individuals who had dental procedures, who also received pre-treatment sedation (oral or TIVA) 14. A list of all individuals screened for tardive dyskinesia with DISCUS evaluations 15. A list of all individuals screened with MOSES side effects evaluations 16. DISCUS forms done over the past year that were rated "5" or higher

	17. A list of individuals diagnosed with tardive dyskinesia and the Active Problem List for each of those individuals 18. Reiss screens (both data and scoring sheets) done since the last review 19. A list of all individuals whose scores matched or exceeded Reiss Screen cut-off values per instrument guidelines 20. Materials related to follow-up provided by the Facility for individuals whose scores matched or exceeded Reiss Screen cut-offs (per #19, above). Documents included integrated progress notes (IPNs), psychological assessments, and psychiatric evaluations done for those individuals. Materials were received for Individuals, #31 and #121. 21. Sample J1: Case reviews for individuals that included all individuals admitted over the past six months, selected individuals who had Individual Support Plan (ISP) meetings after October 15th and selected individuals assessed by the Facility as "best practice" cases for integrated behavioral healthcare. These were Individuals #1, #12, #33, #120, #130, #151, #173, #181, #238, #273, #305, #308, #367, #403, #425, #490, and #513. Materials reviewed were: a. Social History b. Most recent Psychiatric Evaluation (Appendix B format if done) c. Most recent Annual Psychiatric Review/ Annual Psychotropic Medication Review d. Most recent Positive Behavior Support Plan and Functional Behavioral Assessment (FBA) e. Most recent Personal Support Plan f. Most recent Annual Medical Summary g. Most recent Active Problem List h. All Psychiatric Medication Reviews for the past six months i. All MOSES/DISCUS Side Effects Screenings for the past six months j. All Quarterly Drug Regimen Reviews for the past six months k. Most recent Health Risk Assessment Rating – tool and team meeting sheet l. If the individual is assessed at high risk on the basis of polypharmacy or challenging behaviors –copies of the plan to reduce risk (PSP addenda) m. Medical and/or dental plans to increase cooperation/participation and reduce the need for pre-treatment sedation n. Most recent Annual Nursing Summary o. Most recent Neurology Consultation 22. Sample J2: Episodes of Medical Restraint for Dental Procedure: Oral pre-treatment sedations for Individuals #349 (10/28) and #45 (10/18). Total Intravenous Anesthesia (TIVA) procedures for Individuals #588 (11/09), #45 (11/09), #392 (11/9), and #443 (11/10). Materials reviewed related to safety during the procedure included medical orders, physician specified monitoring schedules, restraint checklists, pre and post sedation nursing checklists, integrated progress notes, (IPNs) and dental clinic notes that documented medical monitoring for safety during the procedures. Information reviewed that related to plans to minimize the need to use of medical restraint included individual ISP and ISPA information regarding the need for pre-treatment sedation and the development and implementation of such plans, including completed data sheets if a program was developed and implemented, evidence related to all steps of the facility restraint review process including administrative, and programmatic follow-up

	23. Documents related to risk assessment for individuals assessed to be at high risk for injury due to challenging behavior and/or due to polypharmacy. Reviews were done for Individuals #11, #51, #159, and #173. Materials reviewed included: a. The two most recent Risk Assessment Tools b. The individual's ISP prior to the most recent risk assessment and/or any PSP change of status documentation c. Documentation of assessments and other steps taken to develop an action plan to reduce the risk d. The action plan to address the risks (either PSPA or new PSP) 24. Documents related to individuals who experienced more than three episodes of restraint in 30 days. Document reviewed included integrated progress notes (IPNs) review of restraints, and ISPAs that reviewed the occurrences, psychiatric re-assessments and physician orders involving changes in psychiatric treatment including medication changes. Reviews were done for Individuals #12, #38, and #490. 25. A list of all psychotropic medications newly approved by the Positive Behavior Support Committee (PBSC) and the Human Rights Committee (HRC) during the last six months. Material reviewed included: a. Information from the clinical record (e.g., progress notes, psychiatric treatment reviews, PSPAs) that will help the Monitoring Team understand the reasons/clinical rationales for choice of the medication b. IPNs, PTRs and other psychiatric notes that clarified the reasons the new medications were proposed. c. Consent for use of the Psychotropic Medication d. PBSC and HRC review of the psychotropic medication proposals e. Revised Positive Behavior Support Plan (PBSP) 26. Documents related to psychiatric and neurological care for five individuals who took seizure medication for both neurological and psychiatric indications. Individuals #181, #185, #332, #496 and #588 were reviewed. Materials were neurology clinic visit notes and also any other chart materials selected by the Facility to help the Monitoring Team understand the underlying neurological and psychiatric matters that were discussed. 27. A list of all meetings and rounds that were typically attended by the psychiatrist, and which categories of staff always attend or might attend 28. A list and copy of any new forms used by the psychiatrists 29. Details on any changes in the employment of current psychiatrists and details regarding the employment of any new psychiatrists, including board status, whether contracted or employed, and number of hours per week 30. List of the 108 plans in place to reduce the need for pre-treatment sedation 31. Desensitization plans for Individuals #44, #45, #102, #106, #314 #349, #392, #465, #483, #528, #574, #599, and #490 32. External neurology consultation for Individual #59 (11/03/201 office visit) and external endocrinology consultation for Individual #599 (09/16/11 office visit), and information from Facility records that helped the Monitoring Team understand the reason for the external consultation, and the

	response to the consultation 33. Description of administrative support offered to psychiatrists (e.g. secretarial and administrative scheduling of psychiatric consultations, **People Interviewed:** 1. Dr. Reeba Chacko, Staff Psychiatrist 2. Dr. Terry Hancock, Department Head, Psychology 3. Dr. Victoria Morgan, Department Head, Psychiatry 4. Dr. Jennifer Nguyen, Department Head, Dental 5. Dr. Sergio Luna, Staff Psychiatrist 6. Ms. Debbie Williams, Chief Nurse Executive **Meeting Attended/Observations:** 1. Positive Behavior Support Committee, 01/16/2012 2. Quarterly Review of ISP – Individual #187 on 01/16/2012 3. Quarterly review of ISP – Individual #149 on 1/16/12 4. Medical Morning Meeting 01/17/12 5. Psychoactive Medication Oversight Committee 01/17/12 6. Psychiatric Treatment Review 01/18/12
	Facility Self-Assessment: The Facility provided a self- assessment in a document called a Plan of Improvement (POI). The document provided to the Monitoring Team indicated that the POI had been updated on 12/30/2011. For each provision of Section J, of the POI, the Facility provided several statements or short paragraphs that described steps taken by the Facility to respond to the requirements of the provision items. The statements were listed chronologically for each provision item. The earliest comments dated to early 2010, and the most recent were from December 2011. The POI continued with a series of action steps (AS) that described the Facility's ongoing plan to address the needs of various provisions. The action steps (AS) taken to date showed that the Facility was making progress. For example the Psychiatric Treatment Plans (PTP) described under Provision J3 will help bring needed psychiatric information into the PBSP, Dr. Chacko's transition to full time status (Provision J5) will help overall staffing and will allow Dr. Morgan time to continue implementation of valuable clinical-administrative functions. The deployment of combined case analyses and formulations (Provision J8) will facilitate integrated clinical efforts for the overall behavioral healthcare team. The Facility did not indicate the activities taken by the Facility to conduct the self assessment. It would be helpful for the Facility to do so. Also, the POI did not always present information that was available to the Facility and which was relevant to the self assessment. For example, quantitative data (and analysis of data) could have helped the Monitoring Team understand progress in the area of polypharmacy (Provision J12). The POI also provided self-ratings regarding compliance on the various provision items. The Facility self-

	assessed for compliance on Provisions J1, J7, J11, J12, J14 and J15. The Monitoring Team agreed with Facility assessments for Provisions J1 and J15. For Provision J7, the Monitoring Team agreed that Reiss screens had been deployed as required. However, the provision also required psychiatric evaluations for individuals treated with psychotropic medications, and 42% of the individuals who needed evaluations still did not have them. For Provisions J11, J12, and J14 the Monitoring team found that there was remaining work to be done. The Facility did not self-assess for substantial compliance on Provision J5, but after review of staffing levels, the Monitoring Team found that there was substantial compliance on that provision.
	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 58% of individuals who received psychotropic medication had received psychiatric evaluations, and many evaluations had diagnoses that were not substantiated by the evidence. **For Provision J3:** The provision was determined to be not in compliance. All individuals who were prescribed psychotropic medication had treatment plans, and all had working psychiatric diagnoses. There was no evidence that medications were used for the convenience of staff or for punishment. Psychiatrists' identification of the reason(s) that each medication was used had improved. However, data-based monitoring of psychiatric symptoms was not sufficient. **For Provision J4:** The provision was determined to be not in compliance. There was some progress in nurse monitoring for safety during medical restraints, but many individuals did not have treatment plans to minimize or eliminate the need for the pre-treatment sedation, and there was no process in place to evaluate the effectiveness of the plans. **For Provision J5:** The provision was determined to be in substantial compliance. Staffing has increased to 2.5 FTE psychiatrists. The Facility demonstrated to the Monitoring Team that there was 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 SA. **For Provision J6:** The provision was determined to be not in compliance. Eighty-six psychiatric evaluations (58%) of the needed Appendix B format had been completed. However, they lacked evidence to justify the psychiatric diagnoses, and NOS diagnoses needed to be resolved. In addition, 42% of individuals who need evaluations still did not have them. **For Provision J7:** The provision was determined to be not in compliance. Reiss screens had been provided to all the individuals who required them. However, only about 58% of individuals who receive psychotropic medication had received psychiatric evaluations.

	For Provision J8: The provision was determined to be not in compliance. Significant progress has been made, and combined case formulations are now part of the Functional Behavioral Assessment (FBA) document. However, this process is new, and further progress is needed at the level of the behavioral healthcare planning (FA and PBSP), and at the level of the ISP. **For Provision J9:** The provision was determined to be not in substantial compliance. The Facility had not demonstrated that individuals received the least intrusive and most integrated care. **For Provision J10:** The provision was determined to be not in substantial compliance. Progress has been made, but evaluations must discuss treatment alternatives. **For Provision J11:** The provision was determined to be not in substantial compliance. Overall rates of polypharmacy had not changed. The Monitoring Team noted that a basic structure for polypharmacy review was in place in the form of PMOC, and valuable data on polypharmacy was collected. However, these data were not well analyzed, tabulated or presented. That was needed, to help the Facility focus its efforts to make needed progress. **For Provision J12:** The provision was determined to be not in substantial compliance. In some cases, it was not clear that individuals received needed screenings. **For Provision J13** The provision was determined to be not in substantial compliance. Psychiatric Treatment Plans for new medications have just started to be deployed. **For Provision J14:** The provision was determined to be not in substantial compliance. There were improvements to the consent process, such as the addition of information on the FDA status of the proposed medication. However, consents did not include individually specific information about/risk benefit, or information about treatment alternatives. These were needed. **For Provision J15:** The provision was determined to be in substantial compliance. Integrated care regarding "dual purpose" medications was well managed by psychiatrists who attended the neurology clinics for selected individuals, and reviewed medications prescribed by both neurology and psychiatry.

#	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 the three psychiatrists employed at the Facility at the time of the last visit. The Monitoring Team had reviewed the psychiatrists' curricula vitae during previous visits. Each of the psychiatrists was interviewed during the current visit and their professional activities during the past six months were reviewed. All three psychiatrists were board certified by the American Board of Psychiatry and Neurology, and the Monitoring Team found that they had adequate experience in	Substantial Compliance

		intellectual disability psychiatry.	
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.	A focus of Provision J2 was that any individual who received psychotropic medication should have first received an adequate evaluation and diagnosis by a board certified psychiatrist. To review whether and how this was done, the Monitoring Team first enquired about the number of individuals at the Facility who received psychotropic medication. That information was tracked on an ongoing basis through the Psychiatry Department Database. At the time of the tour, there were 149 such individuals, or 48% of the 310 individuals who lived at the Facility. Each of the individuals had a psychiatric diagnosis that was in the required DSM/ICD format. The Monitoring Team reviewed the overall system that was in place for psychiatric diagnoses and updates. Dr. Morgan clarified that each individual who received care was assigned to one of the three psychiatrists. The primary sources for psychiatric diagnoses were the formal psychiatric evaluations required by the SA, and done by the treating psychiatrist. Appendix B evaluations were in place for 86 of the 149 individuals who need them (58%). Those evaluations are the focus of Provision J6, and the report for that provision includes an analysis of the adequacy of the diagnoses that resulted. In addition to the formal diagnostic evaluations, psychiatric symptoms and diagnoses was also part of many other clinical processes. Key elements were: 1. <u>Psychiatric Treatment Reviews:</u> All individuals assigned to a psychiatrist for ongoing care met with the psychiatrist at least monthly, as part of Psychiatric Treatment Reviews (PTR). PTRs took place in the individual's home, in a sufficiently sized meeting room. Individuals being reviewed either attended the conference or met privately with the psychiatrist just prior to the meeting. PTRs were the principal venue at which the psychiatrist and the IDT reviewed psychiatric diagnoses and treatment, and they provided an appropriate setting to fulfill the requirements for periodic review of psychiatric treatment, as outlined in the DADS Policy and Procedure for psychiatry. PTRs were attended by several IDT team members, including the QDDP, psychologist, behavior analyst, nurse case manager, the psychiatry assistant, and selected DSPs who knew the individual well. As needs required and schedules allowed, the meetings were variably attended by the PCP, by the clinical pharmacist, by other IDT members. Guardians were invited to attend or to participate telephonically. Discussion on each individual lasted 30 minutes to 45 minutes. At the beginning of each appointment the psychiatrist was provided a several page summary which included a report from the individual's psychologist, and the QDDP's report on level of supervision, programming, family contact, and outings. The RN provided information on physiologic data such as weight, diet, BMI, physical health status, illnesses, injuries, consultations,	Noncompliance

		MOSES and DISCUS side effect scales, and labs results. Any new QDDRs were presented for review and summaries of several recent QDRRs were provided. During the visit, the Monitoring Team attended a PTR lead by Dr. Chacko. The Monitoring Team observed the PTR discussion for Individuals #300, #511, #471, and #460. For each of the individuals, part of the PTR discussion focused on a clinical understanding of psychiatric symptoms. In each case, the symptoms discussed were central to the clinical formulation of the individual's case; they were part of the diagnostic criteria for the diagnosis of record that was selected by the psychiatrist. Via the discussion between the psychiatrist and her colleagues, further exploration and a better understanding of the symptoms lead to a better understanding of the individual and the clinical diagnosis. Observations by the Monitoring Team included: • Individual #425 was diagnosed with autism. Discussion during the PTR centered on exploring reasons why a medication (Geodon) had failed to reduce challenging behaviors. The psychologist reviewed a number of psychosocial stressors (new admission and new roommate), and the discussion then turned to the lack of a good understanding about the functional purpose of the target behavior, and how it was linked to the underlying diagnosis of autism. The discussion helped explore some of the Individual's clinical symptoms and this lead to suggestions about modifications in his school program. • Individual #308 was diagnosed with autism and attention deficit hyperactivity disorder. Discussion of ratings of the Connors ratings scales for ADHD (symptoms of impulsivity, shortened attention span, and inattentiveness) alongside noted difficulties with transitions from one activity to another helped clarify the aspects of both diagnoses. • Individual #511 was also diagnosed with autism. The PTR touched on the symptoms of the disorder in her case. • Individual #479 was diagnosed with Bipolar Disorder and ADHD. The PTR discussion included whether the mood lability he experiences is sufficient support for the diagnosis of bipolar disorder. The discussion was inconclusive, but the psychiatrist commented that she will consider whether the individual should continue to have that diagnosis. • Individual #460 was admitted to the Facility two weeks prior to the PTR. Staff from the various disciplines present exchanged information that had been gathered from the referring facility. This information was helpful in providing a complete diagnostic picture, for inclusion in the pending psychiatric evaluation. 2. <u>IDT meetings to consider recommendations for new medications</u>: The clinical process in place at the Facility required the IDT to convene each time a new	

		medication was proposed. Effective 10/31/2011, the Facility revised the ISPA shell for new psychoactive medication. The Monitoring Team reviewed the new ISPA shell. It included a section on the psychiatric diagnosis that justified the new medication. The inclusion of that element in the shell gave the IDT and the psychiatrist an additional opportunity to review the psychiatric diagnosis as part of the justification for the proposed new medication. ISPAs that included discussion relevant to the diagnosis were for Individuals #184 (Psychosis, NOS and Abilify) #30 (Bipolar Disorder and Risperdal), #65 (ADHD - clonidine and Concerta), #315 (Tourettes - Risperdal), #255 (ADHD - Adderal), #591 (OCD/PDD Abilify), and #86 (Bipolar disorder - Abilify). 3. <u>IDT meetings to consider recommendations for medical restraints during dental procedures:</u> The clinical process in place at the Facility required the IDT to convene to consider recommendations for pre-treatment sedation or TIVA. As described in the Plan of Improvement (POI), as of 10/21/2011, the Facility revised the ISPA shell for proposed medical sedation. The new shell asked the psychiatrist and the team why sedation was recommended, and possible psychiatric symptoms/diagnoses were reviewed here as well. The Monitoring Team sampled six individuals who received medical restraints as part of dental procedures (for full details, see Provision J4). The Monitoring Team's analysis included a review of the ISPAs. In a number of these cases, psychiatric symptoms were noted that were relevant to the diagnosis, could explain (at least in part) the difficulties the individual experienced with the dental procedure, and offered guidance as to how the need might be minimized. Examples were Individuals #588 and #349, both of whom had problems with anxiety that was cited in the ISPA. 4. <u>IDT meetings when an individual was restrained more than three times in 30 days.</u> Psychiatrists now attend these meetings, and a clinical review of the circumstances provides an opportunity for the psychiatrist and team to reflect on the clinical formulation of the individual, and how that may have contributed to the presumed need to use restraints. Examples include: Individuals #12, #38 and #490. 5. <u>Annual ISPs and their quarterly updates:</u> Psychiatrists participated in the annual ISP meetings for individuals under their care; those ISPs are discussed under Provision J8. No ISP meetings of individuals who were under psychiatric care took place during the visit; however the Monitoring Team did observe two quarterly reviews of the ISPs for individuals who were under psychiatric care. These were Individual #187, diagnosed with schizoaffective disorder, and Individual #149, diagnosed with Schizophrenia. Dr. Morgan was the treating psychiatrist for the two individuals. In the case of Individual #149, there was a review of the individual's delusional behavior. In both cases there was a review	

		of the rating of psychiatric risk, based on the eight-point scale in use at the Facility. 6. Specialty clinic care. As described under Provision J15. Psychiatrists participated with colleagues in specialty clinics like neurology. During the visit, the Monitoring Team asked a number of questions and conducted a number of analyses. These were intended to explore the manner in which the psychiatric evaluation and diagnosis was conducted. Were the Facility's documents adequate to capture relevant information on psychiatric evaluation and diagnosis? The above paragraphs addressed the issue of where and how needed clinical examinations and deliberations took place. A related but somewhat separate question is whether the clinical information was recorded in a format that allowed the results of those processes to be conveyed to the key documents that organize longer term treatment efforts and guide the overall treatment process. During the visit, these matters were discussed in some detail with Facility leads for psychology and psychiatry. The discussion helped identify that key information needed to be reflected in core documents such as the Functional Assessment (FA), the PBSP, and the ISP. These three documents were updated on a regular basis and at least annually. Another place that often serves as a repository of important clinical psychiatric information is an annual psychiatric review. Annual psychiatric evaluations were not part of the current structure at the Facility. However, Dr. Morgan shared that she had concluded that such a document was needed and she was planning to put such a document in place. Generally, the update will take the form of the Appendix B psychiatric evaluation. Information that has not changed will not need to be repeated each year. The updates will be an appropriate venue for additions to the psychiatric understanding of the individual; for example it will be the appropriate place to comment on diagnoses that have changed, and the justifications for those changes. The POI addressed the issue of how psychiatric information should contribute to integrated behavioral healthcare information: The Facility has developed a Psychiatric Treatment Plan (PTP). The use of that document has just begun. The shell for the PTP was reviewed by the Monitoring Team; it contains the key psychiatric information including information on diagnoses. It will be updated whenever a new medication is introduced, and, during the third quarter of the annual cycle. The PTP will be reviewed by the PBSC and will function as an addendum to the PBSP. Since it contains much information about psychiatric medication, it is reviewed under Provision J3. Psychiatric diagnostic information is also captured via a combined case formulation, discussed under Provision J8. In the assessment of the Monitoring Team, the use of the PTP, annual psychiatric review should provide the needed psychiatric information for integrated behavioral healthcare plans.	

		Improvements in the way information on psychiatric evaluation and diagnosis should contribute to the overall ISP were addressed by the POI via the improved ISPAs described above. Psychiatric evaluations and updates (when available) will also contribute. Information on the psychiatric evaluation and treatment is part of the FA and PBSP, which in turn also contributes to the ISP. Further discussion on this point is included under provisions J8 and J9. <u>Were evaluations completed in a timely manner?</u> A measure of the overall quality of the diagnostic process was the timeliness of the evaluation process. To do so the Monitoring Team reviewed records for 4 new admissions. • Individual #308 was admitted 10/11/11, the initial PTR was on 11/9/11, and the Psychiatric Evaluation was done on 10/19/11 • Individual #130 was admitted on 06/29/11, the initial PTR was on 07/01/11, and the Psychiatric Evaluation was done on 8/3/11 • Individual # 367 was admitted on 10/25/11, the initial PTR was on 11/09/11, and the Psychiatric Evaluation was done on 11/09/11 • Individual # 460 was admitted 01/03/12, and the initial PTR was held on 01/18/12 (attended by the Monitoring Team) Psychiatric assessments for new admissions to the Facility during the past six months were done in a timely manner. <u>Were the target symptoms for psychiatric treatment appropriate?</u> Psychotropic medication treatments targeted symptoms of psychiatric disorders. Since many of the individuals who received treatment had limited language skills, the chosen symptoms included observable behavioral markers for those disorders. In contrast, behavioral treatment initiated by psychologists focused on learned behaviors that limited individual's ability to function optimally. Those challenging behaviors were not necessarily connected to any psychiatric disorders. To review whether psychiatric treatment properly focused on the symptoms of mental illness, the Monitoring Team compared behavioral targets for psychiatric treatment, to behavioral targets of psychological treatment. To do so, the Monitoring Team reviewed all twenty four proposals for new medication treatment reviewed by PBSC during the last six months. The review compared the behavioral markers chosen by the psychiatrists, to the behavioral targets for treatment that that had been chosen by psychologists for the individuals in question, and identified in the PBSP. The analysis showed that in 19 of the 24 medications (79%) psychiatrists had identified at least one behavioral characteristic that was linked to the key features of the underlying psychiatric diagnosis, and which differentiated the evaluation of the medication treatment from the broader challenging behaviors listed for behavioral	

		treatment. Were NOS and "rule out" diagnoses used properly? The Monitoring Team examined the Psychiatry Department Database. The Monitoring Team found that 36/149 (24%) had one or more unresolved NOS diagnoses. The number was high. Was there an adequacy of the process to track diagnoses and diagnostic updates? The Monitoring Team Reviewed the Psychiatry Department database and discussed with the Lead Psychiatrist the manner in which it is used. The database was up to date and was consistent with the diagnoses reported in psychiatric evaluations and diagnostic revisions. The Monitoring Team reviewed whether the same diagnoses were reported in other sections of the record. To do so, the Monitoring Team compared the diagnoses listed in the database to the Active Problem Lists (APL) that are included in the PCP's annual medical review. Records reviewed were the 17 records of the core review sample. In 11 of 17 cases (65%) the same information was contained in the psychiatric database and the APLs. In 6 of17 cases (35%) there were differences between the two lists, even though both reported information in the DSM/ICD format. Differences between the database and the APLs were noted for Individuals #1, #120, #181, #308, #403, and #490. In at least one case (#120) the diagnosis was updated by the psychiatrist but the update did not appear in the APL. The Facility is encouraged to examine the relevant administrative issues, and at the next tour the Monitoring Team will review again the manner in which diagnoses and diagnostic updates are made and tracked. If this is not already done, the Facility should consider a way to update the APL in the record when changes take place, either by replacing the APL in the chart when a change is made or by manually updating the APL in the record.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	Facility practices around psychotropic medication were guided by the DADS Policy and Procedure 007.2 Psychiatry Services (08/30/11). BSSLC did not have a separate policy and procedure document for psychiatric services. Procedures in place for monitoring psychotropic medication use: PTRs, described under Provision J2, were the main venue for review of elective psychotropic medication treatment. Individuals who were treated with psychotropic medications were reviewed monthly and more often if it was needed. During the visit, the Monitoring Team observed a PTR. The Monitoring Team evaluated whether medication efficacy was assessed, whether each medication was linked to behavioral observable characteristics of a psychiatric diagnosis, and whether there were data measures provided to support data driven assessments of treatment efficacy. The Monitoring Team learned that the format for presentation of behavioral data during PTRs was in transition at the time of the visit, as follows:	Noncompliance

		• Data on the challenging behaviors that were the focus of behavioral interventions identified by psychologists in the PBSPs: the psychologist provided Behavioral Data Sheets (BDS). These included graphs (typically, for 12 months) that provided data on the frequency of the challenging behaviors identified in the individual's PBSP. A second graph detailed the frequency of the replacement behaviors, and the doses of the medications. There was also a section on the BDS for the psychologist's comments. • Data on the behavioral characteristics identified by the psychiatrists as targets for medication treatment: A short table at the beginning of the PTR provided information on each medication, the diagnosis to which it was linked, and the psychiatric symptoms/target behaviors. An additional column identified whether ratings were administered to evaluate those symptoms. Based on the particulars of the case, graphs, tables, or other reports or additional information were brought to the PTR that provided information on the individual's progress on the psychiatric measures. PTR discussions were observed for 4 individuals: The clinical discussion for all four individuals was relevant, the discussion was clinically solid and it was integrated – there was substantive exchange of information. • Individual #425: A discussion of his failure to respond to treatment with Geodon was a focus for the PTR and the clinical discussion was substantive and positive. However, the template for the PTR review identified that he was given Geodon for the treatment of autism. The symptoms of autism were listed as aggression and self-injury. The record did not make clear how aggression was linked to autism. • Individual #308: There was a positive discussion of efforts to reduce polypharmacy and the taper of Haldol. The use of clonidine for hyperactivity, a symptom of ADHD was based on data from Conner's ratings scales. However, the PTR document stated that Geodon was prescribed for autism, and the symptom of autism was self injury. The records did not make clear how self injury was linked to autism. • Individual #511 was also diagnosed with autism, and he was treated with clonidine and Prozac. Both medications were linked to repetitive behaviors associated with autism. Stereotypy is a reasonable medication target, although it is best to accompany the medication with a description of why it was a clinical problem for the individual. • Individual #479 was treated with Guanfacine and Vyvanse for hyperactivity associated with ADHD, and for bipolar symptoms associated with Bipolar disorder. Informal IDT discussion identified that the bipolar symptom in question was mood lability, and the diagnosis of bipolar disorder was questionable. A further and valuable discussion explored the diagnosis to which the mood lability was linked. However, these discussions should have taken	

		place before the medication was started. Also a measure for mood lability should have been identified before the medication was started. Had that been done, the IDT could have decided whether baseline measure needed to be taken before treatment began. <u>PBSPs documentation for individuals treated with medications.</u> The Monitoring Team reviewed how psychiatric medication treatment was tracked. In addition to PTR documentation, the SA requires that individuals treated with psychotropic medications must have a non-pharmacological treatment program. All individuals at the Facility who were treated with psychotropic medications did, in the form of PBSPs. In order to determine whether PBSPs contained needed information about medication, the PBSPs for the 17 individuals in Sample J1 were reviewed. The following questions were addressed: • Did PBSPs provide the DSM diagnosis that was related to medication? The information was present for 16 of 24 (66%) of the medications but it was not provided for 7of 24 medications (29%). Records that did not contain the needed information were for Individuals #33, #151, #181, #238, #403, and #490. • Did PBSPs provide the relevant psychiatric targets for treatment? In 23 of 24 cases (96%) they did not, even though that information was provided in the PTR notes. The exception was for Individual #490. Instead of psychiatric targets for medication treatment, the information provided was for the behavioral targets (challenging behaviors) that were the focus of behavioral treatments. This problem has been addressed by the planned addition of a psychiatric treatment program which will include the needed information (see below). • Did PBSPs provide information about side effects? The PBSP template now in use refers the reader to the medication consent form, where the information is provided. <u>Were medications used for staff convenience?</u> The Monitoring Team addressed this question by examination of the records, and by observations made during Psychiatric Treatment Reviews (PTR), during a Positive Behavior Support Committee (PBSC) meeting, and in interviews with staff. There was no direct evidence that medications were used deliberately for staff convenience. However, there were many plans in place (see Provision J2 for analysis of the overlap of behavioral targets between psychiatry and psychology) where the only identified targets continue to be disruptive behaviors that were not directly linked to any psychiatric diagnosis and the medication used targeted behaviors that were the focus of behavioral interventions. In such cases there is always that concern that medications were used for behavior control and perhaps for staff convenience. <u>Were medications used for punishment?</u> The Monitoring Team considered observations made during the tour, examined the records of the 20 individuals in Sample J1 and	

		reviewed the records of three individuals who were given medications as part of behavioral crisis management (chemical restraints). These were for Individual #403 on 09/20/11, for Individual #490 on 10/07/11 and 10/21/11 and for Individual #181 on 09/10/11. Each of these episodes was reviewed by the psychiatrist and the need for restraints was verified by the Lead Psychiatrist. There was no evidence the medications were used as part of punishment.	
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.	Background: Individuals who lived at the Facility were seen in the dental clinic for routine care such as annual appointments, for preventative and restorative dental care, and for dental emergencies such as dental abscesses. Pre-treatment sedation was determined to be necessary if an individual experienced repeated episodes of behavioral difficulty during dental or medical appointments, and the difficulties were of sufficient magnitude to preclude participation in the procedure. The procedure to initiate the use of medical sedation for dental procedures was started when difficulties were encountered during an individual's appointment that was not preceded by the use of pre-treatment sedation. Those difficulties were the basis for a request from the dental clinic to the IDT to meet and discuss the need for medical sedation. The IDT meeting that followed was documented. The discussion was organized by an ISPA shell developed for the purpose. As described in the POI, The shell was revised during the review period. Item included in the shell were: • Medical/dental procedure needed • Reason sedation was recommended • Less restrictive techniques used • Sedation history • Medication to be used • Possible drug interactions • Recommendations from the psychiatrist for individual taking psychotropics • Monitoring procedures to be used • Consent status (person contacted for consent) Review by PBSC/HRC followed. Medical Monitoring for safety during the procedures was guided by DADS nursing protocols for pre-treatment and post-treatment sedation (oral pre-treatment) and post anesthesia care (TIVA). All individuals who received medical sedation needed behavioral plans to minimize the need for restraints. The Monitoring Team reviewed the rates of use of medical restraint for dental care: The dental clinic stated that since the last compliance tour, 33 individuals had been treated with TIVA for dental purposes, and four individuals were treated with oral pretreatment	Noncompliance

		sedation. The Dental department was unable to generate a percentage of dental procedures that utilized medical restraints. The Dental department commented that in the past six months about 10% of the individuals who lived at the Facility were treated with medical restraints for dental care. The Monitoring Team reviewed the list of individuals who had approved plans in place to reduce the need for medical restraint. There were 108 such plans. The Monitoring Team compared the list of individuals who received sedation to the list of individuals who had behavioral plans. Some kind of behavioral plan was in place for 13 of 33 (40%) of the individuals who received TIVA. Some kind of behavioral was in place for 2 of 4 (50%) of the individuals who received oral pretreatment sedation. Pretreatment sedation for medical procedures other than dental was not reviewed during this compliance tour. Plans to reduce the needs for medical restraint were not yet in place for many individuals. The Monitoring Team was informed that the matter is being reviewed by the Facility workgroup for sedation; the workgroup had identified about 25 individuals who were felt to be high priority to receive such plans. The Monitoring Team sampled four cases of TIVA and two cases of oral pre-treatment sedation for review (Sample J2): • ISPAs were reviewed: For Individuals #349 and #588, anxiety was noted but no desensitization was recommended. For Individual #45 the plan was to visit the health center to greet the hygienist, and for Individual #443 a training program to cooperate with the dental hygienist was recommended. For Individual #392 a plan was proposed to meet the dental staff. These plans were not yet implemented. • Restraint checklists were completed in 5of 6 procedures. • Medical orders were written properly. Vital sign monitoring was done during the procedures, but post procedure REACT scores were not provided. For Individual #349, the oral pre-treatment sedation procedures, pre and pro-post sedation nursing forms were filled out with all needed information. For Individual #45, pre and pro-post sedation nursing forms were not provided; IPN notes provided some vital sign information but not the full number of measures per the protocol. Some progress had been made by the Facility since the last compliance tour. Nursing protocols for safety were now in place, a good shell to guide ISPA discussion for the need for treatment sedation had been developed, and a workgroup was meeting to discuss further steps that need to be taken. However, use of the protocol was not consistent, for example as cited above for individual #45. The Facility was found not to be in substantial compliance since the Facility was not able	

		to provide needed information on the rates at which sedation was used, since many individuals who needed plans did not have them and the plans reviewed were often only minimally related to the sedation, and since there was no plan in place to review whether or not efforts to reduce the use of medical restraint were effective.	
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.	One hundred and forty eight individuals received psychotropic medication. This group represented 48% of the 310 individuals who lived at the Facility. Staffing at the Facility continued with the three psychiatrists employed by the Facility at the time of the last tour. The number of hours worked by each psychiatrist has changed. At the time of the monitoring visit Dr. Victoria Morgan worked 20 hours per week, and Drs. Reeba Chacko and Sergio Luna each worked 40 hours per week. The combined level of effort of the three psychiatrists was 2.5 FTEs. All three psychiatrists were board certified by the American Board of Psychiatry and Neurology. The Monitoring Team reviewed the caseload assignments for each of the psychiatrists. Dr. Morgan had a caseload of 30 individuals, Dr. Luna had a caseload of 55 individuals, and Dr Chacko had a caseload of 64 individuals. Administrative support offered to the psychiatrists (e.g., secretarial, administrative scheduling of psychiatric consultation, etc,) continued to be two full time psychiatry assistants. The Facility provided, a determination of the amount of psychiatry FTEs needed. The determination was based on the number of individuals treated in the psychiatry clinic, the need to provide coverage for psychiatry clinics and other clinical responses needed across the campus, the need to provide admission evaluations and updates, to attend meetings such as PMOC and P&TC and physician's meetings, ISPs, and ISPAs, and to attend to needed clinical/administrative issues that concerned psychiatry. The Facility concluded that 2.5 FTEs of psychiatric time was adequate to ensure the provision of services necessary for implementation of this section of the SA. The Monitoring Team agreed.	Substantial Compliance
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as	The Department of Psychiatry provided the Monitoring Team with the names of 86 individuals for whom Appendix B evaluations had been completed, and 58% of the individuals who needed Appendix B Evaluations had received them. This contrasted favorably with the 31 completed evaluations that were in place at the time of the last compliance visit. The overall process of evaluation and diagnosis was described under Provision J2. The overall evaluation process took place not only in the formal evaluations, but also through psychiatrists' participation in PTRs, and specialty clinics of other disciplines, for example	Noncompliance

	described in Appendix B.	neurology. Psychiatrists attended quarterly and annual ISPs, and worked with other behavioral specialists (primarily psychology) for example through the combined psychology-psychiatry workshops. The introduction of the combined case analyses described under Provision J8 also contributed to the process of evaluation and diagnosis. The Monitoring Team reviewed the 17 individuals in Sample J1 for the presence of Appendix B evaluations. Twelve of the seventeen (70%) individual in Sample J1 had Appendix B evaluations and each was reviewed. The format for Appendix B evaluations had fourteen sections, and for all but one (Individual #130) all sections were complete. Individual #130 (admitted to the Facility in June 2011) had only three completed sections. The evaluation should have been completed. There were two new admissions during the second half of 2011, and both were included in Sample J1, and they had completed Appendix B evaluations that had information on all sections. It was positive that all the new admissions received Appendix B evaluations. The eleven completed evaluations varied in length from three to eleven singled spaces pages in length. Generally, the evaluations were detailed and they provided the needed clinical information. There were examples of detailed treatment histories that helped guide current treatment (for example, Individual #490), that presented good medical histories (for example, Individual #181), and relevant developmental histories (for example #308). There were examples of good mental status examinations (for example, Individual #513,) and good psychiatric case formulations (example Individual #305). The Monitoring Team found that there was need to improve psychiatric evaluations in the areas of diagnostic specificity and diagnostic justification. For example, four of twelve individuals (33%) had NOS diagnoses. In many additional cases, specific diagnoses were provided, but not the documentation needed to fully substantiate the psychiatric diagnosis in terms of all of the symptoms that would be required to fulfill the complete diagnostic criteria set forth in the *DSM-IV-TR* or the *Diagnostic Manual of Intellectual Disability (DM-ID*). There were exceptions to this, however. Four of the individuals (#238, #308, #425, and #597), were diagnosed with autism. For those individuals, the diagnoses were in the DSM format and the diagnoses were fully justified. During the compliance tour the Monitoring Team met with the Facility Psychiatrists to review and clarify the level of detail that is required in the documentation of diagnoses. The Lead Psychiatrist told the Monitoring Team that annual updates of the psychiatric evaluations would be put in place. The decision to do so was a positive step. Among other things, annual updates will provide the psychiatrists with a place to reference changes in diagnoses made during the course of the annual cycle, and to report why the	

		changes were made. The Psychiatry Department had not decided on a date for implementation of the annual psychiatric updates.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	In January 2011, the Psychology Department reported that it had completed the Reiss Screen for all individuals who lived at the Facility, with the exception of individuals who received psychiatric services. The Facility did not provide documentation that all individuals, including those who received psychiatric services, had yet either been screened or had a comprehensive psychiatric assessment. To date 86 of the 149 (58%) individuals who require evaluations have had them. Positive Screens: The Reiss screens done on campus identified two individuals who had Reiss Screens above the cutoffs. These were Individuals #31 and #121. Both received psychiatric evaluations and the Monitoring Team reviewed the evaluations. Neither individual was found to be in need of ongoing psychiatric care. Negative Screens: The Facility reported that with the exception of the above individuals, all other individuals screened with the tool did not reach cutoff values on either the total score or individual subscales, and they were considered negative screens. In January 2011 the Monitoring Team reviewed negative screens for Individuals #8, #34, #54, #89, #93, #206, #283, #294, #337, #339, #423, #428, #445, #472, #508, #548, #574, #595 to assure that they had been done properly. They were, and none exceeded the cutoff values. During the current visit, the Monitoring Team sampled additional Reiss Screens that had been rated by the Facility as negative. This was done to increase the number of screens reviewed to 20% of the total. The sample was obtained by selecting every 10th name from the list of individuals who lived at the Facility; if the selected name was for a person who received psychiatric services, the next name on the list was selected. These were for Individuals #43, #95, #102, #111, #140, #154, #230, #297, #303, #353, #380, #386, #422, and #472. None of the screens reached clinical cutoffs, and the Monitoring Team confirmed that they too had been properly rated as negative, based on negative total and subscale scores. The combined total of the two lists was 32 individuals. The combined group of individuals represented a 20% sample of individuals who lived at the Facility and who were not seen by psychiatry. Individuals who are newly admitted needed to receive the Reiss Screen, unless they were seen by psychiatry. During the past six months there were 3 admissions. All were seen by psychiatry and all received psychiatric evaluations (see Provision J2) On the basis of the above, the Monitoring Team concluded that the Facility had carried out the screening as required.	Noncompliance

		The provision remains in non compliance due to the number of individuals who still need psychiatric evaluations.	
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.	There were many places in the Facility where psychologists, psychiatrists, and other behavioral health care providers worked together as part of the IDT. This included PTRs PBSC, and Psychotropic Medication Oversight Committee (PMOC) meetings, quarterly and annual ISP reviews, and co-management of crisis situations (including after-hours on-call work) and debriefings for those situations. Psychiatrist and psychologists participated in workgroups that addressed restraint and pretreatment sedation, and through participation in the combined psychology-psychiatry workdays. Joint work also took place in many other less formal interactions, activities, and venues. In previous reports (see Provision J8 of October 12th compliance report) the Monitoring Team commented that although psychiatry and psychology worked side-by-side, much of the work that involved more than one discipline remained multidisciplinary, rather than interdisciplinary. The combined assessment and case formulation that were required by the SA were not present, and integrated care suffered. In the POI, the Facility reports that it has refocused the psychology-psychiatry workdays, to provide combined case formulations. As of 12/14/2011, combined case formulations had been completed for 19 individuals with November or December ISP meetings. These were reviewed by the Monitoring Team. An example of the product is the combined case-formulation for Individual #50: *"(Individual #50) is an individual who has a positive behavior support plan that targets the symptoms of depressive symptoms, self injurious behavior (SIB), physical aggression, disrobing and loud vocalizations. He has an Axis I diagnosis of Depressive Disorder NOS. His depressive symptoms are characterized by meal refusals, holding his head and crying. Psychoactive medication of Remeron is prescribed to target those symptoms, and he has responded well to this psychiatric treatment. He does demonstrate learned behaviors of physical aggression, self injurious behavior, disrobing and loud vocalizations. (Individual #50) does have a genetic predisposition for depressive symptoms and siblings have been treated with medication. His other targeted challenging behaviors have multiple functions. Speech services should be utilized to allow (Individual #50) to allow an improved range of communication devices and opportunities. "* This was a positive example of an integrated statement that brought together understandings of both behavioral and biological aspects of the individual's functioning. There were many examples of good formulations. The above example was cited since it addressed the roles in treatment not only for psychiatry and psychology, but for speech and language and other habilitation specialists as well. It is an example of a combined	Noncompliance

		understanding that can lead to tangible efforts in active treatment. During the visit, the Monitoring Team learned that the Facility had decided to place a case formulation statement in the template for the FBA document. The Monitoring Team requested and reviewed seven examples of PBRC-approved FBAs that included combined case formulation. The Monitoring Team found that they were useful additions to the FBA and that they were appropriately placed there. The FBA was a natural place for information about the functioning of the individual, and the formulations in the FBA provided a context for the interventions of the various disciplines (e.g. medication and behavioral interventions) that were spelled out in the PBSP that followed. <u>Observations made by the Monitoring Team during the visit:</u> The Monitoring Team attended several meetings and made several observations about the system that was in place to integrate pharmacological treatments with behavioral and other interventions. For example: • The Monitoring Team attended the 01/16/12 PBSC meeting. The committee reviewed FBA/PBSPs that had combined formulations. The case of Individual #20 was noteworthy. That individual was diagnosed with PDD and OCD, and had challenging behaviors that included compulsive self injury. The case formulation clarified that the Individual's symptom of SIB was non-social and was a function of her OCD. This provided the information that was needed, to explain why self- injurious behavior was a proper target for the psychotropic medication Luvox. The clarity of the written presentation facilitated a focused and productive review of the PBSP. • The Monitoring Team attended the 1/17/12 AM Medical Morning meeting. The medical group reviewed several individuals, and issues around psychotropic medication use were well integrated into the discussion of behavioral and general medical care. These included discussions of Individual #112 (the on-call physician responded to after-hours questions about an extra dose of medication taken while on pass), and Individual #169 (who had possible medical complications of treatment with anticholinergic medications). The discussions were examples of positive practice. • The Monitoring Team attended the PTR that took place on 1/19/12. The reviews for Individuals #308 and #425 included discussions between psychology, psychiatry, and nursing. These, too, were examples of positive practice. Presentation of data for that meeting, however, was not adequate (see discussion under Provision J3). • The Monitoring Team also attended the 01/16/12 quarterly ISP reviews for Individuals, #149 and #187. In that case, although psychiatry attended the meeting, the discussion was not integrated. <u>Documents reviewed:</u> The Monitoring Team reviewed the records of the 17 individuals	

		in Sample J1 to explore how pharmacological treatment information was integrated with behavioral and other interventions. How pharmacological information was integrated with information from other behavioral healthcare providers was explored by review of the FBA and PBSP. How pharmacological information was integrated with the overall treatment plans was explored by review of the ISP. Three of the seventeen cases (18%) had combined behavioral case formulations in place. • Individual #1 had a good combined case formulation and important information from the behavioral healthcare team was included in the ISP. This included information on changes in the degree of the individual's hyperactivity. • Individual #425 had a good combined case formulation in place that clarified that medication addressed aspects of his autism, and delineated challenging behaviors addressed by behavioral interventions. The psychiatric component was not addressed in the most recent ISP. • Individual #238 had a good combined case formulation in place that clarified that medication addressed aspects of attention deficit disorder and delineated many challenging behaviors addressed by behavioral interventions. The psychiatric component was not addressed in the most recent ISP. Fourteen of seventeen (82%) individuals did not have combined case formulations in place. For one of those individuals (#403) there was nonetheless information in the ISP that clarified how medication was helpful for his treatment. The medication in question was clomipramine, which targeted compulsive behaviors. In the remaining cases, information about pharmacological treatment in the ISP was uninformative.	
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	The provision required that three elements should be considered before implementation of a PBSP for individuals who received psychiatric care and services. Each of these is discussed separately. <u>The PST and psychiatrist should determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition:</u> The Monitoring Team reviewed the 24 medications that were presented to the PBSC and HRC. The HRC review form documented that less intrusive approaches of some kind had been previously tried for 22 of 24 individuals (92%). For Individual #238 (Risperdal) the place on the HRC form for the review was left blank. For Individual #61 (Clozaril) the only less intrusive approaches named were other medications. However, it was not clear to the Monitoring Team where IDT discussions took place that considered whether proposed new treatment met the above descriptions, or that ongoing treatments continued to meet them. The Monitoring Team will review this matter at the time of the next compliance visit. <u>The PST and psychiatrist should determine whether the individual will best be served</u>	Noncompliance

	use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	primarily through behavioral, pharmacology, or other interventions, in combination or alone: As discussed under Provision J2, all individuals who are treated with medication must have some form nonpharmacological program. The Monitoring Team reviewed each of the records to determine if the PST met to determine the particular modality or modalities of nonpharmacological treatment that was best suited for the individual. There are many places in the process at the Facility where such discussions currently take place. The most central place in the current process is the PTR. In recent months the Facility has started to place a combined case formulation for behavioral health care in the SFA (see Provision J8). Statements on which treatments are needed and why is a key element of those formulations. The Monitoring Team reviewed samples of the combined cases formulations (see Provision J8) and the results were encouraging. However, the process to include combined case formulation as part of the SFA was just initiated, and they are not in place for most of the individuals. For individuals who take psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible: This requirement flows from the preceding requirement which calls for the reasons behind the designation of treatment modality. In essence, it is the "what" that complemented the "why" that preceded it. The Monitoring Team reviewed ISPs for the 17 individuals in Sample J1 for inclusion of behavioral supports. Sixteen of 17 individuals (94%) did so. In one case (Individual #308, newly admitted) the Monitoring Team did not find this; perhaps it was in the process of development. In summary, progress has been made in this provision, primarily due to the initiation of the combined case formulations. However, this process, described more fully under Provision J8, has just been implemented and relatively few individuals have case formulations. The Facility must provide clear and consistent procedures for where and how the deliberations about less restrictive alternatives take place. For those reasons, the provision remains in non-compliance.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible	BSSLC did not have its own policy for psychiatry. Activities of the Psychiatry Department were guided by DADS Policy and Procedures 007.2 Psychiatry Services (08/30/11). That policy required that before the administration of psychotropic medication the PST, including the psychiatrist, PCP, and nurse, must determine whether the harmful effects of the medication outweigh the possible harmful effects of psychotropic medication, and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous that the medications. These requirements paralleled SA requirements. Risk vs. Risk: There were five places in Facility records where Risk vs. Risk Assessments were documented. They were:	Noncompliance

	harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	1. There was a section for risk assessment in the revised ISPA for new medications. Psychiatrists participated in that process. 2. In the Medication Response Profile (MRP) section of the medication consent form, there was review of expected drug responses to specified targeted symptoms and a listing of common side effects. Psychiatrists authored that document. 3. In the PTP there was a medication risk vs. risk summary. Psychiatrists authored that document; the document is currently being piloted on some units (see J13). 4. In the HRC reviews for new medications, there was a section for risk vs. risk analysis. 5. In the template for PTRs, there was a section titled "Conclusion and risk vs. benefit discussion." Psychiatrists dictated that information during PTRs. The Monitoring Team reviewed how and where the nurse, primary care physician, and psychiatrist participated in the IDT process for reviewing risk. Nurses were key participants in the PTR process and attended the IDT review for new medications. Primary care physicians were frequently presented at PTRs, and they review and co-sign PTPs. Psychiatrists author the PTPs and participate in PTRs and ISP meetings for new medications. The Monitoring Team observed the processes for discussing a new medication by attending a PTR (described under Provision J2 and J3) and the Monitoring reviewed the subsequent documentation of the PTR. For each individual, the nurse case manager took the lead in describing physical aspects of the individual's health, including side effects. MOSES (quarterly) and DISCUS (biannual) side effect forms were not reviewed since they were not due for the review in question, but there was general discussion about side effects. The psychiatrist commented for each individual on risk. In the case of two individuals whose medications were being tapered, the psychiatrist commented that due to lack of efficacy the risks outweighed the benefits. For each of the 24 medications reviewed and approved by PBSC and HRC, the Monitoring Team reviewed the following information: MRPs, ISPAs, PTRs s that explained the rationales for the choice of medication, the MRP part of the medication consent, and review of the psychotropic medication by PBSC and HRC. The review showed that: • Risks of taking the medication: For all 24 medications, potential side effects were reviewed. Sometimes, though, the risk that were cited were the risks for having a PBSP. For example, (Individual #255, for Depakote) the cited risk was "the risk of having PBSP is a possible embarrassment for (the individual)." This was confusing since it did not relate to the medication. • Risk of not taking the medicine: the symptoms of the untreated problem were typically cited.	

		• Risk vs. risk analysis: For one of the 24 medications reviewed (Individual # 120, for Risperdal) the required analysis was done, as follows: *"The risk of not using the medicine to keep him for hallucinating, causing harm to himself or others outweighed the side effect of thirst, weight gain, mouth dryness , frequent dehydration, nausea, drowsiness or other possible side effects. "* In the remainder of the cases, no analysis was reported. <u>Alternative treatment strategies (including no treatment):</u> Alternative treatment strategies were not presented in the consent form. The Monitoring Team discussed with the Lead Psychiatrist the possibility of adding this information to the MRP section of the informed consent for medication.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	DADS Policy and Procedure (Psychiatry) 007.2 clarified that State Centers must establish a system to review and monitor individuals who are prescribed two or more psychotropic medications from the same class, or three or more psychotropic medications, regardless of the class. The monitoring system needed to provide information to the State Center's Pharmacy and Therapeutics Committee, to allow tracking and trending of prescribing information by individual, by prescriber, and by medication. At BSSLC that system was centered on the Psychotropic Medication oversight Committee (PMOC), described in reports from previous compliance visits. Information from PMOC was provided to the Pharmacy and Therapeutics committee (P&TC). Key individuals, including the Leads for Psychiatry and Pharmacy, participated in both committees. Polypharmacy reviews at the Facility started at the level of PTRs and QDDRs. The Monitoring Team reviewed these documents for each of the individuals, who were part of Sample J1. Comments on the presence or absence of polypharmacy were part of the template for QDRR reviews, and were included in each review. Drug- drug interactions, drug levels, and laboratory data related to the medications were part of the review process. This represented good practice. In addition to the individual reviews of polypharmacy, the PMOC conducted Facility wide reviews of patterns of use of medications, and certain subgroups of polypharmacy practices. During the 1/17/12 PMOC that the Monitoring Team observed, the committee reviewed all individuals who had intraclass polypharmacy with multiple mood stabilizers. As part of the meeting the committee discussed the circumstances of each of the individuals in questions with that individual's treating psychiatrist. In a number of cases psychiatrists commented that that current medications were needed for individuals to maintain clinical stability (for example Individual #488), since it has been unsuccessfully challenged in the past, although no details were provided. The provision did provide that the polypharmacy regimens could be maintained. However, the	Noncompliance

		Monitoring Team will look for evidence that each medication had independently determined to be clinically necessary on the basis of data. As reviewed in the POI, on 11/22/11 a PMOC subcommittee met with Facility QA staff to discuss continued polypharmacy database development and internal QA audits. These are needed. During the compliance tour the Monitoring Team requested and was presented with overall data for the past year, showing rates of intraclass and interclass polypharmacy. The Monitoring Team noted that overall rates of polypharmacy did not change significantly over the past 12 months: in November 2010 (earliest data presented) there were 58 individuals who received interclass polypharmacy and 25 individuals who received 2 or more medications from the same class intraclass polypharmacy. Thirteen months later, in December 2012 the numbers were unchanged- they remained 58 and 25, respectively. The lack of a decrease in mean rates of polypharmacy was discussed with key PMOC members, who speculated that although the mean data had not changed, there may have to have been decreases in more subtle measures of polypharmacy. For example it was possible that the average number of medications per individuals had decreased (the group of individuals treated with interclass polypharmacy included individuals who took as few as three medications and as many as nine medications). However, relevant analyses of data to support that suggestion had not been done. Other suggested that admissions of individuals on many medications that might have skewed the data. Again, no analyses had been done to explore that possibility. The Monitoring Team later reviewed that admissions during the last six months of 2011 were individuals #308 (who was admitted with three psychotropics and two anticonvulsants for epilepsy) and individual #367 (who was admitted with one psychotropic). It is unlikely that these individuals had a significant impact on the overall numbers. The Monitoring Team reviewed PMOC notes from the 12/29/11 meeting. In the section on Database tracking demonstrated that there had been a discussion about the failure to reduce polypharmacy across the campus. Dr. Morgan discussed that psychiatry caseload had been reduced, in part since some individuals no longer took psychotropics and did not need to be monitored by psychiatry, and others had been discharged. This could have increased the percentage of the medicated individual who remained on caseloads. Here too, there was as no formal analysis. Overall, the Monitoring Team noted that a basic structure was in place and valuable data were available to the PMOC. The next step is to analyze that data, perhaps with trend analyses. The purpose should be to provide the psychiatrists with information that will both support clinicians' effort to reduce unnecessary medications, and allow the Facility to demonstrate progress in that area.	

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.	DADS Policy for Psychiatry 007.2 The Monitoring of Side Effects Scale (MOSES) and the Dyskinesia Identification System is explicit about expectations for the use of MOSES and DISCUS scales: The MOSES must be completed at least every 6 months and the DISCUS must be completed at least every 3 months. The psychiatrist needed to review the results of these scales to monitor the side effects of anticonvulsant and psychotropic medications. Individuals who are prescribed the medication metoclopramide will have the same MOSES and DISCUS monitoring as those receiving psychotropic medications. The records of the 17 Individuals in Sample J1 were reviewed. MOSES evaluations were provided for 16 of the 17 individuals (94%); there was no evaluation for individual #238, who had a screen due in December, after the materials were submitted. MOSES evaluations were done on a six-month schedule, but additional screenings around significant events were not. For example, Individuals #490 and #120 were started on new medications but additional MOSES to screen for side effects were note done DISCUS evaluations were provided for 15 of 17 individuals (88%). DISCUS evaluations were not needed for Individual #33 since he did not take medications that required that screen. A DISCUS evaluation was due in December (after the materials were submitted) for Individual #238, but no evaluation was received for September. Seven individuals had only one DISCUS evaluation. PMOC and the QA nurse made significant efforts to assure that all required screens were administered and physician reviews completed. The internal QA process was reviewed by PMOC in the December meeting and that showed that some difficulties remain; the Lead Psychiatrist will complete a formal training memo for the physicians and RN case managers to address the matter. The Facility list of individuals treated with metoclopramide was reviewed. There were eight such individuals across the campus. The Monitoring Team was provided with a Facility tracking sheet that indicated that DISCUS screenings were done for these individuals. The actual screens were not reviewed. The Facility had made progress with a Facility level monitoring of the results of DISCUS ratings. It was not clear, however, that all individuals who needed screens had received them, or that screens were provided at the required frequency.	Noncompliance
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving	The language of the provision detailed what was required for psychotropic medication plans, and the same requirements were also part of DADS Policy and Procedures 007.2 Psychiatry Services (08/30/11). At the time of the last review, the Monitoring Team found that the Facility was in the process of development of Psychiatric Treatment Plans	Noncompliance

	psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	that would provide required medication treatment plans, but that these were not in place. During the review period, there were changes in the way the Facility used two documents that related to the development of medication plans: • As outlined by the in POI for Provision J9, on 10/26/11 the QDDP Coordinator and Lead Psychiatrist revised the ISPA shell for new psychoactive medication to improve team discussion and documentation. The ISPA shell guided the IDT to review the reasons that the new medication was proposed and the risk associated with giving, or not giving, the medication. The Monitoring Team reviewed the revised shell and examples of its use (details provided near the end of the discussion for this provision). • As outlined in the POI Action Step for Provision J3, the Facility also continued the development of Psychiatric Treatment Plans (PTP). The Monitoring Team reviewed the shell for the PTP. It included the following sections: a. Rationale for Psychiatric Care b. Psychiatric-Behavioral Treatment Formulation (Psychiatric medication and dose, psychiatric diagnosis, and psychiatric symptoms/target behaviors for the treatment c. Psychoactive Medication Changes over the past year d. Medication risk vs. risk summary e. Details for psychiatric treatment monitoring f. Psychoactive medication risk vs. risk summary g. Details of Psychiatric treatment monitoring h. Psychoactive medication goals • Per the POI, at the time of the visit, the clinical use of the PTP was being piloted on one residence for individuals starting new psychoactive medications (details provided near the end of the discussion for this provision). • The Monitoring Team also reviewed a third document in use at the Facility that contained information required by the provision. That was the Medication Response Profile (MRP), part of the form that the Facility used for informed consent. The MRP included information on the expected drug response (the time it would like take for the medication to have effects on the targeted symptoms) and side effects. The Monitoring Team reviewed with the Lead Psychiatrist how these forms would be used for medications that were not new, but which would be continued from year to year. The Lead Psychiatrist told the Monitoring Team that the PTP would be completed both for new medications and as part of the annual update of the PBSP. The update would contain up-to-date information on the use of each of the medications the individual received.	

On the basis of the above, the Monitoring Team reviewed how the information required by the provision would be documented, and concluded as follows:

Required element	BSSLC Document
Psychiatric Diagnosis/pharmacological hypothesis	PTP and MRP
Time line for effects	
By whom, when, and how this monitoring will occur	PTP and Consent
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	Detailed in the PTP/ PBSP/ ISP, implemented through the day-to-day work of the IDT, and monitored via the ISP review process, via PTR, via PMOC and other BSSLC structures.

The Monitoring Team reviewed with the Lead Psychiatrist how the proposed medication treatment plans were to be generated. The Lead Psychiatrist suggested that when the decision to start a new medication was elective, it would typically first be discussed at a scheduled PTR. When the need to start a new medication was more urgent, the decision to do so would be made when the need arose. Consent for the medication would be obtained by the psychiatrist (see Provision J14), and the IDT would review the new medication. At the IDT meeting that generated the ISPA for new medications, the IDT would review the risks of the medication vs. the risk of not providing the medication, and would document the discussion in the ISPA for new medication. Details for the medication plans would be formalized in the Psychiatric Treatment Plan. The consent and PTR would be presented to PBRC and HRC, which would review the consent and treatment plan. The committee also would confirm that the IDT had indeed determined that the most positive and least intrusive interventions were used and that behavioral supports were in place (J9), and that risks of giving and not giving the medicine were considered (J10), and verified that the analysis of risk vs. risk favored the use of the medication.

The Monitoring Team reviewed 4 examples in which the new ISPA shell was used in the process of approval of a new medication. They were for Individuals #86 (ISPA to review proposal for Abilify 10/20/11), #30 (Risperdal 11/15/11), and #65 (clonidine and Concerta, 08/19/11). All contained a good discussion of risk vs. risk and described why the medicine was proposed. The Monitoring Team also reviewed PTPs developed for Individual #120 (Risperdal, October 2011), Individual #25 (Zyprexa- July 2011) and #163 (August 2011). These plans contained the needed elements, with the exception of some of the details of how the psychiatric symptoms would be formally monitored. This could not be done, since the plans for behavioral monitoring of medications are in the

		process of development. (see J3) During the visit the Monitoring Team observed how the process of PBRC approval of medications and PST review of medications took place. These are provided under provisions J2 and J3, respectively.	
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 BSSLC practices on informed consent were guided by (DADS Policy and Procedures 007.2 Psychiatry Services (08/30/11). That document states that State Centers must obtain informed consent (except in the case of an emergency.) BSSLC practices on informed consent were guided by (DADS Policy and Procedures 007.2 Psychiatry Services 08/30/11). That document states that State Centers must obtain informed consent (except in the case of an emergency.) The informed consent form guided the psychiatrist that witnessed verbal consent can be obtained for urgent indications. In those circumstances written consent should still be obtained but not delay the initiation of treatment. During the compliance tour the Monitoring Team confirmed with the Lead Psychiatrist that psychiatry is now responsible for the informed consent and that the psychiatrist spoke directly with the guardian/LAR about the medication. This was a positive practice since it provided the psychiatrist with the opportunity to review with the LAR /guardian the information that was contained in the informed consent, and to answer any questions. The consent forms that were in place at the time of the review include information about Medication name, psychiatric diagnosis, target symptoms and behaviors FDA approval status of the medications Timeline for drug response (expected drug response) Common Side Effects Starting and Maximum Dose The information about the FDA approval for the specified use of the medication was a recent addition to the consent form. If the medication was proposed for use for an "off label" indication, this was specified, along with information about the proposed use of the medication. The information was provided for only 52% of the medication plans, since it was added to the form in the fall of 2011. The addition was an example of good clinical practice. The consent form did not include individually specific information about/risk benefit, or about treatment alternatives (not limited to medications). These were needed. These	NonCompliance

should be included

The process under which informed consent was obtained had not changed since the last monitoring visit of the Monitoring Team. Following the recommendation of the psychiatrist for a new medication, an ISP meeting (attended by psychiatry, psychology, medicine, nursing, pharmacy and Qualified Developmental Disabilities Professional (QDDP) 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. Review by PBRC and HRC followed.

The Monitoring Team examined informed consent documents and PBSC/HRC reviews for 24 new medications that were approved by PBSC and HRC during the six months prior to the visit of the Monitoring Team. The consents for all 24 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. (Note - this procedure was required only when Dr. Chacko was a contract psychiatrist. At the time of the visit Dr. Chacko had just converted to full time employment, and she will now be the prescribing physician for individuals under her care). 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 was to 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.

Result of the review were:

Informed consent element	Monitoring Team Findings
Medication Name	24/24 (100%)
DSM psychiatric diagnosis	24/24 (100%)
Target symptoms and behaviors	24/24 (100%)
FDA indications	13/24 (54%)
Dose range information	24/24 (100%)
Common side effects	24/24 (100%)
Guardian signature	24/24 (100%)

		BSC/HRC approval: 24/24 (100%) During the review period, the Facility added a section on the FDA approval status of the medication. In this section the psychiatrists clarified whether the medication was being used for an approved indication or "off label." In the case of the latter the psychiatrist clarified the basis for the use of the medication. The statement was present in 11 of 24 consents. Thirteen of the medication consents were written before the item about FDA status was added to the form. During previous reviews the Facility clarified that HRC approval was obtained prior to the administration of the medication, and that consent for medication was re-obtained on an annual basis. The Monitoring Team reviewed the informed consents and HRC reviews for all 24 psychotropic medications approved by the HRC during the past six months and found that an informed consent signed by the LAR/Guardian was present for all 24 consents.	
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.	DADS Policy and Procedures 007.2 Psychiatry Services (08/30/11) required the neurologist and psychiatrist to coordinate the use of medications, through the PST process, when medications are used to treat both seizures and a mental health disorder. This DADS policy parallels the requirements of the SA. The Facility Pharmacy provided information on the reasons that anticonvulsant medications were prescribed, as follows: • 57 anticonvulsant medications were prescribed to 54 individuals, for mental health disorders. • 181 anticonvulsant medications were prescribed to 98 individuals, for seizure control. • Eight anticonvulsant medications were prescribed to 8 individuals for both seizure control and mental health disorders. Integration of psychiatry and neurology took place at several points in the clinical process. Neurological care was provided via an outside consultant who provided on site clinics several times per month. Psychiatrists came to that clinic to consult with the neurologist, typically at the time of appointment of individuals who received care (including but not limited to prescriptions of seizure medications for both seizure control and mental health disorders) as described below. Since the neurologist was a consultant, the actual prescribing of medications for seizures was done by the PCPs. Coordination of care, therefore, necessarily included the PCP as well. Psychiatrists and PCPs worked together in many venues, in both formal meetings	Substantial Compliance

		and during the course of their day to day. This includes PCP participation in PTRs which is common, although the PCP was not able to attend the PTR that took place during the visit, due to unavoidable scheduling conflicts. Other venues include the AM medical morning meeting, attended by psychiatrists, PCPs, and pharmacists. The Monitoring Team attended the AM Medical Meeting on 1/17/12. In that meeting the pharmacist provided an excellent review on the use of Keppra, an anticonvulsant. The pharmacist commented on the fact one of the more common side effects of Keppra is anxiety, and the physician and psychiatrists who were at the meeting had an excellent clinical discussion about the use of Keppra with several individuals. That was an example of good practice of integrated care. The Monitoring Team reviewed the records for five individuals who took dual purpose medications: • Individual #181: The neurology clinic note from 10-26-11 was reviewed. Dr. Luna (psychiatrist) and Dr. Brett (Medical Director and PCP) both attended. Seizure frequency and labs were reviewed; there was no need to change medications, including Depakote, which was a dual-purpose medication for both seizures and a mental health disorder. PTR notes were reviewed and they included review of Depakote use. • Individual #332: Was seen in neurology clinic on 07-26-11. The neurologist, PCP and psychiatrist attended the clinic. The neurologist's note made clear that he was aware that the individual was treated with Tegretol as a dual purpose medication, and the psychiatrist and PCP attended the neurology clinic. Tegretol use was reviewed and the neurologist commented on both seizure and mental health aspects of the case. Tegretol levels were documented. The psychiatric use of Tegretol was additionally reviewed in PTR meetings. • Individual #185 was also treated with Tegretol as a dual purpose medication. The neurologist, psychiatrist, and PCP were present at the neurology clinics of 8-17-11 and 10-26-11. The focus was appropriately on seizure control, and complications of seizures. PTR discussion on the medication (for example on 10/18/11) was comprehensive, including a discussion of effects of enzyme induction effects of Tegretol on other medications. • Individual #588 was treated with Depakote for seizures and autism. The neurology clinic on 07-12 was attended by the PCP and was unremarkable. • Individual #496 was treated per the PTR with Depakote for seizures (albeit none in one year, per neurology clinic note of 11/19/09) and with Depakote for "aggression." In a PTR note of 10/20/11 the psychiatrist noted that it is not clear that the Depakote is needed/justified for psychiatric purposes. An obvious possible resolution is the removal of the designation of psychiatric drug for the medication while allowing the neurologist to make decisions on the basis of the seizure needs alone.	

		Overall, the level of integrated care for use of "dual purpose" medications was impressive. The cases reviewed illustrate both straightforward cases (# 181 #332, #185, #558) and also a more complex case (#496) where neurological and psychiatric needs might differ. Of note – careful tracking of the purpose for which seizure medicines are prescribed can be time consuming but as illustrated above, it contributes to coordinated care and is needed. Individual #496 was not included in the list provided by the pharmacy for dual purpose medications.	

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

1. Psychiatrists should provide more evidence to support the cited diagnoses. (Provisions J2 and J6)
2. NOS diagnoses must be resolved whenever it is clinically viable to so. When no clinically viable alternative is available, the reasons must be spelled out. (Provisions J2 and J6
3. The Psychology and Psychiatry Departments need to identify for each medication the measures by which efficacy will be determined, and the way those measures will be tracked. (Provision J3)
4. Behavioral healthcare information provided in the ISP need to reflect the up to date understanding of behavioral healthcare supports that are outlined in FBAs, PBSPs, and psychiatric evaluations. (Provision J8)
5. The Facility should clarify where in the clinical process decisions about least restrictive alternatives are made, and where they are documented. (Provision J9)
6. IDT evaluation of non emergency administration of psychotropic medication should include information on treatment alternatives (including alternatives to medication). (Provision J10)
7. Medication consent forms should include individually specific information about risk/ benefit, and about treatment alternatives (not limited to medications. (Provision J14)
8. MOSES and DISCUS screens should be provided to all individuals who need them. (Provision J12)

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) 12/30/2011 2. BSSLC January 2012 Presentation notes 3. Minutes for the Positive Behavior Support Committee (8/1/2011 – 11/14/2011) 4. Minutes for Behavior Services departmental meetings (6/17/2011 – 11/18/2011) 5. Contracts for professionals providing external peer review, intellectual and adaptive assessment, and counseling 6. Documents that were reviewed included the annual ISP, ISP updates, Specific 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, #11, #12, #20, #21, #26, #33, #38, #62, #66, #76, #88, #95, #130, #133, #151, #159, #163, #173, #181, #185, #202, #254, #264, #281, #291, #316, #349, #367, #381, #399, #403, #417, #422, #425, #453, #467, #474, #490, #504, #511, #513, #528, #590, and #591 7. A sample of records for review of behavior assessment and intervention practices included nine records identified by BSSLC as reflecting "best work" (Individuals #1, #130, #163, #173, #181, #185, #316, #403, and #591) and nine records selected by the Monitor from the Facility list of recently completed assessments and PBSPs (Individuals #76, #95, #202, #254, #264, #291, #422, #425, and #453) **People Interviewed:** 1. Terry Hancock, PhD – Chief Psychologist 2. Kathleen Williamson, Med, BCBA – Psychology Manager 3. Shawn Cureton, MS – Psychology Manager 4. Kim Littleton – ADOP 5. Vickie Morgan, MD – Psychiatrist **6.** Active Treatment Monitors **7.** Direct Care Professionals **Meeting Attended/Observations:** 1. Positive Behavior Support Committee (PBSC) (1/16/2012) 2. Behavior Services/BCBA Meeting (1/16/2012) 3. Human Rights Committee (HRC) (1/19/2012) 4. Restraint Reduction Committee (1/19/2012) 5. Observations in the Cottages, as well as Bowie, Childress, Driscoll, Fannin, and Program Services.
	Facility Self-Assessment: At the time of the site visit, BSSLC reported that Provisions K.2, K.3, K.7, K.11 and K.13 were in substantial

	compliance with the SA. The Monitor was in agreement with the Facility in relation to Provision K.2. The Facility's Plan of Improvement (POI) did not report any rationale for its determination of noncompliance In some areas, such as the provision of intellectual and adaptive assessment, progress had been achieved but further progress was necessary for compliance. Similarly, progress was noted in the content of PBSPs. Observations, however, did not reflect that direct care staff was well-versed in implementing PBSP or possessed the knowledge necessary for successful behavior intervention. It was also of concern that Facility reports of progress and achieved objectives did not always comport with evidence found in the documentation. For example, PBSPs and assessments reported as recently revised were over a year old. There could have been many reasons for the discrepancies, including clerical error. The crux, however, was that the Facility was lacking an effective process for detecting and correcting discrepancies. The general approach by BSSLC to self-assessment reflected an emphasis upon the occurrence of specific events rather than upon qualitative improvement relating to required practices. As with the implementation of a behavior change program, BSSLC must approach compliance with the Settlement Agreement in a systematic and evidence-based manner. Measures of compliance must reflect procedures that capture the salient elements of the task as part of an ongoing process rather than a discrete event that is either in compliance or not. This also requires the Facility demonstrate the ability to use objective measures of performance, openness to measurement outcomes, a consistent and effective use of resources, and a well-organized process for documenting and reporting progress. Without such an approach, the Facility will be challenged to make the changes necessary to satisfy the Settlement Agreement.
	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. Progress was evident in relation to the Structural and Functional Assessments (SFAs), Positive Behavior Support Plans (PBSPs), and psychological evaluations. Many components of the SFAs and PBSPs were accordant with accepted standards of practice. The PBSPs, in particular, were lacking in only a few areas, which reflected substantial improvement from previous site visits. Furthermore, the Facility continued to provide intellectual and adaptive assessment for individuals requiring such testing. Peer review had also been enhanced by the addition of a review of difficult cases by the Facility BCBAs. Since the initiation of the BCBA Review in August 2011, 18 cases had been reviewed and with subsequent revision to several of the reviewed PBSPs. In addition, documentation reflected that the BCBA review had enhanced cooperation with other disciplines, such as psychiatry and dentistry.

	Despite the areas of improvement, however, BSSLC continued to experience significant deficits in some areas. Of particular concern was the regression in efforts to ensure that adequate numbers of BCBAs were employed by the Facility. At the time of the site visit, the Facility had lost two BCBAs and a substantial number of existing staff had reduced participation in classes required to earn board certification. Without an adequate complement of demonstrably competent staff, it will be a challenge for the Facility to achieve substantial compliance in several areas of the SA. Another area of considerable weakness involved PBSPs. Although the content of the PBSPs had greatly improved, the implementation and monitoring of plans remained inadequate. Several of the PBSPs included in the sample lacked adequate criteria for success, did not provide clear instructions for data collection, and did not ensure that treatment targets were analyzed appropriately. Furthermore, data graphs indicated that treatment decisions at times lacked the support of objective evidence. Some individuals were noted to have experienced increases in problem behavior over several months without a review or revision of the PBSP. An additional concern during the current site visit was that reports of progress by the Facility were not always supported by available documentation. Progress had been reported in regard to behavioral/psychiatric case formulations, but none of the cases reviewed, including samples provided by the Facility of "best work", included a case formulation. As this process is new, not enough had been completed to be found in the sample. BSSLC reported substantial compliance with several Provisions of the Settlement Agreement. Evidence provided by the Facility however, did not support the assessments made by the Facility. The specific Provisions were as follows. Provision K.3: This provision requires the development and implementation of internal and external peer review. BSSLC demonstrated substantial progress in developing a sound peer review process. The documentation presented by the Facility reflected, however, that lapses in implementation were present in a sizable portion of the sampled records. Provision K.7: This Provision requires that the Facility will provide psychological evaluations to each individual living at the Facility. Progress toward this requirement was noted during the site visit. A large number of individuals residing at the Facility, however, had not yet been provided the required assessments. Provision K.11: This Provision requires that PBSPs be written so that staff is able to comprehend and implement the intervention strategies. The Facility was unable to present documentation that would reflect the completion of necessary staff training. Furthermore, observations in several settings reflected that staff were poorly prepared to implement PBSPs and often demonstrated minimal effort in addressing undesired behavior.

	Provision K.13: The Provision requires that the Facility employ one BCBA for every 30 individuals residing at the Facility. Documentation provided by the Facility reflected that the BSSLC employed only two BCBAs. Furthermore, documentation indicated that progress toward employing more BCBAs had substantially slowed over the past year, making substantial compliance less likely than during previous site visits. 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, treatment monitoring, and evidence-based practices remain to be addressed before substantial compliance can be achieved.

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<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, only two psychologists were BCBAs as two BCBAs had left employment with the Facility. One of the remaining two BCBAs was Dr. Terry Hancock, the Chief Psychologist. Of the remaining Behavior Services staff, 13 met the criteria for pursuing board certification. Amongst that remaining 13 staff, only five were pursuing board certification

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<tr><td>Total number and percentage of eligible Behavior Services staff who were BCBAs</td><td>0 (0%)</td><td>2 (13%)</td><td>13%</td></tr>
<tr><td>Total Behavior Service staff preparing for/completed BCBA</td><td>4 (26%)</td><td>7 (47%)</td><td>21%</td></tr>
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The number of staff either possessing or actively pursuing board certification continued to be greater than during the baseline visit. The trend at BSSLC, however, was toward fewer staff pursuing board certification. This trend reflected potentially significant difficulties for the Facility. The Monitors have selected the BCBA credential as the most viable measure of demonstrable competence in applied behavior analysis. With fewer staff working toward board certification, the Facility was likely to find it increasingly more difficult to achieve compliance with this Provision of the SA.

During the July 2011 site visit, Behavior Services administrative staff indicated that training, mentoring, and supervision of non-BCBA staff had not resulted in 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 process began in</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		August 2011. As presented later in this section of the site visit report, the process of assigning PBSP development only to BCBAs increased the quality of both structural and functional assessments (SFAs) and PBSPs. Implementation of the PBSPs, however, remained the responsibility of those staff who previously often had not demonstrated competence in applied behavior analysis. Implementing and monitoring behavior interventions, however, also requires demonstrable competence in applied behavior analysis. Evidence obtained during the site visit reflected that those staff who lacked the skills required for behavior assessment and intervention also were unable to effectively ensure PBSP implementation, the collection of behavior data, the graphic presentation of treatment data, and the use of treatment data in making necessary revisions to behavior interventions. These issues are presented later in Section K of this report.	
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 was extensively experienced 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 participates. 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 at baseline that BSSLC lacked a fully functioning internal peer review process. Psychology staff reported a peer review process occurred, but were unable to coherently	Noncompliance

#	Provision	Assessment of Status	Compliance
		present a description of that process or define peer review. In some interviews, peer review was presented as the supervision process with a senior member of the Psychology Department. In other cases, psychology staff perceived treatment monitoring meetings, such as the Positive Behavior Support Committee meetings or meetings of the Interdisciplinary Team, to be peer review. The Psychology Manager corroborated observations of the Monitoring Team and indicated that a traditional internal peer review process, internal or external, did not exist at BSSLC. 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 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. At the time of the July 2011 site visit, the following conditions were noted concerning 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. • The frequency of PBSC meetings 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. • 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. Observations and document reviews in July 2011 also reflected that the Facility had progressed regarding external peer review. On June 17, 2011, a contract was signed with	

#	Provision	Assessment of Status	Compliance
		Texas State University for behavior consultation and external peer review services. As of the current site visit, only four PBSPs had been referred for external peer review. Based upon the report from these referrals, all referrals had been made in December 2011. External peer reviewers offered comments for each of the PBSPs referred. The comments offered, although insightful, were neither specific nor measureable. For example, for one individual, the external peer reviewer suggested that psychotropic medication could have increased thirst and elicited increased self-injury. A review of psychotropic medication was recommended. These were helpful comments, but it was unclear what specific steps were to be followed, what the criteria were for altering treatment strategies, and how revisions to treatment were to be monitored. A formal protocol for external review and reporting, as well as Facility actions following review, could have substantially enhanced the review process. During the current site visit, it was apparent that the steps taken by BSSLC since July 2010 to address peer review weaknesses were robust and extensive. There remained, however, weaknesses within the peer review process. One weakness was the lack of a system to track the global changes in PBSPs because of the peer review process. It is important that the Facility apply a monitoring system to ensure that the peer review process is achieving the desired results and improving the overall quality of PBSPs. A second weakness noted during the current site visit involved PBSPs that, according to the documentation provided, did not reflect inclusion in the peer review process or suggested that the peer review process was not sufficiently thorough to detect problems in the reviewed PBSPs and SFAs. The lack of peer review was supported by four of 18 PBSPs (22%) having not been revised or updated in 18 to 24 months. Examples reflecting an inadequate peer review process included the following. • Twelve of 18 PBSPs (67%) did not include complete success and failure criteria in treatment expectations. • Sixteen of 18 PBSPs (89%) did not include specific instructions for data collection. • Fourteen of 18 PBSPs (78%) did not reflect integration of behavioral and psychiatric assessments. One area relating to peer review in which the Facility did achieve progress was the addition a weekly meeting of the BCBAs and staff who were well advanced in the process toward earning board certification. The purpose of this meeting was to conduct clinical reviews of individuals who were not demonstrating adequate response to behavior interventions, as well as case presentations, reviews of more global behavior issues, and the presentation of articles and other research topics. Since the initiation of the BCBA Review meeting in August 2011, the group had completed a review of 18 cases. Of the 18 cases reviewed, eight resulted in revisions to the PBSP and two	

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<tr><td></td><td></td><td>more produced cooperation with other disciplines, such as psychiatry and dentistry

Despite the areas of improvement, the noted limitations in the sampled PBSPs suggested the peer review process was not used consistently, and global improvements in PBSPs had not been achieved. In addition, the limitations reflected the need for a monitoring system for the peer review process. Although many aspects of the peer review process reflected substantial improvement, conditions noted during the site review indicated the need for additional refinement before compliance with the SA could be achieved.</td><td></td></tr>
<tr><td>K4</td><td>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.</td><td>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. It was recommended at that time that BSSLC continue to add to the available data collection tools and procedures.

During the third compliance visit in July 2011, 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. It was anticipated that data collection procedures would change and improve as new PBSPs were developed.

During the current site visit, 18 records were sampled. Sampling included nine records identified by the Facility as "best work" as well as the nine PBSPs identified as revised in the past six months that were not included in the "best work" records. Based upon a review of these records conducted during the current site visit, it was apparent that some areas of behavior data collection at BSSLC had improved substantially. For example, data collection practices on target behaviors would allow for adequate measurement of progress in 78% of records. In addition, all PBSPs reviewed included monthly review, with that review conducted by a BCBA in 89% of reviewed records.

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<tr><th></th><th>1/2010</th><th>1/2012</th><th>Change</th></tr>
<tr><td>Targeted behavior data collection sufficient to assess progress</td><td>0%</td><td>78%</td><td>78%</td></tr>
<tr><td>Replacement behavior data collection sufficient to assess progress</td><td>0%</td><td>28%</td><td>28%</td></tr>
<tr><td>Data reliability is assessed</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Target behaviors analyzed individually</td><td>0%</td><td>22%</td><td>22%</td></tr>
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Targeted behaviors graphed sufficient for decision-making	0%	39%	39%
Replacement behaviors graphed sufficient for decision-making	0%	28%	28%
Graphed data are reviewed monthly or more frequently if needed, such as due to use of restraints or changes in risk level	0%	89%	89%
Review is conducted by a BCBA	0%	100%	100%
Input from direct care staff is solicited and documented	0%	0%	0%
Modifications to the PBSP reflect data-based decisions	0%	56%	56%
Criteria for revision are included in the PBSP	0%	33%	33%
Progress evident, or program modified in timely manner (3 Months)	0%	33%	33%

Record reviews reflected, as well, that several areas of data collection had not substantially improved since the baseline visit in January 2010. Specific examples are presented below.

Replacement behavior data. Only 28% of records reviewed included adequate data collection and tracking of replacement behaviors. In the majority of cases, the replacement behavior graphs included no data points or all data points at zero. It was not clear whether these graphs reflected no displays of replacement behaviors or that no data had been collected. For Individual #422, the data graph did reflect a value of three for December 2011. The narrative in the progress note stated that, "Staff documented three trials of discrimination training in December." This made it difficult to determine if the value of three on the graph reflected only the number of trials or a measure of performance by the individual.

Data Reliability. The Facility reported that inter-observer agreement (IOA) data had been gathered for each individual with a PBSP as of 11/18/2011. None of the 18 records reviewed, however, reflected any indication of IOA or other reliability measures.

Individually analyzed target behaviors. Only four of 18 records (22%) reflected any attempt by the Facility to make distinctions between targets according to the origins of the behavior targeted or the potential function served by the target. Without this distinction, meaningful changes in behavior could be masked or skewed, rendering the determination of treatment benefits very difficult.

- For Individual #001, the progress note and data graph presented behaviors and

#	Provision	Assessment of Status	Compliance
		symptoms of mental illness interchangeably. It was not clear that the two were seen as different treatment targets. • For Individual #163, the progress note stated that, "[The individual] appeared to be cycling this reporting month as indicated in increase in physical aggression - grabbing at others with 3 Incidents of problematic departure. There is also some concern about his fast pace in eating." There were no indications in the assessment or PBSP that the behaviors noted were in fact symptoms of mental illness. Targeted behaviors graphed sufficiently for decisions. All progress notes reflected only monthly graphs of data. For seven of the 18 PBSPs (39%) reviewed, monthly graphing was appropriate for the selected targets. For others, however, information reflected that graphing across shorter durations would be more appropriate. • For Individual #001, progress note narratives reflected substantial changes in behavior on a weekly basis. No change in graphing was attempted. • For Individual #130, the progress note reflected awareness of the need to review the individual's behavior more often than monthly, and indicated, "The data from this plan will be reviewed at least weekly by the assigned psychologist. [The Individual's] progress will be summarized monthly in the Behavior Data Summary." Although it was appropriate that the psychologist was expected to review the data on a weekly basis, other staff were likely to rely upon the data graphs at the current time and in the future. It was unlikely that the monthly data graph would adequately present the individual's response to treatment. Input from direct care staff. Nowhere in the available records was it presented that direct care staff were offered the opportunity or participated in the review of treatment data for any of the 18 PBSPs. PBSPs reflect data-based decisions. For 10 of the 18 records reviewed (56%), there were indications that treatment decisions were based upon available data. In the remaining records, either no changes in the PBSP were attempted despite indications of poor program efficacy, or reviews of the PBSP only coincided with the annual ISP. • For Individual #173, the PBSP was reviewed or revised twice in two years. Both instances coincided with the annual ISP. • For Individual #95, the targeted behavior had demonstrated an increasing trend beginning in August 2011. The most recent revision of the PBSP occurred in October 2009. PBSPs include criteria for revision. Of the 18 PBSPs reviewed, all included a section to identify criteria for PBSP revision. Of those, however, only six (33%) included criteria that were specific, involved criteria for failure as well as success, and described the process for	

#	Provision	Assessment of Status	Compliance
		determining the need for PBSP revision. The remaining 12 PBSPs indicated only that a review would be conducted on a regular basis and provided an arbitrary target for success. An example of an appropriate criteria statement follows. • For Individual #181, it was stated in the PBSP, "If after 90 days of the start of implementation of this program, there is not at least a 50% reduction in challenging behaviors, the frequency of treatment integrity checks will be increased across multiple staff and shifts, and appropriate training and feedback will be given as necessary. If it is deemed that the program is being implemented correctly and consistently but is ineffective, the psychologist/behavior analyst will make necessary revisions to the program to increase effectiveness." <u>Timely revision of PBSPs</u>. Of the 18 PBSPs reviewed, only six (33%) reflected appropriate revisions following increases in treatment targets. For the remainder of the PBSPs, failure to successfully change either target or replacement behaviors did not result in a change in the PBSP. • For Individual #202, it was indicated that the expectation for self-injury was less than one display per month. For the past year, however, displays of self-injury had been above one, and at times as high as 20 to 40 displays, for 10 of 12 months. The most recent revision to the PBSP was in July 2010. • For Individual #425, the stated goal was to have no displays of self-injury per month by August 2011. In August 2011, the Individual engaged in 16 documented displays of self-injury. Following August, self-injury trended down, but remained well above zero displays. The PBSP had not been revised. Based upon the information obtained during the site visit, it was evident that data collection, presentation, and use at BSSLC remained inadequate. There was a lack of adequate data presentation, as well as failure to use data to identify the need for PBSP revision,; as noted in the two examples above, ,this lack of timely revision in some cases involved individuals who presented potentially dangerous self-injury. As a result, it was not possible to ensure that individuals had not been placed in unnecessary risk due to practices at BSSLC.	
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	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. During the July 2011 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.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.</td><td>At the time of the current site visit, BSSLC reported that Mr. Guercio continued to conduct assessments of intellectual and adaptive ability. Documentation reflected that a total of 94 individuals had received intellectual and adaptive assessments, and that a report had been written for each of these individuals.

During the current site visit, 18 records were sampled. Sampling included nine records identified by the Facility as “best work”, as well as the nine PBSPs identified as revised in the past six months that were not included in the “best work” records. Of those 18 records, 13 included a psychological assessment completed by Mr. Guercio. The table below reflects the status of those 13 reports.

<table>
<tr><th></th><th>1/2010</th><th>1/2012</th><th>Change</th></tr>
<tr><td>Standardized assessment or review of intellectual and cognitive ability.</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Psychological Assessments contained findings from an intellectual test administered within the previous five years.</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Psychological Assessments included a narrative summary of how the results from intellectual assessments more than five years prior would facilitate the understanding of the individual’s strengths and needs.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Standardized assessment of adaptive ability.</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Psychological Assessments contained findings of adaptive assessment conducted within one year prior to the date of the Psychological Assessment.</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Psychological Assessments included a narrative summary of how the results from adaptive assessments current or otherwise would facilitate the understanding of the individual’s strengths and needs.</td><td>0%</td><td>100%</td><td>100%</td></tr>
</table>

The efforts by BSSLC to ensure assessment of intellectual and adaptive abilities of individuals living at the Facility continued to reflect progress in this area.</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		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. During the July 2011 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 During the current site visit, 18 records were sampled. Sampling included nine records identified by the Facility as "best work", as well as nine Structural and Functional Assessments (SFAs) identified as revised in the past six months that were not included in the "best work" records. The findings of the review are presented below.	

	1/2010	1/2012	Change
Assessment or review of biological, physical, and medical status	0%	67%	67%
Review of personal history	0%	78%	78%
A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis	0%	78%	78%
The process or tool utilizes both direct and indirect measures	0%	78%	78%
Identification of setting events and motivating operations relevant to the undesired behavior	0%	78%	78%
Identification of antecedents relevant to the undesired behavior	0%	78%	78%
Identification of consequences relevant to the undesired behavior	0%	78%	78%
Identification of functions relevant to the undesired behavior	0%	78%	78%
Summary statement identifying the variable or variables maintaining the target behavior	0%	78%	78%
Identification of functionally equivalent replacement behaviors relevant to the	0%	72%	72%

#	Provision	Assessment of Status	Compliance

undesired behavior			
Identification of preferences and reinforcers	0%	78%	78%

The 18 sampled SFAs reflected that the Facility had made substantial progress in comparison with the baseline site visit in January of 2010. Of concern, however, was the noted discrepancy between those SFAs included in the "best work" sample provided by the Facility and the SFAs sampled by the monitor based upon reported recent revisions.

	Best Work Sample	Monitor Sample
Assessment or review of biological, physical, and medical status	78%	56%
Review of personal history	100%	56%
A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis	100%	56%
The process or tool utilizes both direct and indirect measures	100%	56%
Identification of setting events and motivating operations relevant to the undesired behavior	100%	56%
Identification of antecedents relevant to the undesired behavior	100%	56%
Identification of consequences relevant to the undesired behavior	100%	56%
Identification of functions relevant to the undesired behavior	100%	56%
Summary statement identifying the variable or variables maintaining the target behavior	100%	56%
Identification of functionally equivalent replacement behaviors relevant to the undesired behavior	89%	56%
Identification of preferences and reinforcers	100%	56%

The primary reason for the noted discrepancy involved four individuals for whom the SFA had not been revised or updated since 2010 or earlier. As these individuals were included in the list of updated SFAs, it was surprising that the record did not include more recent material. As the request submitted was for the most recent SFAs, the monitor was forced to conclude that

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>the SFAs provided were the most recent. For those SFAs that had been updated, the ratings were equal to those in the “best work” sample.

One area of continued weakness was noted in relation to assessment and the SFA. The review of the 18 SFAs revealed only minimal attention was directed toward integrating environmentally-based behavior and the symptoms of mental illness into the assessment process. Twelve of the 18 individuals included in the sample were prescribed psychotropic medication within the past 12 months. Only one of those 12 SFAs (8%), however, attempted to identify the influence of environmental variables 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.

<table>
<tr><td></td><td>1/2010</td><td>1/2012</td><td>Change</td></tr>
<tr><td>Screening for psychopathology, emotional, and behavioral issues</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Differentiation between learned and biologically based behaviors.</td><td>0%</td><td>6%</td><td>6%</td></tr>
<tr><td>Identification of behavioral indices of psychopathology</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Use of one or more assessment tools with evidence of validity in use for people with intellectual disabilities</td><td>0%</td><td>0%</td><td>0%</td></tr>
</table>

In July 2011, there had been progress noted in the integration of psychology and psychiatry practices. A Psychology/Psychiatry Workgroup had been established with the intent of developing a case formulation process for individuals receiving psychotropic medication. The Facility had reported during the current site visit that the case formulation format had been revised in October 2011 and that the case formulation was included in SFAs beginning shortly thereafter. It was therefore surprising that none of the “best work” or recent SFAs included the case formulation or evidence of an integrated assessment process.

Based upon the evidence provided by the Facility, it was unclear to what extent progress had been achieved. It was positive to note that some of the SFAs contained many of the essential components. The fact that the efforts of the Facility were not reflected consistently across all individuals in the sample, and that Facility reports of progress did not match the examined records was of concern. Further review will be needed to determine the degree of progress achieved by BSSLC.</td><td></td></tr>
<tr><td>K6</td><td>Commencing within six</td><td>Based upon the information presented in K5, documentation in the record continued to reflect</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	that, despite substantial progress, psychological assessments were not based upon complete clinical and behavioral data. Examples of an inadequate assessment process included the following. • Four of nine (44%) individuals reported by the Facility as having SFAs updated in the past six months did not have an SFA completed during that period in the record. • Eleven of 12 (92%) sampled SFAs did not include a case formulation or other assessments of mental illness in relation to undesired behavior.	
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	In July 2011, the Behavior Services department had reported changes in the assessment process for newly admitted individuals. These new procedures were evident during the current site visit. As documented in K5, Robert Guercio, MA continued to complete intellectual and adaptive assessments, and incorporate the findings of those assessments into psychological evaluation reports. Individuals newly admitted to BSSLC were also provided with testing of intellectual and adaptive ability as needed. The Behavior Services department also continued the 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. As documented in Provisions C7, K4, and K6, assessments were not always completed as often as needed. • Provision C7, reviewing information about individuals who were restrained more than three times in a rolling 30-day period, found for only two of seven individuals/instances reviewed (29%), individuals' teams reviewed the individual's adaptive skills, as well as biological, medical and psychosocial factors. • Provision K5 reports that a total of 94 individuals had received intellectual and adaptive assessments. • Provision K6 states that four of nine (44%) individuals reported by the Facility as having SFAs updated in the past six months did not have an SFA completed during that period in the record.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></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 11 individuals as being involved in counseling: Individuals #011, #020, #181, #185, #254, #381, #467, #490, #528, #012, #133, #399, and #590.

A review was conducted of the Treatment plans for each of the 11 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>11</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>
<tr><td>Services are goal directed with measurable objectives and treatment expectations.</td><td>0</td><td>0%</td></tr>
<tr><td>Services reflect evidence-based practices.</td><td>0</td><td>0%</td></tr>
<tr><td>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.</td><td>0</td><td>0%</td></tr>
<tr><td>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.</td><td>0</td><td>0%</td></tr>
<tr><td>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.</td><td>0</td><td>0%</td></tr>
<tr><td>Service is identified in PSP and, if applicable, PBSP.</td><td>11</td><td>100%</td></tr>
<tr><td>Staff who provide therapeutic interventions are qualified to do so through specialized training, certification, or supervised practice.</td><td>11</td><td>100%</td></tr>
<tr><td>Staff who assist in therapy, or who supervise homework or milieu activities, receive training and monitoring from qualified therapists.</td><td>0</td><td>0%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>It was a positive step that the Facility continued to provide counseling services to those individuals with an identified need. As it was apparent from the documentation that counseling was not evidence-based and lacked the majority of essential components, it was not evident that participants were obtaining substantial benefit from the counseling. Based upon the noted circumstances, BSSLC had not achieved progress toward the requirements of this provision of the SA.</td><td></td></tr>
<tr><td>K9</td><td>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.</td><td>At the time of the July 2011 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. PBSPs were noted to include the following limitations.
No rationale for selection of the proposed intervention.
A very limited history of prior intervention strategies and outcomes.
The lack of strategies addressing setting event and motivating operation issues.
The lack of strategies addressing antecedent issues.
The lack of strategies to weaken undesired behavior.
The lack of a specific description of data collection procedures.
The lack of 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.

<u>Quality of PBSPs</u>
During the current site visit, 18 records were sampled. Sampling included nine PBSPs identified by the Facility as "best work", as well as nine PBSPs identified as revised in the past six months that were not included in the "best work" records. The findings of the review are presented below.<table><tr><td></td><td>1/2010</td><td>1/2012</td><td>Change</td></tr><tr><td>Rationale for selection of the proposed intervention.</td><td>0%</td><td>78% (100%)</td><td>78% (100%)</td></tr><tr><td>History of prior intervention strategies and outcomes.</td><td>0%</td><td>78% (100%)</td><td>78% (100%)</td></tr><tr><td>Consideration of medical, psychiatric and healthcare issues.</td><td>0%</td><td>78% (100%)</td><td>78% (100%)</td></tr><tr><td>Operational definitions of target behaviors.</td><td>0%</td><td>78% (100%)</td><td>78% (100%)</td></tr><tr><td>Operational definitions of replacement behaviors.</td><td>0%</td><td>78% (100%)</td><td>78% (100%)</td></tr><tr><td>Description of potential function(s) of</td><td>0%</td><td>78% (100%)</td><td>78%</td></tr></table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status				Compliance
		behavior.			(100%)	
		Use of positive reinforcement sufficient for strengthening desired behavior	0%	78% (100%)	78% (100%)	
		Strategies addressing setting event and motivating operation issues.	0%	78% (100%)	78% (100%)	
		Strategies addressing antecedent issues.	0%	78% (100%)	78% (100%)	
		Strategies that include the teaching of desired replacement behaviors.	0%	78% (100%)	78% (100%)	
		Strategies to weaken undesired behavior.	0%	78% (100%)	78% (100%)	
		Description of data collection procedures.	0%	6% (7%)	6% (7%)	
		Baseline or comparison data.	0%	11% (14%)	11% (14%)	
		Treatment expectations and timeframes written in objective, observable, and measureable terms.	0%	33% (43%)	33% (43%)	
		Clear, simple, precise interventions for responding to the behavior when it occurs.	0%	78% (100%)	78% (100%)	
		Plan, or considerations, to reduce intensity of intervention, if applicable.	0%	11% (14%)	11% (14%)	
		Signature of individual responsible for developing the PBSP.	0%	78% (100%)	78% (100%)	

The information presented above reflects substantial improvement in the quality of PBSPs developed at BSSLC since the previous site visit. It is important to note that many of the ratings presented above were suppressed by four individuals for whom it was reported that new PBSPs had been developed but for whom no such PBSPs were provided or found in the documentation. The numbers in parentheses above reflect ratings without those four individuals.

Despite the substantial improvement noted in PBSPs, some noteworthy weaknesses were apparent.

Description of data collection procedures. In all but one PBSP, data collection instructions consisted of directions to use the prescribed behavior data forms. It was important that staff were provided instruction on which form to use. Without specific instructions on how to perform data collection, however, there was likely to be drift in procedures. As a result, data

#	Provision	Assessment of Status	Compliance
		were at an increased risk of poor reliability and treatment decisions impaired. Baseline data. In some cases, there were no baseline data provided for a PBSP. In other records, previous treatment data were provided for comparative purposes, but those data were presented in a manner that would not facilitate the treatment decision process. • For Individual #254, the PBSP stated that there were no baseline data. • For Individual #316, baseline or comparative data consisted of average rates of behavior compiled across five months. Although such information can be helpful, data from across a broad span of time and presented as monthly averages lacks the specificity for adequate treatment decisions. For a limited number of individuals, baseline data were available and clearly reflected a treatment decision process. For example, the PBSP for Individual #403 included a graph depicting a treatment reversal design. This graph provided very specific baseline data. Treatment expectations. Of the 18 PBSPs reviewed, all included a section to identify criteria for PBSP revision. Of those, however, only six included criteria that were specific, involved criteria for failure as well as success, and described the process for determining the need for PBSP revision. The remaining 12 PBSPs indicated only that a review would be conducted on a regular basis and provided an arbitrary target for success. An example of an appropriate criteria statement follows. • For Individual #181, it was stated in the PBSP, "If after 90 days of the start of implementation of this program, there is not at least a 50% reduction in challenging behaviors, the frequency of treatment integrity checks will be increased across multiple staff and shifts, and appropriate training and feedback will be given as necessary. If it is deemed that the program is being implemented correctly and consistently but is ineffective, the psychologist/behavior analyst will make necessary revisions to the program to increase effectiveness." Informed Consent 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	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
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 and the lack of providing rationale and history of prior treatments in the information to consenters, indicated that BSSLC had not achieved success in meeting the obligation of providing sufficient information to the consenter. As a result, consents for treatment could not be considered fully to be informed consent.

Based upon the information provided, BSSLC had achieved substantial progress in relation to PBSP content.
</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>
Based upon documentation obtained during the current site review, BSSLC included data graphs 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 18 individuals are presented below.

At the time of the current site visit, BSSLC reported inter-observer agreement (IOA) and treatment integrity measures for individuals living with a PBSP were conducted. None of the reviewed data graphs, however, included information regarding IOA or treatment integrity.
<table>
<tr><td>Graph Element</td><td>1/2010</td><td>1/2012</td><td>Change</td></tr>
<tr><td>The graph is appropriate to the nature of the data.</td><td>75%</td><td>78%</td><td>3%</td></tr>
<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
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		IOA and treatment integrity measures, and the documentation of those measures on the data graphs.	
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	Documentation presented by the Facility for the current site visit indicated that treatment integrity measures were being conducted. BSSLC, however, reported that the data regarding these measures were unavailable for review due to data entry problems but would be provided later; the Monitoring Team did not receive the information on integrity measures. A Flesch-Kincaid Grade Level was obtained for the direct service staff instructions in the 18 PBSPs included in the sample. Microsoft Word 2010 was used to obtain readability statistics. The measures revealed that direct service staff instruction consistently fell within the 7th to 8th grade reading level. Interviews with direct service staff, as well as residence administrators, indicated that staff infrequently experienced problems understanding PBSPs Observations were conducted in a variety of residences and programmatic areas during the current site visit. A variety of weaknesses was noted during the observations that indicated that staff did not understand PBSPs and was not prepared to implement either formal or informal behavior interventions. • Of the twenty staff who was interviewed during observations, only one staff member was able to discuss a PBSP in detail without asking for assistance or reviewing the written PBSP. • Individual #281 was preoccupied with rolling the sleeves of his t-shirt to the extent that he was unable to focus upon his meal. No formal or informal intervention was offered. • On Tuesday January 17, five individuals were observed in the Fannin C living room engaging in ritualistic behavior. Staff members present in the residence did not act to interrupt the behavior or redirect the individuals. When asked what procedures were supposed to be followed in response to such behavior, staff replied, "We try to find things to keep them busy." • On Tuesday January 17, an individual in the Childress C dining room was observed to drop to the floor, remain on her knees for several minutes, and then crawl back to her chair. The staff present offered verbal prompts to stop that produced no change in behavior. Staff offered no further attempts to address the behavior. When the individual had crawled back to her chair, she was offered verbal praise. • On Wednesday January 18, an individual in Training Area 2 was observed to repeatedly throw training materials to the floor. Staff did not interrupt the behavior and frequently offered verbal praise following displays of the behavior. When asked about the individual's behavior and a PBSP, staff reported that the individual was being "tried out" in the classroom and was doing very well.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Due to the inability of the Facility to produce global treatment integrity and IOA data, it was not possible to reach conclusions regarding the status of Facility efforts in this area. Observations, however, suggested that considerable challenges remained in preparing staff to implement behavior interventions.	
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	Documentation presented by the Facility for the current site visit indicated that treatment integrity and IOA measures were being conducted. Due to reported data entry issues at BSSLC, however, the data regarding these measures were unavailable for review. Without this information, it was not possible to determine whether competency-based training had been provided consistently on the specific PBSPs for which staff were responsible and on implementation of those plans.	Noncompliance
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 two staff who possessed board certification as a behavior analyst. This represented approximately one BCBA for every 196 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 26 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. As the objective measure selected for demonstrable competence in behavior analysis is board certification as a behavior analyst, it is recommended that BSSLC adopt a more intensive effort to ensure that an adequate number of staff complete the requirements for and obtain board certification. (Provisions K1 and K13)
2. In order to determine that the peer review process includes all PBSPs, it is recommended that an adequate tracking system be implemented. (Provision K3)
3. To ensure that the peer review process is comprehensive and effective, it is recommended that a formal rubric or protocol be adopted for behavior assessments and interventions included in internal and external peer review. The Facility would also benefit from a process of tracking

improvements in PBSPs and SFAs over time as related to the peer review process. (Provision K3)

4. It is recommended that the Facility develop a more systematic process for ensuring that the data collection and treatment monitoring process provide an objective and effective measure of each individual. It would be beneficial to include in this process an aggregate monitoring and reporting system that could be used to identify poor response to treatment or lapses in the treatment monitoring process. (Provision K4)
5. The Facility needs to ensure that interventions for undesired behavior and mental illness reflect an integrated approach to assessment that reflects the often complementary nature of the two conditions. (Provision K5)
6. BSSLC should act to ensure that non-PBSP interventions are provided by individuals who possess strengths in regard to evidence based practices, and who can develop and implement interventions that are evidence-based. (Provision K8)

The following are offered as additional suggestions to the Facility:

1. It would be beneficial for the Facility to explore non-PBSP interventions beyond counseling services. Some evidence-based practices that might be considered include picture or object schedules, communication training, and environmental devices that focus attention. These could be included in PBSPs or might be separate program objectives or service objectives (in which case, it would be helpful to reference them in the PBSPs when appropriate).
2. Based upon discrepancies between reported practices and actual practices during the current site visit, it is recommended that the Facility aggressively explore a system for ensuring that Facility practices and policies are being implemented as intended.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: **Documents Reviewed** 1. Plan of Improvement, Section L, dated 12/30/12 2. Presentation Book, January 2012 3. BSSLC Administrative Death Review Committee, Policy: I4.b (no date) 4. BSSLC Clinical Death Review Committee, Policy: I.4.c (no date) 5. BSSCL Policy, Physician Procedures and Best Practice Guidelines, undated 6. Nursing Policy for Bowel Management, Volume 4, Section 2, dated 2009 7. Clinical records for Individuals: #428, #371, #548, #254, #446, #335, #331, #69, #474, #576, #159, #67, #34, #26, #60, #7, #159, #69, #474, #576, #67, #484, #44, #593, #208, #383, #286, #380, #230, #428, and #24 8. Physician CME records, 2011 9. Physician CPR records, 2011 10. BSSLC Death Review Tracking Tools for Deceased Individual #351, Individual #5, and Individual #49 11. BSSLC Death/Discharge Summaries for: Individual #351, Individual #5, and Individual #49 12. BSSLC Death Review Investigations Nursing Services, Individual #351, Individual #5, and Individual #49 13. BSSLC Clinical Death Review Committee Meeting Minutes for: Individual #351 and Individual #5 Individual #49 14. Department of State Health Services – Vital Statistics Unit, Death Certificates for: Individual #351 and Individual #5 15. BSSLC Unusual Incident Report, Unusual Incident Reports for: Individual #351, Individual #5, and Individual #49 16. BSSLC Nursing Death Review Recommendations for: Individual #351, Individual #5, and Individual #49 17. BSSLC Tracking of Nursing Recommendations Sheets for: Individual #351, Individual #5, and Individual #49 18. BSSLC Death Review Process, Internal Corrective Action Plan, Draft, Date: 1/19/12 19. Clinical Pathway Seizure, undated 20. Clinical Pathway Osteoporosis, undated 21. Clinical Pathway Diabetes, undated **People Interviewed**: 1. Mary Anne Brett, MD 2. Adolfo Carvajal, MD 3. Malcolm Lochiel, MD 4. Valarie Kipfer, RN, State Office Nursing Coordinator 5. Daniel Dickson, Director of Quality Assurance 6. Jill Quimby, RN, Quality Assurance (QA) Nurse 7. Brandy Todd, LVN III, QA Nurse **Meetings Attended/Observations**: 1. Observed Individual at the following living areas: Bowie, Childress, and Driscoll Gardens.

	2. Individuals specifically observed for gait abnormalities: #428, #371, #548, and #254 3. Morning Medical Rounds, January 18, 2012 4. CDLP meeting for Individual #7
	Facility Self-Assessment: The Facility provided a self-assessment in the Plan of Improvement (POI). The POI did not provide details as to the Facility's self-assessment processes, but rather listed many actions the Facility had taken beginning in August, 2010 and including actions since the last compliance visit. However, the basis for rating of compliance was not clearly stated for any provision. The Facility does have, and should use, information, including data, that could be useful in assessing and reporting status of compliance. Since the resignation of the Facility's previous Medical Director, the Facility only recently appointed a replacement one month prior to this review; hence, significant progress has not been made towards compliance. The Medical Staff, however, is much more aware of the Settlement Agreement Process, and is now well engaged in developing the Facility's Plan of Improvement. The Facility reported in the POI that it underwent a comprehensive "Medical Provider Quality Assurance Audit" on January 3, 2012. Following the audits, the Facility conducted quality improvement measures. The Facility also reported that the State Office continues to develop algorithms for clinical care. Three algorithms have been completed (diabetes, osteoporosis, and seizure disorder). 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. The Facility had determined that it remained out of compliance with Section L of the Settlement Agreement.
	Summary of Monitor's Assessment: First and foremost, following its meeting with the Medical Staff, the Monitoring Team was most impressed with the significant reorganization of the Facility's Medical Staff, including the appointment of a new Medical Director. Unlike previous reviews, the entire Medical Staff was noted to be well engaged in the Settlement Agreement process, and with the Facility's Plan of Improvement. The Medical Staff is now familiar with what process changes are necessary to gain compliance. Many new processes have been developed that should enhance clinical outcomes, such as the development of a robust, multidisciplinary morning clinical meeting. Physicians are now documenting clinical notes in a SOAP format, and documenting a clinical impression and plan. Annual Medical Assessments are being updated to better reflect the Individuals condition. The Facility will initiate enhanced internal and external physician audits in February, and SharePoint Algorithms will be finalized prior to the next review. Despite such changes, the Medical Staff recognized, as does the Monitoring Team, that the Facility has significant work ahead to become compliant with Section L of the Settlement Agreement. Provision L1: To assess compliance of Provision L1, the Monitoring Team observed individuals at their living areas, attended a Community Living Discharge Planning Meeting (CLDP), attended morning medical rounds, discussed clinical concerns with the Medical Staff, and reviewed clinical record. Specific issues addressed during this review period included preventative health measures, management of osteoporosis,

	chronic health care management, documentation of acute care issues, constipation, seizure disorders, Interdisciplinary Team participation, Emergency procedures, and reviewed physician training. The Monitoring Team concurs with the Facility's Self-Assessment, and determined the Facility to be noncompliant with Provision L.1. The Facility must significantly enhance its provision of medical services to Individuals served by the Facility, ensuring that syndromal conditions, and manifestations are addressed; ensuring the treatment of chronic conditions are at the level of community standard of care, and that they are assessed regularly, are important areas that must be addressed Provision L2: To assess compliance of Provision L.2, the Monitoring Team reviewed the most recent external medical audits, which were conducted on January 3, 2012. The Monitoring Team reviewed the external audit process with staff physicians, and reviewed current policies specific to the audit process. In addition, the Monitoring Team reviewed five complete medical audits for each physician and the action plans for deficiencies. The Monitoring Team also assessed the Facility's Death Review Process. The Monitoring Team agreed with the Facility's Self-Assessment and determined the Facility to be non-compliant with Provision L.2. The Facility must ensure that medical audits include a robust mechanism to evaluate physician's clinical performance. In addition, the Facility must enhance its Death Review Process to include a meaningful Root Cause Analysis, and ensure that leadership at the Facility regularly reviews longitudinal trends analysis. Provision L3: The Monitoring Team reviewed progress towards compliance of Provision L.3, with the Medical Director, and Medical Staff. During a meeting with the Medical Staff and Medical Director, the Monitoring Team was informed that a process to assess clinical indicators has not been developed. The Facility is aware that this process must be developed in the near future, and that quality indicators must reflect clinical practice at the Facility, include an interdisciplinary methodology, include longitudinal trends analysis, implement corrective action, and evoke a mechanism to ensure remedies are effective. Because of these issues, the Monitoring Team concurs with the Facility and determined it to be noncompliant with Provision L.3. Provision L4: To assess compliance of Provision L4, the Monitoring reviewed its current policy on medical services, BSSCL Policy, Physician Procedures and Best Practice Guidelines, undated, as well as Clinical Pathways for diabetes, osteoporosis, and seizure management. The Monitoring Team also discussed with the Medical Staff the Facility's progress towards compliance. The Monitoring Team is favorable towards the Facility's Policy, Physician Procedures and Best Practice Guidelines; however, the policy has yet to be fully implemented by the Facility. The Clinical Pathways provided for review, were determined to be ineffective and must be enhanced. For these reasons, the Monitoring Team agrees with the Facility's Self-Assessment and finds the Facility non-compliant with Provision L4.

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L1	Commencing within six months of the Effective Date hereof and with	To assess compliance of Provision L1, the Monitoring Team observed individuals at their living areas, attended a Community Living Discharge Planning Meeting (CLDP), attended	Noncompliance

#	Provision	Assessment of Status	Compliance
	full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	morning medical rounds, discussed clinical concerns with the Medical Staff, and reviewed clinical record. Specific issues addressed during this review period included preventative health measures, management of osteoporosis, chronic health care management, documentation of acute care issues, constipation, seizure disorders, Interdisciplinary Team participation, Emergency procedures, and reviewed physician training. First and foremost, the Monitoring Team was most impressed with the significant reorganization of the Facility's Medical Staff, including the appointment of a new Medical Director. Unlike previous reviews, the entire Medical Staff was noted to be well engaged in the Settlement Agreement process, and with the Facility's Plan of Improvement. The Medical Staff is now familiar with what process changes are necessary to gain compliance. Many new processes have been developed, that should enhance clinical outcomes, such as the development of a robust, multidisciplinary morning clinical meeting. Physicians are now documenting clinical notes in a SOAP format, and documenting a clinical impression and plan. Annual Medical Assessments are being updated to better reflect the individual's condition. The Facility will Initiate enhanced internal and external physician audits in February, and SharePoint Algorithms will be finalized in prior to the next review. Despite such changes, the Medical Staff recognized, as does the Monitoring Team, that the Facility has significant work ahead to become compliant with Section L, of the Settlement Agreement. <u>Physician Services</u> Since the last review, a new Medical Director has been appointed, and staff physicians have been made more aware of the Settlement Agreement process. The Facility has one Medical Director, who at present maintains a caseload of 98 individuals. Staff physicians maintain the following caseloads: Dr. Carvajal, 65 individuals, Dr. Austin, 45 individuals, and Dr. Lochiel, 100 individuals. Caseloads will be redistributed in the near future. Importantly, the Facility is recruiting a fourth staff physician, which will enable a caseload of 80 to 100 individuals per staff physician. The Medical Director recognizes that her administrative duties will require significant time and effort and is planning to reduce her caseload, while awaiting hire of the fourth physician. Support staff for physician services and the medical office is limited. Currently, the medical office, which schedules all appointments, outside consultations, assists with physical examinations, answer telephones, files records, completes consultation and consent forms, tracks the consent process, liaisons with living area staff, and procures equipment and materials, is supported by one RN and one LVN, and there is no cross cover when one of the two staff are off work. The Monitoring Team will more closely evaluate outcomes related to clinical office staff during its next review.	

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		Review of CPR training records indicated that 4 out of 4 physicians (100%) were current on CPR training. Review of CME reports for the past 12 Months, indicate that 3 out of 4 physicians have either met or exceeded CME requirements for the State for 2011. Because of a scheduling conflict that prevented one physician from attending a CME event, that physician was unable to provide training records for review. There was no specific training obtained by any physician specific to developmental disabilities. <u>Preventive Health:</u> While reviewing health care conditions for the following individuals, the Monitoring Team determined that 100% of the sample was compliant with tetanus booster, influenza vaccine, and pneumonia vaccine (Individuals #428, #371, #548, #254, #446, #335, #331, #69, #474, #576, #159, and #67). To assess preventive health measure in individuals who have syndromal conditions, the Monitoring Team assessed the Facility's efforts to ensure that regular thyroid screening, and screening of neuromotor, and musculoskeletal conditions were regularly provided to individuals with Down Syndrome. A list of individuals with Down syndrome was submitted, along with the date of their last thyroid test. A total of 20 individuals were identified with a diagnosis of Down syndrome. Nineteen (95%) had a current thyroid test. The Monitoring Team observed the following individuals, who are diagnosed with Down Syndrome, at their living area: Individuals #428, #371, #548, and #254, and reviewed their clinical records. Individuals #428, and #254 were reported to have been ambulatory in the past, but lost their ability to ambulate overtime. Personal support plans, the Annual Medical Assessments, and other components of their clinical records, did not demonstrate assertive evaluation or follow-up of their neuromotor or musculoskeletal condition. The etiology of their loss of function was not documented in the Clinical Record. There was no evidence to support that Medical Staff routinely assessed for progression of their functional decline, or other manifestations. Upon observation, Individual #371 was noted to have a moderate abnormal gait, and Individual #548 experienced a broad based gait. Both cases lacked evidence of assertive evaluation of their gait problems, and there was no evidence to indicate that they regularly assessed for progression. Most important, the etiology of their gait abnormality was not identified.	

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		Individuals with Down Syndrome and many other developmental disabilities are more susceptible to both musculoskeletal and neuromotor conditions, such as dysplasia, arthritis, and myelopathy, and must be routinely assessed throughout their life span. The Facility did not have a systematic process to assess neuromotor and musculoskeletal conditions for individuals who reside at the Facility. The Monitoring Team has concerns with the Facility's ability to address preventive health care measures, and general management of individuals with Down Syndrome, and other syndromal disorders. Syndromal disorders occur frequently within developmental disorder settings, most of which have both common, and unique medical and behavioral issues that must be regularly assessed. <u>Chronic Illness</u>: The clinical records of Individuals #446, #335, and #331 were reviewed to assess the management of chronic health care issues. Individual #446: Individual #446 was observed at Bowie living area on January 19, 2012. In addition, clinical records including the most recent Annual Medical Assessment, Personal Support Plan, neurology, orthopedic and physiatry consults for the past two years, MOSES and DISCUS reports for the past 12 months, current medication list, Occupational and Physical Therapy assessments for the past 12 months, and all imaging studies completed in the past two years, were reviewed. At the time of observation, the individual was noted to have a significantly abnormal gait, which appeared ataxic, and experienced contractures and spasticity on the right extremities. The use of a gait belt was observed at times of ambulation. As evident by reviewing consultation notes and diagnostics, standard of care practice remains deficient. The individual has multiple orthopedic abnormalities, including degenerative spine disease, significant kyphoscoliosis, and a neuromotor condition of unknown etiology. None of these conditions had been evaluated as to their etiology, appropriately monitored for progression, or referred to specialists, such as orthopedic spine specialists. A referral to neurology for the treatment of spasticity and follow-up was recommended by the IDT 12/17/11. At the time of this review, there was no evidence that the individual had followed-up with neurology. While reviewing requested records, it was noted that on July 26, 2011, diagnostic testing demonstrated the "mild arterial occlusion." suggesting possible atherosclerosis. There was no evidence identified to indicate that additional follow-up was recommended, nor	

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		was the condition documented on the problem list. Arterial occlusion is generally a progressive condition and can result in severe complications, such as ischemia to organs and extremities. Arterial occlusion is also associated with cardiovascular disease, stroke, and kidney failure. The individual was noted to have undergone breast ultrasound examinations in the past. On September 8, 2010, results of the exam were unremarkable; however, one-year follow-up, on November 2, 2011, a small low-density lesion was noted, along with additional findings. Consequently, a six-month follow-up was recommended. The physician had appropriately signed each ultrasound report and documented a note for the abnormal findings. There was no evidence that the IDT was made aware of this potential significant finding. The ultrasound findings are most probably benign; however, more ominous causes, such as a malignancy, should be considered, and the individual should be monitored for progression carefully. Such findings should be reported to the IDT. Specific to the Individual Support Plan (ISP), there was a lack of evidence to support that the IDT was current on the complexities of the individual's overall health care issues. The individual's Risk Assessment was updated to include a "Medium" risk for falls and fractures. Given the significance of the individual's gait abnormality, the need for a gait belt when ambulating, and the need for Baclofen for spasticity, and osteoporosis, in addition to recently sustaining a fracture of her hand, the Monitoring Team determined that the risk assessment for both falls and fractures should be high. Importantly, physician representation at the ISP meeting, by physician services, was limited. Of six ISP meetings, the individual's physician attended only 1 such meeting (16%). There was no evidence indicating that potentially serious medical issues, such as possible atherosclerosis, degenerative spine disease, and a significant change on recent breast ultrasound was well communicated to the IDT. Also, there was no evidence that chronic medical conditions were regularly and systematically assessed throughout the year on a regular basis, as would be expected in the context of community standard of care. Individual #335 Individual #335 was observed at Bowie living area, on January 19, 2012. In addition, the following clinical recorders were reviewed: Most recent Annual Medical Assessment, which was dated November 20, 2010; most recent Habilitation Annual Assessment, dated March 23, 2011; most recent Personal Support Plan, dated May 4, 2011, and subsequent addendums; past one year MOSES and DISCUS reports; past 12 Months PT/OT consultations; all x-rays, CT, and MRI of brain, spine and joints for past two years. The individual was noted to have at least a moderate shuffling gait, bilateral swollen ankles and application of a gait belt for ambulation at the home. X-rays of the cervical	

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		spine completed on August 2009 demonstrated marked narrowing of the cervical spine and significant signs of degenerative spine disease. The Annual Medical Assessment dated 11/30/10 noted the diagnosis of "osteoarthritis of the c-spine." Recommendations by the unit physician indicated that the individual would need a follow-up c-spine x-ray, every two years. There was no follow-up to specialist for degenerative (arthritic) spine disease, nor was there periodic follow-up by the physician for this condition. The ISP and addendums did not list degenerative spine disease as a concern, and there was no nursing action plan for the condition. Degenerative spine disease is a serious condition that generally progresses and may lead to irreversible paralysis and possibly premature death. Degenerative spine disease, especially when associated with spurring, can be associated with incapacitating pain. Pain assessments were not completed regularly, nor were staff aware to monitor for signs and symptoms of pain. Pain assessments should be conducted daily in such circumstances. The Annual Medical Assessment indicated that the individual has significant cardiac conditions, including a septal wall defect that was never surgically repaired but treated by medication only. The Annual Medical Assessment also indicated that a cardiologist sees the individual regularly. Review of the ISP and addendums demonstrates that the Interdisciplinary Team is aware of the cardiac condition but not the significance of the condition, as there is no mention of prognosis anywhere in the clinical record, including the ISP. Importantly, there was no mention within the ISP or other documents requested indicating why surgery was not indicated. During the past two ISP quarterly reviews, dated 8/31/11 and 12/14/11, there was no participation by physician staff. Given the numerous, and serious medical conditions, including significant degenerative spine disease, septal defect of the heart, recurrent deep venous thrombosis, and congestive heart failure, robust physician input is essential. Also, there was no evidence that chronic medical conditions were regularly and systematically assessed throughout the year, as would be expected in the context of community standard of care. Such followup and involvement of the IDT are essential not only because of their effect on maintaining health of the individual and identifying emerging or worsening conditions, but also because they are important in making decisions about goals, appropriate activities, and supports needed for movement to a more integrated setting. Individual #331 Individual # 331 was observed at the living area. The following clinical documents were reviewed: Orthopedic, neurology, and surgical consultation notes; OT/PT assessments for past 12 months and most recent "Three Year Habilitation Assessment"; most recent Annual Medical Assessment (9/14/11); most recent ISP (9/20/11) and addendum to the ISP (none completed).	

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		The individual was observed at the living area on January 19, 2012 to be resting comfortably in his fabricated wheelchair. The individual was also observed during a physical transfer, and noted the appropriate use of a mechanical (hydraulic) lift. The individual was noted to have had a recent surgical incision on the right hand. Review of the Annual Medical Assessment demonstrated a comprehensive, meaningful clinical review that clearly delineated most of the individual's complex medical issues, and provided sound understanding of those issues noted. Importantly, the assessment outlined the probable cause of the individual's spastic quadriplegia. Review of chest and abdominal x-rays, and PT/OT assessments, indicated that the individual has marked scoliosis, and mild degenerative disease of the spine, which was not included in the Annual Medical Assessment. Also, given the type of neonatal insult, and resulting physical manifestations, the diagnosis of cerebral palsy should be entertained. Such conditions are important to consider because their manifestations remain dynamic throughout the individual's life, and must be regularly assessed, and when possible treated. Review of the clinical record did not demonstrate a regular and systemic approach to managing the individual's chronic medical conditions. The ISP dated 9/20/11 did not assertively comment on significant medical interventions, including the individual's tendon release (7/29/11) and cholecystectomy (8/2/11), nor were there addendums provided that discuss the need for such intervention. The Comprehensive Nursing Assessment (12/2/11) did not address the individual's severe spasticity. The OT/PT component of the ISP did not comment on the individual's tendon release. Importantly, the physician did not participate at the ISP, dated 9/20/11. These interventions could be important in determining such ISP decisions as establishment of different goals and activities, if they affect the individual's physical capacity and need for health care. The Monitoring Team clearly recognized the exceptional medical intervention on the part of the physician in managing the many serious medical conditions. It is essential, however, that the IDT be made fully aware the complexity of such medical conditions, and of significant medical procedures. The Monitoring Team noted exceptional use of hydraulic lifts, and careful transfer of individuals at the Driscoll Living Area. <u>Osteoporosis:</u> During this compliance visit, the Monitoring Team focused on review of assessment and care of men who have or are at risk for osteoporosis. The Monitoring Team will follow up at future visits on the issues raised in this report and will also review assessment and treatment of this condition in women.	

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		The Monitoring Team selected 10 male individuals from a list of all known individuals with osteoporosis. For each sample the Annual Medical Assessment, past three DEXA scans, endocrinology consultations records, medication lists and all records supporting that a pre-treatment evaluation was completed, prior to initiating therapy with specific medication treatments. Individual #131 Individual #131 is a 50-year-old male, diagnosed with osteoporosis, and vitamin D deficiency. Current medications include denosumab, Vitamin D 800 units AM, and calcium 600 mg twice per day (total 1,200 mg). Most recent bone mineral density (BMD} was obtained on September 30, 2010, demonstrating worsening osteoporosis, when comparing both Z and T scores. There was no evidence to support that a pre-treatment evaluation for secondary causes of osteoporosis was performed. Biochemical markers, such as bone specific alkaline phosphatase had not been obtained to assess treatment efficacy. There had been no plans for x-rays or physical assessment to evaluate for vertebral fractures. The individual does not follow-up with endocrinology. Individual #44 Individual #44 is a 47-year-old male, diagnosed with severe osteoporosis, and history of multiple fractures. Current medications include denosumab, Vitamin D 800 units AM, and calcium 600 mg twice per day (total 1,200 mg). The individual was assessed by an endocrinologist at the time of diagnosis, and continues to follow-up with endocrinology annually. Serial DEXA scans had been obtained per recommendation by the endocrinologist, with the most recent scan completed on November 2011. In 2005, the individual was noted to have severe low bone density, and was initially treated with Forteo, which resulted in marked improvement in bone density scores. There were no plans for x-rays of the spine to assess for vertebral fractures. Individual #593 Individual #593 is a 59-year-old male with a diagnosis of osteoporosis. Current medications include alendronate, calcium 600 mg twice per day (1,200 mg total) and vitamin D 400 units AM. The most recent BMD was obtained on 8/2/11, with no significant improvement, and subtle worsening of bone loss of the lumbar spine, despite treatment. There was no evidence to support that a pre-treatment evaluation for secondary causes of osteoporosis was performed. Biochemical markers, such as bone specific alkaline phosphatase had not been obtained to assess treatment efficacy. There were no plans for x-rays or physical assessment to evaluate for vertebral fractures. The individual does not follow-up with endocrinology. Individual #208 Individual #208 is a 57-year-old male with a diagnosis of osteopenia (not osteoporosis).	

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		Current medications include alendronate 70 mg every Friday, ergocalciferol 8,000 units every AM, and calcium 600 mg twice per day (1,200 mg total). The most recent BMD was obtained on 9/28/10, and no T-score or Z-score reached the threshold of osteoporosis, when compared to the initial BMD in 2008. There was no evidence to support that a pre-treatment evaluation for secondary causes of osteoporosis was performed. Biochemical markers, such as bone specific alkaline phosphatase had not been obtained to assess treatment efficacy. There had been no plans for x-rays or physical assessment to evaluate for vertebral fractures. The individual does not follow-up with endocrinology. The Monitoring Team has concern with treating osteopenia with alendronate, especially without careful consideration by the Interdisciplinary Team. Individual #383 Individual #383 is a 65-year-old male with a diagnosis of osteoporosis and Vitamin D deficiency. Current Medications include alendronate, Calcium 600 mg twice per day (total 1,200 mg), and vitamin D 400 units twice per day (total 800 units). BMD was obtained on 3/3/10 and demonstrated osteoporotic T-scores of the hips bilaterally, but normal Z-scores. There was no evidence to support that a pre-treatment evaluation for secondary causes of osteoporosis was performed. There were no plans for x-rays or physical assessment to evaluate for vertebral fractures. The individual does not follow-up with endocrinology. Individual #286 Individual #286 is a 47-year-old male with a diagnosis of osteoporosis. Current medications include alendronate every Friday, Calcium 600 mg twice per day (1,200 mg total), and no vitamin D supplementation. The most recent BMD was obtained on 11/1/11 osteoporosis of the bilateral hips and spine. There was significant worsening of BMD scores of the right hip and spine, when compared to the previous BMD, dated 8/17/09. There was no evidence to support that a pre-treatment evaluation for secondary causes of osteoporosis was performed. Biochemical markers, such as bone specific alkaline phosphatase had not been obtained to assess treatment efficacy. There had been no plans for x-rays or physical assessment to evaluate for vertebral fractures. The individual does not follow-up with endocrinology. Given worsening osteoporosis, the Monitoring Team has significant concern that pharmacotherapy treatment with calcium supplementation is provided without the addition of Vitamin D. Vitamin D is essential for the absorption of calcium. The Monitoring Team is also very concerned that there was no further evaluation to assess secondary causes and effectiveness of treatment, or referral to an endocrinologist, given worsening of BMD, when prescribed alendronate. Individual #380 Individual #380 is a 56-year-old male who had a diagnosis of osteoporosis in 2007, and	

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		was treated with alendronate. Follow-up BMD on 11/17/10 demonstrated improved BMD, with T-scores in the osteopenia range. Upon diagnosis, the individual was prescribed treatment doses of alendronate, calcium and vitamin D. Medications were then discontinued for a period of time and then restarted on November 2011. There appeared to be multiple unit physicians involved in the management of the individual's care. A follow-up BMD is ordered for 11/12. There was no evidence to support that a pre-treatment evaluation for secondary causes of osteoporosis was performed. There were no plans for x-rays or physical assessment to evaluate for vertebral fractures. The individual does not follow-up with endocrinology. Individual #230 Individual #230 is a 61-year-old male with a diagnosis of osteoporosis and vitamin D deficiency. The individual is also diagnosed with monogammapathies of undetermined significance (MGUS). Current medications include treatment doses of calcium, vitamin D and denosumab. The most recent BMD dated 6/8/10 demonstrated osteoporosis of the right hip and osteopenia of the spine. No additional BMDs were available for review. There was no evidence to support that a pre-treatment evaluation for secondary causes of osteoporosis was performed. There were no plans for x-rays or physical assessment to evaluate for vertebral fractures. The individual does not follow-up with endocrinology. Given the diagnosis of MGUS, the Monitoring Team is especially concerned that no additional work-up for secondary causes of osteoporosis or referral to an endocrinologist was obtained. Individual #24 Individual #24 is a 42-year-old male with a diagnosis of osteoporosis. Current medications, as of 12/18/11 do not include vitamin D, treatment doses of calcium or specific therapy for osteoporosis. Prior to 12/18/11, medications included treatment medications for osteoporosis. The most recent BMD provided for review was from 11/23/11, that demonstrated moderate osteopenia of the spine, but no hip results. There was no evidence to support that a pre-treatment evaluation for secondary causes of osteoporosis was performed. There were no plans for x-rays or physical assessment to evaluate for vertebral fractures. The individual does not follow-up with endocrinology. The Monitoring Team is especially concerned that significant medication change was based on the spine BMD only, and that given that the individual has osteopenia, he is not provided preventive doses of Calcium and Vitamin D. Individual #484 Individual #484 is a 41-year-old male with a diagnosis of osteoporosis and anemia. Current medications include treatment medications and doses for osteoporosis. The most recent BMD was assessed on 10/26/10 and demonstrated some improvement when compared to previous BMD assessments. There was no evidence to support that a	

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		pre-treatment evaluation for secondary causes of osteoporosis was performed. There were no plans for x-rays or physical assessment to evaluate for vertebral fractures. The individual did not follow-up with endocrinology. The Monitoring Team is especially concerned that a comprehensive assessment for potential secondary causes of osteoporosis was not completed in an individual with chronic anemia. The Monitoring Team noted that 10 of the 10 cases reviewed (100%) had a bone density study completed within the past three years. The Monitoring Team has significant concerns over the management of osteoporosis at the Facility for the following reasons: There was no evidence to support that a comprehensive evaluation for secondary causes of osteoporosis were obtained, with the exception of one case, which was treated by an endocrinologist; There was no assessment of compression fractures of the spine, which is especially important for individuals with intellectual and developmental disabilities who can not reliably communicate their symptoms. Individual #230 has a known diagnosis of MGUS which may progress to myeloma, given that osteoporosis is a known manifestation of myeloma, a comprehensive initial evaluation and follow-up evaluations should be performed; Individual #484 has a diagnosis of mild anemia of undetermined etiology, and should be evaluated for possible myeloma in individuals with osteoporosis; There does not appear to be a systematic approach to the diagnosis and treatment of the causes, and manifestation of osteoporosis at the Facility. The Monitoring Team did not identify anywhere in the clinical records a comment on risk and benefits of treating or not treating osteoporosis. The Monitoring Team recognizes that osteoporosis can, and should be treated, in most cases, by primary care physicians; however, careful evaluation and monitoring should be conducted before medications are started and for all cases of refractory treatment. <u>Seizure Disorder:</u> The Monitoring assessed the management of seizure disorder at the Facility. The Facility provided a list of all individuals who were on phenobarbital, phenytoin, and combined valproic acid, and lamotrigine. Twenty individuals were prescribed phenobarbital, 33 individuals were prescribed phenytoin, 0 individuals were prescribed thioradazine, and 2 individuals were prescribed combined valproic acid, and lamotrigine. Of the two cases involving the coadministration of valproic acid and lamotrigine (Individuals #141, and #521), there was no indication, following review of the clinical records, that the risks and benefits of this drug combination were discussed through the Interdisciplinary Team, or described in the consent process. In addition to altering drug levels, the coadministration of these two agents can potentiate the development of life threatening rash (Stevens Johnson Syndrome). Based on a list of individuals who experienced status epilepticus within the past six	

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		Months, the Monitoring Team selected five sample cases to review (Individuals #69, #474, #576, #159, and #67, collectively known as sample A). Only one of the five samples (20%) listed the appropriate seizure diagnosis on the Active Problem List and/or Annual Medical Assessment (#576). Only one of the five samples had an EEG within the past five years (20%). Nevertheless, as demonstrated by review of physician progress notes, of the five sample cases reviewed, five of five (100%) had appropriate follow-up by the unit physician, following an episode of status epilepticus during the past six month period. Progress notes indicated that the individual was examined, seizure frequency and current medications were assessed, and relevant laboratory studies were obtained. The following examples describe specific issues reviewed for sample A: Individual #159 The individual has a diagnosis of refractory seizure disorder and recent history of status epilepticus. A neurologist on 8/29/11 and 10/26/11 evaluated this individual. Neither consults documented diagnosis or evaluation of side effects or toxicity. The individual was referred to an epileptologist on 10/26/11 and seen by the epileptologist on 11/30/11. Was to follow-up with neurologist following evaluation by epileptologist; however, at the time of this review, that follow-up had not occurred. The individual is prescribed risperidone, which is known to decrease the seizure threshold, and there is an FDA caution for use in individuals with seizure disorder. The Monitoring Team could not identify the IDT being made aware of this issue, nor determining if the risks outweighed the benefit of continuing risperidone. Individual #69 The Individual is known to have refractory seizure disorder and recent episodes of status epilepticus and was seen by a neurologist on 8/17/11, 10/26/11, and 1/5/12. On 10/26/11, the neurologist recommended to follow-up with epileptologist; however, records provided did not include a consultation report for an epileptologist. None of the neurology consultation reports documented the diagnosis, or evaluation of side effects or toxicity. Individual #474 The individual is known to have history of significant status epilepticus. Neurology consultations were obtained on 4/6/11 and 10/26/11. Drug toxicity and side effects were assessed during the 10/26/11 evaluation but not during the 4/6/11 evaluation. Neither consultation included a diagnosis. The individual was to follow-up in three months following the 4/6/11 consultation; however, the individual was not evaluated until 10/26/11.	

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		The individual is prescribed phenylephrine, which may exacerbate seizure disorder. The Monitoring Team could not identify the IDT being made aware of this issue, nor determining if the risks outweighed the benefit of continuing this drug. Individual #576 The individual had experienced status epilepticus during the past six months and was seen by neurology on 4/7/11, and 7/12/11. Neither report documented a diagnosis, or if side effects and drug toxicity were evaluated. The individual was to follow up in two months following the 7/12/11 consultation, but there was no documentation supporting that this consultation occurred. Individual #67 The individual had experienced status epilepticus during the past six Months. According to records provided, the individual was not seen by neurology since 1/26/11, despite recommendations to follow-up in two months. The individual is prescribed escitalopram, and there is an FDA caution when using this drug in individuals with seizure disorder. The Monitoring Team could not identify the IDT being made aware of this issue, nor determining if the risks outweighed the benefit of continuing this drug. Summary of seizure management: The Monitoring Team noted excellent response by the physician following an episode of status epilepticus. A neurologist evaluated individuals, and when indicated by an epileptologist; however, of the 10 consultations reviewed, five demonstrated significant delay with follow-up recommendations (50%). Of the 10 consultations reviewed, only one (10%) demonstrated a diagnosis, and evidence to support review for drug toxicity, and other side effects. Three of the five samples (60%) reviewed indicated lack of awareness by the Interdisciplinary Team that there was coadministration of a medication that may enhance or facilitate a seizure. It is essential that the Interdisciplinary Team must review all individuals coadministered lamotragine and valproic acid. <u>Gastroenterology/Constipation:</u> From a list of individuals who had a diagnosis of constipation, the Monitoring Team choose three cases to review, known as sample B (#34, #26, and #60). The Annual Medical Assessment, Nursing Assessment, current Medication List, GI consultations for past two years, Active Problem List, most recent ISP, and all data recorded by staff to assess constipation and/or bowel obstruction, and the Clinical Record was reviewed by the Monitoring Team. Nursing Policy for Bowel Management, Volume 4, Section 2, dated 2009 was reviewed. The Policy does not require enhanced monitoring and assessments	

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		for individuals at increased risk for obstruction, and does not require documentation of fluid intake for persons identified at risk for constipation. Individual #34 Individual #34 was diagnosed with atonic colon, and experiences episodes of recurrent constipation. In 2010 the individual developed massive constipation requiring an endoscopic procedure to remove hardened feces. The constipation was so significant that it resulted in renal failure by obstructing urinary output. Diagnosis of "constipation" is listed on the problem list and current Annual Medical Assessment, but its etiology of atonic colon was not well documented. Direct care staff records bowel movements; however, the type of stool and related issues such as difficulties with bowel movements were not recorded. The individual is prescribed medication for constipation; however, there was no enhanced physical assessment by the physician to assess for recurrence of constipation, in this very high risk individual. Importantly, this individual was diagnosed and treated for gastric cancer in 2005, and continues to have low weight, and chronic anemia. The etiology of the anemia was not determined. Medical staff must closely monitor individuals with a history of gastric cancer for both nutritional manifestations, and possible recurrence of cancer. The Annual Medical Assessment, Nursing Assessments, and Personal Support Plan, do not reflect assertive monitoring. Issues such as vitamin B12, folate, calcium, and protein deficiencies are common to occur, even many years following remission of gastric cancer. Severe osteoporosis, resulting from nutritional deficiency is not uncommon. Regular monitoring for such issues was not evident by review of the clinical record. The individual is reported to experience periodic gagging, burping and emesis. The physician documented on the Annual Medical Assessment, "I believe he is now left with psychogenic gagging and emesis at times". The Active Problem List documents "History of Psychogenic vomiting". The Monitoring Team noted that the individual was provided with an Upper GI, and a swallowing study; however, given his significant history of gastric cancer, and severe gastritis, and a known hiatal hernia, more assertive evaluation should have been provided, including an esophogram, which is necessary to help determine the function of the lower esophagus, or re-evaluation of H-pylori. The diagnosis of a psychogenic manifestation of a physical illness should only be determined after careful exclusion of all potential physical causes. The Problem List indicates a diagnosis of "iron deficiency anemia", and the individual was prescribed chronic iron therapy. The etiology of the iron deficiency anemia was not delineated in the clinical record. The Monitoring Team is concerned of the etiology of this condition, as iron deficiency has many causes, including malignancy.	

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		The Integrated Risk Rating Form, dated January 27, 2011, rated the individual to have a low risk rating for GI problems, despite the well-documented GI conditions known. Incidentally, the individual was also determined to be low risk for cardiovascular disease, despite an echocardiogram report demonstrating marked concerns, and also a low risk for fracture, despite the diagnosis of "severe osteoporosis" with a history of hip fracture. Regardless of the fact that the risk rating was completed in January 2011, given the individual's significant health care issues, the risks should have been updated. The Annual ISP did not comment of significance of history of gastric cancer, nor did the physician attend the ISP Given the individual's continued gastrointestinal problems, including a history of gastric cancer, known hiatal hernia, history of positive H-pylori, chronic anemia, severe constipation, occasional emesis, gagging and burping, the Monitoring Team is concerned over the lack of assertive and regular gastrointestinal evaluations, possible need for GI consultation, periodic physical assessments by the physician, enhanced nutritional assessments to periodically monitor for known nutritional deficiencies following gastric cancer. The Monitoring Team is also concerned that the physician did not take an active role in the ISP process. Individual #26 Annual Medical Assessment, dated 11/15/11, indicated a diagnosis of constipation; however, the type of constipation was not indicated, nor was there evidence to support an evaluation to determine the cause of constipation. The individual was admitted to the hospital in May of 2011, for "fever, increased resp" and was diagnosed by the hospital as having "constipation and fecal impaction". This issue was not noted on the Annual Medical Assessment. There are no specific recommendations made by the physician specific to bowel management, in this high risk individual. Review of Physicians Medical Care Review dated 2/2/11,5/5/11, and 10/31/11, demonstrates that no special instructions to direct care staff or nursing staff were recommended by the physician for the individual's known diagnosis of constipation, in this high-risk individual. The physician did participate at the individual Support Plan Meeting on December 6, 2011. Nursing Assessment, dated November 15, 2011, stated "His current weight reflects a weight loss of 2.2# this quarter which is a overall loss of 5.5# for this year." "No changes in his diet have occurred." "Is at the lower end of his desired weight range but has been stable this past year." The assessment also noted that the individual was hospitalized on 5/27/11, for "constipation, and fecal impaction." This issue was not documented on the Annual Medical Assessment dated 11/15/11. Nursing notes indicate that "A new HMP for constipation will be implemented if constipation occurs again."	

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		The Individual Support Plan (ISP) meeting on December 6, 2011, included the participation of the individual's physician. The Health Risk Assessment was not provided for review or discussed at the ISP meeting. The ISP did not include constipation as an important issue to monitor, nor did it address the hospitalization for fecal impaction. Direct Care staff and Nursing staff are not required to enhance monitoring for bowel related issues. There is no documentation to support that the individual has been educated on the importance of self-reporting problems with constipation. There was no evidence that the physician provides enhanced physical assessments for bowel related conditions. The Monitoring Team has concerns over the management of this individual's bowel issues. The individual was diagnosed with cerebral palsy, a condition that is frequently associated with serious constipation, bowel obstruction and perforation. ISP report indicates that the individual is "much less responsive than he has been in previous years," suggesting a significant change in the person's life, and the cause of this change was not delineated in the Clinical Record. Importantly, the individual received scheduled anticonstipation medication, and was hospitalized for fecal impaction during the past 12 Month. The Monitoring Team considers such individuals as high risk, and more assertive management, evaluation, and monitoring should be considered. Individual #60 The individual is diagnosed with advanced Parkinson's Disease, chronic constipation, mild anemia, fecal incontinence, weight loss, and atonic colon with a history of multiple colon resections and abdominal surgeries for small bowel obstruction in the past, all of which indicate that this individual is at significant risk for bowel obstruction, and perforation. The most recent Nursing Assessment and ISP indicate a recent cervical spine fracture. The Annual Medical Assessment dated 1/7/11, did not comment or provide recommendations for recent C-spine fracture. There is no evidence that the physician or nursing staff provide more frequent and regular physical assessments for this serious condition. The ISP did not delineate necessary follow-up care for this issue. The Annual Medical Assessment did not document assertive follow-up and treatment strategies for the management of his chronic constipation and history of obstruction. Review of Monthly Bowel Chart Record for January 2012, found there is evidence of bowel monitoring by direct care staff; however, there are no special monitoring and reporting requirements by direct care staff, such as other physical signs and symptoms to suggest severe constipation or obstruction. Also, Direct Care staff are not consistently reporting on the type of stool and if there was straining, bloating or discomfort, which	

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		are important parameters to assess. Of significance, there are special instructions for Direct Care Staff to monitor and report signs and symptoms of complications of the individual's c-spine fracture; this is a positive finding that should have also been done for constipation or obstruction. The Personal Support Plan dated July 14, 2011 was devoid of any enhanced need for the continued monitoring, assessment of the individual's serious gastrointestinal problems (GI). There were no specific action plans dedicated to the overall management of the individual's chronic constipation and related risks of obstruction and perforation. The Physical and Nutritional Management Plan dated July 15, 2011, did not address the individual's GI problems. The only GI consultation provided for review was dated 11/4/10, which concurred with the treatment of Miralax, increase water intake, senna, and water enemas as needed. The individual is provided with scheduled soap suds enemas (twice per week), and also is provided with fiber supplementation. The Monitoring Team has significant concern regarding the management of the individuals diagnosed with chronic constipation, and related conditions of the bowel. The Facility did not have a systematic approach to the overall management of chronic constipation, including the monitoring, evaluation and treatment of constipation. From sample B, none of the cases (0%) demonstrated consistent medical follow-up for chronic constipation, as a component of chronic care management at the Facility; physicians are reactive to reports of constipation and not proactive by performing regularly scheduled physical assessments. Of sample B, two of the three cases (67%) noted an etiology of constipation. Bowel monitoring by direct care staff did not consistently report the type of stools and related problems associated with bowel movements in the three cases reviewed (0%). There was no documentation or requirement to document attempts of providing additional fluids, or the amount ingested by individuals who have a diagnosis of constipation. One case of Sample B (33%) employed the daily administration of supplemental fiber. Fiber supplementation must be used with caution in individuals with atonic bowel, poor fluid intake, non-ambulatory, and who are prone to bowel obstruction, as it may worsen constipation or hasten bowel obstruction and perforation, in addition to preventing the absorption of medications. There was evidence to support that a physician participated in only one of the 3 PSPs reviewed (33%). <u>Bedrail Safety:</u> The Monitoring Team assessed the safety of bedrails during its observation at the Bowie Living Area, on January 19, 2012. Residential rooms one through six were assessed, and all beds associated with bed rails were determined, by the Monitoring Team,, to be unsafe and not meeting minimum industry standards. Each bed identified demonstrated	

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		loose bed rails, and rails that allowed limbs, neck, and head to become entrapped. The Monitoring Team determined that the bed rails placed individuals at risk. This issue was brought to the attention of Facility leadership at the time of discovery. <u>Community Living Discharge Planning:</u> To assess physician participation in community living discharge planning (CDLP), the Monitoring Team attended the CLDP meeting for Individual #7, and reviewed CDLP referral documents and the clinical record; the following concerns were noted: • The individual has a history and physical signs of cerebral palsy, which was not included as a diagnosis, nor reported to the CLDP team. • A recent echocardiogram indicates an ejection fraction of 50, which is a lower range. In addition several chest x-rays demonstrate cardiomegaly. The issue of cardiomegaly and potential need for follow-up was not reported during the CDLP. • The individual was noted to have significant alopecia, and dark, coarse, black hair on the chest and face. The etiology of this manifestation was no pursued or was the issue reported at the CDLP. • The individual has a history of gait abnormalities since childhood, however, which has appeared to exacerbate more recently. Per review of records, the physician did not provide a formal gait assessment, nor was the gait issue assertively managed by PT/OT. PT/OT reported "independent with gait over all surfaces," while Monitoring Team observation of the individual demonstrated an unsteady gait, the parent reported that her gait has lead to fall injuries, especially when she is anxious, and there is a history of fall injuries resulting in fractures and fractured teeth. • The individual is known to have had serious adverse outcomes from medications in the past, including lithium toxicity, and remains a risk for metabolic syndrome. Adverse reactions and potential for medication adversities were not discussed at the CDLP. • The significance of the individual's hypertension was not appropriately discussed at the CDLP, nor was assertive management noted from review of the Clinical Record. The Monitoring Team could not find regular physical and laboratory assessments by the physician during the previous year. It was especially concerning that an albumin / creatinine ratio, or other specific means to asses for proteinuria, and that the accepting agency was reported that the normal blood pressure should be "140/90 or less". The NIH considers 120/80 or greater as pre-hypertension, and normal blood pressure to be less then 120/80. • The individual had a significant tremor, which exacerbated with intention. This issue was not reported as an important issue at the CDLP; however, the parent of	

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		the individual raised it as a concern, and suggested treatments that have worked well in the past. • The physician participation at the time of the CDLP was limited, and suggested that once the individual "gets into the community it is the responsibility for that new doctor to start over from scratch." The Monitoring Team has significant concern over the extent of physician participation in helping to prepare individuals for transfer to the community. The physician must ensure that all known and suspected medical conditions are evaluated and clearly delineated for participants in the CLDP to understand, and to identify medical related supports and services necessary for the transfer. This case involved many diagnoses and clinical issues that were not appropriately presented to the CDLP team. It is incumbent on the Facility to ensure that all known and suspected medical conditions are clearly listed so that the accepting physician has a clear appreciation of the individual's health care needs. <u>Emergency Response:</u> A comprehensive review of emergency response is located in Section M, of this report. In addition to emergency response, the Monitoring Team identified an individual who required the STAT use of an "EpiPen" (#428), in the event of an anaphylactic response following the individual's monthly allergy injections, as prescribed by the allergist. The Monitoring Team discovered that although the EpiPen was located on the living area, its location was not readily known by living area staff. Importantly, the EpiPen did not accompany the individual to and from the Allergist's office. Following discussion with staff, no specific plan was in place for its use, nor were staff that accompany the individual to the Allergists Office trained on how and when to use the device. The Monitoring Team identified this issue as of critical concern.	
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.	To assess compliance of Provision L.2, the Monitoring Team reviewed the most recent external medical audits, which were conducted on January 3, 2012. The Monitoring Team reviewed the external audit process with staff physicians, and reviewed current policies specific to the audit process. In addition, the Monitoring Team reviewed five complete medical audits for each physician, including action plans for deficiencies. The Monitoring Team also assessed the Facility's Death Review Process. <u>External Audits</u> During the past six months, a total of 34 external medical audits were completed, by four external reviewers. For the most recent external medical audit (round 4), conducted on January 3, 2012, overall essential compliance for the four physicians were as follows: 96%, 92%, 83%, and 100%. Overall essential compliance fell within acceptable range.	Noncompliance

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		Overall non-essential compliance for the four physicians was as follows: 89%, 92%, 89%, and 91%. Overall non-essential compliance fell within acceptable range. Action plans had been developed for areas noted to need improvement; however, because of the timing of the external medical audits and this review, they had not been completed at this time. There is a quality assurance process in place to ensure follow-up. The Monitoring Team remains concerned over the efficacy of the external audits. The audits assess follow-up to required policies and procedures, but they do not provide a meaningful review of clinical performance issues. The Monitoring Team was made aware that DADS Central Office is continuing to develop a review process that includes a performance review. Assessing the quality of care requires that processes and outcomes be evaluated. In its current format, the review excluded outcome indicators. In order to achieve compliance with this provision item, the facility will need to add components to the review that address targeted clinical outcomes. Selecting clinical outcome indicators based on the state-issued clinical guidelines would be an appropriate starting point, since these are the high priority issues targeted by the state. In addition to external medical audits, the Facility had developed a process to conduct its own internal medical audits. This process will be similar the current external audits, and will begin sometime in the future. <u>Death Reviews:</u> Since the time of the last review, three deaths had occurred at the Facility. There was one outstanding clinical death review secondary to pending results of an autopsy. General findings included: • The average age was 56.6 (varied from 52 to 63). • The cause of death in one case was congestive heart failure, secondary to congenital cyanotic heart disease and tetralogy of Fallot. The cause of death in one case was hypovolemia and hypernatremia, secondary to lithium induced nephrogenic diabetes insipidus. The third cause of death was presumed to be related to choking, but had not been confirmed by autopsy. • An autopsy was performed for one of the three deaths. • Do not resuscitate (DNR) status was ordered while residing at BSSLC for all three individuals. • Of the three deaths, two were expected with the individuals receiving hospice care, and their death was at the Facility. One death was unexpected and died in the hospital setting. • In two of the deaths the individuals had multiple emergency room and hospital visits in the months leading up to death.	

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		Since the last review it was positive to find better adherence to the Facility's Clinical Death Review Policy, although some deficiencies were found. The Death Review Investigations by Nursing Services were completed within five working days for all three deaths according. The Death/Discharge Summaries completed by physicians were completed within five working days for two of the three deaths. The Clinical Death Review Committee met within 14 working days for two of the three deaths. The Administrative Death Review Committee Meetings that were due within 14 calendar days after receipt of the Clinical Death Review Committee Meeting Minutes were not completed for two of the deaths. The third death's Administrative Review Committee Meeting was not due at the time of the review. Contrary to other State Support Living Centers, the Facility's policy designated the Medical Director to chair the Administrative Death Review Committee Meeting as opposed to the Facility Director. A review of the Clinical Death Committee Minutes, Death/Discharge Summaries and Death Review Investigations by Nursing Services primarily focused on clinical data and care provided by medical and nursing services. The integration of other care provided by other relevant disciplines was not included in any of the documents reviewed. Only the medical and nursing staffs attended the Clinical Death Review Committee Meetings. It was positive to find that an external physician attended the Clinical Death Committee Meetings. The State Office Medical Director was notified of the Clinical Death Committee Meetings but was not present at the Facility or by telephone. There was documentation that the State Office Medical Director was notified of the meetings. The Death Review Investigations by Nursing Services made seven nursing recommendations for the three deaths. There was documented evidence that all seven recommendations were carried out within five days of the deaths. Review of the above documents did not provide specific content to discern the rationale for the nursing recommendations. The Clinical Death Review Committee, and specific review by the Medical Director and the Nursing Director, was limited to the immediate circumstances resulting in the death of three individuals. It is incumbent upon the Facility to perform a Root Cause Analysis of each death. A Root Cause Analysis reviews the immediate and historic care of the individual, and evaluates sentinel events, as well as chronic disease management. A Root Cause Analysis should involve a review of all clinical and related supports provided to the individual. A Root Cause Analysis will enable the Facility to enhance clinical care and outcomes. The Clinical Death Review Committee made no recommendations for one of the two deaths reviewed and stated that the individual received excellent medical and nursing care. There was one recommendation for the other death to improve an understanding	

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		of hospice policies and procedures. According to the CNE the nursing staff had a meeting with the hospice administration to explain their policies and procedures. Another meeting with the hospice administration was discussed at the Morning Medical Meeting, 1/17/11, at which the Monitoring Team attended. It was agreed that the CNE would arrange a meeting with the hospice administration for relevant Facility staff. The Facility had not conducted a Mortality/Morbidity Review and Analysis of longitudinal data related to deaths to track and trend systemic issues, develop corrective action plans, or the efficacy of the corrective actions. It is essential that all deaths be analyzed over time by means of a trends analysis. The Medical Director, and Facility Director must regularly review mortality trends, and ensure that necessary corrective measures are in place, and are effective. In an interview with the Quality Assurance Director and Quality Assurance Nurse, they acknowledged that the Facility's current death review process did not meet the requirements set forth in the Settlement Agreement or State policies and procedures to ensure that there was a thorough, systematic, and integrated death review process. After much discussion the Quality Assurance Director presented a draft Internal Corrective Action Plan to improve the Facility's death review process. The anticipated draft death review action steps included: • Revised local Facility policy to include: o Steps for conducting the nursing and Facility investigation process to be an integrated approach to identify broad systemic issues related to the death of a person served. o Define a process to require that during the initial five day investigative process there is a cursory review of findings with Medical, Nursing, Incident Management, and Residential Services, and other relevant disciplines to begin the development and implementation of immediate corrective actions. o Define a process that ensures the Facility will conduct Mortality/Morbidity Review and Analysis of longitudinal data, related to deaths, that would track and trend systemic issues, corrective action plans, and the efficacy of the corrective actions. The data will be shared with the Facility's Quality Assurance/Quality Improvement (QA/QI) Council. • The Quality Assurance Director will provide technical support to the Quality Assurance Nurse in development of the Nursing Services Investigation Report to ensure thorough policies and procedures and standards of care, to ensure an accurate analysis of all identified issues and concerns, and to provide a clear, substantial basis for recommendations. • The Facility will procure supplemental technical assistance for report writing training for both the Quality Assurance Nurse and Facility Incident Management	

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		Coordinator who conduct the death investigation process. • The Quality Assurance Department will develop a Mortality /Morbidity Meeting with minutes to document all required components of the Death Review Process. • The Quality Assurance Department will develop a robust Quality Assurance Process to proved oversight for the Facility's Clinical and Administrative Review Process. The Monitoring Team will follow-up for progress made toward the draft death review corrective action plan at the next review. According to the State Office Nursing Coordinator the State was developing a statewide death review policy and procedures that would include an integrated approach to the death review process. The Monitoring Team will look forward to seeing improvement in the death review process at the next review.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	The Monitoring Team reviewed progress towards compliance of Provision L.3, with the Medical Director, and Medical Staff. During a meeting with the Medical Staff and Medical Director, the Monitoring Team was informed that a process to assess clinical indicators has not been developed. The Facility is aware that this process must be developed in the near future, and that quality indicators must reflect clinical practice at the Facility, include an interdisciplinary methodology, include longitudinal trends analysis, implements corrective action, and evokes a mechanism to ensure remedies are affective.	Noncompliance
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	To assess compliance of Provision L4, the Monitoring Team reviewed the Facility's current policy on medical services, BSSCL Policy, Physician Procedures and Best Practice Guidelines, undated, as well as Clinical Pathways for diabetes, osteoporosis, and seizure management. The Monitoring Team also discussed the Facility's progress towards compliance with the Medical Staff. Following review of the Facility's policy, Physician Procedures and Best Practice Guidelines, the Monitoring Team concurs that the policy is comprehensive and does address standard of care approach to clinical practice; however, the much of the policy has yet to be implemented by the Facility. DADS Central Office, in collaboration with Facilities, has developed three Clinical Pathways; Diabetes, osteoporosis, and Seizure Management. The Monitoring Team is unable to do a comprehensive review or provide specific recommendation, in the context of this report. The Monitoring Team believes the process of developing clinical pathways	Noncompliance

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		can provide a resource to improve clinical care. In general, however, the Pathways drafted to date need further development. These drafts do not address many of the important and unique issues related to individuals with Developmental Disabilities; they do not consider the bio-psycho-social aspect of the individual; they do not manifest a Team approach to health care management; and they do not outline acceptable outcomes. Importantly, each pathway is produced in a completely different format from one to another, making it very difficult for providers to efficiently refer to. The Monitoring Team does not believe that the Pathways provided for review will significantly enhance clinical outcomes. The Monitoring Team does recognize that the process of developing clinical pathways is in an early stage and looks forward to seeing the expansion and continued development of these documents.	

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

1. Ensure that the health care clinic staffing is adequate, and does not result in delay in treatments, consults, or diagnostics. (Provision L1)
2. Ensure that the Medical Director has appropriate time to perform all necessary administrative and supervisory duties. (Provision L1)
3. Enhance local training opportunities for physicians in developmental disabilities (Provisions L1)
4. Develop a process that ensures all relevant clinical disciplines address syndromal conditions at the Facility, and that preventive health measures are developed for such conditions (Provision L1)
5. Ensure that all clinical issues are delineated on the Annual Medical Assessments and Problem Lists. All clinical reports, such as Nursing Assessments, PT/OT assessments, outside consultations, and diagnostics must corroborate each other (Provision L1)
6. Ensure that industry standards are implemented when utilizing bed rails. Consider alternative devices, such as low-rise beds, when appropriate (Provision L1)
7. Immediately ensure that all individuals with neuromotor and musculoskeletal disorders are comprehensively evaluated, and provided necessary treatments and therapies. Diagnosis, etiology, and treatment plans must be clearly delineated on the Annual Medical Assessment (Provision L1)
8. Ensure robust, and efficient participation by physicians in the Interdisciplinary Team Process (Provision L1)
9. Ensure that preventative care assessment and management, specific to known syndromes, such as Down Syndrome, are implemented at the Facility (Provision L1)
10. Immediately ensure a systematic, evidence-based approach for the diagnosis and treatment of osteoporosis (Provision L1)
11. For all treatments, therapies that pose risk to the individual, ensure that the Interdisciplinary Team fully understands the risks and benefit of treatments, alternative treatments, and not providing treatment for clinical issues (Provision L1)
12. Ensure that there is prompt follow-up for all medical consultations, including procedures and diagnostics (Provision L1)
13. The Medical Director should review the continued high use of phenobarbital, and phenytoin. A systematic plan should be developed to reduce the use of these medications, when clinically appropriate. The Monitoring Team recognizes that the withdrawal of such medications may be more challenging for individuals with developmental disabilities. All efforts should be well documented (Provision L1)
14. When assessing individuals with seizure disorder, ensure a review of all prescribed medications to ensure that such exposure is not exacerbating the seizure disorder (Provision L1)
15. Develop a systematic process to ensure appropriate evaluation, treatment, and monitoring of constipation (Provision L1)
16. Enhance physician participation in the CDLP process. All health care issues must be evaluated and ensure that appropriate management is provided, and that the CLDP team clearly understands all known and suspected health care conditions and concerns (Provision L1)

17. Ensure that all individuals with known or suspected allergies are triaged by medical staff, as to the causes, and severity of the allergy, and what preventive, and emergency procedures are necessary to support the individual in the event of an allergic reaction Develop a process to ensure direct care professionals are trained as needed. (Provision L1).
18. For individuals identified as having medical needs, such as in the case when individuals with serious allergies are offsite from the Facility, ensure that appropriate medical equipment, medication, and knowledgeable staff accompany individuals (Provision L1)
19. The Medical Director, and other members of the Death Review Committee must enhance the clinical reviews of deaths by ensuring that a Root Cause Analysis, that includes a comprehensive review of long-term medical care, for each death (Provision L2)
20. Develop and implement a strategy to ensure longitudinal trends analysis for all deaths that occur at the Facility. The analysis must be regularly reviewed by the Medical Director, and Facility Director, and ensure that necessary corrective measures are in place and are effective (Provision L2)
21. Ensure that medical audits provide a professional standard for assessing the physician's clinical performance practice. (Provision L2)
22. Develop and implement a quality assurance process for medical services. (Provision L3)
23. Continue development and revision of current Clinical Pathways, (Provision L4)

The following are offered as additional suggestions to the Facility:

1. As long as the Medical Director maintains an active caseload, she should receive supervision by a external physician with equal or greater qualifications. (Provision L1)

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), 12/30/11 2. BSSLC Section M Presentation Book 3. Texas Department of Aging and Disability Services, State Supported Living Centers, Statewide Policy and Procedures, Emergency Response, Policy Number: 044.2, Effective: 9/7/11 4. Texas Department of Aging and Disability Services, State Supported Living Centers, Policy At Risk Individuals, Policy Number: 006.1, Date Approved: 12/29/10, Implementation: 1/1/11 5. Texas Department of Aging and Disability Services, State Supported Living Centers, Statewide Policy and Procedures, Medication Variance, Policy Number: 053, Effective: 9/23/11 6. Texas Department of Aging and Disability Services, State Supported Living Centers, Procedure: Medication Administration Observation Guidelines: Date: 7/2011 7. Texas Department of Aging and Disability Services, State Supported Living Centers, Nursing Protocol: Skin Management and Wound Prevention, Date: 5/2011 8. BSSLC Nursing Guidelines, Revised: 10/31/11 9. BSSLC Nursing Organizational Chart 10. BSSLC Nursing Discharged Summary Training, 1/2011 11. BSSLC Nursing Staffing Minimum Report, 6/2011 through 11/2011 12. BSSLC Monthly Nursing Staffing Ratio Reports, 6/2011 through 12/2011 13. BSSLC Nursing Staffing Pattern Reports, 6/2011 through 12/2011 14. BSSLC Budgeted Nursing Positions Report, 1/12/12 15. BSSLC Current Nurse Case Manager' Caseload for each Unit Report 16. BSSLC of Overtime and Contract Nurses, 6/2011 through 11/2011 17. BSSLC Projected Agency Use for Fiscal Year 2011-2012 18. BSSLC List of Meetings for Nursing Services for the week of the Settlement Agreement Monitors' Visit, 1/16/12 through 1/20/12 19. BSSLC Sample of Nursing Cross-Shift Reports 20. BSSLC Nurse Case Managers' Meeting, 9/22/11 21. BSSLC RN and LVN Meeting, 6/23/11 22. Health and Human Services Enterprise, Position Description for Nurse Manager/Nurse Case Manager Supervisor and Functional Job Description, Draft 23. BSSLC Staff Nursing Duties 24. BSSLC Notification of Physicians after Hours, 10:00 p.m. until 8:00 a.m., Draft (no date) 25. BSSLC On-Call Rotation – After Hours, 1/16/12 through 1/23/12 26. Physician's Meeting Minutes, 9/14/11 through 1/13/12 27. BSSLC Infection Control Committee Meeting Minutes, 8/22/11 and 11/28/11 28. BSSLC Infection Control Committee Guidelines, Revised: 9/1/11 29. BSSLC Infection Control – Handwashing Data, 7/1011, 8/2011, and 9/2011 30. BSSLC Infection Control Rounds Analysis for Third Quarter (July, August, and September, 2011) 31. BSSLC Regional Clinical Laboratory, Epidemiological Report, 7/1/11 through 11/3011 32. BSSLC Infection Control – Immunization Report, 12/9/11

	33. BSSLC Infection by Type Report, 9/1/11 through 1/19/12 34. BSSLC Infection Control Training Curriculum 35. Texas Department of Aging and Disability Services, Infection Control Manual for State Supported Living Centers, Health Statement, Appendix A, © 2003 by Texas Health and Human Services Commission (HHSC) 36. BSSLC Infection Control Prevention and Practices, Training Guidelines, 8/2011, © 2011 by the HHSC 37. BSSLC Competency Training and Development (CTD), Infection Control, Course Due/Delinquent List, 12/8/11 38. BSSLC Cardiopulmonary Resuscitation (CPR)/Emergency Response Committee Meeting Minutes, 6/3/11, 7/11/11, 9/19/11, 10/11/11, and 11/9/11 39. BSSLC Emergency Planning Committee Meeting Minutes, 11/29/11 40. BSSLC CTD, Basic CPR, Course Due/Delinquent List, 12/8/11 41. BSSLC CTD, Basic Life Support for Heath Care Providers (CPR/AED), Course Due/Delinquent List, 12/8/11 42. BSSLC Location List for Automated External Defibrillator (AED) 43. BSSLC Staff Responsibilities Regarding CPR Mock Emergency Drills 44. BSSLC CPR Mock Drill Summary, 6/2011, 7/2011, and 8/2011 45. BSSLC Save a Life, American Heart Association, Heartsaver: CPR AED Workbook, Revised: 9/23/11 46. BSSLC Emergency Equipment In-Service Training Curriculum, 12/1/2011 47. BSSLC CPR Heartsaver AED Instructor Lecture and CPR Instructor Exam 48. BSSLC Quality Assurance Plan 49. BSSLC Nursing – Section M Quality Assurance Audit Procedures and Corrective Action Guidelines, Revised: 12/1/11 50. BSSLC Nursing – Self-Assessment Audit Procedures and Corrective Action Guidelines, Revised: 8/1/11 51. BSSLC Nursing Self-Assessment Audit Reports, 7/2011, 8/2011, 9/2011, and 10/2011 52. BSSLC Nursing Care Plan Committee Function, Effective: 1/2/12 53. BSSLC Daily Care Plan Review Committee Meeting Minutes, 1/3/12 through 1/11/12 54. BSSLC List of Nursing Standardized Procedures – Protocols - Guidelines 55. BSSLC Nursing Education Department, Summary of Activities Performed, 7/2011 thru 1/2012 56. BSSLC Nursing Training Tracking Report for Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs) 57. BSSLC Observing and Reporting Clinical Indicators Curriculum, for non-professional staff 58. BSSLC Human Sexuality Education Curriculum 59. BSSLC Nursing Education Department – Admission Nursing Assessment Training, 1/2012 60. BSSLC Laminated Protocol Cards 61. BSSLC Medication Administration Guidelines, Effective: 10/1/11 62. BSSLC Medication Administration Observation Reports, 7/2011, 8/2011, 9/2011, and 10/2011 63. BSSLC Medication Variance Reports for the past six months and Medication Variance 12 Month Summary 64. BSSLC Pharmacy and Therapeutic Committee Meeting Minutes, 7/28/11 and 10/27/11 65. BSSLC Medication Error Committee Meeting Minutes and Medication Error Data Analysis Summaries, 6/29/11, 8/31/11, 9/28/11, and 10/26/11

	66. BSSLC Medication Variance Committee Meeting Minutes, 11/30/11 67. BSSLC Copies of the last 10 Medication Error Reports 68. BSSLC List of Individuals who have a Self-Administration of Medications Program 69. BSSLC Skin Integrity Nurse Function Job Responsibilities 70. BSSLC Decubitus Tracking Report, 1/16/12 71. BSSLC Pressure Ulcer/Wound Corrective Action Plan, 11/7/11 72. BSSLC List of High Risk Individuals 73. BSSLC Integrated Risk Rating/Discussion Form, 11/7/11 74. Individual Support Plan (ISP) Meeting (Facilitation and Documentation Guidelines) 75. BSSLC Physical and Nutritional Team (PNMT) Nurse Post Hospital Assessment/Evaluation Report form, 12/30/11 76. BSSLC Individuals on Campus with Aspiration Trigger Data Sheets. 77. BSSLC Aspiration Trigger Data Sheet Training Instructions, 9/8/11 78. Sample of 11 Aspiration Trigger Data Sheets for: Individual #79, Individual #39, Individual #54, Individual #260, Individual #60, Individual #90, Individual #169, Individual #440, Individual #363, Individual #465, and Individual #305, 1/1/12 through 1/18/11 79. Sample of the six most recent completed Comprehensive Nursing Assessments for: Individual #253, Individual#252, Individual #567, Individual #579, Individual #149, and Individual #38 80. Sample of Revised Acute Care Plan for: Individual #192 81. Sample of 15 Medication Administration Records and accompanying PNMPs for: Individual #191, Individual #141, Individual #473, Individual #217, Individual #16, Individual #523, Individual #165, Individual #68, Individual #195, Individual #50, Individual #370, Individual #442, Individual #486, Individual #132, and Individual #493, 1/1/12 through 1/19/11 82. Sample of four Hospital Liaison Reports for individuals hospitalized at the time of the monitoring Team's visit for: Individual #169, Individual #342, Individual #481, and Individual #78 83. Sample of 10 most recently completed At Risk Screening Assessments and Risk Action Plans for: Individual #138, Individual #273, Individual #151, Individual #242, Individual #13, Individual #408, Individual #353, Individual #83, Individual #38, and Individual #35 84. Comprehensive Record Review from a Sample of 20 High Risk Individuals from each Unit/Cottage: Individual #38, Individual #481, Individual #411, Individual #554, Individual #363, Individual #395, Individual #284, Individual #231, Individual #474, Individual #97, Individual #163, Individual #52, Individual #181, Individual #186, Individual #105, Individual #87, Individual #86, Individual #422, Individual #342, and Individual #78 **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. Wendy Jackson, RN, Hospital Liaison Nurse 8. Brenda Calvin, RN, Skin Integrity Nurse

	9. Nancy Witt, RN, Shift Manager, Assistant Nurse Educator 10. Leona Sian, RN, Shift Manager/Durable Medical Equipment Nurse 11. Johanna Schroder, RN, Nurse Educator 12. Johnnie Johnson, RN, Nurse Manager, Childress 13. Jim Cloud, RN, Nurse Manager, Cottages 14. Stephanie Hintzel, RN, Nurse Manager, Driscoll 15. Jane Barnett, RN, Nurse Manager, Bowie 16. Numerous Staff Nurses 17. Numerous Direct Care Professionals/Home Leaders **Meeting Attended/Observations:** 1. Meeting with Chief Nurse Executive and Nursing Operations Officer, 1/16/12 2. ISP and At Risk Screening Assessment and Risk Action Plan for Individual #474, 1/16/12 3. Medical Morning Meeting, 1/17/12 4. CPR/Emergency Response Committee Meeting, 1/17/12 5. Medication Variance Committee Meeting, 1/18/12 6. Medication Variance Committee Meeting, 1/19/12 7. Unit Tours in Bowie, Childress, and Driscoll 8. Medication Administration at Program Services for Childress Individuals, at noon, 1/19/12
	Facility Self-Assessment: In the BSSLC Plan of Improvement, updated 12/30/2011, the Facility indicated it was in noncompliance with Provisions M.1 and M.5 and in compliance with Provisions M.2, M.3, M.4, and M.6. This was inconsistent with the Monitoring Team's findings as all provisions were found to be noncompliant. The POI provided lists of some of the activities on which the Facility had or was taking to move toward compliance within each of the six provisions, but did not present a comprehensive assessment of compliance with each of the indicators. The Facility did not indicate the basis for any of the decisions on compliance. The activities reported in the POI went back to January 2011 but included actions taken since the last compliance visit. 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 which are determined in compliance with each of the six provision and those in which improvements are needed.
	Summary of Monitor's Assessment: Provision M.1: This provision was determined not to be in compliance. This provision is an overarching provision that covers multiple nursing related requirements. Although it was evident that much effort had been put forth to comply with all of the requirements, there remained some more work to be done on each requirement to move toward compliance with the whole provision. It was positive to find that a 100% of the nursing positions were filled. The realignment of nursing positions in appointing a Skin Integrity Nurse, another Nurse Educator and an Administrative Assistant the Infection Control Program to enter data should further aid in moving this requirement forward. The Quality Assurance process was continuing to be refined and improved with regard to the quality of the data

	derived from the Nursing Care Monitoring Tools. Nursing Administration and the Quality Assurance Nurse were working toward achieving inter-rater reliability agreement between audits completed by the Nursing Administration the audits completed by the Quality Assurance Nurses. The Infection Control Nurse had received technical assistance from another State Supported Living Center and was beginning to improve the quality of the Infection Control Program. The Emergency Response System continued to move forward with the addition of new emergency equipment and the establishment of the CPR Committee and Special Code Committee. Provision M.2: This provision was determined not to be in compliance. Although much effort had been put forth to improve the quality of the Annual/Quarterly Comprehensive Nursing Assessments, the overall nursing summaries need to be improved to clearly and concisely summarize clinical data for each of individuals' nursing problems/diagnoses in order to determine the individuals' progress toward their established goals and objectives. A new position was approved for a Nurse Case Manager Supervisor, which should provide the Nurse Case Managers with guidance and direction with completing nursing assessments and summaries. Additional technical assistance from an outside nurse expert should be considered. Provision M.3: This provision was determined not to be in compliance. It was positive to find that the Nursing Administration recognized the need to further improve the quality and to individualize the Acute Care Plans and Health Maintenance Plans. A Care Plan Committee comprised of Nurse Managers was implemented in January 2, 2012 to daily review all Acute Care Plans and Health Maintenance Plans developed the day before, to make recommendations for revisions and/or changes and give final approval once the revisions/changes were made to the plans. This committee appears promising as the few plans that were reviewed showed improvement. Provision M.4: This provision was determined not to be in compliance. Although the Nursing Education Department had continued to maintain an excellent system to track all nursing training which demonstrated that at least 95% of the nursing staff were trained on the various policies, procedures, and protocol developed and implemented to date, that alone does not constitute compliance with this provision. In order for this provision to meet compliance, not only must the nursing assessments and reporting protocols be established and implemented, they must be demonstrated through actual clinical practice sufficient to address the health status of individuals served. As was found throughout the other provisions, the assessments and protocols have not been adequately put into practice sufficient to meet individuals' health status needs. Provision M.5: This provision was determined not to be in compliance. Although it was evident that the Nursing Department had put forth much effort toward complying with nursing's responsibilities included in the At Risk Individuals Policy and Procedures by training and monitoring the nursing and other relevant staff, particularly in recent months, the review indicated only minimal progress had been achieved toward compliance. The need for improvements continued. The identification of risk indicators is an integrated process that requires collaboration with all relevant disciplines. The assessment of risk indicators and risk action plan process is still evolving. The Facility needs to provide the clinical disciplines with additional

	guidance and training to ensure that they have a thorough understand of the At Risk Individual and associated requirements. Provision M.6: This provision was determined not to be in compliance. The Nursing Department had continued to conduct an excellent process for reviewing and taking corrective actions for medication errors committed by the nursing staff. However, since the last review the Medication Variance Policy 053 had been implemented. The Nursing Department was charged with the responsibility for implementing and following the Medication Variance Policy. In order to met compliance with this provision, additional issues need to be built into or refined for the infrastructure to function efficiently and effectively, such as a collaborative system developed with the pharmacy regarding procedures/processes for prescribing, ordering, transcribing, preparation, dispensing, delivery and/or administration of medication, storage, security, and accountably of medication, and ensuring medication variances are reported by all relevant disciplines, e.g., nursing, pharmacy, and physicians.

#	Provision	Assessment of Status	Compliance
M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	This provision of the Settlement Agreement includes a number of requirements that address various areas of compliance. These requirements include: staffing, quality assurance efforts, assessment and documentation of individuals with acute changes in status, availability of pertinent medical records, infection control, and mock medical drills and emergency response system. Additional information regarding the nursing assessment and development and implementation of health care plans is found below in Provision M.2 and M.3 reports. Information and recommendations about nursing documentation regarding restraints is included above in Provisions C.5 and C.6 of the report. Information and recommendations regarding nursing documentation for the death review process is reported above in Provision L.2. The Facility's Section M POI stated they were not in compliance with this provision and the Monitoring Team concurs. Review of the Section M POI, Section M Presentation Book, staff interviews and review of documents, provided evidence that the Nursing Department had continued to make steady progress toward achieving compliance in all of the various requirements contained in this provision. <u>Staffing</u> At the time of the review, the Facility census was 310. The Nursing Department continued to maintain a stable and highly dedicated and motivated staff. All of the 119 (100%) budgeted nursing positions were filled, The CNE stated that this was the first time she could recall that all nursing positions were filled. There had been some realignment of nursing positions to enhance nursing services. In 10/2011, two Nurse Case Managers were reassigned to serve as a Skin Integrity Nurse and a Nurse Educator. According to the CNE the Nursing Department continued to use agency nurses, although	Noncompliance

#	Provision	Assessment of Status	Compliance
		they were primarily used to supplement staffing when full time nurses were on extended leave and/or during vacations. Most of the agency nurses had worked at the Facility for an extended period of time and were well acquainted with the individuals. The agency nurses continued to receive the same nursing orientation and refresher training as the full time nurses. A review of the Monthly Staffing Reports for the past six months indicated that the nursing staffing for all units/shifts had not fallen below the established minimum ratios. Based on a review of nursing staffing documentation and interview with the CNE, the Facility appeared to have an adequate number of nursing staff. The CNE stated the State had obtained a new position for a Nurse Case Manager Supervisor, who will be directly responsible for supervising the Nurse Case Managers. The position was posted and expected to be filled in 2/2011. Presently, the Nurse Managers supervise both the Nurse Case Managers and the staff nurses. This new position will free up the Nurse Managers, allowing them more time for direct supervision of the staff nurses. Copies were provided and reviewed of the Health and Human Services Enterprise's Nurse Case Manager Supervisor position description and BSSLC's Functional Duties of the Nurse Case Manager Supervisor. The new position will report to the Nursing Operations Officer. The realignment of nursing positions and the addition of the Nurse Case Manager Supervisor should continue to assist the Nursing Department in efforts to move toward achieving compliance with the Settlement Agreement. <u>Quality Assurance Efforts</u> According to Section M.2 POI, on 12/1/11, new Nursing Audit Teams were put in place. Auditing will be done by Nurse Managers, Shift Nurse Managers, Infection Control Nurse, Skin Integrity Nurse, Hospital Liaison Nurse and Nurse Educators. The Quality Assurance Nurses will complete the inter-rater reliability review. Interviews with the CNE, NOO, and QA Nurses, as well as review of the Quality Assurance Data Reports for the last six months, demonstrated progress in refining the auditing process for the 12 Nursing Care Monitoring Tools, as well as completing the audits, reporting audit findings to the QA Department, analyzing data, and taking corrective action. The revised Nursing Audit Plan, 12/1/11 for conducting audits on the 12 Nursing Care Monitoring Tools included the following: • Staff assigned to complete the following monitoring tools: o Medication Administration - Nurse Managers o Seizure Management, Pain, and Respiratory – Nurse Case Manager o Acute Illness/Injury – Shift Managers o Documentation – Shift Managers o Skin Integrity/Infection Control – Infection Control Nurses and Skin Integrity Nurse o Health Care Plans – Nurse Educators	

#	Provision	Assessment of Status	Compliance
		o Urgent Care/Emergency Room/Hospitalization Visits – Hospital Liaison Nurse o Prevention – QA Nurse o Quarterly/Annual Nursing Assessments – Nurse Educators and Nurse Managers. • QA Nurses completed inter-rater reliability checks. • The QA Nurse selected the monthly sample of records for audit and assigned them to the designated nurse. • The monthly sample of records for audit included: o Two records are audited on each unit with the exception of the cottages. The cottages will audit three records. This includes the sample size for all Nursing Care Monitoring Tools with the exception of those listed below. o Fifteen records are audited on Health Care Plans and Quarterly/Annual Nursing Assessment Monitoring Tools--four records each from Bowie and Driscoll, three records from the cottages, two records each from Fannin and Childress o Seven records are audited on the Infection Control Monitoring Tool. o The number of records audited on the Urgent Care/Emergency/Hospitalization Visits Monitoring Tool may vary according to the number of admission for these services. Interviews with the QA Nurses and review of the nursing QA data reports indicated that the Nursing Department had made improvements in the following areas: Completing the monthly number of assigned audits, more reliable data, and data reported to the QA Department were represented in more usable reports and was represented in both tabular and graphic form. The reports included data by percentage of compliance with each monitoring tool by unit, by month, and the number of records audited. Then, the same data was summarized quarterly. The NOO reviewed the monthly and quarterly audit summaries and directed corrective action on tools that fell below 80% compliance. The quarterly summary for audits completed in July, August, and September, 2011, on monitoring tools that fell below 80% compliance included: • Acute Illness and Injury - 75% • Documentation - 69% • Management of Chronic Respiratory Conditions - 75% • Pain Management - 76% • Seizure Management -74% • Urgent/Emergency/Hospital Visits - 79% There was documented evidence supplied through training records attached to the monthly and quarterly Quality Assurance Reports validating that corrective actions were taken with the nursing staff on monitoring tools falling below 80% compliance. In addition to the systemic corrective action plan, individual corrective action was taken	

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		when significant deficiencies were identified on monthly audits, as well as periodic "spot audits" completed by the Nurse Managers. However, since the many of the critical monitoring tools were consistently falling below the required 80% compliance, the Nursing Department should evaluate competency of the nurse auditors and the quality of the training/corrective actions provided to the nursing staff to improve audit outcomes. The same is true for Self Assessment Audit results discussed below. In addition to auditing the Nursing Care Monitoring Tools, Nursing Administration and the QA Nurses continued to conduct monthly audits on six Self Assessment Audit Tools. Each monitoring tool had an Instruction Sheet for conducting the audits and Corrective Action Plan Guidelines. The completed monthly audits were submitted to the NOO who reviewed the audit results, compiled monthly and quarterly reports, and reviewed the audit results with the Nurse Managers. The Nurse Managers were responsible for providing training/corrective action on audits resulting in less than 90% compliance. The six Self Assessment Audit Tools and assigned administrative staff included: • Nursing Care Plan Monitoring Tool (conducted with the DCPs to determine if they were trained on the respective individuals' care plans and to assess their knowledge regarding their responsibilities for the care plans) - completed by Shift Managers • Post Sedation Chart Review – completed by Nurse Managers • QA Medication Administration (MAR) and Medication Room Audit – QA Nurses/ designee from Nursing Administration • Medication Administration Observation – QA Nurses/designee from Nursing Administration/Shift Managers/Nurse Managers • Care Plan Audit – QA Nurses/designee from Nursing Administration A review of the documents supplied for review, of the six audit tool results for the past six months, only found one overall/campus wide summarized data report for Medication Room Audits. The results of the overall Medication Room Audits included: July – 52% August – 57% September – 57% October – 66% (There were no summaries for November and December) As noted above none of the audits resulted in the required 90% compliance with the audit tool. The low percentage of compliance was of significant concern, particularly since there were accompanying training records and discussions noted in Staff Nurse Meeting Minutes addressing corrective actions. The monthly MAR and Medicine Room audit results reviewed for the past six months consistently fell significantly below the required 90% requirement. This brings into question a possible inconsistency--if those	

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		percentages were so low, how could the Medication Administration Observations be consistently at 95% or greater, since many of the items that would be audited are also contained on the Medication Administration Observation audit sheet. The Nursing Department should evaluate the competency of the auditors conducting Medication Administration Observations. With the exception of the Medication Administration Observation audit results, which were consistently 90% or greater, the other audit results for the remaining five audits fell far below the required 90% compliance, although they also had accompanying training records and discussions noted in Staff Nurse Meeting Minutes addressing corrective actions. From the documents reviewed, Nursing Administration failed to consistently follow the Corrective Action Guidelines for summarizing the monthly and quarterly audits results and making corrective action plans. Further, since there were only marginal improvements found in the audits from month to month after retraining and discussion in the staff nurses' minutes, the quality and effectiveness of the retraining and supervision of the Nurse Managers was questionable at best. The Nursing Department should evaluate the effectiveness of the retraining and corrective action plans provided on the six Self Assessment Tools and revise the approach to improvement as needed. Although neither the Facility nor the State Office had a formalized process for completing inter-rater reliability checks, the QA Nurses reported that working with the QA Director had aided the progress made in completing the inter-rater reliability checks. The QA nurses also reported they had continued to work with the nurses completing the audits to develop consistency and continuity in the interpretation of the items contained on each monitoring tool. The Section M Quality Assurance Inter-Rater Reliability Tracking/Trending Reports was reviewed for September, October, November, and December, 2011. Although the QA Nurses indicated they were beginning to achieve closer agreement between the two sets of reviewers; there was not a consistent 80% or greater agreement on all of the tools. This indicated the need for continued work on identifying the reason for the disparity between the two sets of reviewers. The December, 2011, Section M Inter-Rater Reliability Report chart below demonstrates the percentage of compliance found for each monitoring tool by the two sets of reviewers. Nursing Care Monitoring Tools | Nursing Audit Results | QA Nurses' Audit Results Acute Illness and Injury | n/a | 68%	

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		Quarterly/Annual Nursing Assessment	71%	97%	
		Nursing Care Plans	92%	83%	
		Documentation	70%	80%	
		Infection Control	70%	80%	
		Management of Chronic Respiratory	47%	66%	
		Medication Administration Observation	n/a	n/a	
		Pain Management	n/a	62%	
		Seizure Management	66%	77%	
		Skin Integrity	0%	70%	
		Urgent Care/Emergency/Hospital Visits	75%	93%	

Standardized instructions for conducting Inter-rater reliability checks should be established for each of the Nursing Care Monitoring Tools to ensure that all auditors are consistently determining compliance using the same process and criteria. The lack of clear and specific instructions for the monitoring tools will result in unreliable data derived from the audits conducted by Nursing Administration as well as the QA Nurses' inter-rater reliability data. The Facility and the State should collaborate on developing specific instructions and criteria for conducting inter-rater reliability checks to ensure consistency in auditing the Nursing Care Monitoring Tools across all disciplines and State Supported Living Centers.

Although it was apparent through the Monitoring Team's review that the Nursing Department had made efforts to refine and improve their monitoring processes for auditing the Nursing Care Monitoring Tools and Self Assessment Audit Tools, more needs to be done. The new Quality Assurance Director had provided the Nursing Administration and Quality Assurance Nurses with technical assistance. However, for the Nursing Department to continue to make improvements, it may be contingent upon the further refinement and improvement of Facility's overall Quality Assurance system and the State's Quality Assurance processes and guidelines. Based on the review the following refinements and improvements should be considered:

- The Nursing Department should evaluate competency of the nurse auditors and the quality of the training and/or corrective action plans provided to the nursing staff to improve audit outcomes.
- The Facility and the State should collaborate on developing specific instructions and criteria for conducting inter-rater reliability checks to ensure consistency in auditing the Nursing Care Monitoring Tools across all disciplines and State Supported Living Centers.

<u>Availability of Pertinent Records</u>
Since the last review, it was positive to find that the Facility no longer sent individuals'

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		entire active records to the hospital; only the required transfer information was sent to the hospital. While on site, it was noted that a few documents were missing from the active records, such as copies of care plans. The dates of entries were occasionally found out of order. The time of the dated entries were occasionally missing. Some of the nursing related documents were misfiled. The nursing section of the active record continued to have one major tab for nursing documentation, which may have contributed to misfiling. The Facility should consider adding sub-tabs in the nursing section of the active record to prevent misfiling and aid in the ease of access in locating specific nursing documents. The Facility should continue to ensure that documents are available and filed in a timely manner in individuals' active records, so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> Since the last review, the Facility had made improvements to the Morning Medical Meeting to increase collaboration and integration of services by expanding the membership to include all clinical disciplines. The CNE and Hospital Liaison Nurse attended the Morning Medical Meeting and shared information with the group regarding nursing information for the care individuals needed. In addition, the group reviewed and discussed the status of individuals who were hospitalized and others who had medical problems during off hours. The Chief Pharmacist provided in-service education on various medications. The Monitoring Team attended the Morning Medical Meeting on 1/17/12. It was positive to find active participation by all disciplines in attendance to discuss individuals' care and issues for follow-up action. The Chief Pharmacist provided and in-service to the group on the medication Keppra. The Nursing Department had made improvements in shift-to-shift reports to enhance communication for individuals' treatments and health care. Cross-shift Reports had been standardized across all homes/units for the outgoing and oncoming shifts. The Cross-shift Report form was designed by unit/home, individuals' names were listed on the report with specific follow-up instructions for each individual for each shift, and the writing space was enlarged to accommodate more information and to make the writing more legible. According to the CNE this had improved communication between the shifts and avoided missing or misunderstanding of instructions for follow-up care. A review of sample Cross-shift reports was conducted from each unit during the week of the review. All units sampled, with the exception of Cottage C, were using the revised Cross-shift Report form. The revision to the shift-to-shift reporting and instructions for individuals' follow-up care showed improved communication from past reviews of shift-to-shift reports. Records were reviewed related to acute change in health status for 20 individuals who	

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		the Facility identified as being at risk for specific health indicators, including: Individual #38, Individual #481, Individual #411, Individual #554, Individual #363, Individual #395, Individual #284, Individual #231, Individual #474, Individual #97, Individual #163, Individual #52, Individual #181, Individual #186, Individual #105, Individual #87, Individual #86, Individual #422, Individual #342, and Individual #78. According to the Quality Assurance recent quarterly data for the Nursing Care Acute Illness and Injury Monitoring results were 75% rate of compliance, and Urgent Care, Emergency Room and Hospitalization indicated 79% compliance. However, information was not included as to how, and from what these percentages were determined or exactly what they represent. The Quality Assurance ratings were consistent with the Monitoring Teams' findings in review of the records below. A review of the above records for nursing care related to acute change in health status identified the following trends: Improvements noted from the past reviews: • Since October, 2011 the nursing staff consistently documented in the SOAP format for charting. • There was more consistent documentation in the Integrated Progress Notes when Health Maintenance Plans (HMPs) and Acute Care Plans (ACPs) were developed, implemented, and the direct support professionals (DCPs) were trained in the plans. • ACPs and HMPs had a separate sheet of instructions placed in notebooks in the homes for the DCPs ready reference. • The DCPs were more consistently notifying the nurses of changes in individuals' health status and the nurses were promptly following up with assessments based on their reports. • The nursing staff were consistently notifying the physicians of changes in individuals' health status. • ACPs were more consistently followed through to resolution and documented in the Integrated Progress Notes. • There was more evidence of referral and collaboration with other clinical disciplines, particularly the Physical and Nutritional Management Team (PNMT), regarding individuals' care. • There was an improved description of injuries and wounds documented in the Integration Progress Notes. Areas, as were found in past reviews, that need continued improvement: • There was lack of documentation in the Integrated Progress Notes regarding reporting individuals' with infectious/contagious diseases to the Infection Control Nurse.	

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		• Frequently documentation was missing on the weekends for individuals who required follow-up assessments and care for acute changes in health status. • A full set of vital signs was not consistently taken when individuals were being assessed for acute illnesses, particularly for those with infections/contagious diseases who were prescribed antibiotics. Sometimes only the temperature was taken and documented. • The method temperatures were taken was not consistently documented. • Oxygen saturation assessments did not consistently indicate if they were on room air or oxygen. • Lung sounds were not consistently assessed on individuals' being followed with respiratory issues or after episodes of vomiting. • The nursing staff continued to state in the "P" of the SOAP note "will continue to monitor" or "will monitor closely" but did not state what they would monitor or the frequency. Often there was no continuation of notes regarding what they said they would continue to monitor. • When individuals were prescribed antibiotics, the nurses documented that they continued on antibiotics but did not consistently document individuals' response. • Individuals' response/effectiveness of per necessary (PRN) medications were not consistently documented. • The dated Integrated Progress Notes often did not include the time the notes were written. • Unapproved abbreviations continued to be used. The Nursing Department should reinforce competency–based training regarding the documentation protocol as well as other protocols related to assessing and managing acute changes in health status. <u>Hospital Liaison Activities</u> Since the last review, the Hospital Liaison Nurse had continued to follow hospitalized individuals as reported. The additional activity that changed from the last review was her participation in the Morning Medical Meetings. A review of records for recently or currently hospitalized individuals included: Individual #342, Individual #481, Individual #78, Individual #422, Individual #284, and Individual #342. A review of the above individuals regarding their acute change in health status and subsequent admission and discharge from the hospital showed improvement in following the Hospitalization, Transfers, and Discharge Protocol and the development and implementation of ACPs for their respective nursing problems/diagnoses. There was documented evidence that when the above individuals experienced acute changes in condition the nurses completed a focused assessment regarding the presenting	

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		symptoms and promptly notified the physician. These individuals were transferred to the emergency room and then later admitted to the hospital. The only omission found regarding compliance with the Hospitalization, Transfers, and Discharge Protocol was failure to conduct a nurse to nurse telephone call with the emergency room nurse prior to the individuals' arrival at the emergency room. The Hospital Liaison Nurse followed up on individuals daily through the workweek, completed documentation of contact with the hospital on the Hospital Report form, kept the IDT and family informed of the individuals' health status, attended the Morning Medical Meetings, and gave a status report on each individual hospitalized. The Nursing Department should ensure that the nursing staff place a nurse to nurse telephone call prior to, or while individuals are in transit to, the emergency room and/or hospital. <u>Skin Integrity Activities</u> During 10/2011, the Nursing Department appointed a dedicated Skin Integrity Nurse. The primary responsibilities of the Skin Integrity Nurse were to: Chair the quarterly Skin Integrity Committee Meetings, develop and implement a Decubitus Tracking Database, consult on skin/wound issues in order to assist the other nursing staff with skin/wound care management, provide nurses and other relevant staff training on skin/wound care management, and collaborate with physicians and other relevant disciplines regarding skin/wound care management. In the short time since the Skin Integrity Nurse was appointed, she had made significant progress in setting up a system for managing skin integrity issues. The activities included: • Development of guidelines for the Skin Integrity Meeting. • Development and implementation of a comprehensive Decubitus Tracking Database. • Development and implementation of a comprehensive Pressure Ulcer/Wound Corrective Action Plan. • On 11/14/11 presented Nurse Case Managers with training on the use of the PUSH (A tool used to assess pressure ulcer status from onset to healing in a graph form) tool and E-Z Graphs. She also presented a procedure for collecting data and a procedure for reporting skin/wound issues. • At the time of the review four individuals were assessed and reported in the Skin Integrity Database. Two individuals had stage III pressure ulcers and two other individuals had skin integrity issues. Examples of two records reviewed for individuals with stage III pressure ulcers showed some improvement in the integration and management of skin integrity treatment and care: o Individual #284: A review of individual #284's records 10/15/11 through 1/20/12 indicated that he received adequate care for skin integrity issues as demonstrated below. On 11/3/11 Individual #284 was rated at high risk for	

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		skin integrity issues and had a Risk Action Plan. The objective was to have no skin breakdown. The Risk Action Plan did not include clinical indicators for assessing the health status for the high risk indicators. The action steps include multiple disciplines, e.g., nursing, physical and nutritional management coordinators, physician, and direct support staff. Plans were in place for: HMP for Skin Integrity, Physical and Nutritional Management Plan (PNMP), monitoring through Check and Changing Procedure, and appointment with the Wound Specialist, as needed. Although Individual #284 had integrated plans in place for skin integrity issues, on 10/15/11, he developed two open areas on left buttock (trochanter and sacrum) and at the base of the scrotum. He was referred and seen in sick call the next day and treatment was ordered to the wounds. On 10/20/11, an ACP for Decubitus Care was implemented and the DCPs were trained on their responsibilities. Although the care plan was not developed until four days later, there was documentation in the Integrated Progress Notes that the nursing staff had begun assessing and treating the wounds on every shift. The RNs assessed the size and condition of the wounds weekly and results were documented on E-Z Graphs and PUSH. Tools. A referral was made to the Skin Integrity Nurse who began assessing the pressure ulcers and assisting the nursing staff with the management of wound care. Individual #284 was seen by the Wound Specialist Physician on 10/28/11 for wound care evaluation. There was documentation that care was integrated with the PNMP and PNMT. The pressure ulcers appeared to become infected and antibiotics were ordered empirically on 11/14/11. On 12/16/11, Individual #284 was seen by the Wound Specialist Physician and received wound debridement. The wounds cultured on 12/16/11 found MRSA and Enterococcus Avium organisms. A decision was made to transfer Individual #284 to the Long Term Acute Care Facility (LTACF) with stage IV pressure ulcers for wound care and intravenous antibiotics. On 12/19/12 Individual #284 was transferred via State van to the LTACF. The nursing staff followed the Hospitalization, Transfers, and Discharge Protocol, by completing a preadmission comprehensive assessment, Hospital Transfer Form, sending the required information, communication with the with the LTACF nurse prior to admission, and notification of all relevant IDT and family. The Hospital Liaison Nurse remained in contact through out his stay at the LTACF and kept the IDT informed of his progress. On 1/10/12 the IDT conducted a transfer meeting with all relevant disciplines present, except the physician. Individual #284 discharged from the LTACF on 1/12/12. Upon return to the	

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		Facility, the Clinic RN completed a Post Hospital Nursing Assessment. Upon return to the unit the RN completed a comprehensive nursing assessment. The Skin Integrity Nurse completed an assessment of the pressure ulcers using the E-Z Graph and PUSH Tool, and took appropriate action in response to the findings. On 1/12/12, ACPs for Impaired Skin Integrity, Spasticity, Low Body Weight, and Indwelling-Foley Catheter Rectal Tube were developed, implemented, and the nursing and DCP staff trained on the plans. On 1/13/12, the PNMT Nurse completed an assessment and recommended continuing Individual #284's PNMP. On 1/12/12, the IDT met and reviewed his risks along with actions steps to evaluate and plan his outcomes for high and medium risk levels as well as programming. Risk levels were assessed and the following changes were made: Weight from medium to high, infections from low to high, and urinary tract infections from medium to high. Action steps were revised related to high risk levels changes. As stated above the revised action plan did not include clinical indicators to assess for progress toward outcomes. The Integrated Progress Notes reviewed from 1/13/12 through 1/20/12, indicated that Individual #284 was assessed and wound care provided on every shift. The Skin Integrity Nurse continued to complete pressure ulcer assessments documenting results on the E-Z Graphs and PUSH Tools, as well as documenting in the Integrated Progress Notes. As of 1/20/12 the pressure ulcers remained essentially at the same stage of healing that was documented upon return from the LTACF. o Individual #422: On 8/11/11 Individual #422 was rated at medium risk for skin integrity issues and had a Risk Action Plan. The objective was to have no skin breakdown. The Risk Action Plan did not include clinical indicators for assessing the health status for the high risk indicator, although general action steps were included, the date of implementation of the plan had started prior to the date of the risk assessment and was ongoing. The action steps include multiple disciplines, e.g., nursing, physical and nutritional management coordinators, physician, and direct support staff. Plans were in place for: HMP for Skin Integrity, Physical and Nutritional Management Plan (PNMP). A review of individual #422's records 12/5/11 through 1/20/12 indicated that he received adequate care for skin integrity issues as demonstrated below. Despite the integrated plans, on 12/5/11, the DCP notified the nurse to check Individual #422's left buttock. When the nurse checked his left greater trochanter he was found to have a 1-centimeter open area from a previously healed pressure ulcer. The physician was notified, treatment was ordered, and he was seen in sick call the next day. The pressure ulcer to the left trochanter was assessed as a stage II pressure ulcer. The physician also made a referral to the occupational and physical therapists to map pressure on the wheelchair and recliner. On 12/8/12 pressure mapping on the wheelchair and recliner was	

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		completed and modifications made to relieve pressure. Although there was documented evidence that Individual #422's HMP and PNMP relating to skin integrity issues were followed and the prescribed medical treatment applied to the wound, a new area of eschar was found over the stage II pressure ulcer. On 1/5/12 the physician requested a consult with the Skin Integrity Nurse. On 1/6/12, the Skin Integrity Nurse conducted an assessment and found a small unstageable pressure ulcer at the upper medical margin of his implanted Baclofen pump and areas of chronic breakdown overlying the left greater trochanter. Later in the day, the physician, nurse case manager and physical therapist met with the Skin Integrity Nurse to assess the pressure ulcers using the E-Z Graph and PUSH Tool. After the assessment was completed they discussed and made recommendations for future management of the pressure ulcers. The wound care plan was revised and implemented. The Skin Integrity Nurse continued to consult with the physician, nursing, PNMT, and other members of the IDT. Integrated Progress Notes reviewed through to 1/18/12 showed that the wound care plan was being followed by all relevant disciplines, but the pressure ulcer had not yet healed completely. <u>Infection Control Activities</u> Since the last review, BSSLC continued to have one full-time RN Infection Control Nurse who was responsible for the Facility's Infection Control Program and one part-time RN Infection Control Nurse. The Facility had added an administrative assistant position for data entry and other administrative duties. In 10/2011, the Infection Control Nurse had received two days of technical assistance from an Infection Control Nurse at one of the other State Supported Living Centers. The Infection Control Nurse's office had been moved to the Health Center Building in order to improve access to infection control information and enhance integration/communication with other clinical staff (e.g., physicians, pharmacy, dietitian, occupational and physical therapists, dental hygienists, and psychiatrist). Interviews with the Infection Control Nurse, review of the documentation, and information gathered during the review, indicated that the Infection Control Program had made significant progress toward the process of building an infrastructure to meet the requirements of the Settlement Agreement. Some of the progress noted included: • New tools were developed for entering infection control into the Infection Control Database to make the data presented on the spreadsheet more reliable and usable. • Reported infections were entered into the Infection Control Database which generates quarterly analyses of Infections by Type Reports. • A new protocol and form for reporting real time infections was developed,	

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		implemented, and the Nurse Case Managers trained to ensure all infections were reported to the Infection Control Nurse for follow-up. • The addition of the data entry administrative assistant and improvements made to the Infection Control Database made it possible to update the Immunization Database. The Infection Control Nurse continued to monitor the Immunization Database for immunizations that were due and notified the medical providers. As the Immunization Database capabilities are enhanced, it could be used to develop and implement an immunization scheduling system to alert the Infection Control Nurse and medical providers when required immunizations are due. When the scheduling system is implemented it should aid in preventing delays or omissions in updating individuals' immunizations. • The immunization statuses for individuals' and employees' seasonal flu were tracked, as were their Tuberculosis (TB) screening status. At the time of the review 93% of the individuals had received vaccinations for seasonal flu, Two percent of the individuals did not receive the vaccination due to an egg allergy or the family would not give consent. Five percent of the individuals' family/guardian had not returned the consents mailed to them. Eighty-eight percent of the individuals were current with TB Skin testing. Twelve percent of the individuals have converted skin tests. The Infection Control Nurse reported these individuals were assessed quarterly for possible signs and symptoms of TB. The findings of these assessments were documented the clinical records. If individuals were noted to develop signs and symptoms of TB, they were reported to the physicians. • The Infection Control Nurse received Epidemiological Reports. • The Infection Control Committee Guidelines were revised on 9/1/11. The revision provided the committee with more specific guidelines for the overall Infection Control Program in alignment with the Texas Department of State Health Services, Department of Public Health, and the Center for Disease Control. The Infection Control Committee members were in-serviced on the revised guidelines. • The format for Infection Control Committee Minutes was significantly improved, as was the content of discussions and dispositions. The minutes did not contain a formalized system of reporting the rates of infection to identify trends. • The Infection Control Nurse provided training on Handwashing and Standard Precautions at New Employee Orientation and at annual refresher training. • The Handwashing data was summarized and analyzed for the quarter of July, August, and September, 2011. There was evidence that corrective actions were taken in areas where deficiencies were identified. • The Infection Control Rounds for Environmental Surveillance purposes were completed quarterly. The rounds were conducted in each home on each unit, Program Services, and the Central Kitchen at least one time in a three-month period. Various staff members from each of the units, quality assurance, risk management,	

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		dietary, pharmacy, and custodial staff participated in monitoring of the homes and various locations throughout the Facility at random times in addition to the Infection Control rounds. The Infection Control Rounds data findings and results were summarized into quarterly reports, which were presented at the Infection Control Committee meetings for further review, discussion, and disposition. • There was evidence that the Infection Control Nurse provided training to staff on the units affected by outbreaks of MRSA and Scabies. Although it was evident that the Facility and the Infection Control Nurse had made significant progress since the past reviews and had begun building a stronger infrastructure, there were clinical issues in need of further attention. Infection Control Programmatic issues in need of further improvements included, but were not limited to, the following: • The Facility should make better use of information derived from the Infection by Type data to analyze and trend infections by rates according to standards of practice. The resulting data should be used by the clinical staff to develop and implement local and systemic preventative action plans to control and/or prevent the spread of infectious and contagious diseases. • As a result of the implementation of the preventative action plans there should be a further analysis and documentation of the effectiveness of the outcomes resulting from the interventions. • There needs to be a formalized procedure/process put in place to address data reliability of infections and implementation of Discrepancy Reports to track data reliability issues. • The Infection Control Nurse received Epidemiological Reports but it could not be determined how the reports were used. The Infection Control Nurse should collaborate with physicians and pharmacist regarding the effectiveness of antibiotics prescribed for infections. Typically this is done at Pharmacy and Therapeutic Committee Meetings. • The Infection Control Nurse should initial real time audits of all individuals diagnosed with acute infectious/communicable diseases. These audits should not fall under the randomized sampling procedures of the Facility. Due to the acute nature of infectious disease and the potential for spread, auditing for this area needs to be conducted while the acute infection is active. Conducting retroactive audits will not serve to prevent the spread of infections. • The Infection Control Nurses should collaborate with the Nurse Case Manager and other relevant staff to develop and implement plans of care a when acute infectious/communicable diseases are reported to ensure appropriate clinical interventions were put in place to control/prevent the spread of disease.	

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		Mock Medical Emergency Drills and Emergency Response System Since the last review, the Facility had continued to make progress toward addressing issues related to emergency response. According to a review of the Facility's Section M.1 POI, Section M, Presentation Book, documents supplied in the document request, interviews with staff, and attendance at the CPR Committee Meeting, 1/17/12 the following areas of progress were identified: • Implementation of the revised Emergency Response Policy, 004.2. • During October, 2011, CTD had adopted, implemented, and begun training the staff on CPR and Save a Life, American Heart Association, Heartsaver: CPR AED Workbook, Revised: 9/23/11. All new staff were trained to the revised version in New Orientation Training. Incumbent staff were trained on the revised version as their recertification became due. • All emergency equipment and AEDs required by policy were placed in the designated areas of the campus on 11/30/12. Radio Red Flyer wagons were procured and used to contain and transport the emergency equipment. This was accomplished approximately by 12/2011. • The Emergency Equipment and AED Checklists were revised and implemented 12/2011. Notebooks containing the Emergency Equipment and AED and Checklist were kept in the wagon. The equipment and AEDs were checked daily and signed by the nursing staff. The Nurse Manager or designee reviewed the checklist monthly with appropriate signatures present on the forms. Any needed follow-up or corrective actions were documented on the forms. • The relevant staffs were trained on the location of the emergency equipment. • Signs continued to be posted throughout the designated campus areas (all units and vocational areas) directing and identifying the location of the AEDs and emergency equipment. • The Risk Manager had begun to complete monthly Emergency Equipment Walkthrough checks. • The Facility had developed and implemented a tracking system to trend and analyze drill performance monthly and quarterly. A quarterly summary was completed regarding the number of drills completed, percentage of drills completed and percentage of drills passed, as well as identifying systemic problems requiring corrective action. Drill data was presented in tabular form with a narrative description of findings and corrective actions, when indicated. • According to 9/19/11 and 11/9/11 CPR Committee Meeting minutes, the Facility planned for the QA Nurse and other designated staff (Nurse Educator, Physician, and CTD Instructor) to perform one to two inter-rater reliability checks a month on the mock medical emergency drills. However, there was no documentation supplied regarding the status of the inter-rater reliability checks. • The Mock Medical Emergency Drills were scheduled as specified in the emergency	

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response policy. When the drills were not completed according to schedule they were reported with an explanation on the CPR Mock Drill Quarterly Summaries. There was documentation on the summaries that staff who did not perform the drill correctly after the retry that they were sent to CTD for retraining. Charts of the CPR Mock Drill Summaries are reported below:

CPR Mock Drill Quarterly Summary

Drills	June, 2011	July, 2011	August, 2011	Overall
Scheduled	23	21	23	67
Completed	22	20	22	64
Passed	22	20	22	64
Percent Passed	100%	100%	100%	100%
Percent Completed	96%	95%	96%	96%

CPR Mock Drill Quarterly Summary

Drills	September, 2011	October, 2011*	November, 2011	Overall
Scheduled	22	0	9	67
Completed	18	0	7	64
Passed	18	0	6	64
Percent Passed	100%	n/a	86%	93%
Percent Completed	82%	n/a	78%	81%

*No drills were completed in October due to instructors not trained in the new emergency response policy and new equipment ordered was not available.

- Copies of the completed drills for the units were given to the Residential Directors. Copies of the drills completed at Program Services, Brenham Production Service, Recreation, and Health Center were given to the CNE. The Residential Directors and CNE reviewed the drills and presented the results of the drills the following business day at the Incident Management Review Team (IMRT) meeting to ensure follow-up on any identified issues.
- The CPR Committee continued to meet monthly to review, discuss, problem solve, emergency response system issues, and develop corrective action plans when indicated.
- In addition, the CPR Committee calls a "Special Code" meeting to review, discuss, and take corrective action, as indicated, for actual codes. Such a special meeting was conducted for a code that occurred 12/23/11. The minutes of the meeting were not made available for review, but the outcome of the meeting was discussed at the 1/17/12 CRP Committee meeting that the Monitoring Team attended. During the "Special Code" meeting the committee had identified the need for a Medical Emergency/Code Sheet to use to document real time emergency response. The Medical Emergency/Code Sheet was reviewed, discussed, and approved with the

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		addition of an item to document the time it took staff to respond to the code. • The CPR Committee membership had been expanded to involve a more integrated group of members. CPR Committee membership included, but was not limited to: o Debbie Williams, RN, CNE, Chair o Malcolm Lochie, M.D. o Daniel Dickson, QA Director o Jill Quimby, RN, QA Nurse o Brandy Todd, LVN, QA Nurse o Leona Sain, RN o Johanna Schroeder, RN, Nurse Educator o Charles Jacoby, Risk Management o Shequita Dickerson, CTD o Melissa Moehlmann, Residential services The CTD Delinquent/Due List for Basic CPR indicated that 48 staff were delinquent. This represented a significant number of delinquent staff. The CTD Delinquent/Due List for Basic Life Support (BLS) for Health Care Providers indicated two nurses were delinquent. It is essential that the staff delinquent in Basic CPR and BLS for Health Care Providers be brought up to date as soon as possible. Individuals' lives depend on having a competently trained emergency response staff. Further, it is essential to ensure that all staff are trained in the location of the emergency equipment. Since much of the progress mentioned above had only recently taken place, the Monitoring Team will review the Facility's progress toward the full implementation of those processes at the next review.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	The Facility's POI stated they were in compliance with this provision. Through review of Section M POI, Section M Presentation Book, staff interviews and review of documents, it was evident that the Nursing Department had continued to maintain and make progress in some areas of this provision but was found lacking in progress for other areas, as described throughout the report. Therefore, the Monitoring Team did not find compliance with this provision of the Settlement Agreement. The Nursing Department reported on 11/25/2011, the Nurse Managers were assigned the task of reviewing all new admission nursing assessments to assure accuracy and to provide retraining on the admission assessments if necessary. On 11/9/2011, the Nurse Managers began reviewing all admissions nursing assessments. In 11/2011, the Nurse Educator developed power point training for Admission Nursing Assessments with a competency test. The Nurse Educator sent the training and competency test out to the Nurse Managers and Nurse Case Managers to provide the training. The training and competency testing began on 11/21/11. The Nurse Educator reported as of 11/29/11	Noncompliance

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		75% of the training had been completed, with a 100% completion expected by 12/15/11. At the time of the review there was no report provided indicating that the remaining 25% of the Nurse Managers and Nurse Case Managers had completed the training and testing. The method the Nurse Managers and Nurse Case Managers were trained could not be determined. If they were sent training material to read without didactic instruction and practicum to demonstrate competency, the quality of the training was questionable. Unfortunately, the training did not address an issue identified at the last review, where active medical/nursing problems identified upon admission did not have nursing care plans developed and implemented until approximately 30 days after admission. The admission policy states care plans are to be developed and implemented within 30 days. However, for active medical/nursing problems identified at the time of admission, the Nurse Case Managers should exercise clinical judgment to recognize when individuals' require nursing interventions for the identified active medical/nursing problems, for which care plans need to be developed and implemented promptly. A delay in initiating nursing interventions to address active medical/nursing problems could adversely affect individuals' health status. Nursing assessments were reviewed for Individual #367, admitted on 10/11/11 and Individual #308, admitted on 10/25/11. Although both individuals had an initial and admission nursing assessment within 30 days, only one of the two (50%) new admissions, Individual #367, had HMPs developed and implemented 10 days after admission for all active medical/nursing problems identified at the time of admission. The Nurse Educator reported that an email was sent on 12/15/11 to all Nurse Case Managers regarding the Nursing Discharge Summary Training. The email indicated that the Nursing Discharge Summary was finalized and ready for implementation. The summary was to be completed by the Nurse Case Managers when individuals move to the community. The summary was developed by a workgroup from several State Supported Living Centers (SSLCs) in collaboration with the SSLC Continuity of Services Coordinator. The Nurse Case Managers were instructed to read the Nursing Discharge Summary attached to the email and to respond to the email as evidence that they had read and understood the information. A copy of each email was kept in each nurse's training file in the Nurse Educator Office. The Nursing Discharge Summary was to be fully implemented by 1/1/12. If this was the only training the Nurse Case Managers received on completing the Nursing Discharge Summary, the quality of the training was inadequate. It is essential, in order for individuals transitioning into the community to be successful, that they have a thorough and complete Nursing Discharge Summary. The summary should include at minimum: Baseline information of health status related to their active medical/nursing problems, nursing service needs, special instructions for	

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		medication techniques, preferences, and their unique communication for expressing wants and needs, and how they manifest signs and symptoms of pain, illness, injury, maladaptive behaviors, seizures, or other conditions. In past reviews, the nursing discharge summaries completed on the Comprehensive Nursing Assessments were found to be inadequate to meet the needs of individuals transitioning to the community. Since there had been no community discharges since the Nursing Discharge Summary was fully implemented, none were reviewed. Nursing Discharge Summaries for individuals transitioning to the community will be reviewed at the next review. The Admission/Annual and Quarterly Comprehensive Nursing Assessments for 20 individuals who the Facility identified as being at risk for specific health indicators were reviewed, including: Individual #38, Individual #481, Individual #411, Individual #554, Individual #363, Individual #395, Individual #284, Individual #231, Individual #474, Individual #97, Individual #163, Individual #52, Individual #181, Individual #186, Individual #105, Individual #87, Individual #86, Individual #422, Individual #342, and Individual #78. Of the 20 individuals' Annual and Quarterly Comprehensive Nursing Assessments reviewed for the two most recent quarterly/annual nursing assessments, 35 (88%) were completed timely. Assessments that were not timely completed, or were not included in the documentation provided, were for Individual#342, Individual #395 (missing the two most recent), Individual #181, and Individual #554. Of the 35 quarterly/annual nursing assessments reviewed, the following was found: • Thirty-five of 35 (100%) Annual and Quarterly Comprehensive Nursing Assessments were completed by the Nurse Case Managers. • Thirty-five of 35 (100%) Annual and Quarterly Comprehensive Nursing Assessments had BRADEN skin integrity assessments completed. • Other trends identified through review of the 35 quarterly/annual nursing assessments: o Current active medical diagnoses were consistently included. o Sections I through X of the assessments showed steady improvement in the quality and content from the past review. This was most likely a result of the Physical Assessment and Documentation Class the Nurse Case Managers had completed since the last review. o Twenty of the 20 individuals (100%) were identified as having five or more high and medium risk levels identified. In comparing the most resent high and medium risks identified through the At Risk Assessment Screenings to Section X, Nursing Problems/Diagnoses, the high and medium risk levels were not consistently included on the problem lists. This may be due to changes in individuals' risk levels after the quarterly/annual nursing assessments were	

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		completed. When individuals' risk levels change to high and medium risks, the Nurse Case Managers should complete addendums to nursing assessments to reflect changes in risk levels that require the addition of new nursing problems/diagnoses to the lists. Then, they should develop and implement HMPs to address changes in risk levels. Refer to Provision M.3 regarding issues related to HMPs. o Despite the training and intervention the Nursing Department had put forth in order to improve the quality of the Nursing Summaries since the last review, no significant difference was noted in the analyses and summaries of clinical data. The quality of the nursing summaries varied from unit to unit and Nurse Case Manager to Nurse Case Manager. There was an exception noted with regard to Individual #38's two most recent quarterly/annual summaries, which most adequately analyzed and summarized his clinical data related to each problem, provided the status of progress toward established goals and objectives, and stated the effectiveness of his HMPs. Otherwise, similar to the last review, the summaries continued to contain primarily lists of sequential dates of events, such as hospitalization, medications, diagnostics, and treatment/care plans, with no associated analyses of the data to indicate if the individuals' various heath status was improving, maintaining or regressing during the quarter or from quarter to quarter or annually. o Neither did the summaries indicate the effectiveness of the HMPs. Contained in the summaries were a variety of "catch phrases" to describe individuals' heath status related to their various heath problems, such as: "Had a fair quarter or year." "Had a quiet quarter." "No complication this quarter." Such phrases like these should be avoided because they do not adequately describe individuals' health status in relation to their problems. o Since the last review in order to improve the analysis of clinical data, the Nursing Department had revised the format for Section XI, Nursing Summary into a variety of subsections which included: Review of Health Status from previous quarter/annual, to include any surgeries; Health Risk Review; Nursing problems/Diagnoses identified and read for the diagnoses, and Health Management Plans and Progress. A review of the 35 quarterly/annual nursing summaries found that the segregation of the clinical data did not improve the quality of the summaries. The items contained in the summaries continued to contain raw clinical data without analyses to identify individuals' health status in relation to their problems. With the additional categories in the format, the clinical data were more fragmented, making it even more difficult to discern the individuals' health status in relation to each of their problems. It had been readily apparent through all previous reviews that the Nursing Department hah put forth concerted effort to improve the quality of the nursing summaries.	

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		Therefore, lack of improvement of the summaries does not seem to be for lack of effort on their part. It was further apparent that all levels of nursing management lacked an understanding of how to analyze and summarize clinical data related to individuals' heath problems to determine whether of not there was progress related to their health problems. The Facility and/or State Office should consider providing the Nursing Department with technical assistance from an expert to provide competency-based training to assist the relevant nursing staff with critically analyzing clinical data into clear and concise summaries reflective of individuals' health status. The Facility's Section M POI indicated it was in compliance with requirements of this provision, which the Monitoring Team did not agree.	
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.	The Facility's POI stated they were in compliance with this provision. Through review of Section M POI, Section M Presentation Book, staff interviews and review of documents, it was evident that the Nursing Department had continued to maintain and make progress in some areas of this provision but was found lacking in progress of other areas, as described throughout the report. Therefore, the Monitoring Team did not find compliance with this provision of the Settlement Agreement. In order to improve the quality and individualization of individuals' ACPs and HMPs, on 1/2/12, the Nursing Administration initiated a Care Plan Committee which meets daily through the workweek to review the ACPs and HMPs developed the previous day. The committee was comprised of the CNE, NOO, QA Nurse, and Nurse Managers. Care Plan Committee meeting minutes showed promise in improving the quality and individualization of the ACPs and HMPs. Once the Nurse Case Managers developed the care plans, they were sent to the committee members for review. After the care plans were reviewed and corrections/changes were made they were sent back to the Nurse Case Managers to correct/change. Once the corrections were made the care plans were sent back to the committee to review again, and were either approved or sent back for further revision. This process continued until the committee gave final approval. The Nurse Case Managers were instructed to implement the care plans without delay while reviewing and approving the care plans. A review of four individuals' ACPs that had been reviewed and approved by the committee showed evidence of improvements in the quality and individualization of: Baseline data, goals, nursing interventions, and instructions to DCPs. The dates ACPs were resolved were documented on the two that should have been resolved. The other two ACPs had not had time to be resolved. The only exception found was that there was no documentation DCPs were trained on one ACP. Individuals' ACPs reviewed included: • Individual #163, Otitis External/Media, 1/2/12	Noncompliance

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		• Individual #52, Dental Abscess, 1/5/12 • Individual #97, Ingrown Toenail, 1/6/12 • Individual #474, Impaired Skin Integrity, 1/11/12 The findings of the improvements found in the above ACPs were in sharp contrast to the findings found in the 49 ACPs and 122 HMPs reviewed for the following 20 individuals. Those individuals included: Individual #38, Individual #481, Individual #411, Individual #554, Individual #363, Individual #395, Individual #284, Individual #231, Individual #474, Individual #97, Individual #163, Individual #52, Individual #181, Individual #186, Individual #105, Individual #87, Individual #86, Individual #422, Individual #342, and Individual #78. Trends identified in review of ACPs and HMPs for the above individuals included: • Sixty-one of 122 (50%) HMPs had somewhat adequate baseline data and goals. • Sixty-five of 122 (53%) HMPs were somewhat clinically appropriate and individualized. • Ninety-four of 122 (92%) HMPs indicated that DCPs had been trained. For each ACP a separate DPC training sheet was developed and place in a notebook on the units for easy of access. • Thirty-five of 49 (70%) ACPs had adequate baseline data and goals. • Thirty-one of 49 (63%) ACPs were somewhat clinically appropriate and individualized. • Thirty-nine of 49 (80%) ACPs indicated DCPs had been trained. For each ACP a separate DCP training sheet was developed and place in a notebook on the units for easy of access. • As noted in previous reviews, the continuing trends were identified: o HMPs did not consistently address all high and/or medium risk indicators and active problems that required nursing interventions; most notably missing were HMPs for medium risk indicators. o HMPs were not consistently and/or were rarely reviewed and/or revised at the time of the quarterly/annual nursing assessment or when there was a change in health status. o ACPs and HMPs rarely included proactive/preventative measures to reduce and/or eliminate risk indicators/problems. o ACPs and HMPs rarely contained integrated intervention in collaboration with other relevant disciplines, as required in Sections G and F of the Settlement Agreement. o ACPs and HMPs did not consistently state who would implement the nursing interventions, how often they would be implemented, where they were documented, or how often they would be reviewed and/or revised.	

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		Regardless of the format used, HMPs should be developed and implemented for each specific high and/or medium risk indicator or active medical problem that requires nursing interventions. The Nursing Department used a template for Homeostasis Health Maintenance Plan for Aging and Age Related Health Concerns. These plans included multiple problems; many were related to high and/or medium risk indicators. The nursing interventions and instructions to the DCPs were contained in long running lists. The interventions were not linked to any specific risk indicator and/or active problem. As such, they were not clinically adequate to meet the specific risk indicators or active problems. If such a template is to be used, nursing interventions and instructions to the DCP should be linked to the specific risk indicators and active problems that require nursing interventions and DCPs instructions. Examples of Homeostasis Health Maintenance Plans included the following individuals: Individual #411, Individual #481, Individual #186, Individual #86, and Individual #363. The initiation of the Care Plan Committee was a positive step forward in improving the clinical quality and individualization of the ACPs and HMPs. As the committee moves forward with the reviews, corrections, and revisions of the plans, continued improvement should be noted at the next review. Regardless of how good the plans may look on paper, the actual quality of the care rendered through their use must be demonstrated through actual nursing practices. In order for continued progress to be made regarding HMPs and ACPs, as required in this provision of the Settlement Agreement, the Nursing Department Should ensure the following: • HMPs address all high and/or medium risk indicators and active problems that require nursing interventions. • HMPs are reviewed and/or revised at the time of the quarterly/annual nursing assessment or when there was a change in health status. • ACPs and HMPs include proactive/preventative measures to reduce and/or eliminate risk indicators/problems. • ACPs and HMPs contain integrated interventions in collaboration with other relevant disciplines, as required in Sections G and F of the Settlement Agreement. • ACPs and HMPs include who would implement the nursing interventions, how often they would be implemented, where they were documented, and how often they would be reviewed and/or revised. The Facility indicated it was in compliance with this requirement of the Settlement Agreement. The monitoring Team did not find compliance with this provision.	
M4	Within twelve months of the	The Facility's POI stated they were in compliance with this provision. Through review of	Noncompliance

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	Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	Section M POI, Section M Presentation Book, staff interviews and review of documents, it was evident that the Nursing Department had continued to maintain and make progress in some areas of this provision but was found lacking in progress for other areas, as described throughout the report. Therefore, the Monitoring Team did not find compliance with this provision of the Settlement Agreement. Since the last review, the Nursing Education Handbook was implemented. All nurses, including agency nurses, were required to complete the nursing orientation. Nursing orientation provided three to four half-days of classroom training, with the nurses reporting to their assigned home unit for the remainder of the day. In order to further enhance orientation, nurses were required to train on different units prior to being released from orientation. The Nurse Educator conducted an evaluation at the end of the nursing orientation to evaluate each section that was taught. The average evaluation score was 4.92 out of a maximum rating score of 5. The Nursing Department was in the process developing and implementing a Preceptor Program to mentor the newly oriented nurses. This should further reinforce the newly oriented nurses to adapt to their nursing role and responsibilities working at the Facility. RNs that have not completed the mandated Physical Assessment and Documentation Class were scheduled to take the class in February, 2012. Since the last review, points to remember flyers called "Memory Joggers", were developed for Preventing Aspiration Pneumonia, Vomiting, Sepsis, and Aspiration. Memory Joggers were placed in all homes as a quick reference for the DCP staff. In addition to the Memory Joggers, a flyer for "Call a Nurse for:" listing common signs and symptoms of illness/injury was developed and implemented for the DCP staff to alert them when a nurse needs to be called. During the tours of the units, the "Memory Joggers" and the "Call a Nurse for:" signs were prominently displayed for the DCP staff. The Nurse Educators began teaching the DCPs the Observing and Reporting Clinical Indicators Class in August, 2011. This class included signs and symptoms of illness that the DCPs should report to the nurse immediately. As of 11/15/11, 75% of the DCPs had been trained. Classes were taught to incumbent staff and at New Employee Orientation. Prior to September, 2011, the nursing staff were using the DAP (Data, Assessment, and Plan) method of charting. Beginning in September they changed to the SOAP (Subjective, Objective, Assessment, and Plan) method of charting. The Nurse Educator began training the SOAP method of charting at the RN/LVN and Nurse Case Manager meeting. The Nurse Educator went home to home at shift change and completed face-to-face training on SOAP notes. Each nurse was required to complete a SOAP note with immediate retraining if incorrect. As of 11/28/11 95% of the nursing staff were trained on the SOAP method of charting, with 100% completion by 12/15/11. Training data were not	

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		available for review to confirm if the remaining staff were trained. The Nurse Educator had developed and implemented a Human Sexuality Education Curriculum. At the time of the review two individuals had been referred for the training. One individual received partial training, and then refused further training. The other individual refused to participate in the training. This training will continue to be available for individuals upon referral from the IDTs. As was found in past reviews, the Nurse Educator had continued to maintain a Nurse Training Tracking Database to track all training provided to the nursing staff. The CNE reported there had not been any new policies and procedures developed and implemented since the last review. However, nursing protocol cards had been developed, implemented and the nurses trained on the protocols. The purpose of the nursing protocol cards was to ensure ready access to the nursing staff. The nursing protocol cards included head injury, temperature elevation, pre-treatment/post sedation, antibiotic therapy, diarrhea, vomiting constipation, respiratory distress/aspiration, and documentation when calling the physician. From a review, these nursing protocols were found to be clinically appropriate and in accordance with nursing standards of practice. The nursing protocol cards were printed pocket size, laminated, and put onto a ring to carry. The Nursing protocols were to be carried by all nursing staff while on duty to provide a quick reference and to ensure adherence to the protocols. At the time of the review approximately 50% of the nursing protocol cards had been distributed across campus. Ten other nursing protocols were in the process of development. Additional nursing protocols need to be established and implemented in order to sufficiently address the health status of individuals served. The Nursing Department should ensure that all nursing protocols are established and implemented so that they meet all aspects of individuals' health status needs and are demonstrated through actual nursing practices. It was evident that the Nursing Department had established, implemented Nursing Policies, Procedures, and had recently initiated nine protocols. The initiation of the nine protocols was a promising step forward and other relevant nursing practice protocols should be developed and implemented to assist the nursing staff met the Settlement Agreement requirements for all Section M provisions. However, the recently developed protocols had not yet had time to be consistently demonstrated through actual nursing practice related to nursing assessments, health care planning, and documentation. In order for this provision to meet compliance, not only must the nursing policies, procedures, and protocols be established, implemented, and the nursing staff trained, but also they must be demonstrated through actual clinical practice sufficient to address the health status of individuals served. As was found throughout the other provisions, the assessments, health care planning and documentation protocols have not been	

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		adequately put into practice sufficient to met individuals health status needs. Therefore, this provision was not found in compliance. In order for this provision to meet compliance, not only must the nursing assessments and reporting protocols be established and implemented, they must be demonstrated through actual clinical practice sufficient to address the health status of individuals served. As was found throughout the other provisions, the assessments and protocols have not been adequately put into practice sufficient to meet individuals' health status needs. Therefore, this provision was not found in compliance.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual.	The Facility's Section M POI stated they were not in compliance with this provision and the Monitoring Team concurs. Through review of Section M POI, Section M Presentation Book, staff interviews and review of documents, it was evident the Nursing Department had continued to provide training and monitoring of nursing and DCPs, and other relevant staff, in an effort to move forward with the At Risk Individuals policy, procedures, and processes, including Aspiration Trigger Data Sheet, ISP Meetings (Facilitation and Documentation), and Integrated Risk Rating/Discussion Form. During the onsite review a concern was raised because there were no Aspiration Pneumonia/Enteral Nutrition Evaluations found in the records for individuals who were at high risk for aspiration or who had been hospitalized for aspiration pneumonia multiple times or within the last year. Additionally, a concern was identified that individuals' Aspiration Trigger Data Sheets marked by the DCPs frequently did not contain documentation that the nursing staff had followed up with an assessment and referral to the PNMT. In order to clarify the above concerns, the Monitoring Team met with the CNE, Nurse Educator, Habilitation Director, PNMT Nurse, and State Office Nursing Coordinator to discuss the identified concerns. With regard to the Aspiration Pneumonia/Enteral Nutrition Evaluations, there was no separate evaluation. The State Office Nursing Coordinator explained that the purpose of the Aspiration Pneumonia/Enteral Nutrition Evaluation Sheet was to be used as a guide for the various clinical disciplines to develop the assessments for those individuals at risk for aspiration, and to bring to the ISP/At Risk Assessment Screening meetings. According to the Aspiration Pneumonia/Enteral Nutrition Evaluation guidelines, once the assessments were completed by the other clinical disciplines, the Nurse Case Managers were responsible for compiling the assessments onto the Integrated Risk Rating Forms. With regard to the Aspiration Trigger Data Sheet, the Nurse Educator and PNMP Nurse were working together to provide competency-based training on the Aspiration Trigger	Noncompliance

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		Data Sheets to nursing, DCPs, habilitation therapy, and PNMP monitors. To date, the Nurse Educator reported that 97% of the RNs, 98% of the LVNs, 93% of the agency nurses, and 65% of the DCPs, habilitation therapy staff, and PNMP monitors had received training on the Aspiration Trigger Data Sheets. There was further discussion by the Monitoring Team regarding the definition of what constitutes a trigger and who determines the triggers listed on the Aspiration Trigger Data Sheets. Presently, most triggers noted on the trigger sheets were generic. It was explained that the triggers need to be individualized because different individuals may express triggers differently. It appeared that the Nurse Case Manager developed the trigger listed on the sheets. The CNE explained that the Nurse Case Manager collaborated with the DCPs and other relevant staff to develop individuals' triggers. Another concern was discussed regarding when to refer individuals who have triggers to the PNMT. The Facility staff agreed to follow-up on the concerns identified and discussed during the meeting. Refer to Section O for more information regarding the Aspiration Pneumonia/Enteral Nutrition Evaluations and Aspiration Trigger Data Sheets. A review of Aspiration Trigger Data Sheets, 1/1/11 through 1/18/11, in Bowie C indicated that 11 of the 15 (73%) individuals residing in the home had had triggers sheets. The 11 individuals included: Individual #79, Individual #39, Individual #54, Individual #250, Individual #60, Individual #90, Individual #69, Individual #440, Individual #363, Individual #465, and Individual #305. A review of the 11 Aspiration Trigger Data Sheets indicated: • None of the 11 (0%) trigger sheets were consistently reviewed daily on each shift by the shift nurses. • Six of the 11 (55%) trigger sheets were reviewed daily, Monday through Friday, with the exceptions of a holiday, by the Nurse Case Manager. The Nurse Case Managers worked Monday through Friday and were off on holidays. None of the 11 (0%) trigger sheets required to be reviewed daily by the Nurse Case Manager were reviewed on weekends or on a holiday by the Nurse Shift Managers or designee. • One of the 11 (9%) trigger sheets had triggers documented. On 1/17/12, Individual #465's trigger sheet was marked as having coughing with signs of struggle. The DCPs' Observation Notes on 1/17/12 at 4:45 p.m. documented that the nurse was notified of the trigger. On 1/17/12 at 1745, the Integrated Progress Notes by the RN reported that Individual #465 had begun coughing at the end of the evening meal and then had a seizure. The RN completed thorough assessment per trigger protocol and he was found to be in no distress but did have clear thick nasal discharge. The RN documented she would refer him to sick call and for the nurse to assess him again before the end of the shift. There was no documentation that Individual #465 was assessed at the end of the shift. According to subsequent nursing notes, he was	

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		not assessed again until 0830 on 1/18/12. Thereafter, he was assessed each shift through to 1/19/12 at 0200. The notes indicated his vital signs and O2Sats remained within normal range with no coughing or vomiting. There was no documentation by the nurse or physician that Individual #465 was seen in sick call. Therefore, there was no evidence that Individual #465's trigger for coughing with struggle received adequate followed-up. The Nursing Department should: • Ensure that Aspiration Trigger Data Sheets are reviewed daily on each shift by the staff nurses and daily on the weekends and holidays by supervisory level nurses. • Ensure when individuals experience aspiration triggers that the nursing staff follow the aspiration trigger protocol through to resolution, including appropriate referrals to physicians and/or the PNMT. The Monitoring Team attended the ISP and At Risk Assessment Screening, and Risk Action Plan meeting for Individual #474 on 1/16/12. There was more participation with more substantive discussion by IDT members than observed in previous ISP and At Risk Screening Assessments and Risk Action Plan meetings. The only relevant team member not attending the meeting was the DCP. The Vocational Services Program Assessor was present who knew Individual #474 very well and actively participated throughout the meeting. The Facilitator followed the ISP, At Risk Assessment Screening and Risk Action Plan guidelines and addressed all items. Risk level decisions, in addition to the Risk Guidelines, were based on individualized data when indicated to determine various risk levels. Throughout the discussion the team members made corrections and additions to the risk levels and rationale. Risk levels were changed appropriately based on discussion and clinical data supporting the change in levels. Although the Facilitator and team members followed the ISP, At Risk Assessment Screening, and Risk Action Plan Guidelines, the meeting lasted over three hours. Refer to Section F for more details of Individual #474's ISP. Ten recently completed At Risk Assessment Screening and Risk Action Plans were reviewed for: Individual #138, Individual #273, Individual #151, Individual #242, Individual #13, Individual #408, Individual #353, Individual #83, Individual #38, and Individual #35. The results of the 10 At Risk Assessment Screenings and Risk Action Plans revealed the following trends: • The quality of the At Risk Assessment Screenings and Risk Action Plans varied from IDT to IDT and from unit to unit. While the rationales for clinical data supporting the decisions for determining risk levels showed improvement from the past reviews, there was a need for continued improvement in both the At Risk Assessment Screenings and Risk Action Plans.	

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		• The objectives for the Risk Action Plans were not consistently adequate to functionally measure the efficacy of the plans. • Clinical indicators to be monitored and the frequency were not consistently included or were not adequate to assess progress or lack of progress. • The assessments did not consistently include clinical data from all relevant disciplines. • The plans failed to consistently include preventative interventions to reduce or eliminate the risk levels. • The plans did not consistently include action steps for all relevant disciplines. Specifically related to nursing services, Risk Action Plans for identified high and medium risk levels did not consistently include action steps for related HMPs; only one of 10 (10%) of the Risk Action Plans included action steps for relevant HMPs for all identified high and medium risk levels. • The plans were not consistently integrated into the ISPs. • The actual date the plans were implemented could not be readily discerned, although they contained implementation dates. Although it was evident that the Nursing Department had put forth much effort toward complying with nursing's responsibilities included in the At Risk Individuals Policy and Procedures, particularly in recent months, by training and monitoring the nursing and other relevant staff, the review indicated only minimal progress had been achieved toward compliance. There continued the need for improvements. • The Nursing Department should ensure that HMPs are developed and implemented for all high and medium risk levels that require nursing actions/interventions and are incorporated into the Risk Action Plans to include: o Functional and measurable objectives; o Clinical indicators to be monitored and the frequency sufficient to assess the individuals' progress and the effectiveness of the plans; and o Nursing actions and interventions to address the specific high and medium risk levels, including preventive interventions to reduce or eliminate the risk level. The Facility should ensure that the other disciplines consistently and timely provide the Nurse Case Manager with their clinical risk assessment data to compile into the draft Integrated Risk Rating Forms to take to the ISP and At Risk Assessment and Screening meetings. The State Office should continue to provide the Nursing Department with technical assistance in defining and clarifying the nurses' role and responsibilities regarding the At Risk Individuals Policy and Procedures.	

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		While onsite the Monitoring Team discovered that the required residual checks before bathing on individuals who were enterally fed were not documented in the records. The NOO was notified of the omission and immediately instructed the nursing staff to add the required residual checks before bathing on individuals' treatment records. The Monitoring Team will follow up on the status of nurses completing and documenting residual checks on individuals who are enteral fed prior for bathing at the next review.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The Facility's POI stated they were in compliance with this provision. Through review of Section M POI, Section M Presentation Book, staff interviews and review of documents, it was evident that the Nursing Department had continued to maintain and make progress in some areas of the positive medication administration practices identified at the last review but was found lacking in progress other areas during this review, as described throughout the report. Therefore, the Monitoring Team did not find compliance with this provision of the Settlement Agreement. Since the last review, the Nursing Department had adapted the new State Medication Administration Observation form and revised their procedures for conducting the observations on 10/1/11. A review of the recently adapted form found it lacking for observing issues related to PNMP instructions. This was discussed with the State Office Nursing Coordinator who said she was in the process of revising the form to include PNMP issues to be observed. As a result of the revised procedures, the Nurse Managers/Designee completed quarterly Medication Administration Observations on all nurses. At each medication pass the observer watched 16-20 doses of medications administered. If a Designee completed the observations, the Nurse Manager completed a performance check on the Designee quarterly to assure the observations were completed accurately. The NOO/Designee conducted performance checks on Shift managers to assure the observations were completed accurately. The QA Nurse conducted a performance check on Nurse Managers quarterly and performed up to five medication administration observations per month on various units. Once new nurses were out of orientation the QA Nurse and Shift Nurse Manager/Durable Medical Equipment (DME) Coordinator conducted medication administration observations. All completed Medication Administration Observation forms were returned to the NOO for review and follow-up. A review of the overall Medication Administration Observation data for the four months supplied in the document request found the following percentage of compliance: • July - 95% • August – 98% • September – 98% • October – 99%	Noncompliance

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		In addition, a review of the individual unit's monthly Medication Administration Observations showed corrective action taken and documented on the forms for items falling below 80% compliance. Items falling below 80% included: • Stoma site was not assessed or care provided. • Air rush and/or auscultation of G-tube was not checked for placement. • Flushing of G-tube before and after administration of medications • Lack of complete signatures on the MARs • Lack of start and stop dates on MARs. • Medications were not stored properly, e.g., internal and external medications not separated, food items in refrigerator labeled without date opened, medications not separated from food items, personal food or drink present in refrigerators, and refrigerator temperatures were not monitored daily. A review of the Self Assessment Audit results for the Medication Rooms overall percentage of compliance reported for the four months revealed the following: • July – 55% • August – 70% • September – 72% • October – 69% • (November and December data were not included for review) A review of the Self Assessment Audit results for the MAR overall percentage of compliance reported for the four months revealed the following: • July – 52% • August – 57% • September – 57% • October – 66% • (November and December data were not included for review) The result of these audits fell far below the required 80% requirement set forth in the Self Assessment Audit Guidelines. The low percentage of compliance was a concern found in the last review. Because the Nursing Department had a system in place for monitoring and taking corrective action it was expected that the system would address and resolve the low ratings. These findings comport with the Monitoring Teams observations onsite in the medication rooms in Driscoll. These observations found: • The refrigerator in Driscoll B's medication room had a temperature reading for 1/1/12 through 1/18/12, recorded consistently at 29 to30 degrees Fahrenheit. This was far colder that the acceptable standard temperatures of 36 to 46 degrees Fahrenheit, with an optimal temperature reading of 40 degrees Fahrenheit. The	

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		Nurse Manager attempted to adjust/turn the refrigerator setting to a higher temperature but was not able to turn the dial. It was apparent the refrigerator was malfunctioning. There was no documentation that the abnormal temperature readings were reported. Either the nurses checking the refrigerator temperature did not know the normal refrigerator temperatures or did not realize the impact the abnormal temperature reading could have on medications stored in the refrigerator. This was a significant finding and was not in compliance with standards of medication administration practices related to medication storage that could have a negative impact on all of the other Facility refrigerators storing medications. Also, the refrigerator temperature and temperature check sheet were checked in Driscoll A. The temperature was not checked on 1/17/12. The temperature of the refrigerator was 40 degrees at the time of the observation. These situations should be documented as a medication variance related to improper storage of medications. • In Driscoll D's refrigerator a jug of Golytely was mixed and labeled on 1/16/12 at 7:00 a.m. When the Nurse Manager was asked how long the Golytely could be used after mixed she did not know. The label was peeled back and indicated it needed to be used within 48 hours after being mixed. Consequently, the Golytely was removed from the refrigerator for disposal This was another medication storage issue that needs addressed that could affect other medications that have a time-limited duration for safe administration after being mixed. The Nursing Department and Pharmacy need to ensure that the nurses know long particular medications can be safely used after mixed. • The Control Drug Logs for January 1/1/12 through 1/18/12 were checked for double signatures for shift to shift control drug counts by the on-coming and off-going nurses in Driscoll's medication rooms. In Driscoll B double signatures were not present 1/12/12 and 1/13/12 on the 2 to 10 shifts; and in Driscoll D double signatures were not present on: 1/8/12 on the 10 to 6 shift; 1/9/12 on the 2 to 10 shift; 1/10/12 on the 6 to 2 shift; 1/11/12 on 10 to 6 shift; 1/14/12 on the 10 to 6 shift; and 1/14/12 on the 10 to 6 shift. This was another significant finding that was not in compliance with standards of medication administration practices related to security and storage of controlled drugs. This situation should be documented as a medication variance related to proper security and storage of medications. Additionally, the Facility should check all refrigerators containing medications for proper working order. The continued low rate of compliance with Self Assessment Audits from the MAR and Medication Room Audits coupled with the Monitoring Team's findings in the medication rooms finds the Facility out of compliance with this provision. It was questionable how the Medication Administration Observations could consistently be found be at 95% or greater, since many of the items that would be audited are also contained on the	

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		Medication Administration Observation form. The Nursing Department should evaluate the competency of the auditors conducting Medication Room and MAR Audits, Medication Administration Observations, and the effectiveness of corrective actions taken. The Monitoring Team conducted Medication Administration Observations on 1/19/12 during the noon medication pass in the Program Services Building – Workshop, for 15 Childress residents. Individuals included: Individual #493, Individual #191, Individual #141, Individual #473, Individual #217, Individual #16, Individual #523, Individual #165, Individual #68, Individual #195, Individual #50, Individual #370, Individual #442, Individual #486, and Individual #132. All individuals received medication orally. It was positive to find that the Program Services Building provided a dedicated medication room for the Childress residents. The room provided the nurse with access to water for hand washing, a medication cart, and privacy for individuals. The DCPs assisted the nurses by bring one individual at a time to the medication room and assisted the nurses by staying with individuals while they were receiving their medications, thus helping to create a calm environment free from distractions. The nurses brought individuals' MARs and noon medications securely packaged by the pharmacy with them to the medication room and placed them in the medication cart. During the medication administration pass the nurses were observed to follow correct medication administration procedures, with the following exceptions: • The nurses were unsure regarding presentation, positioning techniques, and detailed information regarding the need/use of adaptive equipment. A review of the PNMPs for each of the individual's observed revealed that the strategies were vague and at times the nurses were unsure as to the purpose of the strategies. Additionally, the medication administration section of the PNMP lacked information regarding staff positions, presentation techniques, and detailed information regarding the need for adaptive equipment. Examples included: o Nurses did not provide a small-bowled spoon to administer medication. The small-bowl spoon was listed on the dining instructions of the PNMP but not on the medication administration instructions. There were numerous other individuals' PNMPs where the dining instructions were not consistent with the medication administration instructions. Nurses were unsure as to what hyperextension looked like with an individual who was kyphotic or had severe curvature of the spine. Refer to Section O.6 for more details regarding the above issues. • Individual #191 was prescribed a ground diet texture but the medication administration instructions did not address the size of the pills or whether to crush medications nor were such instructions included on the MAR. She was prescribed a	

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		fish oil capsule that was larger than the size of ground texture food. This was discussed with the nurse who agreed to check with the PNMT regarding the safety of administering the fish oil capsule. • Individual #195 began coughing with struggle when drinking liquids after taking medication. The nurse responded immediately and assessed her lung sounds and took a full set of vital signs. However, the pulse oximeter was not on the medication cart but a pulse oximeter was obtained from another room. The nurse instructed the DCP to have the Program Services Nurse continue to monitor Individual #195. As discussed above there seems to be a lack of clarity as to when to refer individuals who experienced triggers to the PNMT for evaluation. It is essential that the nurses ensure that all necessary diagnostic and other equipment are on the medication carts when administering medications. The Nursing Department needs to continue improvements in the following areas of medication administration: • The nursing staff are still in need of additional training regarding dysphagia and its impact on administration of medication. Nurses were unaware of how certain strategies, e.g., lifting the handle of spoon, can contribute to improper head positioning and thus increase the risk of aspiration. • The nurses need to ensure that the size and number of pills to administer at any one time are consistent with individuals' prescribed diet texture. • The nurses need to ensure that all necessary diagnostic and other equipment are on the medication cart and readily accessible for use. At the last review the Monitoring Team found the Facility used different brands of Glucometers. The incorrect control solutions for a particular Glucometer were often found, the control solutions were not consistently dated, and the Glucometor Control Check Sheets were not consisted recorded daily. As a result of these findings at the last review the Shift Nurse Manager/DME reported she had evaluated all medical supplies, including Glucometers. The same type Glucometers were ordered and replaced the previous ones in order to achieve standardization and ensure that the same control solutions were used throughout the campus. The problem with the control solution was resolved by placing the entire campus on a three months rotation for replacing all control solutions. The Monitoring Team reviewed the Glucometor Control Check Sheets for January, 2012, kept in the MAR, for Individual #160 and Individual #78 and found that the Glucometers' were tested daily and documented. While onsite the Monitoring Team attended the Medication Variance Committee and Pharmacy and Therapeutic Committee meetings. The Committees' minutes contained substantive information relating to the subjects discussed and plan for future actions.	

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		Since the last review, the Medication Error Committee was officially changed in 10/2011 to the Medication Variance Committee based on the recently adopted Medication Variance Policy, 053. This change expanded the scope of the committee, including all aspects of medication administration practices as defined by policy. The committee included a more integrated approach that included membership comprised of multidisciplinary clinical staff. At the Medication Variance Committee meeting attended by the Monitoring Team, in addition to reviewing and discussing the incidents of medication variances and disposition, the QA Nurse had been tracking and analyzing the total number of individuals that had three or more medication variances for antipsychotic and/or anticonvulsant medications within a quarter. It was positive to find that as a result of the tracking and interventions put in place to reduce the incidents of medication variances occurring repeatedly for a single individual, there was a progressive overall decrease of 70% over the four quarters, e.g., first quarter – 22, second quarter – 10, third - 8, and fourth quarter – 6. A problem with medication refusal was identified and discussed at the 11/2011 committee meeting. In 12/2011 the Nursing Department began tracking medication refusals. The tracking system identified the date, individual, home, medication refused, reason for refusal (behavior/ill), and if the physician was notified of the refusal. This information was provided to the physicians at the Morning Medical Meetings. The committee should also consider reporting medication refusals related to behavioral issues to the psychologists/behavior analysts. The issue of the refrigerator in Driscoll B that was not maintaining correct temperature control was discussed. The CNE and pharmacist will address the problem. Relevant information discussed and the disposition by the committee was presented at the following Pharmacy and Therapeutic Committee meeting. The Facility continued to use the Medication Error/Variance Database to track, analyze, and trend medication error/variance utilizing a root cause analysis approach. The medication error/variance data was presented in a variety of tabular and graphic charts. It was positive to find in reviewing the last three quarters of data that the incidents of medication errors/variances had continued to steadily decrease. The decrease in the incidents of medication errors committed by the nursing staff was no doubt attributable to the Medication Error Committee, chaired by the NOO, who critically analyzed the medication error data each month for each unit and put corrective action in place for identified deficiencies. This was demonstrated through a review the Medication Error Committee Minutes including supporting documentation and summaries of the analyses of medication errors and corrective actions taken. A review of the Medication Variance 12 Month Summary for the first, second and third quarter for 2011, found using the first quarter's report as a benchmark of 180 reported	

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		medication errors/variances compared to the third quarter of 120 reported medication errors/variances indicated a 33% decrease. The data reported in the first three quarters were primarily related to medication errors as defined in the Medication Error Policy, and were mostly errors committed by the nursing staff. With the recent implementation of the Medication Variance Policy, 053, future reports may find an increase in the incidents of medication variances due to reporting more types of variances identified in the policy as well as an increase in reporting medication variances made by the pharmacy and physicians. At the time of the current visit, all requirements of the Medication Variance Policy were not yet fully implemented and put into practice. The policy includes all aspects of medication administration practices at the Facility. According to the policy the Nursing Department was charged with the responsibility of overseeing all aspects of medication variances. Although the Nursing Department and Pharmacy Department had put in place many areas of medication administration practice, in order to achieve compliance with provision, all requirements set forth in the policy must be solidly in place and demonstrated through actual practices. Additional issues need to be built into or refined for the infrastructure to function efficiently and effectively, such as a collaborative system developed with the pharmacy regarding procedures/processes for prescribing, ordering, transcribing, preparation, dispensing, delivery and/or administration of medication, storage, security, and accountably of medication, ensuring medication variances are reported by all relevant disciplines, e.g., nursing, pharmacy, and physicians. The Medication Variance Database needs to be revised to track, analyze, and trend all types of variances and all variances committed by all disciplines. The Nursing Department in collaboration with the Pharmacy Department and other relevant clinical disciplines need to ensure all requirements of the Medication Variance Policy, 053, are implemented and demonstrated in actual practice. The Nursing Department had continued maintain to and make progress in some areas of standard medication administration practices as identified at the last review; however, other areas of medication administration practices lacked progress in meeting this provision's requirements of the Settlement Agreement, as described throughout the report. Therefore, the Monitoring Team did not find compliance with this provision of the Settlement Agreement.	

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

1. The Nursing Department should evaluate competency of the nurse auditors conducting audits on the Nursing Care Monitoring Tools and the quality of the training and/or corrective action plans provided to the nursing staff to improve audit outcomes. (Provision M.1)
2. The Facility and the State should collaborate on developing specific instructions and criteria for conducting inter-rater reliability checks to ensure

consistency in auditing the Nursing Care Monitoring Tools across all disciplines and State Supported Living Centers. (Provision M.1)

3. The Nursing Department should evaluate the competency of the auditors conducting Medication Room and MAR Audits, Medication Administration Observations, and the effectiveness of corrective actions taken. (Provisions M.1 and M.6)
4. The Facility should consider adding sub-tabs in the nursing section of the active record to prevent misfiling and aid on the ease of access in locating specific nursing documents. (Provision M.1)
5. The Nursing Department should reinforce competency–based training regarding the documentation protocol as well as other protocols related to assessing and managing acute changes in health status. (Provision M.1)
6. The Nursing Department should ensure that the nursing staff place a nurse to nurse telephone call prior to, or while individuals are in transit to the emergency room and/or hospital. (Provision M.1)
7. The Facility should continue to ensure that documents are available, filed in a timely manner in individuals' active records, so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services. (Provision M.1)
8. Infection Control Programmatic issues in need of further improvements included, but were not limited to, the following: (Provision M.1)
    - The Facility should make better use of information derived from the Infection by Type data to analyze and trend infections by rates according to standards of practice. The resulting data should be used by the clinical staff to develop and implement local and systemic preventative action plans to control and/or prevent the spread of infectious and contagious diseases.
    - As a result of the implementation of the preventative action plans there should be a further analysis and documentation of the effectiveness of the outcomes resulting from the interventions.
    - There needs to be a formalized procedure/process put in place to address data reliability of infections and implementation of Discrepancy Reports to track data reliability issues.
    - The Infection Control Nurse received Epidemiological Reports but it could not be determined how the reports were used. The Infection Control Nurse should collaborate with physicians and pharmacist regarding the effectiveness of antibiotics prescribed for infections. Typically this is done at Pharmacy and Therapeutic Committee Meetings.
    - The Infection Control Nurse should initial real time audits of all individuals diagnosed with acute infectious/communicable diseases. These audits should not fall under the randomized sampling procedures of the Facility. Due to the acute nature of infectious disease and the potential for spread, auditing for this area needs to be conducted while the acute infection is active.
    - The Infection Control Nurses should collaborate with the Nurse Case Manager and other relevant staff to develop and implement plans of care when acute infectious/communicable diseases are reported to ensure appropriate clinical interventions were put in place to control/prevent the spread of disease.
9. The Facility and/or State Office should consider providing the Nursing Department with technical assistance from an expert to provide competency-based training to assist the relevant nursing staff with critically analyzing clinical data into clear and concise summaries reflective of individuals' health status. (Provision M.2)
10. When individuals' risk levels change to high and medium risks, the Nurse Case Managers should complete addendums to nursing assessments to reflect changes in risk levels that require the addition of new nursing problems/diagnoses to the lists and then develop and implement HMPs to address changes in risk levels. (Provision M.2)
11. The Nursing Department should ensure that all nursing protocols are established and implemented sufficient to meet all aspects of individuals' health status needs and are demonstrated through actual nursing practices. (Provision M.2)
12. The Nursing Department Should ensure the following:
    - HMPs address all high and/or medium risk indicators and active problems that require nursing interventions.
    - HMPs are reviewed and/or revised at the time of the quarterly/annual nursing assessment or when there was a change in health status.
    - ACPs and HMPs include proactive/preventative measures to reduce and/or eliminate risk indicators/problems.

- ACPs and HMPs contain integrated interventions in collaboration with other relevant disciplines, as required in Sections G and F of the Settlement Agreement.
- ACPs and HMPs include who would implement the nursing interventions, how often they would be implemented, where they were documented, and how often they would be reviewed and/or revised.

11. The Nursing Department should: (Provision M.5)
    - Ensure that Aspiration Trigger Data Sheets are reviewed daily on each shift by the staff nurses and daily on the weekends and holidays by supervisory level nurses.
    - Ensure when individuals experience aspiration triggers that the nursing staff follow the aspiration trigger protocol through to resolution, including appropriate referrals to physicians and/or the PNMT.
    - Ensure that HMPs are developed and implemented for all high and medium risk levels that require nursing actions/interventions and are incorporated into the Risk Action Plans to include:
        - Functional and measurable objectives;
        - Clinical indicators to be monitored and the frequency sufficient to assess the individuals' progress and the effectiveness of the plans; and
        - Nursing actions and interventions to address the specific high and medium risk levels, including preventive interventions to reduce or eliminate the risk level.
12. The Facility should ensure that the other disciplines consistently and timely provide the Nurse Case Manager with their clinical risk assessment data to compile into the draft Integrated Risk Rating Forms to take to the ISP and At Risk Assessment and Screening meetings. (Provision M.5)
13. The Facility should check all refrigerators containing medications for proper working order. (Provision M.6)
14. The Nursing Department and Pharmacy need to ensure that the nurses know how long particular medications can be safely used after mixed. (Provision M.6)
15. The Nursing Department needs to continue improvements in the following areas of medication administration: (Provision M.6)
    - The nursing staff are still in need of additional training regarding dysphagia and its impact on administration of medication. Nurses were unaware of how certain strategies, e.g., lifting the handle of spoon, can contribute to improper head positioning and thus increase the risk of aspiration.
    - The nurses need to ensure that the size and number of pills to administer at any one time are consistent with individuals' prescribed diet texture.
    - The nurses need to ensure that all necessary diagnostic and other equipment are on the medication cart and readily accessible for use.
16. The Nursing Department in collaboration with the Pharmacy Department and other relevant clinical disciplines need to ensure all requirements of the Medication Variance Policy, 053, are implemented and demonstrated in actual practice. (Provision M.6)

The following are offered as additional suggestions to the Facility:

1. The State Office should continue to provide the Nursing Department with technical assistance in defining and clarifying the nurses' role and responsibilities regarding the At Risk Individuals Policy and Procedures. (Provision M.5)

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) dated 12/30/11 2. Presentation book 3. DADS Medication Variances Policy, number 053, dated 9/23/11 4. Clinical Records for Individuals #89, #43, #26, 343, and #269 5. Most recent Quarterly Drug Regiment Review (QDRR) for Individuals #89, #43, #26, 343, and #269 6. Document request TX-BR-1201-RC.59 - Single patient intervention reports (intervention reports), new medication orders, and associated laboratory, and all other relevant diagnostic studies for Individuals #167, #69, #255, #547, #332, #264, #407, #133, #53, #493, and #497 (sample D) 7. The first five QDRRs, from document request TX-BR-1201-RC.66 (Individuals #7, 367, #547, #259, and #381) 8. Past six months Polypharmacy Committee Meeting Minutes 9. Psychoactive Medication Oversight Committee (PMOC) Meeting Minutes for December and January 10. Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint form (Face-to-Face Assessment form) 11. First five completed Face-to-Face Assessments provided in TX-BR-1201-RC.57 12. Quality Assurance/Quality Improvement (QA/QI)Council minutes for 12/8/11, and 1/4/12 13. STAT medication database for 11/1/11 through 12/31/11 14. QDRRs for Individuals #305, #568, #131, #109, #80, #381, #547, #61, #259, and #367 15. Adverse Drug Reaction (ADR) Identification and Reporting Process, dated 6/9/2011 16. Power Point Presentation for Medication Observation Training Program for ADRs, undated. 17. Most recent five completed QDRRs (#159, #60, #202, #151and #109) 18. State Supported Living Centers Medication Variance Report form, SSLC 053A, undated 19. Medication Variance Committee Meeting Minutes for July, 2011 through December, 2011 20. DUE Reports for clonidine, benztropine, and citalopram **People Interviewed:** 1. Trey Knittel, PharmD, RPh (BSSLC Pharmacy Director). Amy Randall, PharmD, RPh, and Kenda Pittman, PharmD, RPh (State Office Pharmacy Discipline Coordinator, by phone) **Meeting Attended/Observations:** None
	Facility Self-Assessment: As noted below, the Facility reported substantial compliance with seven of the eight provisions of this Section. The POI did not provide details as to the Facility's self-assessment processes, but rather listed many actions the Facility had taken beginning in August, 2010 and including actions since the last compliance visit. However, the basis for rating of compliance was not clearly stated for any provision. The Facility does have, and should use, information, including data, that could be useful in assessing and reporting status of compliance. Although the Monitoring Team recognizes significant progress made in

	several provisions, substantial compliance was confirmed only for Provisions N.6 and N.7. Provision N.1: The Facility reports substantial compliance with Provision N.1, and stated that a policy was approved that addresses medication order reviews, and that an internal QA process was developed in December to audit pharmacist's review of new medication orders. Provision N.2: The Facility reports substantial compliance with Provision N.2, and stated that a contract clinical pharmacist has been hired full time, and that the clinical pharmacist attends morning medical debriefing meetings. Provision N.3: The Facility reports substantial compliance with Provision N.3, and stated that it has requested nurses to obtain abdominal girths for Individuals with BMI of greater then 25%. Provision N.4: The Facility determined that they remain in substantial compliance with Provision N.4, stating that pharmacy recommendations are more thoroughly documented by physicians and that physicians are documenting their clinical plans from pharmacy interventions. Provision N.5: The Facility states substantial compliance with Provision N.5, and indicated that they are more assertively monitoring completion of MOSES and DISCUS reports. Provision N.6: The Facility reports that they are not in substantial compliance with Provision N.6, of the SA. The Facility reports presenting ADRs at the P&T, and adding known ADRs to the Individuals medication profile. The Facility also reports that all new employees began to receive training on identification and reporting of ADRs. Provision N.7: The Facility indicated that it was in substantial compliance with Provision N.7, stating that DURs were more outcome-based and that an improved process was enacted. Provision N.8: The Facility reported substantial compliance with Provision N.8, stating that pharmacy presented medication variance data at the Medication Variance Committee meeting, and that good ideas were shared at the meeting. It should be noted that the Facility raised concerns that Provision M.6, was determined to be in compliance in that past. The Monitoring Team would like to point out that compliance for M.6 is specific to the nursing department's review of its medication variances, and not the entire medication variance process, which is the responsibility of the pharmacy department.
	Summary of Monitor's Assessment: The Monitoring Team noted enhanced effort on the part of pharmacy, as they work toward compliance with the requirements of this Section. The Monitoring Team determined compliance for Provision N.6, and N.7, but Provision N.4, which was previously noted to be in substantial compliance, was now determined as not in compliance, however, this does not imply that the Facility has gone backward. The Monitoring Team is confident in the ability of the Pharmacy Department to become compliant in the future. It should also be noted that all provisions have been improved since the last compliance review, including improvements for

	Provision N.4. Provision N.1: The Monitoring Team determined that there was lack of evidence to support full compliance with the Provision. Compliance will require the following: Ensure that there is documentation supporting the pharmacist's review of all commonly required laboratory studies for each medication reviewed; ensure review, and documentation that all allergies, and side effects have been reviewed; provide clinically appropriate recommendations for each single patient intervention. The pharmacist must ensure that all appropriate diagnostics have been or will be obtained for each intervention identified. The Pharmacy Department must be aware of necessary clinical interventions, and monitoring specific for medications; ensure that there is documentation of the physician's action plan, and notation if the physician agrees or disagrees with the pharmacy recommendation; ensure that pharmacy has a mechanism in place to assess compliance by physician with the pharmacists recommendations and action plan for each intervention. Provision N.2: The Monitoring Team noted that QDRRs were completed timely in 100% of the sample reviewed, and that physicians demonstrated appropriate actions plans for 80% of the sample reviewed. Because of lack of comprehensive review of all necessary clinical issues, as they related to pharmacotherapy of the individual, the Monitoring Team determined that the Facility is noncompliant with Provision N.2. Compliance will require the Facility to ensure comprehensive review of diagnostic studies, as they relate to pharmacotherapy treatment for the individual, and provide comprehensive recommendations to the physician, as related to pharmacotherapy management. The QDRR process requires appropriate review of medication side effects, in addition to adverse reactions, interactions, and efficacy. The Settlement Agreement requires the Monitoring Team to ensure that clinical practice is at the level of generally acceptable standard of care. Provision N.3: The Facility has significantly improved many aspects of monitoring of polypharmacy and the use of STAT medications at the Facility. The Facility maintains a database for all STAT and one-time orders. A list of all STAT and one-time orders dated 11/1/11 through 12/31/11 was provided for review. The data was presented in table form, and graphic representation that provided extensive insight into the use of STAT medications at the Facility. The Face-to-Face Assessment form was reviewed, and noted to be comprehensive and efficacious. The Facility has also significantly enhanced its efforts to monitor for metabolic syndrome. Both issues require some additional improvements, as delineated in within the body of this report. The Facility must improve its overall monitoring of benzodiazepine use at the Facility, before compliance can be determined. There was no consistent documentation, such as in the ISPs, or other Interdisciplinary Team notes, that demonstrated meaningful review of risks associated with metabolic syndrome, polypharmacy, and the use of benzodiazepines. Such issues must be clearly documented and demonstrate meaningful review, and recommendations by the Interdisciplinary Team process. At this time, the Monitoring Team determined that the Facility is noncompliant with Provision N.3, of the Settlement Agreement. Importantly, the Facility, as part of their current POI has requested that nurses obtain abdominal girths form all Individuals with BMIs greater the 25. BMI is not a good predictor of abdominal girth, and caution should be taken if BMI is to be used to determine the need of obtaining abdominal girth.

	Provision N.4: The Facility continues to make significant improvements with the review process of QDRRs. In the examples reviewed, 90% were reviewed and signed by the appropriate physician. Unfortunately, action plans were not consistently documented on the QDRR in 50% of the examples. Documentation of the physician's action plan is required on QDRR. Because physicians did not document their action plan on the QDRRs, as required, the Monitoring Team determined that the Facility is noncompliant with Provision N.4, of the Settlement Agreement. Future reviews will also require documented evidence that demonstrates that physicians followed through with their action plan. Provision N.5: The provision was determined to be not in substantial compliance. In some cases, it was not clear that individuals received needed screenings. Provision N.6: In general the Facility continues to enhance its ADR process. The Facility had a meaningful process in place to address ADRs. The process includes reporting ADRs to the FDA, when indicated. The Facility now offers excellent training on ADRs to direct care staff and nurse. The Facility collects data on all ADRs for trends analysis. Following specific reviews of five ADRs, the Monitoring Team noted acceptable outcomes, and determined that the Facility is in compliance with Provision N.6. However, the Facility must continue to enhance its process, as the process continues to mature. It is essential that the Interdisciplinary Team is made aware of all ADRs and reviews outcomes and recommendations; the LAR must be made aware of all ADRs; the Facility must ensure robust reporting of suspected ADR's; and a longitudinal trends analysis must be regularly reviewed by the P&T. Provision N.7: In general, the Facility provides an excellent Drug Utilization Evaluation (DUE) process that is comprehensive and clinically meaningful. Recommendations for each DUE are tract for compliance and efficacy. The Monitoring Team determined that the Facility is in substantial compliance with Provision N.7, of the Settlement Agreement. Provision N.8: Because the Facility does not have a well integrated medication variance process that includes oversight by the pharmacy department that ensures; review and reporting of all variances, including those that occur in the context of pharmacy, nursing and physician services, the Monitoring Team determined that the Facility is non-compliant with Provision N.8, of the SA. The Monitoring Team would like to highlight the exceptional medication variance reviews provided by the nursing department.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as	To assess that appropriate diagnostics were reviewed, that pharmacists ensured review of allergies, drug interactions, and side effects of medications, and that appropriate recommendations were made by the pharmacists for each new medication order or when a medication dose was initiated, and that physicians followed pharmacy recommendations and documented their follow-up action plan, the Monitoring Team requested documentation to include the following: Medication orders, drug intervention reports, copies associated diagnostics, and documentation that the physician concurred	Noncompliance

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	clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	with the pharmacists recommendations, current medication list, and evidence to support that pharmacists reviewed allergies, drug-drug interventions, review of side effects and consideration for dose adjustments. The Monitoring Team reviewed documentation request TX-BR-1201-RC.59, and referred to as Sample D (#167, #69, #255, #547, #332, #264, #407, #133, #53, #493, and #497). The Monitoring Team determined that there was lack of evidence to support full compliance with the Provision. As noted in the examples below, issues needing improvement included: • Documentation does not always clearly show the pharmacists review of all commonly required laboratory studies for each medication reviewed, allergies, and side effects. • Clinically appropriate recommendations for each single patient intervention were not always provided. • The physician's actin plan was not always documented, and there were examples in which there was not notation of whether the physician agrees or disagrees with the pharmacy recommendation. • There were numerous examples in which review of the physician order indicated allergies, dates, indication and demographics were listed; however, there was no specific documentation that the pharmacist had reviewed this information. The Monitoring Team wants to point out that these concerns may be issues of documentation and of the ability of the Facility to track and provide evidence of action; in fact, the Facility pointed out (and provided examples) of pharmacy documentation on a number of documents, that the Facility reports shows that reviews had been done and actions had been checked. As reported by the Facility, this is indicated by check marks, circling, underlining, initials or other means to signify that the information was assessed. The difficulty experienced by the Monitoring Team was that this variety of indicators on a variety of forms did not provide a consistent means to track what had been done, to understand what these markings implied, and to ensure they meant actions were completed or followed up on. This process did not ensure a system was in place so that the Facility itself could track the actions. If, in fact, all of these actions have been taken, it should be possible for the Facility to develop a tracking process, to use it to ensure all needed actions take place, and to provide it to the Monitoring Team as evidence of compliance at the next visit. Individual #167 Clozapine dose was changed. The pharmacist noted potential interaction with three co-administered drugs: carbamazepine could decrease clozapine blood levels; and	

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		paliperidone could result in abnormal cardiac conduction; clonazepam could increase clozapine levels. The pharmacist also noted normal white blood cell (wbc) count. The physician acknowledged potential interaction by signing drug interaction monograph. The pharmacist listed on the intervention report of the potential interactions, and that physician would follow-up by discontinuing carbamazepine, clonazepam and paliperidone. Physician action plans and signature listed on the monographs were signed by the physician, but not dated. By review of the physician order, allergies, dates, indication and demographics were listed; however, there was no specific documentation that the pharmacist had reviewed this information. There was evidence to support that the pharmacist assessed a wbc count, but no evidence to support that a carbamazepine level was reviewed. Per review of the single patient intervention report (intervention report), the pharmacist did not provide specific recommendations. The physician action plan was appropriate. Individual #69 This individual was prescribed an antibiotic that would interact with antiepileptic medication by decreasing its blood level. The Monitoring Team notes that decreasing antiepileptic blood levels places the Individual at increased risk for seizure activity. The pharmacist initiated a pharmacy intervention, and notified the physician of the potential interaction. The physician responded to the potential interaction by holding the antibiotic and adding a different antibiotic. The pharmacist noted drug allergies, indication and demographics. Review of the physician order indicated allergies, dates, indication and demographics were listed; however, there was no specific documentation that the pharmacist had reviewed this information. Review of laboratory values was not required for this intervention. Individual #255 The individual was on both Dilantin and valproic acid. The physician ordered to increase valproic acid dose. The pharmacist noted potential drug interaction and informed the physician, and documented on the pharmacy intervention of a need to check both valproic acid and Dilantin levels. The physician documented on drug monograph that she agreed with the pharmacist, and would add a Dilantin level, along with valproic acid level. There was no evidence that nursing and direct care staff were made aware of the potential drug toxicity and need for enhanced monitoring. Staff must always be made aware whenever there is a potential for increased drug toxicity. Review of the physician order indicated allergies, dates, indication, and demographics were listed; however, there was no specific documentation that the pharmacist had reviewed this information. Individual #547 Warfarin dose was to be increased. The pharmacist provided drug interaction	

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		monographs to the physician. The physician reviewed, and signed monographs and noted INR levels were already ordered. The physician initialed and dated each of the three Drug-Drug Interaction monographs.. Review of the physician order indicated allergies, dates, indication, and demographics were listed; however, there was no specific documentation that the pharmacist had reviewed this information. There was evidence to support that appropriate laboratory tests were reviewed. Per review of the single patient intervention report (intervention report), the pharmacist did not provide specific recommendations; the pharmacist reported collaboratively assessing with the prescriber the noted interactions and agreeing on a plan. Although this process may be appropriate and efficient, there is still a requirement to document that this occurred. Individual #332 The individual was prescribed one dose of Clonidine for elevated blood pressure, and was co-administered propranolol. The pharmacist completed a pharmacy intervention report and notified the physician of potential rebound hypertension if Clonidine was discontinued rapidly. The physician documented appropriate rationale on the drug monograph report. The physician did not date monographs. Review of the physician order indicated allergies, dates, indication and demographics were listed; however, there was no specific documentation that the pharmacist had reviewed this information. Review of laboratory studies was not required for this intervention. The pharmacy documented the physicians action plan, however, physician documentation was not noted. Per review of the single patient intervention report (intervention report), the pharmacist did not provide specific recommendations. . The pharmacist reported that the physician was notified, and the pharmacist and physician collaboratively developed a plan, which the physician handwrote on the Drug-Drug Interaction Monograph. It is essential that the Facility identify a standard location for documenting all such outcomes; this ordinarily would be noted on the SPI. Individual #264 The individual was on Seroquel and was prescribed one time injectable dose of ziprasidone as a pre-treatment medication for an ophthalmology appointment, once consent was obtained. The pharmacist reviewed prior EKG, and notified the physician that ziprasidone could alter the electrical conduction of the heart. The physician documentation was not provided. The pharmacist noted on the intervention report that the physician "wanted to use the ziprasidone (he considered the risk of the other agents, such as respiratory depression with lorazepam to be equal/grater danger with the dose needed for behaviors and that the benefit of seeing the ophthalmologist outweighed the risk of a potentially transient QT prolongation". A handwritten note on the drug monograph per pharmacist stated "Pharmacy recs repeat EKG after Geodon admin/clinic visit. (Spoke to Dr in person and he agreed to check EKG)". Follow-up EKG and order for EKG was not provided for review. The Monitoring Team is concerned how the physician	

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		determined the risk, and benefit, and to the extent that the Team was notified of the potentially serious issue. QTc prolongation is known to occur with each of these medications, and additive effects can potentiate QTc prolongation. QTc prolongation is unpredictable and EKGs, although helpful, cannot rule out sudden change with the QTc interval and development of Torsades de pointes (TdP). The Monitoring Team has concern over the overall evaluation for elongation of QTc, and potential development of Torsades de pointes. If there is concern over potential drug interaction of co-administered medications, all risks, and benefits must be clearly identified and presented to the Interdisciplinary Team, and consideration for alternative treatment must be of primary concern; when an alternative medication can not be used then a careful medical evaluation should be completed before starting the medications; that includes serial EKGs, immediately prior to starting the medication, and periodically through treatment. Serum calcium, magnesium, and potassium must be evaluated before treatment; direct care and nursing staff must be specifically notified of the potential of an adverse cardiac outcome, and enhanced monitoring should be ordered by the physician. These issues must be known, and addressed by pharmacy, as part of a pharmacy review for adverse outcome of a new medication. Review of the physician order indicated allergies, dates, indication and demographics were listed; however, there was no specific documentation that the pharmacist had reviewed this information. Review of laboratory studies were not required for this intervention. The pharmacy documented the physician's action plan; however, the physician documentation was not noted. Per review of the single patient intervention report (intervention report), the pharmacist did not provide specific recommendations. Individual #407 The individual was on two medications that could be inhibited by Rifampin, which was initiated for 10 days. The pharmacist notified the physician, provided the physician with drug monograph, and documented the issue on a drug interaction report. The physician documented her response on the drug monograph, noting that the benefit of treatment outweighed a limited potential decrease in efficacy of the two medications (queitiapine and Zocor). The physician signed and dated the drug monograph note. Review of the physician order indicated allergies, dates, indication, and demographics were listed; however, there was no specific documentation that the pharmacist had reviewed this information. Review of laboratory studies was not required for this intervention. Per review of the single patient intervention report (intervention report), the pharmacist did not provide specific recommendations. Individual #133 The Individual was prescribed ciprofloxacin on 11/1/11 for an infection, while already prescribed calcium, metformin and risperidone. The Pharmacy recommended holing calcium; monitor blood sugar for possible hypoglycemia; and check EKG soon after	

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		taking ciprofloxin, to monitor for QTc prolongation. The pharmacist noted that the Individual was known to have a QTc of 441 on 9/17/11. The Physician wrote an order for all of the pharmacist's recommendations and was to obtain a follow-up EKG on 11/2/11, and 11/4/11. The Monitoring Team has concern over the overall evaluation for elongation of QTc, and potential development of Torsades de pointes: If there is concern over potential drug interaction of co-administered medications, all risks, and benefits must be clearly identified and presented to the Interdisciplinary Team, and consideration for alternative treatment must be of primary concern; when an alternative medication can not be used then a carful medical evaluation should be completed before starting the medications, that includes serial EKGs, immediately prior to starting the medication, and periodically through treatment. Serum calcium, magnesium, and potassium must be evaluated before treatment; direct care and nursing staff must be specifically notified of the potential of an adverse cardiac outcome, and to enhance monitoring. These issues must be known, and addressed by pharmacy, as part of a pharmacy review for adverse outcome of a new medication. Review of the physician order indicated allergies, dates, indication, and demographics were listed; however, there was no specific documentation that the pharmacist had reviewed this information. Individual #53 The individual was prescribed Dilantin for seizure disorder. The pharmacist warned the physician about potentially toxicity of Dilantin if Bactrim DS was prescribed for an infection, and documented on the drug interaction form. There was no physician documentation, follow-up orders, nor did the physician sign the drug normograph. By reviewing medication orders, it was apparent that the physician continued Bactrim DS. The pharmacist recommended monitoring Dilantin and free Dilantin levels, while on Bactrim DS. On 12/15/11, ten days after starting Bactrim DS, free Dilantin level was 3.9 mcg/ml, which was well within toxic range, and when repeated, following completion of Bactrim DS therapy, on 12/27/11, the free Dilantin level was 1.0 mcg/ml, within normal range. There was no documentation that physical assessments were to be done to monitor the individual for Dilantin toxicity. There was no evidence that nursing and direct care staff were made aware of the potential drug toxicity and need for enhanced monitoring. Staff must always be made aware whenever there is a potential for increased drug toxicity. Review of the physician order indicated allergies, dates, indication and demographics were listed; however, there was no specific documentation that the pharmacist had reviewed this information. There was evidence to support that a Dilantin level and albumin was evaluated, but no evidence to support review of a recent cbc. Individual #493 The Individual was prescribed Prozac long-term. The physician co-administered high dose ibuprofen therapy for six days. The pharmacist notified the physician of the drug	

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		interaction, indicating moderate risk of bleeding with this combination. The physician decided to reduce the dose of ibuprofen from 400 mg twice per day to 200 mg twice per day, and add Tylenol. The pharmacist documented the risk and the physician's response on the drug interaction report. No further recommendations were provided. There was no recommendation or plan noted to enhance monitoring the individual for potential gastrointestinal bleeding, and discomfort, during the treatment period. The Monitoring Team also notes that the co-administration of any NSAID, such as ibuprofen and Tylenol may result in increase GI bleed. Review of the physician order indicated allergies, dates, indication and demographics were listed; however, there was no specific documentation that the pharmacist had reviewed this information. Review of laboratory studies were not required for this intervention. Per review of the single patient intervention report (intervention report), the pharmacist did not provide specific recommendations. Individual #497 The individual was prescribed Dilantin long-term. The physician prescribed Bactrim DS for 10 days. The pharmacist notified the physician of potential drug interaction, which included Dilantin toxicity. The pharmacist noted on the drug monograph that the "MD ordered Dilantin level for 11/13/11, in 2 days Dil-11.8 7/5/11". A physician order was written for a Dilantin level to be obtained on 11/13/11. The Monitoring Team noted that the Bactrim DS order was initiated on 11/11/11, at 1900. The Dilantin level was obtained on 11/13/11, at 0805, and the level was 13.4 mcg/ml, which was within normal range but elevated from previous levels. Importantly, the package insert for Bactrim DS states the following: 1) "The steady-state mean plasma levels of free and total sulfamethoxazole were 57.4 µg/mL and 68.0 µg/mL, respectively. These steady-state levels were achieved after three days of drug administration" 2) "Bactrim may inhibit the hepatic metabolism of phenytoin. Bactrim, given at a common clinical dosage, increased the phenytoin half-life by 39% and decreased the phenytoin metabolic clearance rate by 27%. When administering these drugs concurrently, one should be alert for possible excessive phenytoin effect." Since the blood levels do not reach steady state for three days, obtaining Dilantin levels just 37 hours after initiating treatment will not determine the extent of drug interaction. Importantly, there were no orders to enhance assessment for potential Dilantin toxicity. There was no plan documented by the physician, and the physician did not sign the Normograph. There was no evidence that nursing and direct care staff were made aware of the potential drug toxicity and need for enhanced monitoring. Staff must always be made aware whenever there is a potential for increased drug toxicity. Review of the physician order indicated allergies, dates, indication, and demographics were listed; however, there was no specific documentation that the pharmacist had reviewed this information. There was evidence that a Dilantin level was evaluated but no evidence to	

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		support that a cbc was reviewed by the pharmacists. Per review of the single patient intervention report (intervention report), the pharmacist did not provide specific recommendations. Summary: Following review of new medication orders, and drug intervention reports, 11 of 11 cases demonstrated documentation that allergies were listed on physician order forms (100%). Zero of 11 cases demonstrated documentation of review for side effects by the pharmacist (0%). Of the two cases that required enhanced EKG monitoring, zero of two (0%), recommended appropriate EKG monitoring by the pharmacist, such as obtaining an EKG immediately prior to initiating the medication, and serially after starting the medication. Of the two cases demonstrating a concern the potential for torsades de pointes, zero of two (0%) had recommendations for appropriate monitoring of electrolytes (potassium, magnesium and calcium). Of the nine cases reviewed that required commonly obtained laboratory studies, one of the nine (11%) demonstrated that all common laboratory studies were reviewed at the time of the new medication order. There was evidence to support that comprehensive and required pharmacy recommendations for each case, such as appropriately recommending pharmacotherapy changes, the need for additional diagnostics, and need for enhanced side effect monitoring was noted in five of 11 cases (45%). There was evidence to support appropriate action plans initiated by the physician, such as recommending pharmacotherapy changes, the need for additional diagnostic, and side effect monitoring in five of 11 cases (45%). Per review of the intervention reports, four of 11cases indicated specific recommendations by the pharmacists to the physician (36%), and of those four cases, there was specific documentation by the physician agreeing with the pharmacists recommendations in 4 of the four cases (100%). Compliance will require the following: Ensure that there is documentation supporting the pharmacist's review of all commonly required laboratory studies for each medication reviewed; ensure documentation that all allergies and side effects have been reviewed; provide clinically appropriate recommendations for each single patient intervention. The pharmacist must ensure that all appropriate diagnostics have been or will be obtained for each intervention identified. The Pharmacy Department must be aware of necessary clinical interventions, and monitoring specific for medications; ensure that there is documentation of the physician's action plan, and notation of whether the physician agrees or disagrees with the pharmacy recommendation; and ensure that pharmacy has a mechanism in place to assess compliance by physician with the pharmacists recommendations and action plan for each intervention.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug	To review compliance for Provision N.2, the Monitoring team requested the current QDRR, 12 months of labs, current Annual Medical Assessment, and past two MOSES and	Noncompliance

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	Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	DISCUS reports, from the first 10 QDRRs completed in November and first 10 QDRRs completed in December of 2011. From the requested 20 QDRRs, the Monitoring Team selected five examples to review comprehensively (#89, #343, #43, #126, and #269) Each of the following examples will indicate the specific QDRR reviewed. In addition, there will be a section that documents the extent of the physician's review of the QDRR, and a section that highlights the pharmacists review, and recommendations for the QDRR. Following each example there is a summary of the Monitoring Team's concern. At the end of the Provision there is an overall summary of the examples. Individual #89 QDRR dated 11/1/11; Previous QDRR dated 7/25/11. Physician Review: Physician Reviewed QDRR: Yes Physician agreed / disagreed with QDRR recommendation: Agreed Physician plan documented: Yes QDRR complete timely or late: Timely Pharmacist Review: The Clinical Pharmacist noted abnormal platelet count and hemoglobin secondary to lymphocytic leukemia, per hematologist. The Clinical Pharmacist reviewed laboratory data from previous QDRR for review, and not more current labs: VPA level was within therapeutic range 7/11/11; Dilantin level was within therapeutic range at 12.8, 7/18/11; Keppra level was within reference range at 15.5, 7/11/11; CMP wnl 7/11/11; Lipids wnl 7/11/11; Vit D within reference range, 7/11/11. The Monitoring Team noted that more recent VPA and Dilantin levels were available for this review period: VPA on 9/14/11 was in toxic range at 116.1, the physician held doses pending recheck, and on 9/15/11 was wnl at 54.3; Dilantin level was available for review on 8/4/11 and 9/14/11, both wnl. The individual is noted to have significant osteoporosis, and the issue of phenytoin use was not discussed by the Clinical Pharmacist. This issue should be discussed through the Interdisciplinary Team Process. MOSES Review: MOSES Date: 8/28/11 Date reviewed by pharmacist: 11/1/11	

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		Date reviewed by physician: 9/9/11 Physician completed prescriber review: Yes Monitor Team comment: None Moses Date: 10/9/12 (incorrect date) Date reviewed by pharmacist: Not reviewed Date reviewed by physician: 1/10/12 Physician completed prescriber review: Yes Monitoring Team comment: Incorrect date/s DISCUS Review: N/A Summary: The pharmacist did not review most recent labs available at the time of the QDRR review. The administration of phenytoin should be questioned because of its potential to result in significant abnormal BMD, and fracture. An incidental finding of a misdated MOSES was observed. Individual #343 QDRR dated 11/1/11; Previous QDRR dated 7/26/11. Physician Review: Physician Review date: 11/2/11 Physician Reviewed QDRR: Yes Physician agreed / disagreed with QDRR recommendation: No Comments Physician plan documented: NA QDRR complete timely or late: Timely Pharmacist's Review: Clinical Pharmacist reviewed labs from previous QDRR. No recent diagnostics available or required. Individual is administered Baclofen, 20 mg bid and 10 mg at noon, for spasticity. Individual is noted to have a significant neuromotor condition. No comment on efficacy of Baclofen treatment. MOSES: None – comment made on QDDRR that no side effects reported. The MOSES is not required by the Settlement Agreement for this medication, but current generally accepted practice standards require some documented review of side effects. No documentation was provided to the Monitoring Team of the source of information that there were no side effects.	

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		DISCUS: N/A Summary: Baclofen is a medication that requires carful monitoring for both side effects, especially for missed doses, and for it efficacy. Baclofen should be titrated to maximum therapeutic dose that demonstrates efficacy without causing side effects. Individuals that demonstrate benefit from Baclofen that have residual signs and symptoms of spasticity may benefit from intrathecal Baclofen. The Monitoring Team questions how effective side effect monitoring of medication screening is for this Individual, since no MOSES was obtained. Individual #126 QDRR dated 11/1/11; Previous QDRR dated 9/19/11. Physician Review: Physician Review date: 11/2/11 Physician Reviewed QDRR: Yes Physician agreed / disagreed with QDRR recommendation: Agreed Physician plan documented: Yes QDRR complete timely or late: Timely Pharmacist's Review: Clinical Pharmacists commented on elevated ALP from 9/29/11 labs, reports that this is "baseline findings, and have improved over previous labs". The pharmacist also commented "since AST&ALT are within reference range, the cause is likely non-hepatic, and may be due to long-term AED use (phenytoin). It is also possible that ALP is reflective of increase bone activity (diagnosed with osteoporosis). There was no specific recommendations to the physician to follow0up on this issue. The Individual does have a significant history of osteoporosis and is administered Denosumab every Month for treatment of osteoporosis. Review of the past 12 Months of labs indicates a persistent elevation of ALP with no overall improvement. There was no evidence to support that the ALP was fractionated into its isoenzymes to determine the type of ALP (bone, hepatic, or other origin, such as kidney or intestine). Elevated ALP in a person who has low BMD must be evaluated for secondary causes of osteoporosis, such as Paget's disease, osteosarcoma, metastatic prostate cancer, osteomalacia, and hyperparathyroidism, among other conditions. Evaluation must take place as soon as the ALP becomes abnormal, one on Denosumab, or before the Medication is started. Dilantin therapy may be causing or exacerbating the Individual serious bone condition and no formal recommendations were made to consider review of this issue.	

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		The Pharmacist noted that on the 8/11/11, the Dilantin level was normal, but "increased 11/1/11 – would recommend checking a new level 7-10 days after dose increase". The physician followed the recommendation and determined the level to be normal. The Monitoring Team noted that subsequent levels obtained on 11/21/11 and 12/7/11 continued to decrease, and no subsequent blood level had been ordered by the time of this review. Laboratory data on 8/3/11, which was within the time frame of the QDRR review period, indicated a subtherapeutic Dilantin level of 3.5, however, no comment was made about this low Dilantin level. The Dilantin level was only again re-checked on 11/3/11. MOSES: Moses Date: 8/10/11 Date reviewed by pharmacist: 11/1/11 Date reviewed by physician: 8/11/11 Physician completed prescriber review: Yes Monitoring Team comment: Individual is reported to have significant spasticity secondary to neuromotor condition. MOSES reported NA for #39 (Rigidity/complaints of muscle pain or aches). Pharmacist commented mask face and determined not to be medication related, and weight issue, that was reported have stabilized. Moses Date: 2/8/11 Date reviewed by pharmacist: (previous QDRR – no MOSES for current review) Date reviewed by physician: 2/11/11 Physician completed prescriber review: Yes Monitoring Team comment: Individual was reported to have significant spasticity secondary to neuromotor condition. MOSES reported NA for #39 (Rigidity/complaints of muscle pain or aches). DISCUS: N/A Summary: The individual is prescribed multiple medications, including Denosumab for osteoporosis, ferrous sulfate for chronic anemia, phenytoin for seizure disorders. Each of these medication raised concerns by the Monitoring Team that more assertive evaluation was needed. The Individual had an elevated ALP, with no determination as to its etiology. An elevated ALP requires evaluation in Individuals with known or suspected kidney and bone disease, as well as other conditions. Secondary causes of osteoporosis must be excluded before treatment with Denosumab. The Interdisciplinary Team must review the use of Dilantin for Individuals with severe bone disease, such as osteoporosis. Chronic use of iron therapy requires a definitive diagnosis, and should be used	

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		judiciously in Individuals with potential nephrotic syndrome. The issue of significant sub-therapeutic Dilantin level on 8/3/11, should have been documented on the QDRR, and given the continued wide fluctuation with Dilantin levels, recommendations for more frequent monitoring should have been made. Individual #43 QDRR dated 11/1/11; Previous QDRR dated 7/26/11. Physician Review: Physician Review date: 11/2/11 Physician Reviewed QDRR: Yes Physician agreed / disagreed with QDRR recommendation: Agreed Physician plan documented: No (did not document action plan on QDRR QDRR complete timely or late: Timely Pharmacist's Review The individual was noted by the Monitoring Team to have had moderately elevated Phenobarbital levels on several occasions throughout the past 12 Months. The QDRR listed the levels in a table, and the only comment made was "Phenobarbital level is just above range and phenytoin levels are trending upwards – continue to monitor for dose-related side effects and make adjustments, if necessary". In this particular case, Phenobarbital levels were noted elevated on 11/10; 12/10, and then on 7/14/11; 8/8/11; and 10/21/11 (all elevated). The next phenobarbital level was not obtained until 1/12/12 (normal). The Individual is prescribed calcium citrate, Dilantin and Phenobarbital. Calcium Citrate can alter absorption of Dilantin, and Dilantin can alter Phenobarbital levels. Calcium Citrate is prescribed at the same time as other medications in the AM. Calcium Citrate should be administered at alternate times because it can bind and inhibit absorption of Dilantin. Phenobarbital and Dilantin alter the metabolism of each other. This complex drug-drug interaction may contribute to the fluctuating Phenobarbital levels, and should be considered in a clinical review. The issue of drug-drug interaction was not commented on. Importantly, Given the narrow therapeutic window for Phenobarbital, the Monitoring Team has concerns with infrequent drug monitoring of this drug. Most concerning is that when the Phenobarbital level was 49.5 on 8/8/11, a follow-up Dilantin level was not obtained until 10/21/11, and even then, the level was still minimally elevated at 42.5, and follow-up Phenobarbital level was not obtained until 1/12/12, almost three Months later. The Individual was noted to have a significantly low Vitamin D level, and the Individual's medication regimen was changed to enhance Vitamin D absorption.	

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		Given that this Individual is treated for osteoporosis, and received Denosumab as a medical treatment, recommendations to evaluate the causes of vitamin D deficiency should have been provided to the physician. Also, review of the use of Dilantin should be recommend review by the Interdisciplinary Team. MOSES: Moses Date: 8/26/11 Date reviewed by pharmacist: 11/1/11 Date reviewed by physician: 9/5/11 Physician completed prescriber review: Yes Monitor Team comment: Pharmacist provided comprehensive review of MOSES. DISCUS: N/A Summary: The physician did not document action steps to address the pharmacist's recommendation, on the QDRR. Persistent low levels of Phenobarbital were not assertively delineated on the QDRR report, nor were recommendations to ensure more frequent monitoring of Phenobarbital in this particular case. The Individual is administered Calcium Citrate at the same time as Dilantin and other medications. Calcium Citrate should be given before or after Dilantin. The pharmacist did, not offer assertive recommendations to the physician regarding the need to determine the etiology of chronic low vitamin D levels. Individual #269 QDRR dated 11/1/11; Previous QDRR dated 7/26/11. Physician Review: Physician Review date: 11/2/11 Physician Reviewed QDRR: Yes Physician agreed / disagreed with QDRR recommendation: N/A (no recommendations) Physician plan documented: N/A QDRR complete timely or late: Timely MOSES: None DISCUS: N/A Summary: Moses was not completed for this individual. The Pharmacist reported, "no side effects are reported". The Monitoring Team questions how the efficacy of side effect Monitoring is by direct care staff, and nursing staff. The Pharmacist reviewed all relevant	

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		labs. The individual is prescribed metoprolol for hypertension. The Clinical Pharmacist did not address the issue of hypertension during the QDRR. Overall Summary: Following review of sample C, it was noted that five of five QDRRs were completed timely (100%); Physician had reviewed and signed five of five QDRRS (100%); in four cases (80%) did the physician documented appropriately; laboratory studies were appropriately assessed in only one of five cases (20%); five of five QDRRS did not require completion of a DISCUS, and three of five QDRRs (60%) included a MOSES (MOSES is only required when assessment of tardive dyskinesia is needed). The Monitoring Team raised concern with the clinical recommendations in five of five cases (100%). The Monitoring Team noted that QDRRs were completed timely in 100% of the sample reviewed, and that physicians demonstrated appropriate action plans for 80% of the sample reviewed. Because of lack of comprehensive review of all necessary clinical issues, as they related to pharmacotherapy of the individual, the Monitoring Team determined that the Facility is non-compliant with Provision N.2. Compliance will require the Facility to ensure comprehensive review of diagnostic studies, as they relate to pharmacotherapy treatment for the individual, and provide comprehensive recommendations to the Physician, as related to pharmacotherapy management. The QDRR process requires appropriate review of medication side effects, in addition to adverse reactions, interactions, and efficacy. The Settlement Agreement requires the Monitoring Team to ensure that clinical practice is at the level of generally acceptable standard of care. One source that might be a resource regarding standard of care practice for medication regimen reviews (QDRRs) is the Central Management Services (CMS) - Guidelines for Medication Regimen Reviews (http://www.aging.pitt.edu/professionals/resources/S&C-06-29-11-F428MedRegReviewInstructorGuide.pdf). Based on this review, the Monitoring Team determined that the Facility is not in compliance with Provision N.1, of the SA.	
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	Review for STAT medication use The review for STAT medication use at the Facility included the review of the five most recent uses of chemical restraint at the Facility (TX-BR-1201-RC.57). Documents reviewed included the Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint form (Face-to-Face Assessment form), Quality Assurance/Quality Improvement Council Meeting minutes for 12/8/11, and 1/4/12, and copy of the STAT medication database.	Noncompliance

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	in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	The Monitoring Team noted significant enhancement with the Facility's process in reviewing STAT medications. A comprehensive database is maintained that enables thorough review of all STAT medications at the Facility. The Facility reports reviewing all STAT medication use at the Quality Assurance/Quality Improvement Council Meeting, and that a comprehensive Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint form is completed for every restraint, which enables both the pharmacist and psychiatrist to document their activity in reviewing the use of STAT medications. The Facility maintains a database for all STAT and one-time orders. A list of all STAT and one-time orders dated 11/1/11 through 12/31/11 was provided for review. The data was presented in table form, and graphic representation that provided extensive insight into the use of STAT medications at the Facility. The Face-to-Face Assessment form was reviewed, and noted to be comprehensive and efficacious. The Monitoring Team reviewed the first five completed Face-to-Face Assessment forms provided in TX-BR-1201-RC.57. It was noted that there was a pharmacy section documented by the pharmacists in five of the five cases (100%). The pharmacist documented justification for the use of the STAT medication in one of the five cases (20%). The pharmacist discussed the individual's maintenance medication in two of the five cases (40%). The pharmacist discussed efficacy of the STAT medication in zero of the five cases (0%), and the checklist noted efficacy in five of the five cases (100%). The pharmacist documented a risk analysis for the use of the STAT medication in zero of the five cases (0%). The pharmacist provided a documented recommendation in zero of the five cases (0%). The Monitoring Team noted a psychiatrist review section on the Face-to-Face Assessment on five of the five cases (100%). The psychiatrist documented justification for use of the STAT medication in five of the five cases (100%). The psychiatrist commented on the need or not, to change the dose of the maintenance medication in one of the five cases (20%). The psychiatrist document if side effects were present in five of the five cases (100%). The psychiatrist discussed risks and benefits of the use of the STAT medication, versus alternate therapies including no treatment, in zero of the five cases (0%). The psychiatrist documented recommendations in one of the five cases (20%). The Quality Assurance/Quality Improvement Council minutes for 12/8/11 and 1/4/12 were reviewed. The minutes did not document a summary or other meaningful review for the use of STAT medications. Summary: The Monitoring Team observed significant improvement in the process for reviewing STAT medication use at the Facility. The Face-to-Face Assessment form is routinely	

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		completed for all restraints. The Monitoring Team noted that the pharmacist and psychiatrist documented on every Face-to-Face Assessment, when a chemical restraint was initiated. The Monitoring Team, however, did not see efficacious input by the psychiatrist and pharmacist in many important areas. For example, the pharmacists did not did not document a risk analysis review for the use of chemical restraints, nor did he document if the use of the STAT medication was justifiable. Importantly, the pharmacist did not provide meaningful recommendation specific to the use of the chemical restraint. The psychiatrist, for example, did not did not document the need or not, to change the maintenance medication, nor did the psychiatrist documents specific recommendations or risks and benefits of the use of the STAT medication, verses alternative therapies, including no therapy. The Monitoring Team noted excellent data collection for the use of STAT medications, however, there was no documentation by the Quality Assurance/Quality Improvement Council of their review of the use of STAT medications, and longitudinal trends analysis. <u>Polypharmacy Review:</u> <u>The following example represents concerns specific to polypharmacy practice at the Facility.</u> The Monitoring Team assessed the first five QDRRs, from a document request TX-BR-1201-RC.66 (Individuals #7, 367, #547, #259, and #381), and Polypharmacy Committee Meeting Minutes Of the five QDRRs reviewed, five of five (100%), demonstrated polypharmacy drug use by the individual. Five of five (100%) noted an appropriate justification for the use of polypharmacy. Drug-Drug interactions were commented on in five of five cases (100%). No comments were made about whether or not there were significant potential Drug-Food interactions. Efficacy of the use of polypharmacy was documented in zero of the five (0%) cases. The Facility had initiated a Psychoactive Medication Oversight Committee, which evaluated trends and issues related to polypharmacy use at the Facility. The Monitoring Team reviewed the minutes of the meetings of October 19, 2011, November 22, 2011, December 29, 2011, and January 17, 2012. The quality and efficacy of reviews improved as the committee became more formalized. The most recent two reviews were excellent and demonstrated a comprehensive analysis of polypharmacy at the Facility. Summary: Overall, the Facility is assessing the use of polypharmacy very well. When addressing polypharmacy at the time of the QDRR, drug-food interactions and a comment about the	

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		efficacy or lack of efficacy would be advantageous. Also, the Interdisciplinary Team should clearly document issues related to polypharmacy, such as risk for side effects, treatment efficacy, and plans to reduce or maintain polypharmacy treatment. Although these are discussed at the Psychoactive Medication Oversight Committee meetings, the information does not make its way back to documentation on the QDRR. <u>Benzodiazepine Review</u> The following example is to highlight important considerations for the use of benzodiazepines at the Facility. The Monitoring Team request all evidence to support the Facility's review of benzodiazepines, and was informed that the Facility reviews the use, and trends of benzodiazepines through the Psychoactive Medication Oversight Committee Meeting. Following review of the information provided (TX-BR-1201-RC.54), the Monitoring Team did not identify a comprehensive review for the use of benzodiazepines, delineated in the January 17, 2012 or December 29, 2011 Committee Meeting minutes. Summary: The Facility did not comprehensively review the use of benzodiazepines. Benzodiazepines should be regularly reviewed by the Facility, specific recommendations initiated to determine efficacy, and possibility of discontinuation, and trends analysis of use by the Facility. <u>Metabolic Syndrome</u> <u>The following examples are to delineated relevant findings specific to the management of metabolic syndrome.</u> Individual #305 Individual #305 was noted to have a diagnosis of Diabetes Type II, and is treated with Metformin. His accuchecks are above 150, and HDL is significantly low at 19. The Facility did not assess abdominal girth; however, the QDDR indicated that "based on current BMI, waist circumference likely < 40 inches". Waist circumference is a very important indicator that is necessary to monitor for metabolic syndrome. Waist circumference helps to determine abdominal obesity, which is the risk factor for metabolic syndrome. BMI may be normal in individuals with increased abdominal obesity. Given that the Individual has diabetes, has a very low HDL, the Individual is at risk for metabolic syndrome. This risk was not identified on the Integrated Risk Rating Assessment. The Psychiatric Assessment dated 10/12/11 clearly identified the risk factors for metabolic syndrome, with the exception of abdominal girth, and recommended close monitoring for metabolic syndrome. There was no documentation to support that the Interdisciplinary Team had reviewed the significant risk factors	

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		associated with this Individual being prescribed risperidone, with a diagnosis of diabetes, and other risks associated with metabolic syndrome. Individual #133 Individual #133 is prescribed Metformin for diabetes, and risperidone for mood disorder. The Individual is diagnosed with diabetes and hyperlipidemia, as well as coronary artery disease. The QDRR indicated an HDL of 28, accucheck of 115 and 124 (143 on 12/12/11 per psychiatric treatment review), and noted that the "waist circumference is likely <40 inches (BMI indicates normal weight)". There was no recommendation to monitor for risk of metabolic syndrome, per the QDRR. Also, given that the individual has diabetes, has a low HDL, blood pressure was not reported, and that waist circumference was not assessed, the Risk Rating Assessment did not indicate metabolic syndrome was a potential risk factor. The Psychiatric Treatment Review dated 12/16/11, noted multiple labs, but did not comment on blood pressure, or abdominal girth, and did not consider the Individual at risk for Metabolic Syndrome. There was no documentation to support that the Interdisciplinary Team had reviewed the significant risk factors associated with this Individual being prescribed risperidone, with a diagnosis of diabetes, and other risks associated with metabolic syndrome. Individual #568 Individual #568 is diagnosed with diabetes Type II, and hypertension per the Annual Medical Assessment dated 8/15/11. The individual is prescribed enalapril for hypertension, lovastatin for cardio protection, carvedilol for hypertension, and metformin for diabetes, and risperidone for bipolar disorder. The QDRR dated 10/24/11, indicated that the HDL was "below goal at 39 mg/dl", did not comment on recent accuchecks, noted that the individual's blood pressure was controlled by medications, and did not document a waist circumference, but stated that "waist circumference is likely < 35 inches (based on current BMI)". The QDDR reported that the individual "does not have enough risk factors to clinically identify Metabolic Syndrome". Even though the individual has significant hypertension, diabetes that requires treatment, low HDL, the Facility did not indicate metabolic syndrome as a risk on the most recent Integrated Risk Screening Assessment. The Psychiatric Treatment Review dated 12/1/11, did not comment specifically about metabolic syndrome. There was no documentation to support that the Interdisciplinary Team had reviewed the significant risk factors associated with this Individual being prescribed risperidone, with a diagnosis of diabetes, and other risks associated with metabolic syndrome. Summary: The Facility did not comprehensively evaluate individuals for metabolic syndrome. It is required to assess all risk factors, including blood pressure, and abdominal girth when assessing for metabolic syndrome. The Facility did not assess abdominal girth. Also, if	

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		an individual's hypertension is controlled by medications, controlled hypertension is a risk factor for metabolic syndrome, as is controlled diabetes and lipid disorders. The QDRR and psychiatric assessments must clearly indicate a comprehensive review for risk factors associated with metabolic syndrome. Metabolic syndrome should be included (under other), as a risk factor when completing the Integrated Risk Assessments if there is a concern that metabolic syndrome is a potential risk. The Interdisciplinary Team must review all individuals who are at risk for metabolic syndrome, especially if they are diabetics and on a neuroleptic that predisposes obesity and diabetes. Metabolic syndrome is a serious medical condition that must be carefully monitored, prevented and when necessary treated. Overall Summary for Provision N.3: The Facility has significantly improved many aspects of monitoring of polypharmacy, and the use of STAT medications at the Facility. The Facility has also significantly enhanced its efforts to monitor for metabolic syndrome. These issues require some additional improvements, as delineated in within the body of this report. The Facility must improve its overall monitoring of benzodiazepine use at the Facility, before compliance can be determined. There was no consistent documentation, such as in the personal support plans, or other Interdisciplinary Team notes, that demonstrated meaningful review of risks associated with metabolic syndrome, polypharmacy, and the use of benzodiazepines. Such issues must be clearly documented and demonstrate meaningful review, and recommendations by the Interdisciplinary Team process. At this time, the Monitoring Team determined that the Facility is noncompliant 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.	To review compliance with Provision N.4, the Monitoring Team selected ten QDRRs (#305, #568, #131, #109, #80, #381, #547, #61, #259, and #367) that were provided as part of the document request. The following is a review of each QDRR and summary of the Monitoring Team's findings: Individual #568 QDRR dated 10/24/11 was signed by the physician, who agreed with recommendations but did not document comments actions. The Psychiatrist reviewed and signed the QDRR and indicated agreement, however no action plan was documented. The Clinical Pharmacist proposed three action plans, and the prescribers checked "agree" to each plan, signifying that they would perform proposed actions. However, they did not document their specific action plans that will need to be monitored by the Clinical Pharmacist. Individual #305 QDRR dated 12/19/11 was not signed by the physician, did not indicate if agreed or not	Noncompliance

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		with pharmacists recommendation, and no action plan was documented. Individual #131 QDRR dated9/7/11 was signed by the physician, who did not indicate if agreed, or did not agree with the pharmacist's recommendation, and no action plan was documented. Individual #109 QDRR dated 10/21/11 was signed by the physician, who agreed with recommendations and documented action plan. Individual #86 QDRR dated 9/13/11 was signed by the physician, who agreed with recommendations, and documented action plan. The psychiatrist signed and agreed with recommendations and documented an action plan. Individual #381 QDRR dated 9/28/11 was signed by the physician, who agreed with recommendations and indicated an action plan. The psychiatrist signed the QDRR and agreed with recommendations. An action plan for the psychiatrist was not required for this QDRR. Individual #547 QDRR dated 11/16/11 was signed by the physician who agreed with recommendations, and documented an action plan. Individual #61 QDRR dated 10/25/11 was signed by the physician who agreed with recommendations; however, action plans for all recommendations were not documented by the physician (two of the four recommendations indicated action plans). The Facility reported that the physician actually carried out appropriate actions to address the recommendations. Individual #259 QDRR dated 11/30/11 was signed by the physician who agreed with recommendations but did not document an action plan. Individual #367 QDRR dated 10/26/11 was signed by the physician who agreed with recommendations and documented an action plan. The psychiatrist agreed with recommendations, signed the QDRR but did not document an action plan. In this example the Individual was on Haldol, and was experiencing abnormal movements of the eyes. The pharmacist recommend neurology consult to determine if the movements were seizures. The psychiatrist should have indicated that he would examine the individual to exclude	

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		extrapyramidal symptoms secondary to Haldol. For the 10 QDRRs reviewed by the Monitoring Team the Physician signed nine of the 10 (90%); agreed with recommendations made by the pharmacists in eight of the eight (100%) that included recommendations by the pharmacist; and documented an action plan for five of the 10 (50%) QDRRs. Five of the 10 QDRRs required review by the psychiatrist and in these examples five of the five (100%) were singed by the psychiatrist; five of the five (100%) agreed with the pharmacists recommendations; and two of the five (40%) documented an action plan by the psychiatrist. Summary: The Facility continues to make significant improvements with the review process of QDRRs. In the examples reviewed, 90% were reviewed and signed by the appropriate physician. Unfortunately, action plans were not consistently documented on the QDRR in 50% of the examples. Documentation of the physicians action plan is required on QDDR. Because physicians did not document their action plan on the QDRRs, the Monitoring Team was not able to verify that the physician considered and followed the recommendations from the pharmacist, and therefore determined that the Facility is noncompliant with Provision N.4, of the Settlement Agreement. Future reviews will also require documented evidence that demonstrates that physicians followed through with action plans to implement recommendations.	
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.	To determine compliance for Provision N.5, the Monitoring Team referred to Provision J.12, of this report. It should be noted, however, that the pharmacy department has significantly enhanced methods to ensure appropriate completion of MOSES and DISCUS Assessments by developing a database tracking system and reporting compliance issues at P&T Committee. DADS Policy for Psychiatry 007.2 The Monitoring of Side Effects Scale (MOSES) and the Dyskinesia Identification System is explicit about expectations for the use of MOSES and DISCUS scales: The MOSES must be completed at least every 6 months and the DISCUS must be completed at least every 3 months. The psychiatrist needed to review the results of these scales to monitor the side effects of anticonvulsant and psychotropic medications. Individuals who are prescribed the medication metoclopramide will have the same MOSES and DISCUS monitoring as those receiving psychotropic medications. The records of the 17 Individuals in Sample J1 were reviewed. MOSES evaluations were provided for 16 of the 17 individuals (94%); there was no evaluation for individual #238, who had a screen due in December, after the materials were submitted. MOSES evaluations were done on a six-month schedule, but additional	Noncompliance

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		screenings around significant events were not. For example, Individuals #490 and #120 were started on new medications but additional MOSES to screen for side effects were note done DISCUS evaluations were provided for 15 of 17 individuals (88%). DISCUS evaluations were not needed for Individual #33 since he did not take medications that required that screen. A DISCUS evaluation was due in December (after the materials were submitted) for Individual #238, but no evaluation was received for September. Seven individuals had only one DISCUS evaluation. PMOC and the QA nurse made significant efforts to assure that all required screens were administered and physician reviews completed. The internal QA process was reviewed by PMOC in the December meeting and that showed that some difficulties remain; the Lead Psychiatrist will complete a formal training memo for the physicians and RN case managers to address the matter. The Facility list of individuals treated with metoclopramide was reviewed. There were eight such individuals across the campus. The Monitoring Team was provided with a Facility tracking sheet that indicated that DISCUS screenings were done for these individuals. The actual screens were not reviewed. The Facility had made progress with a Facility level monitoring of the results of DISCUS ratings. It was not clear, however, that all individuals who needed screens had received them, or that screens were provided at the required frequency.	
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.	To determine compliance for Provision N.6, the Monitoring Team reviewed the Facility policy on Adverse Drug Reaction (ADR) Identification and Reporting Process, dated June 9, 2011, Pharmacy and Therapeutic Committee Meeting Minutes, the Medication Observation training program for direct care staff and nurse, ADR data for trends analysis, and r the three completed ADRs from August, 2011 The Facility had a meaningful process in place to address ADRs. The process includes reporting ADRs to the FDA, when indicated. The Facility now offers excellent training on ADRs to direct care staff and nurse. The Facility collects data on all ADRs for trends analysis. The following is the Monitoring Team review of the Facility's most five recent ADRs (#159, #60, 202, #151, and #109): Individual #159: ADR dated 8/8/11 demonstrated a comprehensive review by the pharmacist. The ADR	Substantial Compliance

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		was reported to be secondary to recommended maximum dose of the medication, and per review, the event should have been documented as a medication variance and not an ADR. The LAR was notified and specific treatment was provided Individual #60 ADR dated 8/25/11 demonstrated comprehensive review by the pharmacist. Notification of the LAR was not documented, otherwise complete. Individual #109 ADR dated 8/31/11 demonstrated comprehensive review by the pharmacist. Action plan was not documented, otherwise complete. Individual #202 ADR dated 9/17/11 lacked a documented action plan, otherwise complete. Individual #151 ADDR dated 11/3/11 Indicated that the LAR was not notified, otherwise was complete. In the five examples reviewed by the Monitoring Team, four of the five (80%) were noted to be ADRs; symptoms of the ADRs were well documented in five of the five (100%) examples; documentation was found that the LAR was notified in three of the five examples (60%); the suspected medication was documented in five of the five examples (100%); treatment was provided in four of the four (100%) examples that required treatment; and a meaningful action plan was documented in three of the five (60%) examples. Review of the January 19, 2012 P&T Committee Meeting Minutes, demonstrated excellent review of individual ADR's. A trends analysis was not documented. Overall Summary: In general the Facility continues to enhance its ADR process. Following specific reviews of five ADRs, the Monitoring Team noted acceptable outcomes, and determined that the Facility is in compliance with Provision N.6. However, the Facility must continue to enhance its process, as the process continues to mature. It is essential that the Interdisciplinary Team is made aware of all ADRs and reviews outcomes and recommendations; the LAR must be made aware of all ADRs; the Facility must ensure robust reporting of suspected ADR's; and a longitudinal trends analysis must be regularly reviewed by the P&T.	
N7	Commencing within six months of the Effective Date hereof and with	To review compliance for Provision N.7, the Monitoring Team reviewed the Facility's P&T Committee Meeting Minutes from 1/19/12; reviewed two completed DUEs	Substantial Compliance

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	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.	(clonidine and benztropine); reviewed a DUE offered on citalopram following an FDA warning; and the Facility's Drug Utilization Evaluation (DUE) Process, dated 10/18/11. Review of the Facility's DUE Process, dated 10/18/11, demonstrates a comprehensive method to provide DUEs on a scheduled basis, at least one per quarter, and as necessary based on adverse outcomes at the Facility, and when new concerns or recommendations are determined by the FDA and/or manufacturer. The process promotes an interdisciplinary approach to developing the DUE schedule and provides methods to ensure that recommendations have been followed through and efficacy of DUE recommendations. Review of DUEs: • DUE for citalopram was provided on October 20, 2011, secondary to an FDA advisory. The DUE included review of all individuals who were on the suspect medication to ensure appropriate dosing. The DUE identified one individual who was prescribed an elevated medication dose, and the dose was immediately decreased, after review by the physician. Meaningful recommendations were provided. • DUEs for benztropine and clonidine were provided as scheduled events, per selection by the P&T Committee. Both were exceptional quality, and identified Individuals at risk. Meaningful recommendations were provided. • The Facility provided a total of four DUEs for review by the Monitoring Team--three scheduled DUEs and one non-scheduled DUE, secondary to an FDA advisory, since the last Monitoring Review. • The P&T committee meeting minutes, dated January 19, 2012, documented a follow-up to all DUE recommendations and noted that recommendations were addressed. Overall Summary: In general, the Facility provides an excellent DUE process that is comprehensive and clinically meaningful. Recommendations for each DUE are tract for compliance and efficacy. The Monitoring Team determined that the Facility is in substantial compliance with Provision N.7, of the Settlement Agreement.	
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	To evaluate compliance of Provision N.3, the Monitoring Team reviewed the DADS Medication Variances Policy, number 053, dated 9/23/11 and the State Supported Living Centers Medication Variance Report form that was developed by DADS Central Office; The DADS Medication Variances Policy, number 053, dated 9/23/11 was noted to be comprehensive and complete, addressing all areas of medication variances. The policy	Noncompliance

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	action regarding actual and potential medication variances.	provides excellent direction for the Facility. The State Supported Living Centers Medication Variance Report form was reviewed and determined to be comprehensive and efficacious, and if employed appropriately at the Facility, will enable an efficacious Medication Variance process. The Monitoring Team reviewed the Medication Variance Committee Meeting Minutes for July 2011 through December 2011. All of the minutes reviewed reflected excellent reviews by the Nursing Department. Nurses are self-reporting, documentation is concise, and corrective action is well documented. There was no documentation regarding physician-related medication variance issues in any of the minutes, and pharmacy provided absolutely no input into the process for the July through September committee meeting, and only commented on administration variances made by nursing services. Pharmacy did not report on medication variances that occurred within the context of the pharmacy department, such as dispensing and storage issues, nor did pharmacy provide a comprehensive summary of all medication variances, or recommendations, and did not describe actions to ensure that medication errors were reported correctly and that meaningful corrective actions were made. As Provision N.8 is in the Pharmacy section of the SA, by implication the responsibility for ensuring the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances, Facility wide, falls within the responsibilities of the Pharmacy Department. Pharmacy is responsible to ensure that all disciplines, including nursing, physician and pharmacy services identify and report on medication variances to ensure the following are done: • Ensure oversight of the medication variance process at the Facility • Ensure that all areas of medication variances, including storage, prescribing, dispensing, and administration are assessed, documented, reviewed and that appropriate actions steps are developed for each discipline, as necessary, and that recommendations for corrective measures, and remediation are provided. • Ensure that trends analyses are developed and provided for each area of the medication variance process, including storage, prescribing, dispensing, and administration for each discipline and collectively. • Nursing, physician, and pharmacy services are responsible for collecting, and documenting data elements for medication variances, and providing this information to pharmacy for review (Administration errors per nursing; prescribing error per physician services; dispensing and storage per pharmacy). • Recommendations and remediation actions must be determined through the Medication Variance Committee, and approved by the Director of Nursing, Medical Director, and Director of Pharmacy. The Pharmacy Department is	

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		responsible to ensure that recommendations and remediation occurs. Overall Summary: Because the Facility did not have a well-integrated medication variance process that includes oversight by the Pharmacy Department, as delineated above, the Monitoring Team determined that the Facility is non-compliant with Provision N.8, of the SA. The Monitoring Team would like to highlight the exceptional medication variance reviews provided by the nursing department.	

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

1. The Pharmacy Department must immediately enhance its review of new medication orders, and orders when there is a dosage change, as outlined under Provision N.1. (Provision N.1)
2. The Facility must ensure a mechanism to document that a pharmacist had reviewed all new medication orders and orders with medication dose changes, not just orders that required an intervention report. It is essential that the mechanism includes acknowledgement of review for allergies, and other requirements for provision N.1, such as an electronic statement, or stamp (Provision N1)
3. The Facility must immediately enhance its process for evaluating the use of benzodiazepines, as outlined in Provision N.3, of this report (Provision N3)
4. The Facility must immediately improve its assessment of Metabolic Syndrome, as outline in Provision N.3, of this report (Provision N3)
5. The Interdisciplinary Team process must comprehensively review the use of STAT medications; the use of benzodiazepines, and polypharmacy, including anticholinergics; document such review; and provide appropriate recommendations when necessary for each Individual prescribed such medications (Provision N3)
6. Ensure that physicians document their action plan on the QDRR review forms. Also, ensure that there is documented evidence to support that the physician action plan was followed. (Provision N4)
7. As the ADR process continues to mature, it is essential that the Facility continues to enhance ADR reviews, as outline in section N.4, of this report (Provision N6)
8. Pharmacy Department must enhance its participation and oversight of the Facility's Medication Variance Process.(Provision N8)

The following are offered as additional suggestions to the Facility:

1. The Facility might wish to review published information about standards of care such as the Central Management Services (CMS) - Guidelines for Medication Regimen Reviews (http://www.aging.pitt.edu/professionals/resources/S&C-06-29-11-F428MedRegReviewInstructorGuide.pdf).

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. BSSLC Plan of Improvement (POI), dated 12-30-2011 2. BSSLC Presentation Book 12/30/11 3. BSSLC Physical and Nutritional Management Plan (PNMP) Policy 11/14/11 4. Record reviews: a. Sample 1: Individuals #5, #30, #291, and #318 b. Sample 2: Individuals #33, #163, #303, #403, #411, #536, #570, and #575 c. Sample 3: Individuals #26, #53, #54, #86, #88, #126, #231, #303, #392, and #567 d. Sample 4: Individuals #7, #195, #250, #403, #497, and #579 5. Active Record and Individual Notebook (All About Me book) for Individuals #154 and #449, and Active Record for Individual #367 6. A list of all therapy and/or clinical staff (OT, PT, SLP, RD, AT), and Physical and Nutritional Management team (PNMT) members, including credentials 7. A list of continuing education sessions or activities participated in by PNMT members since last review (7/2011) 8. Minutes, including documentation of attendance, for the PNMT meetings for the past 6 months 9. Individual PNMT reports as available for individuals reviewed above 10. Tools used to screen and identify individuals' PNM health risk level 11. Most recent PNM screening documents and results for all individuals sorted by home and in alphabetical order 12. Tools used to assess PNM status and needs 13. A list of PNM assessments and updates completed in the last two (2) quarters 14. PSPs for the sample individuals 15. Completed Physical Nutritional Management Plans (PNMPs) for all sample individuals 16. Tools used to monitor implementation of PNM procedures and plans 17. A list of individuals for whom PNM monitoring tools were completed in the last quarter 18. Tools utilized for validation of PNM monitoring 19. For the past two quarters, any data or trend summaries used by the Facility related to PNM, and/or related quality assurance/enhancements reports, including subsequent corrective action plans 20. Dining Plan template 21. PNM spreadsheets generated by the Facility 22. 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 July 2011, who have had unplanned weight loss of 10% or greater over six (6) months;
f. During the past 6 months, have had a choking incident;
g. During the past 6 months, have had a pneumonia incident;
h. During the past 6 months, have had skin breakdown;
i. During the past 6 months, have had a fall;
j. During the past 6 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

23. List of individuals who have received a videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation since the last review
24. Curricula on PNM used to train staff responsible for directly assisting individuals, including training materials
25. Tools and checklists used to provide competency-based training addressing:
    a. Foundational skills in PNM; and
    b. Individual PNM and Dining Plans
26. 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 Childress (1), Driscoll (2), Bowie (2), and Program Services (5)

Meeting Attended/Observations:

1. Daily activities on Driscoll, Fannin, Childress, and Program Services
2. Mealtimes on Driscoll, Fannin, and Program Services
3. PNMT meeting 1/17/12
4. Medication Administration (Program Services-12 pm 1/19/2012)
5. IDT meeting for Individual #547

Facility Self-Assessment:

In the BSSLC Plan of Improvement, updated 12/30/2011, the Facility indicated it was in noncompliance with Provisions O.2, O.3, O.4, O.5, O.6 and O.8 and in compliance with Provisions O.1, and O.7. This was inconsistent with the Monitoring Team's findings as all provisions were found to be noncompliant. BSSLC stated that Provision O.1 was in compliance due to the presence of a PNMT which the Monitoring Team agrees was present; however, Provision O.1 also includes review and development of the PNMP, which were found to be not in compliance. Therefore Provision O.1 was noncompliant with the Settlement Agreement. Provision 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 and analysis of acquired data. A

	change in self assessment status was noted regarding Provision O.8. The Previous POI stated compliance with Provision O.8 which differs from the determination of noncompliance with this review. The POI 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. Great strides had been made which included the appropriate membership and participation of all relevant disciplines, and implementation of a localized policy outlining the roles and responsibilities of the PNMT. There was still no evidence that data were collected and the IDT or PNM team was reviewing this data to better identify system issues or respond to recurrent issues on a regular basis. Additionally, this provision is an overarching 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 risk process continued to improve in its ability to identify those individuals who are at increased risk, individuals were not provided with a comprehensive assessment by the PNM team or IDT in response to a change in status. **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. Per the HT

	director, BSSLC's goal was that this would be in place by the next visit. **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. Seventy-five percent 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. Positives include a revised PNMP format that will provide more information regarding areas of risk as well as listing relevant triggers. Another positive was that the PNMPs included detailed information regarding adaptive equipment, bathing/showering positioning, transfer information, mealtime strategies as well as communication strategies. Additionally, to help improve critical thinking and to assist the IDT in improving reliability of risk, BSSLC developed a guideline that directed the team towards improved risk identification. Included in the guideline were questions the team should ask themselves when assigning risk. An example of questions included: • Does the person have any positional requirements post meal? • Does the bed need to be elevated?

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The	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 • Coye Hoth RD • Marissa Rudloff OT • Kristi Wanner RN	Noncompliance

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	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.	PNM Team (PNMT) attendance records and meeting minutes from 07/08/2011 to 12/6/2011 documented the following attendance numbers. • SLP attended 21 of 21 meetings • OT attended 20 of 21 meetings • PT attended 19 of 21 meetings • RN attended 19 of 21 meetings • RD attended 15 of 21 meetings The makeup of the PNMT is in compliance with standards set forth by the Settlement Agreement. 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 IDT. 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 review of 100% of individuals hospitalized with aspiration pneumonia, three of four individuals were discussed at the PNMT but there was a lack of detailed discussion regarding the onset of the event as well as details regarding steps to mitigate future risk. For example: • Individual #318 was diagnosed with aspiration pneumonia on 11/19/11. PNMT minutes indicated that the person was observed twice for positioning but there was no further discussion or information. • Individual #291 was diagnosed with aspiration pneumonia on 7/11/11. The PNMT minutes state that the IDT plan has sufficient supports but does not provide any information regarding what these supports are and what was reviewed post hospitalization. There was still not a QA component to the PNMT in which data relevant to physical and nutritional supports are reviewed and analyzed by the team. Reviewing and identifying trends and the root cause of these trends will allow the PNMT to streamline and pinpoint trainings and/or assessments in an effort to prevent future occurrences, 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.	

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		PNMPs were not clearly developed with input from all members of the IDT or reviewed consistently by the IDT. 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.	Individuals for sample #1 were chosen from the list of individuals who were diagnosed with an aspiration and/or choking event over the past 6 months. The sample consisted of four individuals who accounted for 100% of the individuals who experienced such an event. Individuals for sample #2 were chosen from a list provided by BSSLC of individuals who were identified as being at a high risk of aspiration and/or choking. The sample was chosen by choosing fifth name on the high risk aspiration list and every other name on the high risk choking list. This accounted for a 20% sample of individuals who were at a high risk of aspiration and a 50% sample of individuals who were at a high risk of choking. Sample #3 consisted of 10 individuals or 20% of the individuals at BSSLC who received enteral nutrition. The sample was chosen by selecting every fifth individual on the enteral nutrition list provided by BSSLC. Based on a review of sample #1 #2, and #4, 10 of 17 (58%) records reviewed accurately identified individuals who are at an increased risk of physical and/or nutritional decline. Examples of the individual not being appropriately identified include: • Individual #318 was identified as being at a "medium risk" of aspiration but per guidelines should have been listed as a "high risk." The IDT has the ability to lower the risk; however, there was no evidence of the rationale behind the lower risk score. • Individual #403 was listed as a medium risk of falls but per guidelines should have been listed as high due to the number of falls resulting in serious injury. • Individual #547 was listed as a medium risk of choking and aspiration although there was a history of eating unsafe food items and having a severely impaired swallowing function secondary to an absent epiglottis. More information regarding this individual will be listed under O.3. To help improve critical thinking and to assist the IDT in improving reliability of risk, BSSLC developed an additional guideline that directed the team towards improved risk identification. Included in the guideline were questions the team should ask themselves when assigning risk. An example of questions included: • Does the person have any positional requirements post meal? • Does the bed need to be elevated?	Noncompliance

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		These additional guidelines had only been in place for a limited time so the Monitoring Team was unable to gauge the effectiveness of thee guidelines in improving the identification of risk. Another concern regarding risk identification was the lack of team responsibility regarding the assignment of risk. The Monitoring Team was told that risk categories completed prior to November were not consistently accurate but there was no process in place to revisit these individuals until their annual ISP review. An example was Individual #425 who had a diagnosis of pica and was observed multiple times during meals grabbing items that were not in agreement with his recommended texture and shoving the grabbed food item in his mouth to prevent retrieval from staff. The IDT was aware of this behavior but there was no attempt to revisit the risk rating. Based on a review of 12 individuals' OT/PT assessments (sample #1 and #2), nine of 12 (75%) individuals were provided with an annual assessment or update by the PNM team or IDT that contained general information on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning during the course of the day and during nutritional intake. While many assessments contained the listed components, they contained a lack of root cause analysis as well as a lack of comparative analysis. The oral motor section of the assessments continued to show 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 #557's OT/PT assessment stated the person had poor lateral tongue functionality but did not provide information on how this impacted the swallow. • Individual #303's OT/PT assessment stated that range of motion was limited but did not provide information as to the functional impact or provide objective measurable information regarding swallow function. The lack of comparative analysis and root cause analysis resulted in difficulty determining the effectiveness of the interventions or whether the individual improved or regressed since the last assessment. Zero out of four (0%) Sample #1 individuals who were diagnosed with a PNM issue were assessed by the PNMT or IDT. For example: • Individual #30 was diagnosed with bacterial pneumonia on 9/8/11 and aspiration pneumonia on 11/29/11 with no evidence of detailed discussion or assessment by the PNMT. The IDT conducted a risk screening on 12/14/11 but there was no evidence of discussion regarding etiology of the event.	

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		• Individual #291 had aspiration pneumonia on 7/11/11 with no evidence of discussion or assessment by the PNMT or IDT. • Individual #318 had aspiration pneumonia on 11/19/11 with no evidence of discussion or assessment by the PNMT or IDT. The IDT conducted a risk screening on 12/14/11 but there was no evidence of discussion regarding etiology of the event or need for additional assessment. Many times, the event would be discussed but there was a lack of investigation as to what precipitated and potentially caused the event. Another issue was regarding the inconsistency in which the Aspiration Trigger data Sheets were completed. Please refer to Provision O.6 for details regarding lack of aspiration trigger notification.	
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 remained vague at times and was lacking the detail needed to ensure safe consistent delivery of service. This included lack of information regarding staff positioning and texture or consistency of liquids or medications. Another issue noted with the PNMPs was the inconsistency within the document regarding positioning. On multiple occasions, the PNMP stated two different positions for the same activity without clarification regarding which position was correct. Based on a review of an identified sample of 22 individual records (Sample #1, #2 and #3), individuals were not provided with a comprehensive PNMP as evidenced by: • In ten of 22 records reviewed (45%) comprehensive strategies for medication administration were included. • In zero of 22 records reviewed (0%) positioning recommendations were consistent within the plan. • In six of 22 records reviewed (27%) comprehensive strategies for oral hygiene were included. • In two of 22 records reviewed (9%) personal care instructions and the need for HOB elevation were included. Examples of individuals who were not provided with a comprehensive PNMP included: • Individual #318's PNMP stated that head of bed (HOB) should be elevated during enteral feedings under the positioning section but under the dining section stated that the individual should be upright. This was a pervasive issue. • Individual #30 oral care section of the PNMP simply stated the position for oral	Noncompliance

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		care but not other information relevant to safe oral care. (i.e., staff positioning). Additionally, the medication administration section of the PNMP lacked information regarding staff positioning, presentation techniques, and detailed information regarding the need for adaptive equipment. Again, this was a pervasive issue. Per observation of medication administration Program Services on Jan 19, 2012 at 12 pm, nursing was unsure regarding techniques listed on the PNMP. Strategies were vague at times and nursing was unsure as to the purpose of the strategy. Examples included: • Nurse not providing a small-bowled spoon to administer medication • Nurses unsure as to what hyperextension looks like with some who is kyphotic or has severe curvature of the spine. Positives noted through review of the same 22 PNMPs included: • In 22 of 22 records reviewed (100%) individual adaptive equipment was included. • In 22 of 22 records reviewed (100%) bathing/showering positioning and instructions were included. • In 22 of 22 records reviewed (100%) positioning instructions for wheelchair and/or alternate positions instructions were included. • In 22 of 22 records reviewed (100%) transfer instructions were included. • In 22 of 22 records reviewed (100%) the mealtime/dining plan included intake strategies for mealtime and snacks • In 22 of 22 records reviewed (100%) the mealtime/dining plan included diet consistency. • In 17of 22 records reviewed (77%) positioning of individual during medication administration and oral care were included. • In 22 of 22 records reviewed (100%) communication strategies to enhance PNM services were included. Another positive noted was that BSSLC was in the process of revising the PNMPs to include more information regarding oral care and medication administration as well as adding information pertaining to risk and triggers. Per report of the Habilitation Director, the new PNMPs will be completed by December 2012 as the new format was being rolled out in coordination with the annual assessment. Based on a review of an identified sample of 22 individual records (Samples #1, #2, and #3) PNMPs were not formally developed with input from the team. In zero of 22 records reviewed (0%), PNMPs were clearly developed with input from the IDT with an	

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		emphasis on DCPs, medical/nursing staff, and behavioral staff (if appropriate). Per record review, there was evidence in the ISPs 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 #30, #291 and #126. In 22 of 22 records reviewed (100%), there was documentation in the ISP 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 IDT but were updated by Habilitation Therapies as indicated by a change in the person's status or as dictated by monitoring results. In zero of four records reviewed (0%) (Sample #1), PNMPs were reviewed by the IDT as indicated by a change in the individual's status. Examples of when PNMPs were not reviewed by the IDT as indicated by a change in the individual's status or as dictated by monitoring results. • Individual #30 was diagnosed with bacterial pneumonia on 9/8/11 and aspiration pneumonia on 11/29/11 with no evidence of detailed discussion or assessment by the PNMT. The IDT conducted a risk screening on 12/14/11 but there was no evidence of discussion regarding etiology of the event. • Individual #291 had aspiration pneumonia on 7/11/11 with no evidence of discussion or assessment by the PNMT or IDT. • Individual #318 had aspiration pneumonia on 11/19/11 with no evidence of discussion or assessment by the PNMT or IDT. The IDT conducted a risk screening on 12/14/11 but there was no evidence of discussion regarding etiology of the event or need for additional assessment. A concern noted by the Monitoring Team regarded Individual #547. Individual #547 had a modified barium swallow study completed on March 23, 2011 that identified that the individual had an absent epiglottis and was at a severe risk of aspiration. Among the recommendations included alternating liquids and solids and ensuring that multiple swallows were provided with each bite secondary to severe pharyngeal residue. On March 30, 2011, the PNMP was revised to include this information (this represented a seven day delay). On March 31, 2011, an OT/PT assessment was provided that contained a brief statement that the strategies at times aggravated the individual. No recommendations were provided to address this statement. On April 6, 2011, a revised PNMP was provided that did not contain any of the strategies that were recommended through the process of the MBSS. There was no evidence of why this change occurred and no evidence of the team discussing this significant change. This change placed the	

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		individual at a much higher risk of aspiration, risk that could have been reduced by following the recommended strategies. On January 18, 2012, the individual was diagnosed with pneumonia. This is an example of the dangers involved when the team does not come together to discuss and share their expertise regarding cases. When questioned as to why all the strategies were removed, the IDT did not appear to be knowledgeable of the occurrence or as to the reason this would have been done. Head of Bed Assessment is an area that has just begun to be implemented at BSSLC. Based on a review of the two that were reviewed, BSSLC is on the right path in this area but has many assessments that have yet to be completed. At the time of the review, 116 individuals required their beds to be elevated but only nine of the 116 had received an assessment. Per report, the HT director stated that the assessments were only conducted when there was a significant event (i.e., aspiration pneumonia). It is imperative that the assessments are proactively provided at a minimum to those individuals who are at an increased risk of aspiration. Waiting until an issue arises is a reactive approach and puts individuals at an unnecessary increased risk of aspiration.	
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 IDT 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. Forty-five observations (19-positioning and 26 dining) 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 ten of 26 (38%) observations, staff were following mealtime plans. • In eight of 19 (42%) observations staff were following positioning instructions. • In three of three (100%)observations staff were following transfer instructions, Examples of where staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan included: • Individual #449 was not provided with cues to alternate liquids and solids and was observed receiving thin liquids when the plan called for nectar. • Individuals #25, #595, and #472 were observed taking large bites when the plans called for small bites.	Noncompliance

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		• Individual #303 was observed with no pillows behind his head, slumped forward with no pillow under his knees or elbows. This resulted in his knees being retracted, potentially increasing the risk reflux secondary to increased abdominal compression. • Individual #138 was observed with no pillow between her rib cage and pelvis as defined in the PNMP to help reduce skin breakdown. • Individual #87 was observed poorly positioned as evidenced by significantly leaning to the right as a result of inadequate support. 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. Additionally, staff were not observed reading the plan prior to the meal. Based on interviews with direct support professionals: • In five of ten (50%) interviews with staff, they were able to identify the location of PNMP and/or mealtime plan. • In five of ten (50%) interviews with staff, they could describe individual-specific PNMP strategies. • In four of ten (40%) interviews with staff, they could describe the schedule for implementation of PNMP strategies. • In six of ten (60%) interviews with staff, they stated they had received training for PNMP strategies. • In four of ten (40%) interviews with staff, they could describe the intent of the aspiration trigger process and the DCP's role in its implementation. Individuals in the front dining room being assisted by school employees were at an increased risk of harm secondary to lack of knowledge regarding the dining plans and lack of implementation. Examples of lack of implementation included: • Individual #417 was not provided with a youth spoon or plate guard. • Individual # 511 was observed with poor posture (leaning over food), and chugging liquids without intervention by staff. The integration of strategies developed by BSSLC must be done in a more detailed manner to insure adequate implementation and knowledge of staff working with the individuals. Dining plans and PNMPs should be trained and implemented by all staff.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that	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. Staff who are found to be	Noncompliance

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	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.	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. 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. Training rosters will be available on the homes, and it will be the responsibility of the home leader to ensure that only staff who have received individualized training be allowed to work with individuals who have individualized techniques. As of this review, this process has not been formally implemented and therefore will need to be reviewed at the next compliance visit. Per observation of the medication administration at Program Services, nursing was still in need of additional training regarding dysphagia and its impact on administration of medication. Nursing was unaware of how certain strategies (i.e., lift the handle of	

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		spoon) can contribute to improper head positioning and thus increase the risk of aspiration.	
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 PNMP policy was revised to include the frequency of the monitors for individuals at risk as well as the areas in which the monitors were expected to be completed (i.e., bath, meal, oral care). This creation of this policy was a positive step and per review of the monitoring data, individuals who were at an increased risk did receive increased monitoring. Issues included monitoring results not being utilized in a manner to help drive future services and/or training and lack of accuracy. 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. The monitoring policy 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, there was a lack of data acquisition and analysis regarding the completion of the monitoring forms. Another concern noted with the monitoring was the accuracy of the monitors. On 1/17/11, the Monitoring Team was observing a mealtime on Program Services D. A PNMP coordinator (PMMPC) was monitoring at the same time. Per review of the monitoring form completed by the PNMPC, there were discrepancies between the PNMPC and Monitoring Team. For example: • Individual #472 was observed eating fast and taking large bites without staff cueing. The PNMPC stated that the activity was completed at a safe rate. A review of Facility monitoring reports from 10/2011 to 12/2011 documented that staff and individuals were not being monitored in all aspects in which the individual was determined to be at increased risk. Per review of ten individuals who were identified as	Noncompliance

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		being at a high risk (sample #2): o 119 of 204 (74%) monitoring forms focused on oral intake (meals and snacks) o 14 of 204 (6%) monitoring forms focused on bathing o 0 of 204 (0%) monitoring forms focused on medication administration o 32 of 204 (15%) monitoring forms focused on Oral Care. There was a formal process in place that stated individuals with increased PNM issues were provided with increased monitoring; however, based on the gathered sample, monitoring of meals still was disproportionally high as the PNMP policy called for 25% monitoring of all areas of risk (meals, snacks, bathing, etc.) The risk process did include a monitoring component where the IDT 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. Due to this informality, it was unclear as to who was responsible for what monitoring area (i.e., meal, bathing, snack, oral care). The frequency of monitors appear to be 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 and medication administration to ensure proper technique and consistency of care. While the PNM status was scheduled to be regularly reviewed during the IDT 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 • Triggers were often monitored for multiple days without evidence of referral to Habilitation Therapies to assist with determining the etiology of the trigger.	

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		Examples of the trigger issues were: • Individual #318 had five triggers occurring on 12/17/11 (coughing) but there was no documentation in the observation detailing the event and there was no evidence of nursing notification. • Individual #411 had multiple triggers occurring on 9/8/11 and 11/7/11 with no evidence of nursing notification. The Monitoring Team reviewed the Active Record and Individual Notebook (All About Me book) for Individuals #154 and #449, and Active Record for Individual #367. The Active Record Audit table of contents for both the Individual Notebook and the Active Record (revision dated 11/17/11) included the Aspiration Triggers Data Sheet. Aspiration Trigger Data Sheets were not found in any of these records. However, the revised table of contents for these records had not been implemented yet (per interview with Unified Records Coordinators and the Director of Quality Assurance), so it is possible that these sheets were not yet expected to be found in these records. The Monitoring Team will look for the presence of these sheets at the next compliance visit.	
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 IDT 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 ISP annual planning meeting, 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 risk and using that data to drive the further individualization of triggers or provision of care. Issues with the current trigger process were described in Provision O.6. 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 (i.e., eating and positioning strategies) to address issues related to an increased risk for an individual were effective. There was no detailed comparative analysis of data or assessment findings. Outcomes were reviewed through the risk process but effectiveness of strategies was not. There was no system in place that allowed for the overall tracking and trending of the monitoring data. A system did accumulate the data but did not provide information	Noncompliance

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		regarding the difference between effectiveness of the plans and staff implementation of the plans. For example, a "no" response may indicate that the individual required cues to perform a strategy or it could mean that staff was cued to carry out a strategy. Due to this inability to discern between the two, the data are not reliable in determining effectiveness or implementation. Per report of the HT director, a new monitoring process is set to roll out next month that is designed to address this issue and therefore will need to be reviewed at the next compliance visit.	
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.	There were approximately 52 individuals listed as receiving enteral nutrition. The Monitoring Team requested enteral evaluations for individuals in the sample. The following section was based on a sample gathered from individuals who received enteral nutrition (Sample 3). Ten 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 IDT. 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 ten individuals (sample 3), no individuals had received the interdisciplinary enteral nutrition assessment provided by the State. All ten 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. 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.	Noncompliance

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		All individuals were provided a PNMP and Dining Plan; these elements would likely also 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. The need for continued enteral nutrition was not integrated into the PSP. Based on a review of ten individuals' PSPs, zero of ten (0 %) (Sample #3) who received enteral nutrition, the individual's PSP clearly documented the rationale for the continued need for enteral nutrition.	

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

1. Integrate into the PNMT process a method for data analyses and review. (Provision O.1)
2. Aspiration Pneumonia/Enteral Nutrition Evaluation should be expanded to focus on root cause of incident and do a better job providing assessment of the situation rather than just recalling the event and the current plan of care (Provision O.3).
3. Medication administration, Oral Care, and Head of Bed elevation should be expanded to include information regarding number of pills the individual can tolerate at a time, strategies to assist with oral care, and degree level of head of bed elevation. Habilitation Therapies and Nursing should collaborate to determine the safest method for individuals to receive medication administration. (Provision O.3)
4. Per report, the HT director stated that the Head of Bed assessments were only conducted when there was a significant event (i.e., aspiration pneumonia). It is imperative that the assessments are proactively provided at a minimum to those individuals who are at an increased risk of aspiration. (Provision O.3)
5. BSSLC should take an intensive look at the use of recliners for alternate positioning and identify other options for alternate positioning or develop a better system to ensure that individuals are appropriately positioned. (Provision O.4)
6. Nursing and Habilitation Therapies would benefit from increased collaboration and training as it relates to the safe administration of medications. Areas covered should include correct staff and individual positioning, presentation techniques, and safe wash down techniques. (Provision O.5)
7. Criteria should be established regarding when to contact Habilitation Therapies to assist with assessing and determining the potential etiology of occurring triggers.(Provision O.6)
8. Development of a system to track the occurrence and nonoccurrence of triggers should be developed to allow for the team to determine the effectiveness of the PNM interventions. (Provision O.7)
9. 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. (Provision O.8)
10. Aspiration Pneumonia/Enteral Nutrition Evaluations should evaluate the potential for moving an individual to a less restrictive form of receiving enteral nutrition. (Provision 0.8)

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 12/30/2011 2. BSSLC Presentation Book 12/30/11 3. Record Reviews: • Sample 1: Individuals #5, #30, #291, and #318 • Sample 2: Individuals #33, #163, #303, #403, #411, #536, #570, and #575 • Sample 3: Individuals #26, #53, #54, #86, #88, #126, #231, #303, #392, and #567 • Sample 4: Individuals #7, #195, #250, #403, #497, and #579 • Sample 5: Individuals #56, #133, #181, #249, #513, #478, #56, #576, and #579 • Sample 6: Individuals #130, #308, and #367 4. BSSLC Occupational/Physical Therapy Services Policy 11/14/11 5. BSSLC PNMP Policy 11/14/11 6. 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. 7. PNM maintenance Logs (July2011-present) 8. OT/PT assessments template 9. Wheelchair seating, PNM clinic assessment templates and related documentation OT/PT-related spreadsheets. 10. 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. 11. 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 Childress (1), Driscoll (2), Bowie (2), and Program Services (5) **Meeting Attended/Observations:** 1. Daily activities on Driscoll, Fannin, Childress, and Program Services 2. Mealtimes on Driscoll, Fannin, and Program Services 3. PNMT meeting 1/17/12 4. Medication Administration (Program Services-12 pm 1/19/2012) 5. IDT for Individual #547

	Facility Self-Assessment: BSSLC's self-assessment identified compliance with Provision P.1 and noncompliance with Provisions P.2, P.3 and P.4. The self-assessment was inconsistent with the Monitoring Team's assessment of noncompliance for each aspect of this provision. Provision P.1 was found to be not in compliance secondary to lack of assessment post a significant change in status as well as the assessment not being comprehensive. The POI contained completion dates for accomplishments but did not clearly link these accomplishments back to the provisions and provide information regarding the remaining barriers or issues that needed to be resolved in order to obtain compliance. Areas of improvement noted by BSSLC include: • Expansion of the OT/PT assessment to focus more on the identified Habilitation-related risks. • Creation of a data base for the monitoring
	Summary of Monitor's Assessment: **Provision P.1:** This provision was determined to be not in compliance. BSSLC has open positions for PT and 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 ISP. **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 BSSLC 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 issue with the process was that while data system collected data, it was not aggregated in a way that

	allowed productive trending and analysis. See Provision O.7 for more information. Additionally, the occurrence of the monitoring did not consistently follow facility policy. Positives included an improved OT/PT assessment format that focuses more on the areas of risk and what interventions are in place to mitigate the risk. Other positives included: • Timely completion of annual assessments • Improved monitoring process • Evidence of communication and or collaboration in the OT/PT assessments.

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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 four Occupational Therapists, one Certified Occupational Therapy Assistants, 3.2 Physical Therapists and one Physical Therapy Assistant (PTA). There are openings for one OTs, 1.2 openings for PTs, and one opening for a PTA. With the current staffing, ratios for Occupational Therapy were 1:77 and PTs 1:96. 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. Sample 4 was gathered from choosing every fourth individual listed on BSSLC's high risk for falls list. Sample 5 consisted of eight individuals (100%) who experienced the highest number of falls over the past 6 months.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Sample 6 consisted of three individuals (100%) who were admitted since the last compliance review. All individuals had received an OT/PT assessment. If newly admitted, this occurred within 30 days of admission (Sample #6). The assessments submitted were completed by both OT and PT. Assessments indicated whether or not the individuals (samples #1, #2, #3, #4, #5, and #6) required OT/PT supports and services for 40 of 40 (100%) records reviewed. The OT/PT assessment contained sections that covered movement, mobility, range of motion and independence, but 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: • There was no discussion of potential for skill acquisition in areas such as eating, ADLs, fine motor function, and positioning. • 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. Examples of lack of comparative analysis included: • Individual #133 OT/PT assessment stated that the individual's ambulation has been declining for years but there was no evidence in the assessment to explain why this had occurred or the degree in which it had declined in the past year. Lack of comparative analysis and objective measurements were especially noted with the OT/PT updates. Another concern was how findings of an assessment would drastically change in such a short time span and when a specific consult was made by the IDT. Multiple records reviewed from Sample #4 contained recommendations to continue with current plan of care with issues such as gait or diet texture. Upon review of the assessments at the IDT, the IDT requested another assessment with the findings representing a different recommendation without evidence of a change of status. For example: • Individual #403's OT/PT assessment on 7/13/11 stated the gait was unchanged and no supports were needed. Another assessment completed on 12/21/11 stated that one leg was shorter and the individual required a lift in	

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		their shoe. Due to the extent of the injury (fractured leg), part of the assessment should have focused on the leg as well as all facets (gait, leg length) that would potentially be impacted by such an injury. • Individual #7's oral assessment on 6/24/11 stated that a ground texture was appropriate for safe dining. On 7/27/11, at the request of the IDT, another assessment was done and stated that a chopped texture was sufficient. An individual's swallow would not improve spontaneously on its own without direct treatment or in the case of spontaneous recovery post stroke. In this case, neither incident occurred. Per report, the reason behind the change in status was that his dentures were properly fitted for the second assessment but there was no evidence of this being documented. The significant change in recommendations without a significant change in status draws into question the aggressiveness and comprehensiveness of the OT/PT updates and their ability to identify potential decline in a proactive manner. Per interview with the Habilitation director, reports of conversations were provided to explain the changes but none of the explanations were clearly documented in the record. Forty of the 40 (100%) assessments (Sample #1, #2, #3, #4, #5, #6) reviewed contained medical issues and health risk indicators but only two of 40 (5%) consistently provided 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 #291 and #303's OT/PT assessment contained a diagnosis list but did not provide information or links to how these diagnoses impacted the level of care. This issue was noted by BSSLC and a new OT/PT assessment was developed and implemented as of July 2011. Based on review of the records (sample 6), the new format is much improved and provided for more information regarding risk. Due to the limited sample of newly formatted assessments, more review will be needed to ensure this information is provided consistently. Evidence of communication and or collaboration was present in the OT/PT assessments. Based on review of 40 OT/PT assessments, 100% included signatures and date of both OT and PT. Based on review of 40 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. Three of three individuals (new	

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		admissions-sample #6) had received an OT/PT assessment. For individuals receiving services (Sample #1, #2, #3, #4, #5, #6) the individual was provided an OT and/or PT assessment every 3 years, with annual interim updates or as indicated by a change in status. 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 IDT 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 #30 was diagnosed with bacterial pneumonia on 9/8/11 and aspiration pneumonia on 11/29/11 with no evidence of detailed discussion or assessment by the PNMT. The IDT conducted a risk screening on 12/14/11 but there was no evidence of discussion regarding etiology of the event. • Individual #291 had aspiration pneumonia on 7/11/11 with no evidence of discussion or assessment by the PNMT or IDT. • Individual #318 had aspiration pneumonia on 11/19/11 with no evidence of discussion or assessment by the PNMT or IDT. The IDT conducted a risk screening on 12/14/11 but there was no evidence of discussion regarding etiology of the event or need for additional assessment.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable	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 findings in the comprehensive OT/PT assessment or update with analysis to justify specific strategies. The problem was that objective measurable data was lacking. See above in Provision P.1 for examples. Based on reviews of PNMPs and other positioning plans for 40 individuals (Sample #1, #2, #3, #4, #5, #6) equipment was specified for 39 of 40 (97%) plans reviewed. Within 30 days of the annual ISP, or sooner as required for health or safety, a plan was developed as part of the ISP but was not consistently reviewed by the IDT. Plans were generally limited to the PNMP that was reviewed at the time of the annual ISP 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 IDT	Noncompliance

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	outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	related to program changes or changes in status. For example: • Individuals #87 and #575 had their PNMPs updated in response to a change in status but there was no evidence of IDT review or discussion of these changes. Other than the evidence of direct intervention, the primary support provided was via the PNMPs. PNMPs and Special Program Objectives (SPOs) 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 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 40 individuals (Sample #1, #2, #3, #4, #5, #6) the rationale for the plans were clearly stated in the OT/PT assessment or update for 40 of 40 (100%) plans reviewed. Assessments clearly stated that the PNMPs should be followed as well as stating the function of the device. This has continued to improve with each review. Based on reviews of PNMPs and other positioning plans for 40 individuals, equipment was specified and identified for 38 of 40 (95%) plans as indicated; however, the rationale for the provided equipment was not consistently present on the PNMPs. Staff did not consistently implement interventions and recommendations outlined in the PNMP and/or Dining Plan. Forty-five observations (19-positioning and 26 dining) 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 ten of 26 (38%) observations, staff were following mealtime plans. • In eight of 19 (42%) observations staff were following positioning instructions. • In three of three (100%)observations staff were following transfer instructions.	

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		Examples of where staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan included: o Individual #449 was not provided with cues to alternate liquids and solids and was observed receiving thin liquids when the plan called for nectar. o Individuals #25, #595, and #472 were observed taking large bites when the plans called for small bites. o Individual #303 was observed with no pillows behind his head, slumped forward with no pillow under his knees or elbows. This resulted in his knees being retracted potentially increasing the risk reflux secondary to increased abdominal compression. o Individual #138 was observed with no pillow between her rib cage and pelvis as defined in the PNMP to help reduce skin breakdown o Individual #87 was observed poorly positioned as evidenced by significantly leaning to the right as a result of inadequate support. BSSLC utilized recliners as a primary method of alternate positioning. The problem is that it is extremely difficult to establish and maintain an appropriate position in a recliner due to the overall lack of support. When staff were asked about the lack of pillows or supports, the overwhelming response was that pillows were not available to them.	
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.	Adaptive equipment generally was available but 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 four of four (100%) individuals reviewed in the sample (sample 1). 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 ten (50%) interviews with staff, staff were able to identify the location of OT/PT plans.	Noncompliance

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		o In five of ten (50%) interviews with staff , staff could describe individual-specific OT/PT strategies. o In four of ten (40%) interviews with staff, staff could describe the schedule for implementation of OT/PT strategies. o In five of ten (50%) interviews with staff, staff stated they had received specific training for OT/PT strategies.	
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	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 with the individuals. This includes pulled and relief staff (Refer to Section O-5). A policy/protocol addressing the monitoring process did exist and provided information regarding frequency of monitors and staff responsible. This was an improvement since the previous visit. Based on review of the BSSLC PNMP policy, a system was 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 The issue with the process was that while data system collected data, it was not aggregated in a way that allowed productive trending and analysis. See Policy O.7 for more information. Additionally, the occurrence of the monitoring did not consistently follow their own policy. 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. As mentioned in P.2 and P.3, the increased training and monitoring did not	Noncompliance

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		translate into increased implementation and knowledge of interviewed staff.	

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

1. Changes in status should trigger an automatic OT/PT assessment or review if related to area of practice (e.g., fecal impaction, skin breakdown, falls, aspiration, pneumonia, and choking, and/or neurological event). The action taken by OT/PT should be clearly documented and followed to resolution. Observations are not assessments and do not provide the needed objective data to allow for comparative analysis or to appropriately direct services. (Provision P.1)
2. The areas of activity tolerance, ADLs, and balance should be addressed consistently and in a comprehensive manner. Information should be measurable to allow for comparative analysis from year to year. If there are strategies listed on the PNMP then there should be an assessment indicating why the strategies listed were appropriate and the method for determining these strategies. (Provision P.1)
3. BSSLC should take an intensive look at the use of recliners for alternate positioning and identify other options for alternate positioning or develop a better system to ensure that individuals are appropriately positioned. (Provision P.2)
4. 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 P.4)
5. A data system should be developed that allows for data analysis and trending. While data is gathered, it was not gathered in a manner that lended itself to identifying issues facility wide and utilizing that information to drive future training or services. (Section P.4)

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: **Documents Reviewed**: 1. Client Services/Medical Services/Dental Policy, undated, not numbered 2. Print out of dental calendar from June 27, 2011 through January 29, 2012. 3. List of "other reasons for missed appointments for past six months", dated 1/23/12 4. List of "missed dental appointments for past six months", dated 1/23/12 5. BSSLC Annual Exam and Recall Tracker 6. Dental Records for Individuals #441, #7, #86, #59, and #305 7. Initial Dental Assessment and Dental Reports for Individuals #462, #367, #130, and #308 8. Annual Exam and Recall Tracking Spreadsheet, undated 9. All Quarterly Dental Audits 10. List of "Missed Dental Appointments for Past Six Months" 11. Pre-sedation, and Post-sedation forms 12. Presentation Book, January 2012 13. POI, December 30, 2012 **People Interviewed:** 1. Jennifer Nguyen, DDS **(**Dental Director), Deanna Otts, RDH, and Russell Reddell (State Office Dental Coordinator) **Meeting Attended/Observations:** 1. Oral hygiene observations at Childress of Individuals: #486, #242, #65, #233, #165, #7, and #221
	Facility Self-Assessment: The Facility provided a self-assessment in the Plan of Improvement (POI). The POI did not provide details as to the Facility's self-assessment processes, but rather listed many actions the Facility had taken beginning in August, 2010 and including actions since the last compliance visit. However, the basis for rating of compliance was not clearly stated for any provision. The Facility does have, and should use, information, including data, that could be useful in assessing and reporting status of compliance. The Facility reports hiring a new dental director just prior to the last compliance visit, who will oversee the Settlement Agreement process for Dental Services. The Facility reports noncompliance with Provision Q.1, and Q.2; however, it reports enhancements in many areas, including improving the Annual Dental Assessment form, conducting dental audits to ensure dental services are complete, working more collaboratively with the behavioral health department in developing a meaningful desensitization program, revision of the daily dental log to include more detailed information that can be used to assess behavioral issues and treatment needs, improved oral hygiene at the Facility, and hired a part time dentist to help ensure dental services are better provided. The Monitoring Team concurs with the Facilities self-assessment, and notes the marked improvements made in the interim since the last compliance visit.
	Summary of Monitor's Assessment: The Monitoring Team has recognized a complete reorganization of the Facility's Dental Department, which

	now has a new Director. Unlike previous reviews, dental services are now moving forward towards developing meaningful processes that, if implemented, will help to ensure compliance. The Monitoring Team was delighted to see the dental office staff's enthusiasm and dedication while working towards compliance. The Monitoring Team is very pleased with the increased number of direct care hours provided by dentists, and progressive use of technology and programs, such as the procurement of a handheld mobile x-ray device, portable hygiene unit, and the development of home dental visits. Other enhancements include the development of a daily dental log, which notifies the living area of what dental services are required that day; and a biweekly oral hygiene monitoring program, where by the hygienist visits homes and monitors tooth brushing. The Monitoring Team would like to highlight the exceptional improvements noted in oral hygiene, and compliments the Dental Department's efforts to enhance oral hygiene practice at the living area. Importantly, the Monitoring Team would like to draw attention to the dedication and effort on the part of direct care staff, who are ensuring quality oral hygiene to individuals served by the Facility. The Monitoring Team recognizes that the Facility is behind where it should be, as does the Dental Director. Both parties, however, believe that given the department's new direction, compliance should be achieved. Q.1: At the time of this review, the Monitoring Team determined that the Facility is noncompliant with Provision Q.1. Compliance will require enhanced tracking of all dental services, continued improvements with oral hygiene efforts, ensuring that all dental supports and services are provided, as needed. Q.2: The Monitoring Team determined noncompliance for Provision Q.2. Compliance will require significant improvement of integrating dental services into the IDT process; enhance tracking of outcomes and adverse outcomes related to dental services; improve on the use of sedation, including TIVA; and address issues related to restraint and desensitization.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental	<u>Dental Services Staffing:</u> Since the last Monitoring Review, the Facility has hired a new Dental Director, who works four, 10-hour days per week. The Dental Director maintains a caseload and treats approximately 85% of the individuals residing at the Facility. The Facility also has a part-time Dentist who works two, ten-hours days per week, and treats approximately 15% of the individuals residing at the Facility. The Facility has only one dental assistant and two Hygienists, and there is no additional clerical support. The dental assistant does most of the clerical support. The Monitoring Team recognizes that each dental practitioner requires at least one dental assistant, in order to provide services. Some special dentistry offices require two dental assistants for each practitioner. The Monitoring Team strongly recommends that the Facility review its dental staffing plan, to ensure efficiencies and that staffing issues do not prevent timely dental treatments. <u>Dental Services Tracking:</u>	Noncompliance

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	disabilities shall satisfy these standards.	Since joining the Facility, the new Dental Director has reviewed the dental records of all individuals who reside at the Facility, and noted when their last examination occurred, what the recall interval is, date of last recall, and pending treatments. The Monitoring Team was provided with a copy of the Facility's Annual Exam and Recall Tracker spreadsheet, which was not dated. The document was not accompanied with an explanation key, and the Monitoring Team was unable to decipher the format of the tracking system. The Dental Director has initiated a process called "Dental Quarterly Audits", and had reviewed the dental records of each individual to determine if the records noted outstanding service needs. A summary of the audits was not provided and because of the scope of this, determination of the audit reports could not be verified by the Monitoring Team. The Dental Director, however, reported that the Facility is 97% current with all annual examinations, compared to 85% in August, 2011, and 87% current on dental cleaning, compared to 65% in August, 2011. Future reviews by the Monitoring Team will require a comprehensive understanding of all dental visits for the past six months, and all scheduled future appointments; type of treatment and procedures; x-rays obtained and required; specific types of restraint used, response to restraint, risk/benefits of the restraint, pre and post monitoring of restraints; level of cooperativeness of the individual for dental services; outcome of the dental visit; pending required dental services; level of oral hygiene; the need for desensitization or other intervention to reduce need for restraint required, provided, and response by the individual to the desensitization program. The Facility's Quality Assurance Initiatives for Dental Services will be reviewed in the Future. The Monitoring Team will also request data to ensure that individuals are being appropriately assessed for adverse outcomes following a dental procedure, including treatment for pneumonia that occurred within five days of a dental procedure, and traumatic injury occurring within 24 hours following a dental procedure. The Monitoring Team will also review the Facility's Quality Assurance Initiatives, including trends analysis (dental visits, adverse outcomes, <u>Dental Imaging:</u> The Monitoring Team did not assess the Facility' ability to provide necessary dental imaging for the individuals served. Future reviews will assess specific information and data to determine if all necessary x-rays have been obtained (scheduled and emergency x-rays), and if not what is the imaging status for each Individual. The Monitoring Team noted that the Facility has obtained a mobile x-ray unit that will enhance their effort to obtain necessary x-rays for Individuals who do not like to visit the dental office and my	

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		also reduce the need for the use of pre-treatment sedation for some individuals.. <u>Oral Hygiene:</u> The Monitoring Team reviewed Annual Dental Assessments on Individuals #441, #7, #86, #59, and #559. Of the six examples, one (16%), was noted to have poor oral hygiene; three (50%), indicated fair oral hygiene, and two (33%) had good oral hygiene. During observations at the living area, the Monitoring Team noted that five of five (100%) of the individuals observed were noted to have had their teeth brushed prior to bedtime. It is evident that the Dental Department's efforts to enhance oral hygiene are working. The Monitoring Team certainly compliments their effort and especially notes the accomplishment of direct care staff at the living area. <u>Dental Assessments For New Admissions:</u> The Monitoring Team requested the Initial Dental Examination Reports for individuals who were admitted to the Facility within the past six months, and date of their admission. Records for Individuals #462, #367, #130, and #308, were provided. The following is a summary of the four examples reviewed: Individual #367 The individual was admitted to the Facility on 10/11/11, and was examined by the dentist on 10/27/11. A treatment plan developed stating that tooth #29 required treatment was documented and noted that necessary x-rays were obtained. The Examination Report was not completely filled out. For example, in box 4, there was nothing indicated for management needs; if in fact no treatment is required, then NA should be delineated. The same issue was noted for box 10. Individual #308 The individual was admitted on 10/25/11, and evaluated by the dentist on 11/14/11. The exam was noted to be limited because x-rays were unable to be completed. A treatment plan was not documented. The Examination Report was not completely filled out. For example, in box 4, there was nothing indicated for management needs; if in fact no treatment is required, then NA should be delineated. The same issue was noted for box 10, and 11. Individual #130 The individual was admitted on 6/29/11, and evaluated by the dentist on 7/14/11. Behavior classification was determined to be "4"; however, no behavior management needs were documented and noted on the examination report. Treatment was provided, which included filling two teeth. Box 9, of the examination report was not completed; hence, x-ray needs were not made aware.	

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		Individual #460 The individual was admitted to the Facility on 1/3/12, and was scheduled for initial dental evaluation on 1/24/12. Review of treatment for newly admitted Individuals verified the dental office arranged an initial assessment within 30 days (which is within an acceptable time period) in four of the four examples provided (100%). <u>Annual Dental Exam & Assessment:</u> Nine Annual Dental Examinations and Assessments were provided for review, as part of a document request (Individuals #61, #335, #446, #599, #59, #86, #411, 7, and #305). Assessments for Individuals #61, #335, and #446 were dated prior to this review period six-month interval, so were not included in this sample. The following is a summary of the Monitoring Team's review of the assessments: The Monitoring Team identified that the Annual Examination form was updated, and that Annual Dental Assessment for Individuals #441,and #7 were completed on the new, updated form D. Individual #86 The Annual Assessment dated 9/7/11, did not have clinical or x-ray findings documented on the form (not needed in this case because completely edentulous). Periodontal disease was not assessed. Good oral hygiene was noted. The individual was noted to be edentulous, and would not cooperate with impressions for dentures. Treatment plan was not documented, and next visit was noted to be in "12 mo. exam". The Annual Dental Report recommended to improve brushing of gums at least twice per day, and that no pathology was present, oral health was good and that the Individual was partially cooperative. There was no documentation on the report about the need for dentures and the issues precluding obtaining dentures for the individual. Individual #59 The Annual Assessment, dated 9/7/11, did not complete the periodontal disease section of the assessment, noted fair oral hygiene, moderate plaque and minimal calculus, and that recall was necessary in three months. The Assessment indicated that tooth 27R required filling because of decay. The Assessment noted that x-rays (FMX) was obtained under TIVA on 12/2/10. The Assessment noted that the individual has partial, lower dentures and that the individual will not sit for impressions, indicating partially cooperative (fair) with regards to behavior. Treatment plan indicated the need to fill tooth #27, and "recall q 3 mo". The Dental Report dated 9/12/11, recommended the need for improved brushing of gums, twice per day and to use suction brushing.	

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		Individual #411 The Annual Examination Record, dated 1/3/12, was noted to be more comprehensive then the older form (Annual Dental Assessment). The examination noted stage III periodontal Disease, and that last radiographs were completed on 8/19/11, and no caries were noted. The form also indicated if the exam was completed or not, and in this case it was complete. The new form did not indicate what pending services might be needed, such as a treatment plan for periodontal disease (although the recommendation below of "improved brushing of teeth/gums" might be considered to be the treatment plan). The form also did not indicate the extent of plaque or if calculus was present. The Annual Dental Report dated 1/3/12 noted a dental risk rating of low, and indicated what dental services were provided during the year and level of cooperativeness. The report's treatment plan and findings were noted to be more comprehensive than previous reviews. The only specific recommendations provided were "improved brushing of teeth/gums" and "suction brushing," but did not indicate a frequency. The report did not comment on when follow-up was needed. Individual #7 The Annual Dental Examination Record, dated 1/9/12, was complete and indicated fair oral hygiene, and Stage I periodontal Disease. Most recent radiographs were dated 12/27/11. The Annual Dental Report, dated 1/10/12, recommended improved brushing twice per day, the need for dentures or partials, and that brushing should be done daily by staff. Significant findings and clear instructions to staff were documented on the report. Summary: The new Dental Record Annual Examination form was noted to be more efficient; however, the Facility should consider if documenting the extent of plaque and calculus on this form would be beneficial. It is apparent that findings and recommendations were better delineated on the Annual Report forms for Individuals #7 and #411, when compared to the other reports. There was a significant discrepancy between the dentist's findings and what was reported on the Annual Report for Individual #305. The Annual Dental Assessment forms for Individuals #86, #59, and #559, were not fully completed. Of the examples reviewed: • Two of six (33%) provided meaningful recommendations to staff; • Six of six (100%) indicated an oral hygiene index; • Four of six (67%) indicated the extent of plaque and calculus present; • Four of six (67%) documented when x-rays were last obtained; • Zero of six (0%) commented on the risks and benefits of dental treatment, versus no treatment, which is especially important consideration when behavioral issues are present, or if any form of restraint is required.	

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		Emergency Dental Services: The Monitoring Team reviewed Emergency Dental Services during the last review period and noted it to be effective. No changes with regards to the process have occurred during the interim period. There were no examples reviewed during this Review Period. Subsequent reviews by the Monitoring Team will require record reviews of dental emergencies to ensure that treatment was provided as necessary, and timely, and that the LAR, and IDT was made aware of the incident. Documentation of the issue will need to be placed in the Integrated Progress Notes. Overall Summary: The Monitoring Team is exceptionally pleased to see progress and actions that have occurred with the new leadership of the Dental Department, and the motivation, and effort by the department's staff. It was made clear that the entire department is motivated and working towards compliance for Provision Q.1, of the Settlement Agreement. The Dental Director had reviewed all records, has many processes in place to enhance dental services at the Facility, and is providing more direct care to individuals then ever occurred in the past. The Monitoring Team, as did the Dental Director, recognized that the Facility is behind where it should be, with regards to Settlement Agreement compliance. However, the Facility and Monitoring Team believe that given the department's new direction, compliance should be achieved. Following review of the Dental Offices staffing, the Monitoring Team strongly recommends that the Facility leadership, along with the Dental Director, review the staffing needs of the Dental Department.	
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	Missed Dental Appointments: By review of a list provided entitled "Missed Dental Appointments For Past Six Months", dated 1/23/12, the Monitoring Team noted that 132 appointments were missed: • 16 secondary to behavior issues • seven secondary to illness • 90 secondary to either a reschedule or no-show • 17 for other or unknown reasons. Based on information provided, the Monitoring Team was unable to determine the rate of no show, but the number of missed appointments secondary to rescheduling, no-shows and unknown reasons, is significant. Mechanical Restraint Use: Following review of a document request seeking a list of all individuals who required mechanical restraint for dental procedures, the Facility Indicated that no individuals	Noncompliance

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	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.	receive mechanical restraint for dental procedures. The Monitoring Team will request a list of Individuals who require any form of physical restraint as well as physical positioning for dental procedures at the next Monitoring Review. The Monitoring Team would like to ensure that in the event of anyone requiring their head, and neck to be physically stabilized, there has been medical clearance to ensure such practice. <u>Pre-Treatment Sedation:</u> To assess the use of pre-treatment sedation for dental procedures, the Monitoring Team request a list of all individuals who received pre-treatment sedation, and to provide names and dose of medication. The Monitoring Team was provided two copies of forms for individuals called "PRE Procedure Sedation" and one form for an individual titled "Post Procedure Sedation". One form was completed but did not have the name of the Individual listed, and the names listed on the two remaining forms were illegible. At the time of future reviews, the Monitoring Team will need specific data for the evaluation of pre-treatment sedation. <u>Assessment for Restraint and Behavior Support:</u> The Dental Director informed the Monitoring Team that as Individuals receive dental services, they were being assessed for the level of support that they require for dental procedures and examinations, including the need for desensitization programs, as well as oral and intravenous medications. Future reviews by the Monitoring Team will require an absolute understanding of all necessary supports required for dental services, including physical support, need for restraint and type of restraint, and behavior intervention, and to provide trends analysis for all restraint and behavior support. Importantly, each behavior program must regularly document the Individual's progress, and when necessary, alternative program development. <u>Desensitization Programs:</u> The Monitoring Team was informed that the dental office has begun collaborative efforts with the Behavior Services Department and is in the process of enhancing their approach to desensitization. The Monitoring Team will review the Facility's progress in this area during future reviews. <u>Oral Sedation:</u> The use of oral sedation is reported on in Section J, of this report. The Facility was found not to be in substantial compliance since the Facility was not able to provide needed information on the rates at which sedation was used, since many individuals who needed plans did not have them and the plans reviewed were often only minimally related to the sedation, and since there was no plan in place to review whether or not efforts to reduce the use of medical restraint were effective.	

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		It should be noted that the Dental Director will be taking a certification course on dental sedation <u>Integration of Dental Services into the IDT Process:</u> To help assess integration of dental services in the IDT process, the Monitoring Team requested Individual Support Plans (ISP) and addendums to ISPs for 10 Individuals. These documents were not provided for review. In the future, ISPs and supporting documents will be reviewed to ensure that the individuals' oral health care needs are clearly delineated within the context of the ISP. Current status of oral health care, issues related to providing oral health care, and risks and benefits, including no treatment, and plans to overcome barriers to providing oral health care must be well documents and addressed by the IDT. The Monitoring Team noted anecdotally that many Integrated Risk Assessments included dental issues as a high-risk issue. While attending a CDLP meeting, the Monitoring Team noted that the Dentist was present, and reviewed issues related to dentures; however, the accepting agency was not made aware of daily oral hygiene needs, and specific dental follow-ups. The Monitoring Team Reviewed the PSPs for Individuals #441, #7, #86, #59, 305, and #559, and determined that dental representation was not sufficient because it did not adequately represent the Individuals condition and supports necessary to ensure adequate oral health care. Furthermore, the Monitoring Team did not find copies of dental notes and recommendations in the integrated progress notes.	

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

1. Ensure that there is a comprehensive, and efficient mechanism to review scheduled appointments, and treatments. (Provision Q1)
2. Ensure that all radiographs, annual examinations and necessary treatments are provided timely, and in cases that treatments were not provided, ensure that there is comprehensive documentation providing a clinically relevant explanation as to the delay. (Provision Q1)
3. Ensure that the extent of plaque and calculus, and other indictors of oral health, is well documented at the time of each visit. (Provision Q1)
4. Enhance the Dental Department's participation in the Interdisciplinary Team Process. (Provision Q2)
5. Ensure that the Facility's program to minimize need for restraint, such as desensitization, is fully implemented. (Provision Q2)
6. Expand and intensify the current efforts for improving general oral hygiene at the living areas (Provision Q1)
7. Ensure to establish a mechanism to address refusals, now-show, and re-scheduled appointments, and demonstrate its effectiveness. (Provision Q2)
8. As part of the Facility's Quality Assurance Process, track for potential adverse outcomes following dental appointments, including reported physical trauma within 24 hours following a dental procedure, and treatment for pneumonia, within five days following dental procedure, as well as treatment outcomes, to demonstrate efficacy of oral health care at the Facility. (Provision Q1)
9. Enhance the reporting, tracking and review of pre-treatment sedation and post-treatment sedation. (Provision Q1)

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. BSSLC Plan of Improvement (POI), dated 12/30/2011 2. BSSLC Presentation Book 12/30/11 3. Record Reviews of Individuals: • Sample 1: Individuals #5, #30, #291, and #318 • Sample 2: Individuals #33, #163, #303, #403, #411, #536, #570, and #575 • Sample 3: Individuals #26, #53, #54, #86, #88, #126, #231, #303, #392, and #567 • Sample 4: Individuals #195, #250, #403, #497, and #579 • Sample 5: Individuals #56, #133, #181, #249, #513, #478, #56, #576, and #579 • Sample 6: Individuals #130, #308, and #367 4. DADS Policy 016 Communication Services and Supports (10/7/2009) 5. BSSLC Speech Language Pathology Policy (11/2011) 6. A list of people with Alternative and Augmentative Communication (AAC) devices 7. AAC screening forms 8. AAC evaluation and Speech Language assessment template 9. Monitoring tools template for AAC and SLP programs 10. Completed monitoring forms 11. Communication dictionaries for individuals identified as having decreased communication 12. AAC-related spreadsheets 13. 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 (DCPs) on Childress (1), Driscoll (2), Bowie (2), and Program Services (5) **Meeting Attended/Observations:** 1. Daily activities on Driscoll, Fannin, Childress, and Program Services 2. Mealtimes on Driscoll, Fannin, and Program Services 3. PNMT meeting 1/17/12 4. IDT for Individual #547
	Facility Self-Assessment: BSSLC Plan of Improvement, updated 12/30/11, provided comments/status for Section R. BSSLC stated that all provisions were noncompliant. This was consistent with the Monitoring Team's findings. Since the new assessment process was developed in November 2010, approximately 183 individuals (60%) of the census have received the new comprehensive assessment. This represented an increase of 34% since the previous compliance visit when 84 individuals had received the new format. The POI 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. Additionally, it would assist the process to identify all action steps that are felt to be needed to gain compliance. This will allow for the Monitoring Team to provide guidance should the Facility begin to proceed in a direction that is felt to be incongruent with the SA.
	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 not in compliance. Individuals identified as having decreased communication were being provided with the needed assessments. Assessments had shown significant improvement since November 2010, which is when the format of the assessment was revised. Assessments were noted to be mostly comprehensive and provided clear details and strategies to improve the individuals' level of communicative functioning. At the time of the review, 183 new assessments had been completed which accounted for 60% of the census. Additionally, BSSLC presented a plan that would ensure all individuals would receive the new comprehensive assessments by the end of 2013. The problem noted by the Monitoring Team was that while the comprehensive assessments were detailed and met all the requirements of the SA, the updates generally provided a review of consults provided over the past year and did not contain any information regarding how the individuals' present status differs from the previous assessment or updater. Failure to provide this analysis results in a risk of failure to identify the beginnings of functional decline. **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 consistently 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.

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R1	Commencing within six months of	The Facility did not provide an adequate number of Speech-Language Pathologists or	Noncompliance

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	the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	other professionals (i.e. Assistive technology (AT) specialists) with specialized training or experience. As of this review, BSSLC had four full-time Speech-Language Pathologists. This represented a decrease of one therapist since the last compliance visit but per report of the HT director, an additional SLP was starting February 1, 2012. General tasks in which Speech Pathology is responsible: Attendance at: • Pre-admission meetings • 30 day planning conferences for all new admissions • Annual planning conferences • PNMT meetings • ISP meetings • Conduct/write Communication Assessments • Provide direct treatment services • Maintain training data as applicable • Develop and implement augmentative and alternative communication devices • In-service and monitor use of the devices • Maintain contact with personnel regarding school age residents • Provide consultation, counseling and referral as needed • Provide new employee orientation • Meal Monitoring Based on a review of CVs for each therapy clinician 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 will fill all the available positions, therapists continued to primarily pass the development of programs to individuals who lack the expertise needed to write functional and sequential goals. Through the IDT process, objectives should be clearly identified as well as the individual most appropriate to develop and follow said goal. This process will improve the likelihood that all goals and objectives are functional and relevant to the intended outcome. Three of 12 (25%) individuals reviewed (sample #1 and #2) did not have appropriate communication goals. Examples of goals not being written appropriately or not written at all included: • Individual #536's ISP stated to assist with communication wallets needed but did not provide any additional information. • Individual #318's Communication assessment states that the individual responds appropriately to greetings but the goal written by the QMRP focused	

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		on responding to social greetings. • Individual #411'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, consistently write goals, monitor goals and ensure staff involvement with implementation of the plans. At the time of the review, direct speech services were primarily limited to individuals who had AAC devices.	
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 basic communication goals to improve expressive language. In 37 of 40 records (Sample #1, #2, #3, #4, #5, #6) (100%) 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. An Example of where the Communication assessment was not comprehensive included: • Individual #54 stated that the individual recognized 15 objects but did not provide information regarding what objects. Improvement of the communication assessments completed post November 2010 (when a new format was implemented) continued to be noticed. 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. Continued improvement regarding the comprehensive communication assessments was an area in which BSSLC excelled. The problem noted by the Monitoring Team was that while the comprehensive	Noncompliance

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		assessments were detailed and met all the requirements of the SA, the updates generally provided a review of consults provided over the past year and did not contain any information regarding how the individuals' present status differs from the previous assessment or updater. Failure to provide this analysis results in a risk of failure to identify the beginnings of functional decline. 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. Since the new assessment process was developed in November 2010, approximately 183 individuals (60%) of the census have received the new comprehensive assessment. This represented an increase of 34% since the previous compliance visit when 84 individuals had received the new format. 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.	

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		All individuals admitted since the last compliance visit received a communication assessment within 30 days of admission. Since the previous review, there were three individuals admitted to BSSLC. Records for these individuals were requested (sample 6). Three of three 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 12 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 consistently written by the SLP. Rationales and descriptions of interventions regarding use and benefit from AAC and environmental controls as well as communication strategies were not clearly integrated into the PSP. 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. Four of 40 records (10%) reviewed (Sample #1, #2, #3, #4, #4, and #6) 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 #30's PSP just stated the individual's current status and did not include any information regarding how to facilitate communication. • Individual #478's PSP simply stated that speech must be available on a consultative basis and did not provide any information regarding the individuals status or methods to improve communication Communication information was not integrated into the daily schedule. o Zero of the 40 records (0%) (Sample #1, #2, #3, #4, #5, and #6) reviewed had communication interventions and methods to improve communication integrated into the daily schedule. Communication interventions were referenced in the assessment section of the ISP 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.	Noncompliance

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		• Individual #33's assessment stated that signs should be utilized to help improve cooperation and comprehension but there was no evidence of these strategies integrated into his service objectives. General AAC devices were readily available in all common areas. Four of the four (100%) homes (Childress, Driscoll, Fannin, and Bowie) had general AAC devices present in the common areas. Although devices were present, the use of the devices throughout the day was not evident. 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, washing hands, and bathing) 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 #33 was not observed using sign or communication book. • Individual #163 was not observed using communication dictionary.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	A monitoring system was in place that tracked the presence of the AAC and working condition of the AAC but did not address the effectiveness of the device. A review of Facility monitoring reports from October 2011 to December 2011 documented: • In three of three (100%) monthly reports reviewed, the presence of the AAC was documented. • In three of three (100%) monthly reports reviewed, the working condition of the AAC was addressed. An improvement noted since the previous visit was that the SLP had begun to monitor the implementation as well as the effectiveness of the communication devices used by individuals; however, monitoring did not cover the use of the AAC during all aspects of the person's daily life in and out of the home. Additionally, there was not a system in place in which the team routinely came together to discuss progress with the communication interventions and therefore the ability to review and revise was inconsistent. Staff were not trained in the use of the AAC. Although AAC is trained during new	Noncompliance

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		employee orientation, the information contained within the training did not filter down and present itself at the home level. Zero of the ten direct support professionals interviewed (0%) were knowledgeable of the communication programs as evidenced by: o In three of ten (30%) interviews with staff, staff could describe individual-specific communication strategies. o In zero of ten (0%) interviews with staff, staff could describe the schedule for implementation of communication strategies. o In zero of ten (0%) interviews with staff, staff stated they had received individual-specific training for communication strategies. Instances in which staff could not describe individuals' communication included: • Discussion with two DCPs at Driscoll indicated that staff were not knowledgeable of the communication dictionary or its contents. • DCPs on Fannin were unable to explain the schedule in which the shared devices would be utilized and the method for providing assistance with these devices.	

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

1. 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. (Provision R.1)
2. Assessments and updates must provide detailed comparative analysis to allow for better determination and identification of functional decline. (Provision R.2)
3. Individual communication programs should be integrated into PSPs through skill acquisition programs as well as PBSPs to ensure the AAC devices, environmental controls, and communication strategies are meaningful to the individual and the individual 's communication system is applicable in multiple environments. (Provision R.3)
4. Monitoring must be provided at a level that will ensure consistent implementation of devices and strategies in all settings and must be continuous throughout the day. (Provision O.4)

The following are offered as additional suggestions to the Facility:

1. BSSLC would benefit from additional SLPs, however, if this is not obtainable, the reassignment or developed of an additional Speech Tech would assist the Speech department in better being able to monitor implementation as well as model the use of person and general AAC devices.

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) 12/30/2011 2. BSSLC January 2012 Presentation notes 3. Minutes for the Positive Behavior Support Committee (8/1/2011 – 11/14/2011) 4. Minutes for Behavior Services departmental meetings (6/17/2011 – 11/18/2011) 5. Contracts for professionals providing external peer review, intellectual and adaptive assessment, and counseling 6. Documents that were reviewed included the annual ISP, ISP updates, Specific 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, #11, #12, #20, #21, #26, #33, #38, #62, #66, #76, #88, #95, #130, #133, #151, #159, #163, #173, #181, #185, #202, #254, #264, #281, #291, #316, #349, #367, #381, #399, #403, #417, #422, #425, #453, #467, #474, #490, #504, #511, #513, #528, #590, and #591 **People Interviewed:** 1. Terry Hancock, PhD – Chief Psychologist 2. Kathleen Williamson, Med, BCBA – Psychology Manager 3. Shawn Cureton, MS – Psychology Manager 4. Kim Littleton – ADOP 5. Vickie Morgan, MD – Psychiatrist **6.** Active Treatment Monitors **7.** Direct Care Professionals **Meeting Attended/Observations:** 1. Positive Behavior Support Committee (PBSC) (1/16/2012) 2. Behavior Services/BCBA Meeting (1/16/2012) 3. Human Rights Committee (HRC) (1/19/2012) 4. Restraint Reduction Committee (1/19/2012) 5. Observations in the Cottages , as well as Bowie, Childress, Driscoll, Fannin, and Program Services.
	Facility Self-Assessment: At the time of the site visit, BSSLC reported that no Provision was in substantial compliance with the SA. The Monitoring Team was in agreement with the Facility. The Facility Self-Assessment of Section S consisted primarily of the documentation of specific events, such as the start or completion of a specific task. Qualitative statements, when provided, were not based upon

	objective criteria. Rather, these statements were presented in an informal narrative, such as indicating that a particular effort required further improvement. Based upon such statements, it was not clear that the Facility had implemented a comprehensive and systematic process to measure progress toward compliance with the SA. The Facility Self-Assessment also included a Plan of Improvement. This Plan of Improvement typically comprised discrete events or practices to be completed. The evidence listed by the Facility for these items included statements such as "PSP Observation Checklist" and "Email." This approach to self-assessment reflected an emphasis upon the occurrence of specific events rather than upon qualitative improvement relating to required practices. As with the implementation of a skill acquisition program, BSSLC must approach compliance with the Settlement Agreement in a systematic and evidence-based manner. Measures of compliance must reflect procedures that capture the salient elements of the task as part of an ongoing process rather than a discrete event that is either in compliance or not. This also requires the Facility demonstrate the ability to use objective measures of performance, openness to measurement outcomes, a consistent and effective use of resources, and a well-organized process for documenting and reporting progress. Without such an approach, the Facility will be challenged to make the changes necessary to satisfy the Settlement Agreement.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at BSSLC from 1/16/12 through 1/20/12. Record reviews continued off-site following the site visit. Based upon information gathered during the current site visit, it was apparent that no provisions of Section S were found to be in substantial compliance with the Settlement Agreement or to show substantive improvement in comparison with previous findings. Furthermore, BSSLC was found to have engaged in practices that the Monitoring Team had cautioned the Facility to avoid. Of considerable concern was the movement by the Facility away from both comprehensive assessment of personal skills and the use of specific skill acquisition programs that include objective and measureable goals. It was also noted that the skill acquisition plans that were developed lacked individualization and frequently did not address needs that were identified by the existing assessment process. It was also of great concern that the Facility reported, and observations supported, an almost total lack of formal skill acquisition training in community settings. Although individuals living at the Facility were provided the opportunity to engage in community activities, with very few exceptions these community activities did not include or support the development of skills necessary for living in the community. There exists a very real obligation for the all residential facilities to provide intensive and comprehensive teaching so that individuals increase independence and the probability for successful integration into the community. Evidence from the current site visit reflected that BSSLC was not fulfilling this obligation. Furthermore, the Facility demonstrated a trend away from the assessments and training necessary to fulfill this obligation. A substantial investment of resources and effort will be necessary for BSSLC to address the

	current situation and move toward compliance with the Settlement Agreement.

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	In January of 2010, a review of skill acquisition programs (Specific Program Objectives or SPOs) at BSSLC indicated that the Facility had provided an adequate number of training programs. Although the SPOs consistently lacked the components necessary for effective teaching, each individual was provided with several training programs in her or his ISP. Through July of 2011, each site visit reflected sufficient numbers of SPOs. During the January 2012 site visit, it was noted that BSSLC had substantially reduced the number of SPOs for each individual. In the place of SPOs, it was often noted that the individual was provided with Staff Service Objectives (SSOs). An SSO typically consisted of an informal strategy for encouraging the use or development of a skill. Staff indicated during interviews that the movement from SPOs to SSOs did not reflect a reduction in the use of formal or rigorous teaching. Comparisons of SPO and SSO documentation, however, reflected a variety of limitations in the use of SSOs. • Documentation of SSOs was consistently less thorough and detailed, often consisting of general statements rather than data on the use or learning of specific skills. • SSOs were implemented less consistently and less frequently than SPOs. For example, Individual #26 had an SSO for money management. Documentation reflected only two instances since September 2011 that the SSO had been conducted. No data were available in the record to reflect skill learning or utilization. • It was typically not possible to determine from documentation that an individual was benefiting from an SSO by either maintaining existing skills or strengthening new skills. Based upon the available information, it appeared that the supplanting of SPOs by SSOs was counterproductive in regard to the provision of effecting teaching, as well as to the achievement of compliance with the SA. The review of skill acquisition training at BSSLC during the current site visit revealed a reduction in the quality of SPOs in addition to the reduction in quantity noted above. The site visit conducted in January 2010 reflected an almost total lack of essential components in the SPOs. These same conditions were noted in July of 2010. In January 2011, a sample of the "best" SPOs was selected by BSSLC. This sample, which was limited to SPOs that had been written but not yet implemented, reflected modest improvement in SPO content. The improvement was attributed to the incorporation of the Murdoch Center Program Library into the SPO development process. Additional improvement was noted in July of 2011. Although the Murdoch Center Program Library can be a valuable resource in training program development, there are associated limitations. In January and July of 2011, BSSLC had been cautioned about the use of the Murdoch Center Program Library. Specifically, it was discussed with the Facility	Noncompliance

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		that the Murdoch materials reflect only a foundation upon which skill acquisition programs can be based. In order to develop adequate SPOs, the Facility was encouraged to make use of thorough assessments to revise the Murdoch programs to fit the unique needs of each individual living at BSSLC. During the current site visit, it became evident that BSSLC had utilized the Murdoch Center Program Library in precisely the manner the Monitoring Team had advised against using. Some of the specific problems that were noted in the SPOs during the current site visit included the following. • No task analysis had been completed for any of the SPOs reviewed. Although the Murdoch materials include a generic task analysis format, a full task analysis for each individual is encouraged. BSSLC failed to conduct individual task analyses. As a result, SPOs were not tailored to the unique learning needs, current skills, or physical condition of each person. • Each individual was started at step one of every SPO regardless of demonstrated ability. As a result, many individuals were required to participate in unnecessary instruction targeting skills they already possessed. It was not uncommon to discover individuals who had demonstrated mastery at every level of the SPO. Documentation for Individual #387 reflected that she had become agitated and stated, "this really pisses me off" under such circumstances. • In addition to the required participation in training on existing skills, individuals were frequently required to demonstrate mastery for extended durations. For example, Individual #381 demonstrated mastery of step one of an oral hygiene SPO in September 2011. She remained on step one of the SPO through December of 2011, at which time her behavior had deteriorated to frequent refusals to cooperate with teaching. As indicated above, individuals residing at BSSLC at the time of the current site visit were not provided a task analysis as a part of SPO development. Records did reflect, however, that each individual had been provided with skill assessment by means of the Functional Skill Assessment (FSA). Unfortunately, it was not clear from a review of individual records and program documentation that the findings of the FSA had been effectively used in the development of skill acquisition programs or that the FSA was revised as indicated by data from training. • Individual #130 was provided an SPO to identify coins. The findings of the FSA indicated she independently could identify all coins except for a half dollar. The SPO required that the individual participate in steps to recognize a penny, nickel, dime and quarter--coins that the FSA indicated she could identify. • For Individual #151, the FSA indicated that hand-over-hand assistance was required for SPO implementation. SPO data from the time of the FSA indicated that the individual could complete tasks upon presentation of a verbal cue. • Individual #367 was provided with an SPO for identifying coins. Documentation from the FSA reflected that the individual demonstrated no concept of the function of money. It was therefore doubtful that the identification of coins was functional for the individual.	

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		Observations and record reviews also indicated weaknesses relating to other specific assessments. • Individual #30 was diagnosed with bacterial pneumonia on 9/8/11 and aspiration pneumonia on 11/29/11 with no evidence of detailed discussion or assessment by the PNMT. The PST conducted a risk screening on 12/14/11 but there was no evidence of discussion regarding etiology of the event. Identification of the etiology would provide information regarding whether an appropriate intervention to minimize future aspiration would involve acquisition of skills involved in dining or other oral intake. • Individual #291 had aspiration pneumonia on 7/11/11 with no evidence of discussion or assessment by the PNMT or PST. • Individual #318 had aspiration pneumonia on 11/19/11 with no evidence of discussion or assessment by the PNMT or PST. The PST conducted a risk screening on 12/14/11 but there was no evidence of discussion regarding etiology of the event or need for additional assessment. Apart from issues relating to assessment, there were other indications that BSSLC had not exercised sufficient diligence in the development of skill acquisition training. • Individual #26 was diagnosed with Cerebral Palsy and experienced substantial difficulty with fine and gross motor function. SPOs requiring fine and gross motor coordination did not reflect instructions regarding the individual's limitations due to Cerebral Palsy. This is an example in which a task analysis must be tailored to account for the physical condition of the individual. • Individual #11 was provided with an SPO for enhancing his ability to stay on task at work. The instructions for the SPO consisted primarily of providing a command to "Stay". The expectation of the SPO was that the individual would stay at his workstation for 45 minutes. No environmental supports or specific reinforcing consequences were included in the SPO to strengthen the on-task behavior. The individual was noted to be absent for 56% of trials. • Individual #490 was provided an SPO for the use of money. The content of the SPO reflected a procedure for compliance with staff requests rather than effective use of money skills. • Individual #88 was provided an SPO to teach selecting a preferred activity. The SPO required that the individual participate in an activity rather than select a preferred activity. • Individual #33's assessment stated that signs should be utilized to help improve cooperation and comprehension but there was no evidence of these strategies integrated into his service objectives. • Individual #30's PSP just stated the individual's current status and did not include any information regarding how to facilitate communication. • Individual #478's PSP simply stated that speech must be available on a consultative basis and did not provide any information regarding the individual's status or methods to improve communication. • As reported in Provisions P1 and P2, there was no discussion of potential for skill acquisition in areas such as eating, ADLs, fine motor function, and positioning. PNMPs and Special	

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Program Objectives (SPOs) 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.

It was surprising to note during the current site visit that, despite the use of the Murdoch Center Program Library, the SPOs lacked many of the essential components of a skill acquisition program. One possible reason for this circumstance involved the lack of individualization in the SPOs. Without individualization, essential components of skill acquisition programs such as operational definitions of teaching targets, discriminative stimuli, consequences, and teaching instructions cannot be adequately presented. Documentation and staff interviews indicated that SPOs were used as written in the Murdoch Center Program Library without any customization.

	01/2010	01/2012	Change
Plan reflects development based upon a task analysis	0%	0%	0%
Behavioral objective(s)	0%	75%	75%
Operational definitions of target behavior	0%	13%	13%
Description of teaching conditions	0%	0%	0%
Schedule of implementation plans for sufficient trials for learning to occur	0%	0%	0%
Relevant discriminative stimuli	0%	0%	0%
Specific instructions	0%	0%	0%
Opportunity for the target behavior to occur	0%	88%	88%
Specific consequences for correct response	0%	6%	6%
Specific consequences for incorrect response	0%	0%	0%
Plan for maintenance and generalization that includes assessment and measurement methodology	0%	0%	0%
Documentation methodology	0%	0%	0%

Based upon the information obtained from observations, record reviews and staff interviews, it was evident that the efforts by the Facility to provide skill acquisition training were inadequate. There was minimal evidence that BSSLC made use of valid and reliable assessment procedures. Furthermore, what assessment information that was available was not used to develop skill acquisition programs tailored to the unique needs of the individual. It was also abundantly clear that BSSLC had not used the Murdoch Center Program Library appropriately or heeded the cautionary recommendations from the Monitoring Team regarding those materials. As a result, SPOs were generic and lacked the essential components for teaching. Documentation also reflected that the Facility rarely attempted to revise or altering teaching strategies when SPO data reflected undesired responses from individuals.

In addition to substantial weaknesses relating to skill assessment and SPO development, BSSLC also demonstrated substantial limitations regarding the provision of active treatment. The Facility did have in place a system for monitoring active treatment or engagement. Despite a considerable investment of time by the Facility, however, evidence did not reflect that this system produced

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accurate information or resulted in adequate levels of engagement.

Data provided by the Facility indicated an average level of engagement across all settings of 61.3% in January of 2012, with a range of 57.6% to 66.8% obtained across the previous six months. To develop a basis of comparison for the current site visit, the Monitoring Team conducted observations in a variety of settings across the BSSLC campus. 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 Present	Individuals Present	Individuals Engaged	% Engaged
PS Front Dining Room	3	5	5	100%
PS Front Dining Room	4	9	4	44%
PS Dining Room	4	8	8	100%
PS Dining Room	3	3	3	100%
BISD	3	4	0	0%
PS Dining Room C	4	2	2	100%
Fanin C Dining Room	4	10	8	80%
Fanin C Dining Room	5	9	7	78%
Fanin A Living Room	1	5	0	0%
Fanin A Living Room	1	5	0	0%
Childress C	4	8	7	88%
Childress C Living Room	3	6	0	0%
Childress D Dining Room	1	3	0	0%
Childress C Training Area 2	2	4	1	25%
Childress C Training Area 3	2	5	0	0%
Childress C Training Area 4	1	4	3	75%
Childress B Trade District	2	7	2	29%
Bowie B Living Room	3	9	0	0%
Driscoll Training Center 1	2	3	1	33%
Driscoll Training Center 3	2	7	0	0%
Driscoll Training Center 4	1	3	0	0%
Driscoll Training Center 6	2	5	0	0%
Recreation Center Bingo	4	11	2	18%

The level of engagement noted by the Monitoring Team during the site visit was substantially lower than that obtained by the Facility. Engagement across all settings, including meals where engagement was typically the highest, was 38%. When meals were eliminated from the sample data, the level of engagement fell to 17%. Specific circumstances noted during observations included the following.

- At 5:17pm on Tuesday January 17 in the Fanin A living room, five individuals were observed. Although staff was present, no materials were available for active treatment. One individual was asleep on a couch, a second was dragging a chair about the room, and the remaining

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		individuals were engaged in ritualistic behavior that involved self-stimulatory or other repetitive and nonfunctional actions. • At 5:30pm on Tuesday January 17 in the Childress C living room, six individuals were observed with three staff present. No materials were available. One individual was engaged in self-restraint, three others were displaying ritualistic behavior, and the remaining two individuals were seated quietly while wearing Posey restraint mittens. • At 8:17am on Thursday January 19 in the Bowie B living room, nine individuals were observed with three staff. No materials were available upon entry, but staff made materials available soon thereafter. Minimal effort was made, however, to ensure that materials were used or individuals were engaged. One individual was given a coloring book and asked if she would like to "color." No crayons were made available at that time or during the following 15 minute remainder of the observation. • At 8:54am on Thursday January 19 in the Driscoll Training Center #1, a staff member was reading from a book on astronomy to five individuals with severe to profound intellectual disabilities. The passage being read included statements regarding comparative weights of a cubic foot of soil collected on various sized planets. Several individuals who reside at BSSLC attend school at the Brenham Independent Schools District (BISD) operations on the Facility campus reflected that operations in this area were no better than other portions of the Facility. In fact, in various ways, the BISD services at BSSLC were less adequate than other services at BSSLC. Observations of the program at the BISD area did not provide evidence of either integration with the supports and services provided by BSSLC or of individualized training and skill acquisition to promote growth and independence. • Observations in the BISD program dining room reflected little attention to individual needs or supports. Although the dining room was organized for cafeteria service, all individuals had food brought to them rather than serving themselves. Staff frequently was observed performing activities for individuals, such as cutting food or pouring beverages, rather than supporting independence. In other circumstances, individuals with identified needs for adaptive equipment at times did not receive the equipment until later in the meal. There were very few inquiries about preference noted. No formal training was implemented during the meal. Interviews with staff in the dining room reflected a pervasive perception that staff in BISD were not required to implement programs as diligently as in the rest of the Facility. • Staff working in the BISD program demonstrated inadequate responses to undesired behavior. In the dining room, several individuals were observed pacing about anxiously. Staff did not act to assist these individuals or address their behavior. In the BISD classroom, individuals were observed engaging in challenging behaviors such as stereotypic behavior, pacing, agitation, and attempts to depart the classroom. Other than blocking departure from the room, staff did not act to address the noted behaviors. During visits to the BISD classroom, other than one individual who was typically working on classwork, no other academic or training activities were provided.	

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		Based upon information obtained from the Facility, as well as observations and document reviews, it was reflected that BSSLC had not acted with the necessary diligence to ensure that individuals were provided with adequate levels of engagement. Furthermore, data did not indicate that the Facility was capable of accurately monitoring the performance of employees toward ensuring necessary engagement.	
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.	Based upon a review of assessment practices, it was noted that BSSLC displayed difficulty in ensuring that individuals received complete and comprehensive assessment as part of the PSP process and training program development. Specific deficiencies that involved psychological assessments are presented in Section K of this report. Assessment problems in addition to psychological and behavior assessment were also noted. BSSLC had adopted the new Functional Skills Assessment (FSA) developed by DADS. The FSA 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. 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 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	Noncompliance

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		assessed. Based upon the review at BSSLC, the FSA was unable to meet this burden.	
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	Due to the limitations noted in Provisions K4, K5, K6, K7, and K9, as well as in Provisions S1 and S2, it was frequently not possible to determine if training programs addressed pertinent needs of the individual. Without accurate and comprehensive assessment, it was not possible to clearly identify the specific needs of the individual and establish specific teaching goals from which to measure progress. As a result, it was probable that BSSLC did not possess a clear measure of each individual's strengths and needs, and could not develop, monitor or revise training programs with accuracy. As documented in Provision S1 of this report, several observations were conducted of residences and training areas at BSSLC during the current site visit. During these observations, not a single circumstance was noted in which an employee was conducting formal training. Several circumstances were noted, however, in which staff demonstrated an inability to conduct informal training. • Individual #33 was observed in Training Area #2. Staff indicated the individual was participating in a "trial program" to fold towels, a skill he was reported to use in his home. In the training area, staff would place a pile of assorted towels and clothing items on the table in front of the individual and state "fold these." The individual would wad up the items and toss them into a second pile. At various times, the staff member would provide verbal praise regardless of the performance of the individual. In addition, when the staff member would turn away from the table, the individual would sweep all of the items onto the floor. An interview with the staff member included the statement that the individual was doing "very well" with the trial program. • In the Program Services dining room, Individual #417 was observed to demonstrate adequate fine and gross motor skills. Upon being presented with her plate of food, staff proceeded to cut the individual's meat rather than to encourage independence. • Individual #21 begins to slap her face and head when attention is offered to a peer. Staff	Noncompliance

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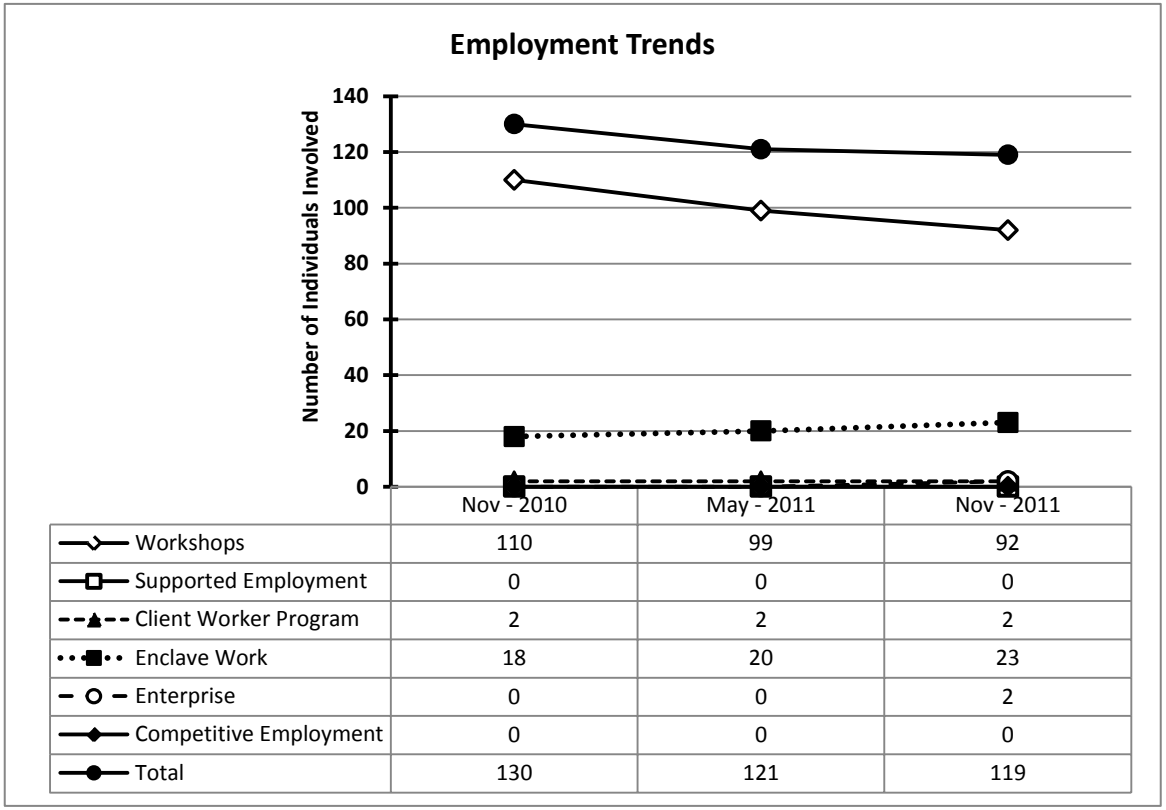
		block slaps, but do not address the issue regarding attention by providing the individual with attention either contingently or non-contingently. • None of five staff questioned in the Driscoll training areas was able to discuss aspects of SPOs or SSOs without referring to a copy of the document.	
	(b) Include to the degree practicable training opportunities in community settings.	The Facility provided a breakdown of vocational opportunities provided to people living at BSSLC. As illustrated in the graph below, training opportunities decreased from November 2010 to May 2011. Since that time, however, overall vocational opportunities have remained stable. BSSLC did provide a modest increase in Enclave employment opportunities, jobs that are located at local business but at which work is not integrated with other employees without disabilities.  Data presented by BSSLC did reflect an increasing trend toward the provision of community outings.	Noncompliance

	Nov - 2010	May - 2011	Nov - 2011
Workshops	110	99	92
Supported Employment	0	0	0
Client Worker Program	2	2	2
Enclave Work	18	20	23
Enterprise	0	0	2
Competitive Employment	0	0	0
Total	130	121	119

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		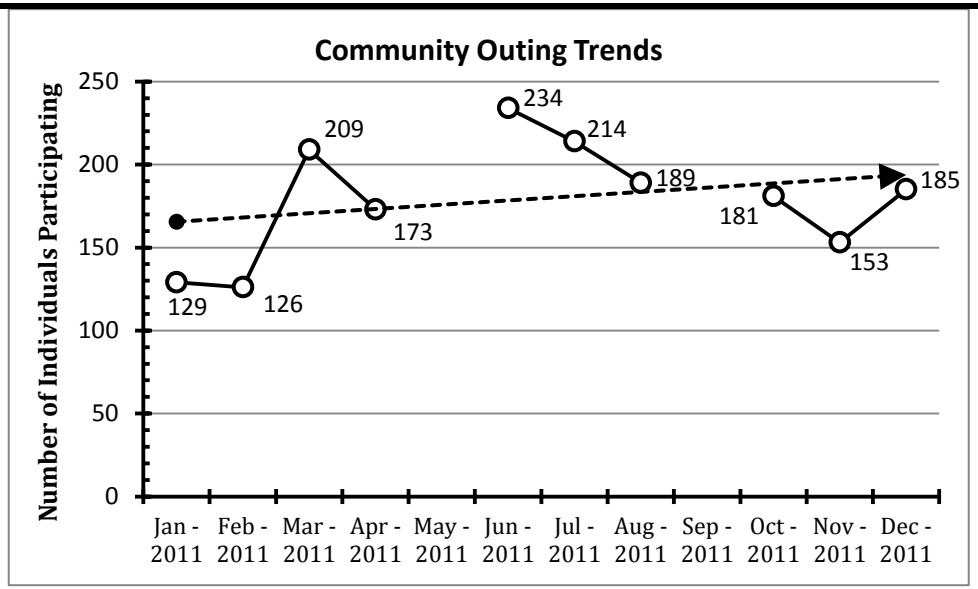 Despite modest improvements in outings and Enclave employment (which are jobs that are located at local business but do not involve participation with other employees without disabilities), BSSLC continued to demonstrate inadequate efforts to help individuals integrate into the general community. The most noted weakness in this area involved the almost total absence of formal skill training in locations other than those operated by BSSLC. Upon request, the Monitor was allowed to accompany two individuals on a trip to the local McDonalds. During this trip, a money management program for each individual was formally conducted. The staff involved in the trip implemented the programs appropriately and the two individuals purchased items of their choosing. The observed activities provided a very good example for how SPOs could be implemented in the community during recreational or other types of community outings. In order to gather a broader sample, staff were asked to provide the names of 10 individuals who are involved in similar program opportunities. Staff initially indicated that there were not 10 individuals living at the Facility with similar programs, but that five individuals might have such SPOs. Upon further discussion, however, it became evident that the two individuals involved in the observed trip were the only two individuals living at BSSLC who were provided with formal community implementation of SPOs. Although the observed outing provided a good example of what could be achieved, it was evident that the Facility had not yet implemented such training on a broader scale.	

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

1. The Facility must act to ensure that SPOs reflect needs identified in the skill assessment process. SPOs should also be developed that build upon each individual's existing skills, do not include unnecessarily lengthy periods of success, and reflect an emphasis upon skills that are functional and likely to facilitate independence and community integration. (Provision S1)
2. The Facility would benefit from processes to increase the validity and reliability of measures relating to the provision of active treatment across programmatic and residential areas. (Provision S1)
3. The Facility should ensure that formal and informal training in the BISD program at BSSLC is rigorous and comports with the expectations of the Settlement Agreement and for the remainder of the BSSLC programs. (Provision S1)
4. It is critical that BSSLC act to ensure that SPOs are based upon comprehensive assessments. It is recommended that the Facility provide skill-related assessment to every individual living on campus. These assessments should include a task analysis of specific skill areas. In addition, however, assessments should reflect a valid measure of individual preferences and reinforces, and guide the training process to include elements to encourage and support each individual's participation in training programs. (Provision S2)
5. It is essential that BSSLC develop a more diligent and intensive strategy for increasing training and employment in community settings. SPOs that are implemented on campus should include a procedure for formal implementation in the community. SPO implementation in the community should adhere to the same expectations and requirements as training implemented at the Facility.

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), updated 12/30/2012 2. Brenham State Supported Living Center Presentation for January 2012 for Settlement Agreement Monitoring Team Visit 3. Section T Presentation Book materials 4. Draft DADS Policy 018: Most Integrated Setting Practices, undated 5. DADS Policy 004: Personal Focus Assessment, dated 09/01/11 6. Community Integrated Discussion Record, revised 03-2010 7. Since last on-site review, a list of all individuals who have requested community placement, but have not been referred for placement 8. Since last on-site review, a list of all individuals who have been transferred to community settings, excluding those whose discharge may be classified as an "alternate discharge" 9. Since last on-site review, a list of all individuals who have died after moving to community living 10. A current list of all alleged offenders committed to the Facility following court-ordered evaluations 11. For the last twelve months, a list of individuals who were reported to have been assessed for placement 12. Community Placement Report, dated Tuesday, December 06, 2011 13. For the last twelve months, lists of all trainings/educational opportunities provided to individuals, families, and LARs to enable them to make informed choices 14. Annual Report: Obstacles to Community Transition, Fiscal Year 2011, Data as of 8/31/2011 15. Community Placement Obstacles, dated December 06, 2011 16. Since last on-site review, a list of all individuals who have had a Community Living Discharge Plan (CLDP) developed 17. Mental Retardation Authority (MRA) Community Living Options Information Process (CLOIP) Worksheets for ten individuals: Individuals #30. #45, #94, #134, #189, #252, #254, #465, #523, #543 18. Individual Support Plans/Personal Support Plans (ISPs/PSPs) and Personal Focus Assessment (PFA) for Individuals #1, #8, #50, #130, #133, #367, #406, #481 19. Completed CLDPs for four Individuals #2, #9, #556, #594 20. Partial CLDPs for 13 Individuals #7, #32, #108, #173, #181, #242, #246, #273, #375, #434, #442, #492, #598 21. Pre Move Site Reviews for Individuals #2, #9, #127, #275, #294, #502, #556, #594 22. MRA Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan for Individuals #2, #9, #127, #275, #294, #502, #556, #594 23. Completed Post Move Monitoring (PMM) checklists for Individuals #2, #9, #127, #275, #294, #502, #556, #594 24. Record Reviews for #1, #7, #8, #20, #21,#50, #130, #149, #308, #362, #460, #474, #481

	People Interviewed: 1. Debra Green, Admissions and Placements Coordinator (APC) 2. Andrew Williams, Post-Move Monitor (PMM) 3. Debbie Burgett, APC Specialist 4. Jim Sibley, DADS Consultant **Meeting Attended/Observations:** 5. ISP annual planning meetings for Individuals #21 and #474 6. CLDP for Individual #7
	Facility Self-Assessment: The Monitoring Team reviewed the BSSLC POI. For the most part, the 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 many specific 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. There are many opportunities to set measurable performance goals for each of the provisions and to use these over time to self-assess progress. For example, the POI reported that a Program Auditor had been assigned to begin monitoring Section T as of December 2011, and this would provide a good opportunity to gather baseline data and develop performance goals and measurement methodologies. **For Provision T1**, the Facility indicated it was in compliance with several provisions, including T1c1, T1c2, and T1c3, each of which address requirements related to the CLDP. The Monitoring Team concurred with that assessment only in the case of T1c3, which requires the Facility to review the CLDP with the individual and, as appropriate, the LAR to facilitate their decision-making regarding community living needs. The POI indicated that a review of five completed CLDP documents showed information continued to be reviewed with LAR and individual and this was evidenced by the CLDP signature roster. The Monitoring Team suggests that signatures alone would not be a sufficient indicator of compliance with the intent of this provision; however, the CLDP typically contains additional evidence of review with the individual and LAR, that taken together with the signature roster, could provide the necessary substantiation. The Facility should expand its definition of this performance measure to include this information. The POI also relied upon its review of the five completed CLDPs to make its assertion of compliance with Provisions T1c1and T1c2, but the Monitoring Team's review of the completed CLDPs did not find those documents typically included the specific name and title of each responsible Facility staff as the POI indicated. The Facility also asserted compliance with T1h, which requires the issuance of a Community Placement Report, and the Monitoring Team concurred with this assessment. The POI stated that APC verifies information of the Community Placement Report by meeting with state office data analyst monthly to verify data used in the report, but there remain concerns about the reliability of some of the data as

	reported by the IDTs, particularly related to how LAR choice impacts referrals. **For Provision T2**, BSSLC stated it was not in compliance with the PMM process and the Monitoring Team concurred. Action Steps for this provision noted that the Facility would conduct reviews of PMM checklists to ensure compliance beginning on 12/14/2011. There was also a report of the following data: "IRR at 72% on 1st attempt. IRR at 80% on 2 trials. IRR at 85%, 87% and 90%." It was not stated how the inter-rater reliability was determined, nor on what variables. The Monitoring Team commends the effort to use data to measure and demonstrate progress, but additional detail as to what is being measured, and how, is needed to evaluate the meaning of the data. **For Provision T3**, no rating is required. **For Provision T4**, the Facility indicated it was not in compliance. It stated that Facility to Facility transfers were now included in the Draft of the statewide Most Integrated Setting Policy, which the Monitoring Team confirms.
	Summary of Monitor's Assessment: This Section was found to be not in compliance overall. Significant deficits in the Facility's assessment processes continued to hamper these efforts to develop and implement adequate transition planning. This remained a matter of substantial concern to the Monitoring Team. **For Provision T1**, six individuals had transitioned to community living and there were 13 active referrals. The Monitoring Team did find substantial compliance in two of the provisions, T1c3 and T1h. Respectively, these addressed the review off the CLDP with the individual and LAR to facilitate their decision-making regarding supports and services needed for community living and the issuance of a Community Placement Report. Otherwise, the Facility was not in compliance with the rest of the provisions. BSSLC still failed to adequately assess, plan for, and implement a plan for each person's needs for education and awareness about community living options. The Monitoring Team encourages the Facility to continue to work toward development of an individualized education/awareness strategy for each individual that takes in to account their specific learning needs. Continuing deficits in assessments also translated to many instances in which the IDT failed to identify in each individual's ISP the protections, services, and supports that needed to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs, or the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences and the strategies intended to overcome such obstacles. In turn, these deficits were apparent in CLDPs that did not adequately reflect the protections, services and supports an individual would need to make a successful transition to community living. **For Provision T2**, the Facility reported it was not in compliance with either of the sub-provisions, and the Monitoring Team concurred. The Monitoring Team found that the PMM Checklists generally appeared to be completed in a timely manner, but there were questions about the actual completion date of at least one such document. Overall, the Monitoring Team remained very concerned that the PMM process had not

	been implemented in a sufficiently rigorous manner. Deficits in the transition process, from both the CLDP and the PMM, had appeared to play some part in post-transition deaths that had occurred in each of the past three monitoring periods. A new Post-Move Monitor had been hired on November 1, 2011, and was completing training with the APC. The Facility reported that a Program Auditor had been assigned to accompany the Post-Move Monitor on all PMM visits to review the accuracy of the Post-Move Monitor's monitoring of community placements. The Monitoring Team commends this step, particularly given the short tenure of the new Post-Move Monitor and the serious issues with deaths that have occurred during transition periods and been reported on by this Monitoring Team over the past three site visits.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	Transition Outcomes During Last Six Months: • Community Transitions: There were six transitions to community living between August 2011 and January 2012. This figure was 50% below the rate of placement in the previous six months, which the APC attributed in part to an expanded CLDP process. • Referrals for Community Transitions: The Facility reported that IDTs had made a total of six referrals for community placement between August 2011 and January 2012. At the time of the site visit, BSSLC had thirteen active referrals in process, according to the Community Placemen Report. • Returns from Community Placement: There were no returns from a community placement during this six month period. • Deaths Following Community Placement: There was one death following community transition that occurred shortly after the 90-day Post-Move Monitoring period. The Monitoring Team found that PMM procedures for this individual may not have been as rigorous as required to ensure the successful transition and protection of the individual. See Provision T2a for additional details. Actions Taken to Encourage and Assist Individuals to Move to the Most Integrated Setting: During this past six months, BSSLC had taken some steps that were intended, at least in part, to assist IDTs to more effectively implement their responsibilities to encourage and assist individuals to move to the most integrated settings appropriate to their needs. Examples included: • The APC provided training to QDDPs and other IDT members on the referral process. • The APC provided training to IDT members on most identification of obstacles to the most integrated setting. • Facility IDTs continued to receive external consultation on the ISP process,	Noncompliance

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		including the identification of protections, supports and services needed in the most integrated setting. • IDTs received instruction as to a DADS State Office directive that each SSLC team member was expected to include in his/her assessment/evaluation a recommendation regarding the individual's appropriateness for transition to a more integrated setting, and delineation of the supports the individual would need in that setting, and had begun to implement this requirement to a certain extent. • BSSLC completed an initial analysis of obstacles to community placement and developed several action plans to address those, as further described in T1h. Conclusion: This provision was found to be not in compliance. The Monitoring Team commends the activities and initiatives described above. As detailed in the rest of this Section T and in Section F above, however, outcomes in the areas of assessment and planning for protections, services and supports (see Provisions F1c, F1d, F1e, F2a1 F2ab, and T1b1); education for community awareness (see Provision T1b2); and transition and discharge planning (see Provisions T1c1, T1d, and T1e) indicated the Facility could not yet be said to be effectively assisting and encouraging individuals to move to the most integrated setting.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	Status of Policies and Procedures: The Facility reported that it had made no changes to transition and discharge policies. As noted in Provision T1a, the APC had been providing ongoing training to QDDPs and IDT members as to the requirements and processes contained in the existing statewide policies. The Monitoring Team found many instances in which the requirements of the statewide policies were not yet being implemented as required, and these are described below. It was reported to the Monitoring Team by a statewide consultant working on the ISP process that some practices had been changed, and some additional changes were being contemplated, but that the statewide policies had not yet been revised to reflect these.	Noncompliance
	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	Identification by the IDT of Protections, Services, and Supports That Need to be Provided in the Most Integrated Appropriate Setting: As described in Provision F1e, IDTs were not proficient in identifying the most integrated setting appropriate to an individual's needs. IDTs at BSSLC had recently been provided clarification and training as to their individual responsibilities to make a specific recommendation about the most integrated setting. The State Office had provided a directive that each SSLC team member must include in his/her assessment/evaluation a recommendation regarding the individual's appropriateness for transition to a more integrated setting, and delineation of the supports the individual would need. As was discussed at the parties' meeting in June, in addition to assessors providing recommendations in each of their assessments, the	Noncompliance

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	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.	determination of the professionals on the team should be documented clearly in the ISP. The professionals' recommendation should be presented to the entire team, including the individual and LAR, for consideration. Based on team discussion, including any opposition from the individual or his/her LAR, the entire team then should make a decision regarding any potential referral for community transition. (Also, see F1e for a further discussion of the IDT's failure to discriminate between the identification of most integrated setting and a decision not to make a referral based on LAR choice.) The portion of the directive for each discipline to include recommendations regarding the most integrated setting and supports/services needed in that setting had not yet been fully implemented at BSSLC. Inclusion of recommendations was more in evidence in the most recent ISPs, such as those completed since December, 2011, but it was still not implemented consistently across all disciplines. For zero of eight (0%) recent ISPs were such recommendations found consistently in the ISP assessments. The most consistent disciplines in this regard were Habilitation Therapies and Nursing. The Monitoring Team found many instances in which the IDT failed to identify in each individual's ISP the protections, services, and supports that needed to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs, particularly since the teams often failed to appropriately identify the most integrated setting, as further described in F1e and T1b3. In most instances, the ISP simply identified the supports and services to be provided at the Facility and indicated the same array would be required if community living were to be considered. <u>Identification by the IDT of Major Obstacles to an Individual's Movement to the Most Integrated Appropriate Setting:</u> The Facility had provided training to QDDPs and IDT members in August 2011 pertaining to the identification of obstacles and planned to repeat this training on a semi-annual basis. There were examples during this site visit of IDTs polling all members of the team as to the most integrated setting and barriers thereto, including during ISP meetings for Individuals #474 and #21. The Monitoring Team still continued to find many instances in which the IDT failed to identify in each individual's ISP the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences For five of eight (63%) recent ISPs reviewed by the Monitoring Team, the IDTs indicated that no barriers were present. In each of these cases, however, the IDT determined the most integrated setting to be BSSLC, based primarily on LAR choice. In these instances, the LAR preference that the individual remain at BSSLC was not typically identified as an obstacle that should be addressed with a strategy to overcome it, <u>Identification and Implementation by the IDT of Strategies Intended to Overcome</u>	

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		Obstacles: The Monitoring Team found many instances in which the IDT failed to identify in each individual's ISP the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences and the strategies intended to overcome such obstacles. For zero of eight (0%) recently completed ISPs did the IDTs adequately identify and implement strategies intended to overcome obstacles. Examples may be found in F1e and T1b2 of the failures of IDTs to implement strategies to enhance movement toward the most appropriate integrated setting. Conclusion: This provision was found to be not in compliance. New practices had been initiated that appeared to hold promise for guiding the IDT to make a thoughtful consideration of the most integrated setting appropriate to an individual's needs, the supports and services needed in that setting, the obstacles to movement and the devising of strategies to overcome those obstacles. For the most part, these new practices had not yet had a significant impact on the ability of the IDTs to consider each of these factors. Instead, it appeared they simply accommodated the new formats, but without applying the logic associated with them. The practice that seemed to hold the most immediate promise was the directive from State Office that all disciplines would make an assessment of the most integrated setting and provide recommendations for supports and services in that setting. While implementation was still spotty, there was an indication that IDT members were beginning to apply these requirements. This may, once universally implemented, provide the foundation for a more thorough consideration of community living 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.	Provision of Adequate Education About Available Community Placements to Individuals and Their Families or Guardians to Enable Them to Make Informed Choices: In December 2011, the parties met and agreed to a set of criteria for evaluation of Provision T1b2. The Monitoring Team had the following findings for each of the criteria: An individualized plan for each individual (e.g., in the annual ISP) that is: • Measurable, and provides for the team's follow-up to determine the individual's reaction to the activities offered • Includes the individual's LAR and family, as appropriate • Indicates if the previous year's individualized plan was completed. In the ISP process itself, the Monitoring Team found that little attention was devoted to careful assessment of the individual's specific need for education in this area, even when lack of awareness was identified as an obstacle to movement. For zero of eight (0%) recently completed ISPs were there individualized plans for increasing awareness of community living options that took into account the learning needs of	Noncompliance

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		the individual. Examples of the lack of an individualized plan included: • For Individual #406, who had indicated an interest in moving to the community, but whose guardian was opposed, the only plan by the IDT was to provide education upon request. • For Individual #50, the IDT identified there were no obstacles to community living, but further determined that BSSLC was the most integrated setting at the time so that the IDT might better determine his preferences and increase his understanding of community living. The IDT only recommended that he tour community living options twice during the upcoming year, even though he had no other community education experience since 2010. It was unlikely this tour schedule would be sufficient to meet his learning needs or allow the IDT to evaluate his preferences. <u>An annual provider fair that includes:</u> • Outcomes/measures are determined and data collected, including o Attendance (individuals, families, staff, providers) o Satisfaction and recommendations from all participants • Effects are evaluated and changes made for future fairs The Facility continued to hold an annual provider fair and was preparing to add a second fair scheduled for January 28, 2012. This was to be held on a Saturday in hopes of increasing family/LAR attendance, as weekday scheduling had been identified as a possible barrier for participation. <u>Regular SSLC meeting with local MRAs:</u> As a practice, the APC had held Interagency Planning Meetings with local MRAs and BSSLC to coordinate admissions and discharges and had continued this practice during the past six months. <u>Education about community options that ensures:</u> • Outcomes/measures are determined and data collected on, for example: o Number of individuals and families/LARs who agree to take new or additional actions regarding exploring community options. o Number of individuals and families/LARs who refuse to participate in the CLOIP process. • Effects are evaluated and changes made for future educational activities 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	

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		Monitoring Team reviewed a sample of ten CLOIP Worksheets for ISPs held during December 2011. For only two of ten (20%) had the MRA Service Coordinator held a discussion with the individual's LAR or correspondent. For only four of ten (40%) did the MRA Service Coordinator document the individual responded to the CLOIP interview in a way that indicated any meaningful understanding of the proceedings. Of these, one individual indicated a preference to remain at BSSLC, one gave ambiguous answers and two indicated a desire to live elsewhere. For these two individuals (Individuals #252 and 543), in particular, there was no apparent follow-up by the MRA Service Coordinator. <u>Tours of community providers in which:</u> • All individuals have the opportunity to go on a tour (except those individuals and/or their LARs who state that they do not want to participate in tours). • Places chosen to visit are based on individual's specific preferences, needs, etc. • Individual's response to the tour is assessed. The Facility provided a list, printed on December 9, 2011, of community tours that had been completed since during the last six months. A total of six tours had been provided during this period, with a total of 17 individuals (unduplicated) participating. As this was the only vehicle for acquainting individuals with community programs prior to a referral being made, this did not appear to provide sufficient opportunities for the 310 individuals residing at the Facility to obtain enough experience about community living to form an opinion, much less participate in informed decision-making. The Facility should examine how it might expand on the CLOIP tour process to make more such opportunities available to individuals. <u>Opportunities are provided to visit friends who live in the community</u> No evidence was provided as to the provision of such opportunities for individuals to visit friends who live in the community. <u>Education may be provided at:</u> • Self-advocacy meetings • House meetings for the individuals • Family association meetings, or • Other locations as determined appropriate The Facility did hold self-advocacy meetings for adults and youth, but a review of the	

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		minutes for the past six months indicated there had been no focus on community living options. No additional evidence was provided as to community living awareness opportunities occurring in other settings. <u>A plan for staff to learn more about community options that includes:</u> • management staff • clinical staff • direct support professionals The APC continued to provide training for various IDT members to educate them about community options, including the opportunity to attend provider fairs and training on the referral process and obstacles identification. The Facility should also consider CLOIP tours and other opportunities to visit community programs as part of its overall plan to assist staff to earn more about community options. The Facility provided lists of CLOIP tours, but did not provide a list of staff who may have attended. <u>Individuals and families who are reluctant have opportunities to learn about success stories:</u> • As appropriate, families/LARs who have experienced a successful transition are paired with families/LARs who are reluctant; • Newsletter articles or presentations by individuals or families happy with transition No evidence was provided as to the provision of such opportunities for individuals and families/LARs to learn about success stories. <u>Conclusion:</u> This provision was found to be not in compliance. The Monitoring Team commends the efforts of the Facility toward promoting education and awareness. Overall, BSSLC still failed to adequately assess, plan for, and implement a plan for each person's needs for education and awareness, as described in Provisions T1, F1 and F2. IDTs 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. These plans could include, and integrate, purposeful community integration activities; community tours; self-advocacy; community work, job exploration, and volunteer activities; developing and/or maintaining relationships with people living and working in the community, and other approaches the Facility might explore and create. All of these provide opportunities for increasing awareness of community living and should be considered in developing an integrated and individualized strategy for each individual.	

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	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	Assessment Practices Pursuant to Transition and Discharge Policies and Procedures: The Facility reported it used the Community Living Options Discussion Record (CLODR) as the process for assessing individuals for community placement. The Community Living Options discussion was not yet implemented in such a manner that it could be considered an effective assessment for placement. From observations and document reviews as described in Provisions F1e, T1a, and T1b above, this did not yet appear to be the case. The ability of the PSTs to engage in critical thinking, interdisciplinary assessment and actual person-centered planning was still developing and continued to require considerable investment in staff training and mentoring. DADS and the Facility had undertaken some efforts to improve these processes. The new ISP format, which was in the very early stages of implementation, placed additional emphasis on the living options discussion and specifically required the IDT to assess individual and LAR preferences as well as IDT recommendations in distinct sections, followed by a section entitled Living Option Determination at the conclusion of the plan. This appeared to have some promise in terms of identification of the most integrated setting appropriate to the individual's needs, a team decision that frequently was different from the actual team decision to make a referral for community living. This is discussed in more detail in F1e above. In addition, as noted in T1b1, IDT members were to provide a recommendation regarding the most integrated setting in their individual assessments, and this was not yet consistently occurring. Percentage of Individuals Assessed as Required: BSSLC reported that it did not have any evidence that any individuals had been assessed for placement. The Monitoring Team interviewed the Director of Quality Assurance, who had reported this evidence. He confirmed the Facility did not yet have adequate assessment practices in place to meet the requirements of this provision and were therefore not able to provide a list of individuals who had been assessed. The Monitoring Team concurred with this assessment of current status. Conclusion: This provision was found to be not in compliance. The Monitoring Team found there was no formal assessment process that included a substantive interdisciplinary evaluation and discussion. This was consistent with the Facility's own evaluation of their assessment process.	Noncompliance
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	There had been no changes to the CLDP process or policy since the previous site visit. Timeliness of Development and Implementation of CLDP: The Facility was working to ensure that IDT identification and recommendation of an appropriate integrated community setting resulted in a timely placement within the 180 day timeframe required by Texas DADS SSLC Draft Policy: Most Integrated Setting Practices 018.1, undated. It	Noncompliance

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	coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	was noted that at times there appeared to be an inordinate length of time between referral and submission of a referral packet to the MRA, and between receipt of the provider list from the MRA and the initiation of provider visits. For example: • For Individual #442, the referral date was 5/16/11, but the referral packet was not sent to the MRA until 11/30/11. • For Individual #375, the referral date was 6/1/11 and the packet was set to the MRA on 6/14/11. The MRA responded with the provider list on 7/14/11, but no pre-selection visits had yet been scheduled The Monitoring Team also reviewed the Community Placement Report, dated December 06, 2011. Of the six community placements that had occurred since August 2011, zero (0%) were completed within the 180 day timeframe, although several of these missed the mark by 15 days or less. The average time between referral date and community transition was 224 days. Four of the 13 current active referrals (29%) appeared to have exceeded the 180 days, with several more close to reaching that timeframe. Exploration and development of individualized community living options can be a time-consuming process and there are situations in which the 180 day timeframe will appropriately be exceeded. DAD's policy also acknowledges this and provides an avenue to apply for and receive a waiver when needed. 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. It should be noted here as a disclaimer that the evaluations above of these timeframes were based on the meeting dates that were listed in the Community Placement Report, which may not always accurately reflect the original referral date. The statewide database resets the meeting date to the most current ISP date when each new annual ISP data is entered, so it was found after review that, for at last two individuals (#173 and #181), the time elapsed from the original referral was longer by about one year than the Community Placement Report indicated. <u>Development of CLDP in coordination with the MRA:</u> A review of four completed CLDPs indicated that four of four (100%) evidenced that the plan was developed in coordination with the responsible MRA. In addition to the required participation in the referral meeting, the MRA attended the CLDP meetings and completed the Continuity of Care-Move Site Review Instruments for the Community Living Discharge Plan as further described in T1e below. <u>Conclusion:</u> Overall, Provision T1c as found to be not in compliance. At times there appeared to be an inordinate length of time between determination of referral and submission of a referral packet to the MRA, and between receipt of the provider list from the MRA and the initiation of provider visits. In addition, there were a number times in	

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		which placements did not occur within the 180-day requirement. The APC should develop and monitor a tracking list and make follow-up with IDTs to ensure timely actions when necessary. Overall, the Facility continued to make progress in terms of balancing timeliness of completing a transition with a cautious approach toward selection of the best provider for an individual. Coordination with the MRA in the development of the CLDP did not appear to be of significant concern at this time, but there remained concerns related to the adequacy of the CLDPs that were developed. Some of these concerns were related to adherence to policy, such as the identification of Facility staff to ensure each prescribed support was implemented as required. Other, weightier concerns had to do with the failure by the IDTs to adequately identify the appropriate essential and non essential supports for each individual. These deficiencies are described in more detail in T1c1, T1c2, and T1c3 below.	
	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.	<u>Identification of Essential and Non-Essential Supports:</u> 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 ISP. The IDT did appear to rely heavily on the ISP and the assessments associated with it to guide the identification of the essential and non-essential supports. The potential problem with this was that the IDTs did not demonstrate proficiency in overall needs assessment, the interdisciplinary process necessary to integrate the assessment findings into a comprehensive support plan, or the identification during the ISP planning meeting of the supports and services needed and desired in a community setting, as described in Provision T1b, Provision F1c, and Provision F2a. Examination of this element of the Settlement Agreement will therefore be contingent to some degree on a positive evaluation of these items at some point in the future. The Monitoring Team attended the single CLDP meeting held during the site visit, for Individual #7. Through record review, the Monitoring Team identified significant health concerns and other needs the team had failed to adequately assess prior to the CLDP meeting, nor were they adequately addressed during the CLDP meeting. Examples of the concerns identified included, but were not limited to, a possible cardiac condition, recent exacerbation of gait abnormalities without an examination of etiology, hypertension management, serious adverse outcomes from medications in the past including lithium toxicity, remains a risk for metabolic syndrome, and a history of adverse reactions and potential for medication adversities, among others. Because the IDT was unaware of these circumstances and/or the potential for harm, they were unable to ensure the provider was sufficiently aware of the potential for harm nor ensure strategies were developed to ensure protection, either at the Facility or for the new living environment.	Noncompliance

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		Coordination of CLDP with provider staff: A review of completed CLDPs and participation in the CLDP meeting held while on site during this monitoring visit indicated provider staff were very involved in the CLDP process. The Monitoring Team recommends that the Agreements section of the CLDP may be used more creatively to ensure adequate supports, services, and protections are provided and maintained. For example, during the CLDP for Individual #7, there was a concern raised about the individual's need for certain medications and whether there may be a lapse in medications if the 30-day supply provided by BSSLC ran out before the individual's community Medicaid took effect. The Monitoring Team suggested this might be a place for an agreement to be forged that would ensure the provider as willing to cover the medications if such a lapse were to occur. This was added to the standard agreements. As another example, SSLC staff have indicated at times that community providers do not notify them of certain incidents that may indicate an adjustment concern for an individual, particularly one that might benefit from technical assistance from the individual's IDT. The agreements section may be used to specify circumstances in which the provider agency will notify the Facility of such concerns. Conclusion: This provision was found to be not in compliance.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	Responsible staff identified for needed actions: For zero of four (0%) completed CLDPs reviewed did the Facility consistently identify the Facility staff responsible for each of the essential and non-essential supports. Instead, the responsible party was often listed simply as BSSLC or the provider agency's name. Only rarely were specific responsible parties listed by name. It was not clearly stated that Facility staff had any responsibility to monitor or follow up with the designated provider staff to ensure implementation and/or timeliness for each and every support. Completion timeframes for needed actions identified: For four of four (100%) completed CLDPs reviewed, the Facility did consistently identify timeframes for completion for each of the essential and non-essential supports. Conclusion: This provision was found to be not in compliance. CLDPs should identify the responsibility of the provider agency staff to actually implement certain action steps, but should also assign responsibility to Facility staff by name to ensure that all required activities are completed, even if a provider or MRA staff has primary responsibility for the activity. The implementation of the Facility Pre-Move Site Visit may provide an avenue for designating the responsibility of Facility staff, as the APC could take responsibility for ensuring the completion of essential supports and plans for non-essential supports at the time of the Pre-Move Site Visit.	Noncompliance
	3. Be reviewed with the	Review of CLDP with Individual and, as appropriate, the LAR: A review of both	Substantial

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	individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	completed and partial CLDPs indicated individuals participated in CLDP proceedings and that IDTs considered the responses of individuals to pre-selection visits in making selections of providers. Review of these documents also indicated that families and LARs were kept informed and their input was solicited at appropriate steps throughout the CLDP process. Conclusion: This provision was found to be in substantial compliance.	Compliance
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.	Adequacy of Assessment: Assessments were still not being consistently well integrated into a comprehensive assessment in a manner that allowed for the CLDP to adequately reflect the needs and supports to be provided in the community setting. In order to be considered a current and comprehensive assessment of needs and supports, the findings and recommendations must be accurate and reflect all significant information the PST and the community provider would need to develop an appropriate transition plan. As described in Provision T1c1, the Monitoring Team identified significant health concerns and other needs for Individual #7 the IDT had failed to assess prior to the CLDP meeting. The Monitoring Team did not review closed records for other individuals who had moved to the community to ascertain whether assessments completed prior to their moves accurately reflected their needs for supports and services, but the findings for Individual #7 called into question the assessment processes and findings that must form the basis for this required comprehensive 45-day assessment. The Monitoring Team interprets this requirement of comprehensiveness to include that the assessment must accurately reflect needs for supports and services, not simply that assessment documents be produced within 45 days of departure. The Monitoring Team strongly recommends the Facility take action, through policy directive, training and quality monitoring, to assure assessments are being completed in a thorough, accurate and detailed manner. Timeliness of Assessment: The APC had instituted a "pre-CLDP" meeting to review assessments and make assignments for any updates or revisions that needed to be made to the current assessments. This was a positive practice that should be continued. The final assessments were then reviewed as a part of the CLDP meeting. These processes in themselves appeared to be adequate for purposes of ensuring that assessments were available and current within 45 days prior to the individual leaving the Facility. BSSLC needed to focus its attention on whether these assessments were adequately prepared as described immediately above. Conclusion: This provision was found to be not in compliance. Facility action must address the adequacy of assessment practices overall before compliance can be achieved under this provision.	Noncompliance

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T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	MRA Continuity of Care Process: The Monitoring Team reviewed six MRA Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan and found that these were not always completed in accordance with policy expectations. In some instances, items to be reviewed were not documented as required. Examples included: • For Individual #2, the MRA did not indicate whether the site manager/administrator verified services and supports could be provided that were necessary to assist the individual in achieving outcomes. • For Individual #594, the MRA did not indicate whether the site manager/administrator responded that there were any DADS identified environmental or safety concerns at the time of its last visit to the residence. • For Individual #294, the MRA did not verify on the DADS Quality Reporting System website that the residential provider contract was in good standing. These missing elements were of particular concern because there was no evidence provided that the Facility noted the discrepancies and/or followed up to ensure that all requirements were met. Pre-Move Site Visit Completed by Facility: BSSLC had also been completing Pre-Move Site Reviews, as required by policy. The Monitoring Team requested copies of all Pre-Move Review Site Reviews for individuals who had moved to a community home since the last monitoring visit. Reviews for eight individuals were provided for Monitor review, which was completed off-site following the monitoring visit. The documents reviewed appeared to have been completed in a timely manner following the CLDP and prior to the actual transition date, per the completion date. The instrument also calls for the attestation that verified the provider is in good standing with DADS, using the DADS Quality Reporting System website, and to attach the printed verification. These were included for zero of the eight individuals (0%). Conclusion: This provision was found to be not in compliance. The Facility must follow-up on any deficits or gaps in information identified through the MRA Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan. It must also ensure its own Pre-Move Site Reviews include all the required elements, including the attestation the provider is in good standing.	Noncompliance
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility	Quality Assurance Processes to Ensure Development of CLDPs: Other than the process by which the APC tracks the provision of the 45-Day assessments by the various disciplines and review of each CLDP by a DADS APC Specialist, there were no formal quality assurance processes in place to ensure development of CLDPs. The Monitoring Team found that the quality and timeliness of assessments have become	Noncompliance

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	implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	critical factors that hamper the development of appropriate and comprehensive CLDPs, as further described above in T1d. It was reported that a QA Auditor had been assigned to monitor Section T as of 11/28/2011. As of the date of this Monitoring visit, no monitoring results were available. Quality Assurance Processes to Ensure Implementation of CLDPs: The Pre-Move Site Review conducted by the APC had provided an additional layer of scrutiny to ensure that essential supports were in place prior to an individual leaving the Facility. The Monitoring Team commended this initiative, as the existing MRA pre-move site visit did not focus heavily on ensuring specific supports were in place. A Program Auditor had been recently assigned to accompany the Post-Move Monitor on PMM visits to monitor the accuracy of the findings. Conclusion: This provision was found to be not in compliance. The Facility had initiated some actions toward developing quality assurance processes. This was a positive step. It is recommended that clear performance goals and outcome measures be defined, along with appropriate methodology for obtaining the data. BSSLC should also ensure these are coordinated with quality assurance measures that address the overall quality of assessments at the Facility.	
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,	Obstacle Information Gathered: The APC was beginning to gather data on the obstacles. • Data for five fiscal years, 2007 through 2011, were reported in the new annual report. Data included number of placements, types of obstacles identified (even though the data collection system was noted to be flawed), and the concerns of LARs and individuals that led to their preference to not be referred. • The data system needs to be able to separate out the difference between an obstacle to referral and an obstacle to placement. • The data system only allowed one obstacle to be recorded per individual. This confounded the data. Annual Obstacle Analysis by Facility: The APC had written an assessment report regarding these obstacles, with data through 8/31/11 (i.e., for fiscal year 2011). The report focused on obstacles to referrals for transition to community living and developed action plans to address these, as well issues of data integrity • A high level of individual and LAR reluctance o The majority of LAR concerns were about feeling uncomfortable with the individual living in the community and providers not being able to meet needs. The APC proposed educational opportunities to help ease fears. • A high level of rescinded referrals o The cause for the increase in rescinded referrals was postulated to be that	Noncompliance

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	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.	IDTs made referrals when guardianships lapsed that were later rescinded when the guardianship was renewed. • Problems in the way the Facility collected data on obstacles. o The APC described a plan for additional training for IDTs, LARs and families regarding the identification of obstacles to transition. Training for IDT members began in August, 2011, and will be completed on a semi-annual basis. Plans for providing training to LARs/families are to be developed in the future. <u>Appropriate Steps Taken by DADS to Overcome or Reduce Identified Obstacles:</u> DADS took steps to overcome or reduce these obstacles. • DADS created a report summarizing obstacles across the state and included the Facility's report as an addendum/attachment to the report. The statewide report was dated October 2011. • The statewide report listed the 13 obstacle areas used in FY11. DADS will be improving the way it categorizes and collects (and the way it has the facilities collect) data regarding obstacles. • DADS indicated actions that it would take to overcome or reduce these obstacles o Eleven numbered items were listed. Five were related to the IDT process and upcoming changes to this process, three were related to working with local authorities and local agencies, two were related to improving provider capacity and competence, and two were related to funding initiatives regarding slot availability and the new community living specialist positions. In general, these were descriptions of the early steps of activities related to addressing obstacles to each individual living in the most integrated setting. o DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS). <u>Conclusion:</u> This provision was found to be not in compliance, although activities at the facility and state levels demonstrated progress towards substantial compliance with this provision item. Improvements in data collection and analysis, implementation of new ISP processes, and actualization of the planned activities to overcome or reduce obstacles will be necessary for substantial compliance to be obtained.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall	<u>Timeliness:</u> The Facility issued a Community Placement Report on Tuesday, December 06, 2011, covering the period of 8/1/2011-12/6/2011. The report was issued in a timely manner.	Substantial Compliance

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	issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	Required Reporting Categories: The report was in the standardized format as prescribed by DADS State Office. It listed: • Six community placements • Thirteen current referrals • Two rescinded referrals • Three individuals who preferred community, not referred-LAR choice • One individual who preferred community, not referred-other reason • One individual for whom the LAR prefers community, not referred. During December 2010, the Monitoring Teams requested some information regarding transition be added to the reports in order to capture categories of individuals who had either requested community transition, or whose teams had determined they could be appropriately placed in the community. The State worked with the Monitoring Panel to add categories to the Community Placement Report template each of the Facilities uses, including Individual Prefers Community, Not Referred – LAR Choice; Individual Prefers Community, Not Referred – Other Reasons; and LAR Prefers Community, Not Referred, and these are included in this report. It was not clear that the data provided in one of these categories was accurate. While the Community Placement Report lists only three individuals who preferred community, but were not referred due to LAR choice, BSSLC's annual obstacles report lists 28 such individuals in *Table 4: Individuals not recommended for movement that prefer to reside in the community from the Brenham State Supported Living Center, FY 2011.* The Monitoring Teams also asked that a final category be added that includes a list of names of individuals who would be referred by the IDT except for the objection of the LAR, whether or not the individual himself or herself has expressed, or is capable of expressing, a preference for referral. As noted above with regard to provision T.1.a of the Settlement Agreement, professionals on individuals' teams need to make independent recommendations regarding the appropriateness of an individual for community placement. The State indicated that at this time, its data system did not include this information, but it was working toward being able to produce the data the Monitoring Panel requested. The Monitoring Team observed during this site review that many IDTs continued to find no barriers to community living, yet decided BSSLC was the most integrated setting based on the LARs' preferences. In addition, as noted in T1g above, the Facility produced data in its annual obstacles report that indicated LAR choice was frequently the only reason IDTs did not make a referral. The Monitoring Team looks forward to reviewing data that provides an accurate picture in this area in the future. Conclusion: This provision was found to be in substantial compliance, as the report was made in a timely fashion and included the required data as agreed among the parties.	

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		The Monitoring Team notes its concern related to the accuracy of some of the data and encourages DADS and the Facility to examine these issues.	
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.	A new Post-Move Monitor had been hired on November 1, 2011 to replace the staff person who resigned in August 2011. This new staff person had been a QDDP at the Facility prior to taking on the Post-Move Monitor role. The APC had provided training that included partnering with the Post-Move Monitor throughout PMM visits that had taken place since the hiring. Some additional training with a Post-Move Monitor from another facility was expected to take place in the near future. During the transition following the resignation of the incumbent Post-Move Monitor, Individual #9 died in the community under circumstances that might possibly have been addressed and ameliorated by a more rigorous PMM process. These circumstances are described more fully below under Facility's Best Efforts to Ensure Supports are Implemented and Use of Standard Assessment Tool. The Monitoring Team reviewed PMM Checklists for eight individuals who had moved to the community since July 2011 and interviewed the APC and newly-hired Post-Move Monitor. The Monitoring Team assessed both timeliness of the PMM visits and the use of the standardized tool for completing the assessment for the presence of CLDP-prescribed supports. Findings included: Timeliness of Post-Move Monitoring Visits: The Monitoring Team found that the PMM Checklists were being completed in a timely manner in most cases. Each of the 7, 45 and 90-day PMM visits were made within the required timeframes. The only exception noted was the 45-Day Checklist for Individual #9, which was completed under questionable circumstances. It was not clear when the 45-day PMM Checklist was completed, as the APC reported the visit itself was made by the resigning Post-Move Monitor on August 17, 2011, but the Checklist was later filled out by the APC. The APC reported this was accomplished through a phone conversation with the former Post-Move Monitor. However, in a review of the PSPA following the site review on October 21, 2011, it was documented that the IDT recognized on that date that a 45-day Checklist had never been completed for a visit that was reported to have occurred on August 17, 2011. This called into question whether the 45-day Checklist provided to the Monitoring Team for review was completed prior to the individual having a fatal accident shortly after the end of the 90-Day monitoring period. (See below in this section for additional details regarding this case.) It is recommended that PMM Checklists should be signed and dated by the person	Noncompliance

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		filling it out on the date it is completed. Use of Standard Assessment Tool: In each case, the PMM visits were documented using the prescribed standardized tool, the Post-Move Monitoring Checklist as revised in May 2011. In at least two instances, the Checklist was recorded by the APC at some point following the completion of the actual PMM visit by the Post-Move Monitor. These both occurred in mid-August as a result of the resignation of the Post-Move Monitor. It was reported by the APC that the resigning Post-Move Monitor relayed the information to the APC by phone. One of these was the 45-day PMM checklist for Individual #9 who died shortly after the 90-day visit. Assessment of Presence of Supports Called for in CLDP: BSSLC did not consistently provide an adequate assessment of the presence of supports called for in the CLDP. In the most serious of these instances, Individual #9 died following a series of behavioral incidents. Individual #9 was known to have behavioral concerns, including a propensity to leave an environment without adequate supervision. Shortly after the 90-day PMM visit, the individual again ran into traffic during a behavioral incident and was struck by a car and critically injured. Individual #9 was hospitalized for eleven days, requiring multiple and extensive surgeries, before dying as the result of injuries. Incidents of this type had not been adequately reported in the 45 and 90-day PMM visits, including one in which the individual ran into traffic and caused an accident which resulted in injury to a staff person. The lack of adequate assessment of the individual's need for behavioral support led to an inadequate response and follow-up by the Facility, as described in more detail under the next heading. Other deficits identified in the process of assessing the presence of supports included: • There were some other occasions in which no documentation was entered in a support category. For Individual #294, there was no indication of the presence of PJs to be worn at night, an essential support, for either of the 7 or 45-day PMM visits. • There were instances found in which the Post Move Monitor noted that a nonessential support was not due or in place at a 7-Day visit and that follow-up would take place at the following 45-Day visit. The Post Move Monitor did not consistently obtain and document the plan for putting those non-essential supports into place. This should be accomplished as a rule, but is particularly important when supports need to be put into place between the 7 and 45-Day visits. • As described in Provisions F 1c, F1d, F2, and T1c1, there also continued to be some barriers to thorough PMM review as a consequence of the failure of the IDTs to adequately assess the needed supports of individuals either at the	

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		Facility or in the community. The IDTs also did not yet provide adequate direction to the Post-Move Monitor as to the evidence required to accurately ensure the presence of essential and non-essential supports. For example, in many instances the IDTs continued to indicate the evidence required to verify essential supports related to training were to be only a training roster. This was observed both in the documents reviewed and during the CLDP held during this site visit. As described in Provisions T1c1 and T1e, the Monitoring Team provided substantial technical assistance to the IDT to think through the various types of evidence that could ensure the supports were being adequately implemented. It is worth repeating here that the IDT should clearly state the necessity to interview and observe for staff compliance and knowledge in addition to the paper review of a training roster. Facility's Best Efforts to Ensure Supports are Implemented: The Monitoring Team found that the Facility did not take and/or document adequate follow-up to ensure supports were implemented in all cases, as exemplified in the circumstances surrounding the death of Individual #9. The Facility did not engage the individual's IDT in review of the PMM findings and request assistance as is required by state policy during the initial 90 day-period and no technical assistance was provided by the Facility's IDT. The only documented meeting of the IDT occurred on 10/21/11, one day after the fatal accident had occurred, although before the individual died. It was noted in the PSPA at that time that the IDT recommended that the APC should correct the 90-Day PMM Checklist for several items, including to incorporate dates of when the individual had displayed challenging behaviors. These additions, made on October 25, 2011, indicated at least one more behavioral incident than was included in the original Checklist. These circumstances further reflect the deficits in thorough documentation. The IDT also recommended that the BSSLC Quality Assurance Department should review the incident and develop an action plan for the Facility to improve communications between the Facility IDTs and the monitoring system. The Monitoring Team was not provided with any documentation of such a plan. The POI did make a general reference to steps of 1) scheduling a meeting with IDT, community provider, and MRA if issues/concerns are noted during the 7, 45, or 90 day PMM visits, and 2) conducting reviews of PMM checklists to ensure compliance with this provision, but these steps were simply a reiteration of the requirements of policy. There was no specific action plan to address the obvious flaws in the Facility's implementation of the policy steps. The Monitoring Team urges the Facility to complete the review of the circumstances of this tragic situation and develop a detailed and measurable action plan to ensure it does not recur. It should be pointed out that this failure to adequately follow-up or document that	

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		follow-up was not an isolated incident. There were other instances in which the Post-Move Monitor failed to document any follow-up when needed supports were not in place. For example, for Individual #294, the Post-Move Monitor indicated the individual was not actively engaged in meaningful activities designed to address his/her needs at both the 7 and 45-day visits, but failed to provide any comments as to the nature of the situation or recommended follow-up. <u>Conclusion:</u> This provision was found to be not in compliance. The Monitoring Team remained very concerned that the PMM process had not been implemented in a sufficiently rigorous manner. Deficits in the transition process, from both the CLDP and the PMM, had appeared to reduce the ability of the Facility to address deficiencies in providing supports, and that these deficiencies may have played a part in post-transition deaths that had occurred in each of the past three monitoring periods. The Monitoring Team met with the APC and PMM to convey this concern and provided an explicit description of the expectations regarding careful Post-Move Monitoring. The Monitoring Team will expect to see the following, at a minimum: 1. The Post-Move Monitor takes an active role in ensuring the supports identified in the CLDP are appropriate and measurable, and that the IDT prescribes sufficient and appropriate methodology for obtaining evidence that supports are being implemented as required. 2. All PMM visits are completed on a timely basis as required and as dictated by the needs of each individual; 3. Sufficient documentation of the presence of supports is made in writing and kept in a comprehensive file that includes documentation of all follow-up actions taken by the PMM. This may include, but not be limited to: copies of incoming and outgoing emails; copies of all evidentiary documents collected pertaining to the individual's support needs before during or after the PMM visit; notes to the file regarding phone conversations; 4. Sufficient documentation of the plans in place to implement supports that have due dates following the PMM visit; 5. In addition to the above, documentation of all interaction with the individual's IDT regarding the individual's adjustment and the identification and accomplishment of any technical assistance needed to ensure a successful transition.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move	The Monitoring Team was not able to review the accuracy of the Facility's monitoring of community placements during this site visit as none were scheduled. The Facility had suggested completing a "mock" visit in which it would essentially re-enact the 90-day visit that had already been completed. It was determined this would not satisfy the SA requirement that such visits shall occur before the 90th day following the move date, and	Not Rated

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	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.	would not necessarily provide an adequate basis for evaluating the accuracy of the Facility's monitoring during that crucial period. In the future, the Facility may want to consider, if otherwise appropriate to an individual's needs, choosing to schedule a PMM visit earlier than the projected 7, 45 or 90-day dates. This would be consistent with the policy that the PMM visits occur within those windows of time, rather than specifically on or near the actual 7th, 45th or 90th date. For example, a 45-day visit may occur any time within the 7-45 day window, so long as adequate consideration is given to the actual needs of the individual for the timing of the monitoring visit. Other Actions: The Facility reported that a Program Auditor had been assigned to accompany the Post-Move Monitor on all PMM visits to review the accuracy of the Post-Move Monitor's monitoring of community placements. The Monitoring Team commends this step, particularly given the short tenure of the new Post-Move Monitor and the serious issues with deaths that have occurred during transition periods and been reported on by this Monitoring Team over the past three site visits. Conclusion: This provision was not rated.	
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.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the	BSSLC did not have any alternate discharges during the past six months. The response to the document request indicated one such placement had taken place, but this placement actually took place prior to the previous site visit and was reported on in the last monitoring report.	Not Rated

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	provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	Conclusion: This provision was not rated, as the Facility had no alternative discharges during the past six months to evaluate.	

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

1. IDTs 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. (Provision T1b2)
2. The Facility should examine how it might expand on the CLOIP tour process to make more such opportunities available to individuals. (Provision T1b2)
3. Ensure timeliness of actions related to referrals and community placements are included in its development of the quality assurance procedures required under Provision T1f. Quality assurance processes should be undertaken focusing on whether an adequate and reasonably intensive exploration and development process is taking place, including the collection of data regarding the number and types of community exploration activities undertaken for each individual on the list of current referrals. (Provisions T1b1, T1d, and T1f)
4. The Facility should take action, through policy directive, training and quality monitoring, to assure assessments are being completed in a thorough, accurate and detailed manner. (Provision T1b)
5. The APC should develop and monitor a tracking list of action steps that need to be implemented once a referral is made and make follow-up with IDTs to ensure timely actions when necessary. (Provision T1c)

6. The Agreements section of the CLDP should be used more creatively to ensure adequate supports, services and protections are provided and maintained. (Provision T1c1)
7. CLDPs should identify the responsibility of the provider agency staff to actually implement certain action steps, but should also assign responsibility to Facility staff by name to ensure that all required activities are completed, even if a provider or MRA staff has primary responsibility for the activity. The implementation of the Facility Pre-Move Site Visit may provide an avenue for designating the responsibility of Facility staff, as the APC could take responsibility for ensuring the completion of essential supports and plans for non-essential supports at the time of the Pre-Move Site Visit. (Provision T1c2)
8. Clear performance goals and outcome measures for ensuring the development and implementation of the CLDP should be defined, along with appropriate methodology for obtaining the data. BSSLC should also ensure these are coordinated with quality assurance measures that address the overall quality of assessments at the Facility. (Provision T1f)
9. DADS and the Facility should examine the accuracy of data in the Community Placement Report, particularly related to a) original referral dates for community living and b) the number of individuals who prefer community living but are not referred due to LAR choice. (Provision T1h)
10. Post-Move Monitoring documentation should include, at a minimum:
    a. The Post-Move Monitor takes an active role in ensuring the supports identified in the CLDP are appropriate and measurable, and that the IDT prescribes sufficient and appropriate methodology for obtaining evidence that supports are being implemented as required.
    b. All PMM visits are completed on a timely basis as required and as dictated by the needs of each individual;
    c. Sufficient documentation of the presence of supports is made in writing and kept in a comprehensive file that includes documentation of all follow-up actions taken by the PMM. This may include, but not be limited to: copies of incoming and outgoing emails; copies of all evidentiary documents collected pertaining to the individual's support needs before during or after the PMM visit; notes to the file regarding phone conversations;
    d. Sufficient documentation of the plans in place to implement supports that have due dates following the PMM visit;
    e. In addition to the above, documentation of all interaction with the individual's IDT regarding the individual's adjustment and the identification and accomplishment of any technical assistance needed to ensure a successful transition. (Provision T2a)

The following are offered as additional suggestions to the Facility:

1. The Facility may want to consider, if otherwise appropriate to an individual's needs, choosing to schedule a PMM visit earlier than the projected 7, 45 or 90-day dates. This would be consistent with the policy that the PMM visits occur within those windows of time, rather than specifically on or near the actual 7th, 45th or 90th date. For example, a 45-day visit may occur any time within the 7-45 day window, so long as adequate consideration is given to the actual needs of the individual for the timing of the monitoring visit.

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Brenham State Supported Living Center (BSSLC) Plan of Improvement (POI), updated 12/30/2011 2. Brenham State Supported Living Center Presentation for January 2012 for Settlement Agreement Monitoring Team Visit 3. Section U Presentation Book materials 4. ISP for Individual #144 5. ISP Addendum for Individual#598 6. List of individuals for whom a guardian had been obtained in the last six months 7. Restriction List, dated January 16, 2012 8. DADS draft policies, undated: Guardianship; Advocate; Self-Advocacy; Affirming and Protecting Rights 9. ISPs and Rights Assessments for seven Individuals: #1, #8, #50, #130, #308, #367, $381 10. Minutes of Self-Advocacy meetings held for the past six months **People Interviewed:** 1. Cheryl Powell, Human Rights Officer (HRO) 2. Kimberly Behrens, Director of Community Relations **Meeting Attended/Observations:** 1. Human Rights Committee 2. ISP for Individual #21
	Facility Self-Assessment: The Monitoring Team reviewed the BSSLC POI. BSSLC indicated it was not yet in compliance with any of the provisions for Section U. The Monitoring Team concurred with this assessment. The POI indicated that the DADS statewide policies, procedures and practices that will provide guidance to the facilities in these requirements of the Settlement Agreement were still pending final issuance and that it was awaiting this final guidance prior to developing local policies. As the Facility anticipates the promulgation of these policies, it should also consider what outcome and/or performance measures it will use to assess progress once policies are in place and being implemented. These measures may then be used to support the self-assessment process in the future. The POI listed some of the actions the Facility had taken or was planning to take to meet the requirements for this Provision. For example, it had developed a plan to restore the BSSLC Advocate Program in order to obtain advocates for individuals served and updated and revised all Advocate Program documents; begun training of QDDPs on the step of obtaining an advocate; obtained a local attorney to offer services for a discounted fee, if needed, for family members or anyone seeking guardianship of individuals at BSSLC; and, continued to make routine updates to the list of individuals in need of guardians.
	Summary of Monitor's Assessment: BSSLC indicated it was not yet in compliance with any of the provisions for Section U. The Monitoring Team concurred with this assessment. The POI indicated that the DADS State Office workgroup is continuing to work on development of statewide policies, procedures and

	practices that will provide guidance to the facilities in these requirements of the SA. During on-site interview, the Facility reported it was awaiting this final guidance prior to implementing significant changes. A summary of the findings follows: **Provision U1:** This provision was determined to be not in compliance. BSSLC did maintain a list of individuals in need of a guardian that was updated regularly, but the list was not currently prioritized. There was no standardized process by which an individual's discrete needs for decision-making and informed choice were assessed. The Facility IDTs and HRC often failed to recognize a decision that an individual could not give informed consent in many broad areas of life constituted a restriction that needed to be carefully reviewed and then addressed with a plan to ameliorate, just as with other restrictions such as money management or behavior support. The Monitoring Team commends early efforts by the HRO to help teams begin to engage in more thoughtful consideration of an individual's need for guardianship, including both training and hands-on technical assistance, but there remained a substantial need for additional guidance and training from DADS in this area. **Provision U2:** This provision was determined to be not in compliance. Three new guardians had been obtained during the past six months. The pending policy on Guardianship would designate the HRO as the Facility's Guardianship Coordinator and require establishment of a Guardianship Committee. The HRO reported the Committee would not be formally established until the final statewide policy was available. The draft of the policy should more clearly state the role of the Committee in assisting individuals to obtain guardians. In advance of the promulgation of the statewide policies, the HRO had undertaken several activities to enhance resources for individuals who may require assistance with decision making, such as negotiating with a local attorney to provide guardianship assistance at a reduced rate to potential LARs, working with the Community Relations Department to re-establish an Advocacy program, establishing a youth self-advocacy program and taking preliminary steps toward forming a Guardianship Committee. These steps were to be commended.

#	Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision 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:	<u>Status of Policies and Procedures:</u> Statewide policies and procedures remained in draft form, according to the HRO. The statewide drafts previously made available to the Monitoring Team for review included policies on Guardianship, Advocate, Self-Advocacy and Affirming and Protecting Rights. It was not known when these policies would be finalized, and the Facility was awaiting final versions before localizing the requirements. No changes had been made to Facility policies in this area in the meantime. <u>Maintenance of Prioritized List:</u> The Facility maintained a list of individuals in need of guardianship, organized by area of residence. This list was entitled Restriction List and included certain other information regarding rights restrictions for each individual. It did not appear to be comprehensive in this later regard as it did not include all restrictions on individuals' ability to give informed consent. The Monitoring Team also	Noncompliance

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	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.	reviewed the list for timeliness of updates to the list and the prioritization process. • Timeliness of Updating Process: The HRO reported she continued to update the list on an ongoing basis. The most recent list reviewed was dated January 16, 2012. She also noted many of the individuals have lapsed guardianships, but that she continues to send out renewal notices and assists as much as possible with gathering and submitting documents for those renewals in order to avoid such lapses whenever possible. • Prioritization Criteria: The list provided for review was not prioritized. The pending statewide policy on Guardianship provided instructions as to the prioritization criteria to be used in considering the need for guardianship and designating a priority status for each individual. DADS may want to review the somewhat differently worded instructions for prioritization in the draft policy on Guardianship on page 4 under Guardianship list and in number 5 of Exhibit A to ensure a consistent process. BSSLC reported it had not made formal changes to its written prioritization processes as it awaited the final statewide policies. Assessment of Functional Capacity to Render a Decision: The Facility reported the IDTs did not use an individualized assessment process to determine that an individual was in need of an LAR or to what extent or for what discrete purposes guardianship was required, and the Monitoring Team concurred. The Monitoring Team found that, consistent with the lack of a robust and thoughtful approach to assessment in many areas as documented throughout this report, the PSTs still did not adequately assess decision-making capacities nor develop appropriate action plans to address deficits. The Monitoring Team did review seven Rights Assessments, a tool used annually as part of the ISP to assess and document rights restrictions. There is a segment in the Rights Assessment that addresses an individual's capacity to give informed consent in seven categories. As has been the case in each previous site visit, the Monitoring Team found each of the individuals reviewed were determined by the IDT to be unable to provide informed consent in every category. At the same time, the Monitoring Team found little evidence to document how the IDT assessed each individual's capacities in each of these categories. The Monitoring Team also reviewed the ISPs for these individuals and found little such evidence was included in those documents, either, as only one of the seven (14%) included giving or withdrawing informed consent in the discussion of rights restrictions. Even for this individual (#481), no assessment was used to justify the rationale that the individual would not be able to understand, nor were any strategies developed to enhance the individual's ability to participate in decision-making. The HRC also failed to adequately review the restrictions on informed consent made by the IDTs. The Monitoring Team found the HRC did not routinely address the Informed Consent section of the Rights Assessment, even though this section usually indicated individuals were not able to give informed consent. During the HRC meeting held during	

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		the site visit, the Monitoring Team did not observe the committee to address this section during its review of the annual Rights Assessments. The Monitoring Team also noted the Facility maintained a Restriction List. This list indicated, among other things, the restrictions approved by the HRC for each individual named. There were "informed consent" restrictions noted in many instances, but none of these were related to the seven areas of informed consent included in that Rights Assessment category. The HRC should apply the same standards for review of this restriction of informed consent that it applies to other restrictions identified in the Rights Assessment. In a positive step toward enhancing these assessment processes, the HRO had been providing some training and technical assistance to IDTs in consideration of the need for guardianship. For example, the HRO provided guardianship training to the QDDPs and Social Workers in October 2011. This training was attended by 27 staff. The curriculum also included an overview of the developing Advocacy program and how to make a referral. In addition, the HRO had begun to provide hands-on technical assistance to IDTs in the process of considering guardianship issues. Two examples were provided in the Presentation Book for Section U; one was as a part of the ISP annual meeting and one was an addendum for the purpose of considering the need for a guardian. The Monitoring Team commends this effort by the HRO to help teams begin to engage in more thoughtful consideration of an individual's need for guardianship, but had reservations about the apparent outcomes of the process at this point. In both examples reviewed, there was no specific discussion of how the IDT evaluated the individual's decisional capacity, other than general statements that the teams made a determination based on staff observations and/or the Functional Skills Assessment. There were also no specific action plans devised to address assisting the individual to enhance decisional skills. The Monitoring Team found the documented team discussion for Individual #144 to include some valuable and important points, such as sharing with the individual's potential guardians the need to take the individual's wishes into account and support the individual's independence; however, the IDT's recommendation for a blanket guardianship of person due to "challenging behaviors" and a psychiatric diagnosis did not include any additional recommendation about how the individual might be supported to participate in the decision-making process. This was of particular concern because the individual was noted to be very vocal about wants and needs, able to express opinions in many areas of life, and able to set personal goals at a certain level. A guardianship decision or recommendation should have addressed these issues in detail. Facility IDTs continue to need training from DADS to prescribe a process for how an assessment should be accomplished and how to use the results to determine a person's specific range of decision-making abilities so that guardianship does not extend beyond	

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		the areas needed by the person. The most relevant of the draft policies to provision of guidance to the IDTs in assessing the decisional capacity of individuals was Affirming and Protecting Rights. This policy included a revised version of the Rights Assessment that had a greatly expanded section on the evaluation of an individual's capacity to give or withdraw informed consent. This was a positive step. The Facility may wish to consider additional resources regarding decisional capacity, which exist nationally, that may further inform and amplify the development of needed training. A sampling of such resources include:: • *Decisions By and For People with Mental Retardation: Balancing considerations of Autonomy and Protection*, James W Ellis; • *Decision-Making Capacity in Adults: Its Assessment in Clinical Practice, Bellhouse,* et al; • *Alternatives to Guardianship* on-line training found at maine.gov/guardianship, which provides additional assessment documents; and, • A variety of resources found at guardianship.org Conclusion: This Provision was found to be not in compliance. While the Facility did maintain a list of individuals it deemed to be in need of a guardian that was updated regularly, the list was not currently prioritized. There was no standardized process by which an individual's discrete needs for decision-making and informed choice were assessed, such that it remained unclear a decision to recommend guardianship was based on an adequate rationale. It was also not clear the Facility IDTs and HRC viewed their decision that an individual could not give informed consent in many broad areas of life as a restriction that needed to be carefully reviewed and then addressed with a plan to ameliorate, just as with other restrictions such as money management or behavior support.	
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	Status of Policies and Procedures: As indicated above under Provision U1, statewide policies and procedures pertinent to Provision U2 remained in draft form. The draft policies included those on Guardianship, Advocate and Self-Advocacy. Local policies had not yet been modified, but such action was anticipated to be completed once the statewide policies were formally promulgated. Efforts to Obtain LARs: New guardians for three individuals had been obtained during the past six months, and one additional guardianship was in process. The Facility had initiated some efforts toward obtaining LARs or other resources for individuals in need of assistance for decision-making and informed consent. • Guardianship Committee: The draft statewide policy designates the HRO as the Guardianship Coordinator for the Facility. According to the draft statewide Guardianship policy, a Guardianship Committee is to be developed that will be	Noncompliance

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	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.	responsible for developing, prioritizing and maintaining a list of individuals who do not have either the functional capacity to make decisions regarding their own health or welfare or an existing LAR to make such a decision. The HRO reported she had identified members for this committee, but did not plan to formally constitute it until the pending statewide policy was finalized. The identified members included the following Facility staff: a QDDP, a Program Auditor, a Nurse, and a Psychology Tech. In addition, identified members included an individual, a family member and a community member. Responsibilities and requirements found in the Guardianship policy include meeting regularly to discuss guardianship needs at the center and maintain meeting minutes that include: requests for guardianship services, the date of the meeting, members in attendance, items reviewed and decisions made. It was unclear in the body of the policy whether the Guardianship Committee was expected to somehow act on requests for guardianship services, other than in developing and maintaining the prioritized list; however, Exhibit A explicitly stated the Guardianship Committee's role included assisting individuals to obtain guardians. It is recommended the policy more clearly list each of the actual responsibilities of the Guardianship Committee. • Advocacy Program: BSSLC had focused considerable attention on the development of an Advocacy program, which would provide an alternative to guardianship in appropriate circumstances. The Monitoring Team commended this initiative. The HRO and Director of Community Relations were collaborating to revise and update procedures for this program. A job description had been created. The Department of Community Relations was assisting in the development of recruitment materials and procedures had been devised to process advocate applicants through the existing volunteer application process under Community Relations. This process includes both a background check and fingerprinting. Community Relations will also provide a general volunteer orientation, to be followed by additional training by an individual's QDDP on the specifics of the advocacy role. • Self-Advocacy Program: The pending statewide Self-Advocacy policy designated the HRO to serve as the Self-Advocacy Coordinator for the Facility. The Monitoring Team noted the Facility was already providing supports for organized self-advocacy, which was to be commended. In addition to the ongoing Self-Advocacy program for adults, the Facility had initiated a separate program for youth. The Monitoring Team reviewed the minutes of Self-Advocacy meetings held since the last monitoring visit and recommends that Facility consider obtaining and implementing a formal choice-making/self-advocacy curriculum that would foster the abilities of individuals to participate in meaningful decision-making about their lives. There are many good examples of	

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		such curricula for individuals with intellectual disabilities that may be adapted for use by the Facility. For example, the California Department of Developmental Services has developed a number of consumer-friendly publication and workbooks that may be useful. These can be viewed and downloaded at http://www.dds.ca.gov/ConsumerCorner/Publications.cfm. • Other Actions: The HRO negotiated a verbal agreement with a local attorney to offer guardianship services at a reduced rate for potential LARs for individuals living at BSSLC. Conclusion: This Provision was found to be not in compliance. As part of the Facility undertaking an effective and appropriate large-scale effort to solicit guardians, BSSLC should ensure it has an appropriate methodology in place to determine the actual need for guardianship as described above in U1. DADS should provide this guidance through the formal promulgation of policy as soon as possible. The Facility was to be commended for its efforts toward developing a variety of additional resources for individuals who require some level of assistance in making decisions, such that guardianship was not the only option. Many of these, such as the Advocacy Program and the preparations toward establishing a Guardianship Committee were in early or preliminary stages. The Monitoring Team looks forward to seeing all aspects of support for decision-making and informed consent in full operation at the time of the next site visit.	

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

1. DADS should provide guidance as to the fulfillment of the requirements for Provision U through the formal promulgation of policies as soon as possible. Once received, BSSLC should quickly develop and implement local policies. (Provisions U1 and U2)
2. The HRC should apply the same standards for review of this restriction of informed consent that it applies to other restrictions identified in the Rights Assessment. (Provision U1)
3. The Facility should obtain and implement a formal choice-making/self-advocacy curriculum that would foster the abilities of individuals to participate in meaningful decision-making about their lives. (Provision U2)
4. The pending statewide policy on Guardianship should more clearly list each of the actual responsibilities of the Guardianship Committee. (Provision U2)
5. DADS should review the somewhat differently worded instructions for prioritization it gives in the draft policy on Guardianship on page 4 under Guardianship list and in number 5 of Exhibit A to ensure a consistent process. (Provision U1)

The following are offered as additional suggestions to the Facility:

1. The Facility should consider additional resources regarding decisional capacity, which exist nationally, that may further inform and amplify the development of training. A sampling of such resources include::
   - *Decisions By and For People with Mental Retardation: Balancing considerations of Autonomy and Protection*, James W Ellis;
   - *Decision-Making Capacity in Adults: Its Assessment in Clinical Practice, Bellhouse,* et al;
   - *Alternatives to Guardianship* on-line training found at maine.gov/guardianship, which provides additional assessment documents; and,

- A variety of resources found at guardianship.org

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. BSSLC Plan of Improvement (POI) 12/30/11 2. BSSLC Presentation Book (undated) 3. List of SSLC Policies 2/3/12 4. BSSLC Policy IV.3.a Unified Record Keeping Practices 12/17/10 5. BSSLC Policy Competency Training and Development revised May 2008 6. BSSLC Policy III.2.a Dental 11/14/11 7. BSSLC Policy III.2.c Pharmacy Services 12/29/11 8. BSSLC Policy III.2.d Physical Nutritional Management Plan 11/14/11 9. BSSLC Policy III.2.f Physician Procedures and Best Practice Guidelines 4/14/11 10. BSSLC Policy III.2.i Occupational/Physical Therapy Services 11/14/11 11. Draft BSSLC Policy A.1 Policy & Procedures Guidelines undated 12. Draft BSSLC Policy D.2 Maintaining & Providing ANE Resource Guide 12/30/11 13. Draft BSSLC Policy D.3 Participating In & Completing Incident Management UIR Committee 12/30/11 14. Draft BSSLC Policy E.2 Quality Assurance Measuring Trends 12/30/11 15. Draft BSSLC Policy E.3 Developing, Implementing & Tracking Corrective Action Plans 12/30/11 16. Draft BSSLC Policy W.26 Standards of Care Protocol 2/1/12 (sic) 17. Active Record Order and Maintenance Guidelines (AROG) revised 10/28/10 18. Individual Notebook Record Order and Guidelines for Filing and Thinning revised 10/28/10 19. Master Folder Filing Instructions revised 10/19/11 20. Active Record for Individuals #154, #367, and #449, the Individual Notebooks (All About Me books) for Individuals #154 and #449, and the Master Record for Individual #449 21. November audits of records for Individuals #68, #190, #230, #249, #304, #380, #408, #570, #595, and #598 22. December audits of records for Individuals #33, #91, #173, #223, #247, #377, #415, #481, #492, and #570 23. Document titled "Record Audits from Bowie for the Month of November 2011 and their findings" with information from audits of records for Individuals #249 and #598 24. Spot Check form for record of Individual #249 dated 12/29/11 25. Documents for each unit titled "Record Audits for the Month of December 2011 and their findings" with information from each record audited in December 2011 26. Graphs of audit findings from July-November 2011 with overall monthly compliance, compliance for the whole period for each monitoring tool item, and compliance for each individual record audited during the period 27. Recordkeeping and General Plan Implementation Guidelines for audits revised April 2011 28. Email of 8/22/11 from Margaret Zwerneman to Residence Directors regarding documentation of training on Observation Notes 29. Chart Audit Tool form revised 11/30/ 2011

	30. Summaries of interview tools on use of records for Individuals #195 (August 2011), #246 (September 2011), #68 (October 2011), and #190 (November 2011) 31. Problematic Tracking System for Interview Tool with information from interview tools for Individuals #195 (August 2011), #246 (September 2011), #68 (October 2011), and #190 (November 2011) 32. Policy –Procedure Review Committee Meeting Minutes of January 25, 2012 33. Verification of Crosswalk of State Office Policy with Center Policy undated 34. Draft Master Table of Contents of Policy and Procedure undated 35. Consultation Reports for Individuals #30, #59, #90, #102, #134, #398, #411, #434, #446, #536, #575, and #599 **People Interviewed:** 1. Group interview with Margaret Zwerneman and Deborah Borah, Unified Records Coordinators (URCs), Joyce Carnegey, CARE Coordinator, and Daniel Dickson, QA Director 2. Group interview with program auditors 3. Janet Crane, QDDP Coordinator 4. QDDPs Anne Schrengauer, Pam Boehnemann, Fil Edmonson, and Kathryn Seifert 5. House Supervisors at Cottage B and Fannin A 6. Kristi Wanner, RN, PNMP Nurse 7. Susie Johnson, Settlement Agreement Monitor, and Daniel Dickson, Director of QA **Meeting Attended/Observations:** 1. Annual ISP Planning Session for Individual #154 and Individual #547
	Facility Self-Assessment: The Facility provided a self assessment in its Plan of Improvement (POI). The Facility reported that none of the provisions of this Section were yet in compliance. The Monitoring Team concurs with this assessment. The Plan of Improvement provided some narrative descriptions of actions the Facility had or was taking to move towards compliance within each of the provisions, but did not present a comprehensive assessment of compliance with each of the indicators. The steps reported in the POI went back to 2010 but also included actions taken since the last compliance visit. Some data that could be used to assess status were provided for Provision V3 but not for other provisions; the Facility did not indicate the basis for any of the decisions on compliance. The Facility reported action plans for achieving compliance. The Action Plans specified the action to be taken, what evidence would be used to confirm status, start and projected completion dates, and the current status. All action plans were listed either as "In Process" or "Not Started" and had dates of completion ranging from 12/30/11 (after the Self-Assessment was submitted to the Monitoring Team but before the compliance visit) to 6/30/12. However, some of the actions had been in place for at least several months, such as conducting audits using a form called the "Section V Settlement Agreement Monitoring Tool. The Facility had been conducting audits using a tool called the "Settlement Agreement Cross-Referenced with ICF-MR Standards"; because there was no action plan to develop another tool, it was unclear whether the action was different from what was currently being done. Other actions were clearly in development.

	Data provided for Provision V3 could be used as one piece of information to be considered in assessing compliance. As noted in the Assessment of Status, there was not yet measurement of interobserver agreement to validate the accuracy of the data. Nevertheless, the Facility could note this as an example of data that could be used to evaluate status of compliance.
	Summary of Monitor's Assessment: Although the Monitoring Team concurs with the Facility's self-assessment that it does not yet comply with any provision of this section, the Monitoring Team also recognizes the significant improvements that have occurred. Overall, the Facility had made significant progress in meeting the requirements of this Section. Nevertheless, although the Facility had made a number of improvements in the records, audits, use of records, and policy development and implementation, no provision of this Section is yet in compliance. Improvements are needed in consistent documentation in records so that all needed information for decisions is available, posting of assessments, and staff use of records for daily implementation of supports and services. The Facility maintained a Unified Record consisting of an Active Record, Master Record, and an Individual Notebook called the All About Me" book. In addition, the Facility is developing an overflow record called the Inactive Record. Although the condition of records continued to show improvement over records at the baseline review, there were still numerous errors and deficiencies in documentation, although there had been improvement. The Facility was addressing these through corrective actions arising from audits, both for specific deficiencies in individual records and systemic actions intended to improve documentation. The Facility had increased the number of audits done and had a process to notify appropriate staff of the need for corrections, to require a report of completion of corrections, and to spot-check to determine whether reported corrections had actually been completed. Documentation of required corrections and their completion could be clearer so that it is easier both to ensure completion of corrections is accurate and to track whether the same issues arise repeatedly over time. Sampling of interobserver agreement to ensure accurate recording should be implemented. Finally, each audit should include review of the Individual Notebook and the Master and overflow documentation. Use of the records by staff to plan and implement treatment, intervention, and training is mixed. Staff interviewed could easily find documents and could describe how they used information from the record, observations showed documents used in meetings to ensure accurate information, and communication through IPN documentation had improved. However, staff providing direct care could not state the interventions planned for individuals without checking the records, and evaluations needed by the IDT were not posted timely to the Share Drive to permit review. Both DADS and the Facility had developed or revised policies needed to meet the requirements of the Settlement Agreement. Other policies still need to be developed; drafts of some have been prepared but

	not finalized yet into policy. The Facility should develop a process to ensure all affected staff are aware of and understand their responsibilities for newly implemented or revised policies.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	The 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. BSSLC is also developing a table of contents for an Inactive Record for overflow documents that will be kept at the Facility for two years and then sent to the state's centralized storage. When documents are purged from the Active Record, they are to be sent to Central Records to be place in the Inactive Record or Master Record as appropriate; 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. The Individual Notebook accompanies the individual wherever the person goes for supports and services provided by the Facility. <u>Recordkeeping Policy</u> 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." The Facility policy was in process of revision. Per report of the URCs and Director of QA, these two items have been addressed in the draft policy. Active Records were filed in two or three charts, depending on the amount of documents involved. An Active Record Order & Maintenance Guidelines (AROG) 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. The AROG was in process of revision at the time of the compliance visit; the new table of contents was approved by the Policy and Procedure Review Committee on 1/25/12.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Accuracy and Completeness of Records 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 #154, #367, and #449, the Individual Notebooks (All About Me books) for Individuals #154 and #449, and the Master Record for Individual #449. Individual #449 was selected by computer randomization from among records remaining to be audited by the Facility during January; Individual #154 had an annual ISP meeting during the visit: and Individual #367 was randomly selected from among admissions since the last compliance visit who had been at the Facility longer than 30 days. For the Active Record, the Monitoring Team checked for the presence of each item on the Active Record Order & Maintenance Guidelines (AROG). To do this, the Monitoring Team used a tool used as part of the audits at the Facility called the Active Record Audit; there was a form for the Individual Notebook and for Chart 1 and Chart 2. Per interview with the URCs and Director of QA, this tool used a revised table of contents that was to be implemented (pending final revision), in February; to confirm whether documents were available and filed in the correct location, the Monitoring Team checked each against the current AROG found in front of the charts. Many documents are not applicable in each 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 appropriate section of the record. The Monitoring Team completed both the review using the AROG and also the audit tool titled Settlement Agreement Cross Referenced with ICF-MR Standards for Section V. Although records were generally in order and, for the most part, complete and legible, none of the Active Records reviewed met all the requirements of Appendix D and Facility policy. The table below reports the percent of documents listed as required that were found in the Individual Notebook and Active Record. Following are examples found in the three records:	

Individual	Individual Notebook	Active Record
#154	79%	83%
#367	NA	73%
#449	79%	83%

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		• For Individual #154, current QDRRs and PNMP data sheets were not found in the Active Record. The Monitoring Team identified deficiencies in consistency with the table of contents, and in current and complete records. • For Individual #367, no restraint checklists were found in the record, but the individual's Safety Plan stated there had been restraints used. Several documents were found in different sections than stated in the AROG. The Monitoring Team identified deficiencies in consistency with the table of contents, completeness of records, having dates on documents such as reviews, and order of records. • For Individual #449, data sheets for Specific Support Objectives and Specific Program Objectives did not match those in the Action Plans. Some QDRRs were not found in the record. The Monitoring Team identified deficiencies in consistency with the table of contents, current and complete records, and order of records. • In all three records, purging of materials did not match the maintenance guidelines, as older documents remained in the Active Record. The Master Record for Individual #449 was also reviewed. It appeared in order, with the required documents. However, the Facility did not have a process to ensure that all documents that were to have been purged were sent for filing in overflow or master records. Review of Active Records, as noted above, found that materials that should have been sent for filing remained in the Active Records. In reviews throughout the report, the Monitoring Team found other examples of errors in the records. For example, • A speech/communication assessment for Individual #490 was found in the record for Individual #21. • The dated Integrated Progress Notes often did not include the time the notes were written. • Review of nursing documentation found that a few documents were missing from the active records, such as copies of care plans. The dates of entries were occasionally found out of order. The time of the dated entries were occasionally missing. Some of the nursing related documents were misfiled. • As reported in Provision F2d, program data were missing from a number of records. <u>Accessibility and Security of Records</u> When asked, Home Supervisors in Cottage B and Fannin A were able to show where the Individual Notebooks were and to state and show what information was found in them. These books were readily accessible. Furthermore, when the Monitoring Team went to a	

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		home to look for an Individual Notebook for Individual #449, the staff stated the individual was off campus at a movie, and the book was taken by staff who accompanied him; the next morning, the Monitoring Team returned, and the book was accessible at the home where the individual was eating breakfast. <u>Share Drive</u> 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 Notification Calendar lists all the required assessments for the individual, and the IDT 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 QDDP for the individual for whom an ISP 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 ISP meeting, so this system was not yet fully useable for review by IDT members. Assessments were filed on the Drive by department; there was no folder that contained all assessments. Having all assessments copied to one folder for an individual would make it more convenient for an IDT member to open and view assessments in preparation for an ISP meeting. During an interview with QDDPs, the Monitoring Team asked to see the assessments in the Share Drive for Individual #453, whose annual ISP planning session was to be held within 10 days. According to the Notification Calendar on the Share Drive, six assessments of 24 assigned (25%) showed the date posted. The QDDPs stated that the date is posted when the assessment is posted. Although there was no standard format for folders in the Share Drive, QDDPs were able to navigate through it and show where documents were. In summary, although auditing of records had continued, this had not resulted in significant improvement in compliance of the records with requirements of the SA since the last compliance visit.	
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	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.	Noncompliance

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	develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	DADS continued to develop and revise policies and provided a listing of policies in development and revision that included implementation dates. Policies developed or revised since the last compliance visit, per the DADS list, were: • 007: Psychiatry Services 8/30/11 • 011: Pharmacy Services 9/26/11 When DADS develops policies, the Facility may add to them and provide detail on specific procedures to implement them at the Facility. For example, the Facility operationalizes the policy by identify specifically who is assigned particular responsibilities. The Facility is now focusing on ensuring the facility policies include everything required in the state policy. BSSLC had worked diligently to review and revise its process of policy development and implementation. Not only had several policies been developed or revised, but a revised format for policies has been developed that should make them more accessible and useful. <u>New and Revised Policies</u> New statewide policies implemented since the last compliance visit include: • DADS Policy 011 Pharmacy Services (effective 10/10/11) • DADS Policy 053 Medication Variances (effective 9/23/11). This policy was noted to be comprehensive and complete, addressing all areas of medication variances. The policy provides excellent direction for the Facility. New BSSLC policies implemented since the last compliance visit include: • Policy III.2.a Dental 11/14/11 • Policy III.2.c Pharmacy Services 12/29/11 • Policy III.2.d Physical Nutritional Management Plan 11/14/11 • Policy III.2.f Physician Procedures and Best Practice Guidelines 4/14/11 • Policy III.2.i Occupational/Physical Therapy Services 11/14/11 In addition, several facility policies were in draft form awaiting approval. Following the compliance visit, the Facility provided minutes of the Policy-Procedure Review Committee meeting of 1/25/12 and the Quality Assurance/Quality Improvement Council meeting following the compliance visit documenting that these policies had been approved. • Draft BSSLC Policy A.1 Policy & Procedures Guidelines undated • Draft BSSLC Policy D.2 Maintaining & Providing ANE Resource Guide 12/30/11 • Draft BSSLC Policy D.3 Participating In & Completing Incident Management UIR Committee 12/30/11	

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		• Draft BSSLC Policy E.2 Quality Assurance Measuring Trends 12/30/11 • Draft BSSLC Policy E.3 Developing, Implementing & Tracking Corrective Action Plans 12/30/11 • Draft BSSLC Policy W.26 Standards of Care Protocol 2/1/12 (sic) • Drug Utilization Evaluation <u>Policies Needing Revision</u> There are still several policies that should be revised or developed either as a requirement of the Settlement Agreement or as a means toward having procedures in place that will lead toward compliance with the SA. • While the Facility demonstrated elements of a regular risk screening, assessment and management system the Facility does not as yet have a policy that comprehensively addresses the requirements of this section of the SA. • The BSSLC policy on CTD was last revised in October 2008. It includes a list of required courses by type of position, but that list is dated 2000 and does not match current requirements. The policy should be updated to match current requirements. • BSSLC did not have its own policy for psychiatry. Activities of the Psychiatry Department were guided by DADS Policy and Procedures 007.2 Psychiatry Services (08/30/11). • DADS Policy 109 on guardianship is in draft form and is needed to provide guidance to facilities. Because policies on Guardianship, Advocate and Self-Advocacy were still in draft form, local policies had not yet been modified. <u>Procedures for Development, Approval, and Implementation of Policies</u> The Settlement Agreement Monitor and Director of Quality Assurance reported that the process of policy development and the format of the policies and policy manual were in process of change. Draft policy A.1 that governs the process for policy development and implementation provides steps for identifying the need for policy development or revision, responsibility for drafting policy and getting comments from affected departments and staff, review and approval, entry into the policy manual, notice to departments and staff, and responsibility for training. The Monitoring Team notes that the responsibility for training staff was assigned to department heads and suggests that a centralized process be developed at least for specific critical policies to ensure all relevant staff receive consistent training. The policy manual was being revised so that sections of the manual would match sections of the Settlement Agreement. As policies are being developed, they are labeled	

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		according to the sections of the manual (for example, the policy that governs Incident Management UIR Committee is labeled D.3). The draft policy manual table of contents was divided into sections, and the specific policies were to be listed within their sections, along with dates of revision, approval, and implementation. This will greatly improve ease of access to policies by staff and make the manual more useful. Furthermore, draft Policy A.1 assigns the QA Director to save new or revised policies to the manual on the computer Share Drive, which would make it readily accessible. <u>Training and Implementation of Policies</u> 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 stated each individual department trains staff on policy changes (which is consistent with the draft Policy A.1 requirement). The Facility also provided three emails from the Settlement Agreement Coordinator to "DL DADS BRS All Users" with a link to click on new policies. The Facility did not provide any other description of training provided or of evaluation of staff understanding of the new or revised policies. Per interview, the Facility had not determined how to capture training documentation campus-wide. The Monitoring Team suggests that, for certain policies, it might be essential to ensure the training is consistent, covers the same issues, and evaluated understanding, which would require some centralized development of the training. The Monitoring Team recommends that the policy development and implementation process address how the need for such centralized development be determined as part of approval of policies. Furthermore, as noted in several areas of this report, there are still numerous instances in which policies are not implemented consistently and accurately. The Facility has a number of audits in place to monitor implementation of many policies, and the Monitoring Team will continue to review whether these audits and other facility actions will result in consistent and accurate implementation. Although not all policies needed to implement the SA have been developed either at Facility or statewide level, much progress has been made.	
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	The Facility had one audit process for review of ten records per month and a second program audit process that included review of a few specific requirements in additional records as part of a quality review that involved a variety of topics. <u>Random Audits</u> In response to a recommendation from the last compliance report, the Facility had implemented a process to select records for audit through a computerized random	Noncompliance

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	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.	selection process. Two individuals were randomly selected from each of the five living units each month, making a total of 10 random audits per month. Audits were performed of the Active Record and the Individual Notebook; there was no audit of the overflow records or the Master Record to ensure documents would be available if needed. When the Individual Notebook was not at the unit when the audit was done (that is, was accompanying the individual to other programming), it was not audited. The two URCs carried out the audits. The URCs are in the Department of Quality Assurance and therefore provide independent audits. Overall, the reviews were done in a consistent manner. The audits involved use of two tools. The first tool was the "Active Record Audit" that had a form for Individual Notebook and a form for Chart 1 and Chart 2. The form listed in order (per the AROG table of contents) the documents that were either required to be in the record or were in the record if needed. There was a column to state whether the document was present ("Yes"), absent ("No"), or not required for this individual ("N/A"). There was a column with the same headings to check whether the document was in order. There was also a column for comments, where the URCs could state the reason a "No" was checked or make other comments such as a need to thin/purge outdated documents. The second form, which was the statewide audit tool, was titled "Settlement Agreement Cross-Referenced with ICF-MR Standards" and included requirements to meet documentation guidelines in Appendix D of the Settlement Agreement, as well as whether all components of the Unified Record were in place and whether staff used information from the record in making decisions. Information noted on the Active Record Audit was used in completing this second form. Most of these completed audit forms only had items filled in if they were rated "No." Although there was an assumption that the others were rated "Yes," there was no way to determine that all items had been checked and not overlooked. For example, audits provided for December 2011 showed that six of the 10 audits (60%) did not include the Individual Notebook, but that was not noted on this audit form. The Monitoring Team recommends that each item rating be documented on the form. The Facility had developed a set of guidelines that gave rules for rating items on the monitoring tool and provided guidance for what the auditor needed to look for. The URCs listed items to be corrected in the Comments section of the "Settlement Agreement Cross-Referenced with ICF-MR Standards" form and also attached a handwritten sheet of items. They then prepared, for each unit, a list of the items to be corrected for each of the two audited records.	

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		These lists of issues to be corrected are sent to the Residence Director, QDDP group for unit, RN Case Managers, and residential clerical, with a due date giving a week to make corrections. When corrections are completed, the responsible person is to send the URC an email stating the corrections are complete. The URCs copy these statements to the original list of items to be corrected. The documents provided by the Facility for December 2011 were difficult to follow and ensure corrections were completed. Issues that made it difficult to ensure all corrections were made include: • The corrections were entered in narrative and not in an order that made it easy to match each correction to the item needing to be corrected. • On some forms, corrections for the two audited records were mixed, so it was time-consuming to match corrections to the appropriate record. • Some corrections involved referrals to clinicians for updated information such as assessments. No evidence was provided that these records were updated or that there was follow-up to ensure the clinicians provided the information. Then the URCs pick a chart with many required corrective actions and spot-check to determine if corrections were completed. If reported corrections have not been completed accurately, the URCs send a follow-up notice with copies to the Assistant Director of Programs, CNE, QDDP Coordinator, and Director of Quality Assurance, and the process repeats. The Facility provided the corrective action notice, including the report of completed actions, for the November 2011 audit for Individual #249. The record audit findings and spot-check for Individual #249 revealed the following: • Although checkmarks over the required corrective actions apparently indicated that corrections had been completed, the information in the cell for documentation of corrections did not confirm that. For example, "Social Summary is dated 11-7-05" had a checkmark, but the documentation of correction stated, "QDDP does not do social summary I (sic) believe the social worker on Driscoll is working on the summaries and updating them little by little." However, the spot-check stated the updated social summary was found in the record. • Four of five required corrections under "Program" had not been completed, although the documentation of corrections had reported that all except two had been completed (one of which was the social summary described above). For example, the documentation of corrections stated the most current Rights Assessment was placed in the chart. The spot-check reported that the Rights Assessment was not updated. • A cell to report corrections of items not found completed on the spot-check had information that all the remaining Program corrections had been made. The	

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		Facility did not provide information showing that a further spot-check was done. Given that the person reporting those corrections had inaccurately reported originally, it would be important to make sure the corrections had been completed. There was not a procedure in place to determine interobserver agreement on ratings on either the Active Record Audit or the Settlement Agreement Cross Reference with ICF-MR Standards forms. It is therefore unclear how accurate the ratings are. As an example, record audits were completed in both November and December 2011 for Individual #570. Although there were some findings consistent across the two audits (indicating corrections had not been completed) the December audit included two needed corrections that should have been reported also in the November audit. The Rights Assessment and Job Training-Employment Services and Vocational Assessment were dated July 2010 and were outdated by November 2011. The Monitoring Team selected by computer randomization one record that was due to be audited in January, for Individual #449. For this individual, the Monitoring Team audited the Active Record on one day and, because the Individual Notebook was off-campus with the individual, audited that chart the following morning. Immediately after that audit, both URCs independently audited the records. Agreement on presence of each item on the Active Record Audit between the two URCs for all items rated by both URCs and which one or both URCs found applicable was 81%. Agreement between the Monitor and one URC for all rated items was 84%; for all items on the Active Record Audit that the Monitor, URC, or both found applicable, agreement was 74%. Agreement on the state-mandated Settlement Agreement audit form between the two URCs was 100% and between the Monitor and one URC was 77%. These figures do not support that the definitions of items and criteria for rating were clear and observable. The Facility should review the definitions, attempt to discover why ratings differ across auditors, and revise the definitions to ensure clarity and improve accuracy of audits so the data available are more usable for decision-making by the Facility. Since agreement figures for the state-mandated audit form were similar to those at prior compliance visits to other facilities, DADS may wish to review the monitoring form and definitions. To summarize, the Facility was carrying out more random audits than required by this provision and had a process to notify appropriate staff of the need for corrections, to require a report of completion of corrections, and to spot-check to determine whether reported corrections had actually been completed. Documentation of required corrections and their completion could be clearer so that it is easier both to ensure completion of corrections is accurate and to track whether the same issues arise repeatedly over time. Sampling of interobserver agreement to ensure accurate recording should be implemented. Finally, each audit should include review of the Individual	

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		Notebook and the Master and overflow documentation. <u>Program Audits</u> In addition to the audits by Records Clerks and URCs, a second audit process conducted by program auditors was in place. 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 program auditor is assigned Active Record audits to carry out each month. 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); this tool had been revised since the last visit and now checked more Appendix D requirements such as legible 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 (for example, by assigning a sample of records each month that would be reviewed by both a URC and a program auditor on the same day, and determining level of agreement on the items that are found on both audit tools), and the additional data could provide more information for implementation of quality improvement efforts. <u>Use of Audit Information for Improvement</u> For each item on the Settlement Agreement Cross-Referenced with ICF-MR Standards form, the findings were aggregated monthly. Graphs were provided to the QA/QI Council of the percent compliant on each item, the percent of all items compliant for each individual record audited, and the overall percent of items compliant each month. Graphs provided to the Monitoring Team for audits from July 2011 through November 2011 showed overall compliance each month at approximately 90%. Items with much lower compliance were: • Signature with first/last name • The record is consistent with this table of contents • Portions of the records that are no longer needed are disposed of properly As a result of these findings, the Facility established a corrective action plan for the signature issue. The Facility provided the Monitoring Team with information on the training and sign in sheets showing a large number of staff who had been trained. The Facility did not have a process to determine whether the training was effective. It was positive to note that the information on compliance led to a systemic action. Because	

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		each audit looks at a several-month set of documents, any change (or lack of change) in the percent compliant on this item will not be evident for several months. When a systemic corrective action is taken, the Facility should identify a way to determine its effect. At the last compliance visit, the Facility reported there was not yet a process to track and trend data from the Active Record Audit on the types of errors overall nor the number or type of errors at specific units. Neither the POI nor interview revealed that such a process had been developed. For example, there was no tracking reported of the absence of current assessments. 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. <u>Assessments on Share Drive</u> The Share Drive provided quick accessibility to a number of documents. As noted in an interview reported in Provision V4, staff often go to the Share Drive for information because the records are being used by other staff. One form of audit of the contents of the Share Drive is a grid entitled "Personal Support Plan Notification – January 2012" was provided to the Monitoring Team. No process to audit the Share Drive was reported to the Monitoring Team. Because there were no guidelines or naming conventions for the S Drive, which is set up by Unit, Home, and Individual but has no standardized set of folders, it would be difficult to establish a routine process to track timeliness of posting documents including assessments and evaluation. To audit, it would be necessary to necessary to search through multiple folders in order to locate all the available assessments. It is recommended the process be reviewed, streamlined and standardized to be of more practical use to IDT members as they prepare for ISP meetings. As reported in Provisions F1 c and V4, assessments were not posted consistently within required timelines.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	Although there was improvement in documentation and timely recording, some problems still remained that brought into question how data were used for decision-making. Recently, the monitoring teams, DADS, and DOJ agreed that a proposed list of actions for the SSLCs to engage in to demonstrate substantial compliance with this provision item that was submitted by the monitoring teams would be used for the next onsite review. Even though BSSLC did not yet have this list, the items are presented below, with examples and comments on status. <u>Records are accessible to staff, clinicians, and others</u> Other than checking accessibility during records audits, BSSLC was not yet assessing this. The Monitoring Team observed that:	Noncompliance

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		• Active Records and Individual Notebooks were generally accessible. As reported in Provision F2c, staff were consistently able to locate the record and the programs found in the ISP. • The overflow records, while accessible, were not yet organized in a way that would make it easy to find documents. The Facility was in process of developing an Inactive Record to address this. • The Share Drive makes records easily accessible. However, not all records (such as assessments) are posted timely on the Share Drive. For example, during an interview with several QDDPs, the Monitoring Team asked to see the assessments in the Share Drive for Individual #453, whose annual ISP planning session was to be held within 10 days; policy requires assessments to be posted to the Share Drive at least 10 days prior to the annual ISP meeting. According to the Notification Calendar on the Share Drive, six assessments of 24 assigned (25%) showed the date posted. Furthermore, as reported in Provision F1c for three recent ISPs, in none of the three were all required assessments posted 10 days prior to the ISP annual planning meeting as required; several of the required assessments were not posted for any of the three individuals. <u>Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure)</u> Other than checking whether data sheets are found in the Active Record or Individual Notebook, the Facility was not yet assessing this. In general, documentation appeared timely. However, the Monitoring Team observed examples of problem including: • For Individual #449, data sheets for Specific Support Objectives and Specific Program Objectives did not match those in the Action Plans. Some QDRRs were not found in the record. This might indicate that quarterly review by the QDDP was based on inaccurate information or was not used in determining progress and notifying the IDT of need for action. • As reported in Section K, data collection for PBSPs had improved substantially, but there were still areas that needed improvement. These included the lack of data on replacement behaviors and the lack of a specific description of data collection procedures. As a result, usefulness of the data was limited. <u>Integrated Progress Notes (IPNs) indicate the use of the record in making these decisions</u> BSSLC was not yet assessing this, and the Monitoring Team was unable to determine from the IPNs whether and how they were used but could identify entries that could be useful. Interviews using the Interview Tool for Use of the Record included responses that the IPNs were useful. The Monitoring Team observed that: • There was more consistent documentation in the IPNs about nursing and health issues, which made the information readily available as decisions about health care were assessed:	

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		o When Health Maintenance Plans (HMPs) and Acute Care Plans (ACPs) were developed, implemented, and followed through to resolution. o About infections, contagious diseases, and wound care. • Physician progress notes documented follow up after episodes of seizures, including relevant laboratory studies, which made the information available for decision-making. • Of 17 consultations by non-Facility clinicians reviewed by the Monitoring Team, the Monitoring Team found IPN entries by the Facility clinician for 12 (71%). <u>Records are used for providing supports and services</u> BSSLC was not yet assessing this. Although, as reported in this provision, records were used in the process of making decisions about supports and services, there were gaps in use of records for actually providing the supports and services, as the following examples demonstrate: • As reported in Provision F2c, although records were accessible, staff were not consistently able to describe the contents of the ISP or programs without referring to the documents. • As described in Provision R3, communication interventions were referenced in the assessment section of the ISP 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. • As reported in Provision S2, staff could not describe aspects of SPOs or SSOs without referring to the documents, and neither formal nor informal training were observed to occur during living unit observations. • As reported in Provision O4, staff did not implement interventions outlined in the PNMP. • As explained in Provision L1, information from the record was not used in a CLDP meeting to identify supports and services an individual would need upon moving to community living. <u>Staff surveyed/asked indicate how the unified record is used as per this provision item</u> Prior to the last compliance visit, the Facility had implemented a process to monitor how staff use the records. The URCs selected one individual per month; there was no randomization or other defined selection process. For that individual, an email was sent to staff from the individual's PST with a set of questions on the Settlement Agreement Provision V.4—Interview Tool for Use of the Record. Each discipline is to fill out responses to the questions and return by email. A URC then summarizes the answers.	

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		Since the last compliance visit, the Facility had implemented both a tool to summarize the responses in the interviews and the Problematic Tracking System for Interview Tool, a tool to track the number of positive and negative findings, exceptions (that is, problems identified with documentation or its usefulness), and recommendations by the URCs. This appeared to be a very good start toward tracking findings and identifying areas for improvement. The Facility provided summaries of four interview questionnaires conducted August-November 2011. • For four of four interview questionnaires (100%), information was provided on general ways in which the record is used to provide information for decision-making; for Individual #68, specific information related to decisions on specific conditions was reported, supporting an impression that the record was reviewed and used in decision-making for that individual. • Four of four interview questionnaires (100%) reported several ways in which the record is used at various meetings. • Zero of four interview questionnaires (0%) reported that information can always be found in the record, although all four indicated that information can usually be found. Problems included the need for information over a year old that had been thinned, assessments not up to date (therefore requiring review of the assessments posted in the S Drive), and PTRs not filed in the record (which was reportedly being addressed). • Four of four interview questionnaires (100%) described ways in which reports from other disciplines helped plan treatments or interventions. Three of four interviews (75%) included at least one specific example from one discipline that identified how a particular set of information helped in addressing a particular area of treatment. • Four of four interview questionnaires (100%) concluded that the records were used for decision-making. The Problematic Tracking System for Interview Tool reported several recommendations, including: • "Make sure that after 30 days retention in the Individual Notebook, documents are moved to Active Records." • "Contact staff requesting timely and accurate filing." • "Instruct Staff to follow guidelines in filing and thinning, and advise them that some medical documents may be retained longer in instances where there is extended or necessary followup for a chronic illness." Although no actions based on these recommendations were reported in either the POI or	

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		interview, this document could provide valuable information for identifying areas of improvement, especially if analysis of this information is done in conjunction with information found in the audits of records. The Facility should be sure to report at the next compliance visit on such use of this information. The Monitoring Team also did interviews of QDDPs, the QDDP Coordinator, and the PNM nurse asking the same questions. However, these interviews asked the questions in general rather than specific to an individual, and some interviews were in groups. Recognizing that some Monitoring Team interviews included information from up to four individuals, the following was reported: • In three of three interviews (100%), staff were able to describe a specific example of using information from the record and the decision for which the information was used. • In two of three interviews (67%), staff described one or more specific ways records are used during meetings; in the other, a general statement was given that the record brings information together. • In two of three interviews (67%), it was reported that information is typically available; the other interview reported that information was inconsistently available. One interview noted that there are occasionally documents that are not current. One interview stated the medical charts are constantly in use, so staff often go to the Share Drive for information. • In three of three interviews (100%), staff gave a specific example of using a report from another discipline when planning a treatment or intervention. <u>Observation at meetings, including ISP meetings, indicates the unified record is used as per this provision item</u> The Facility did not provide to the Monitoring Team information that assessment of use of records occurs in meetings. However, the Monitoring Team did observe the records in use. For example: • At the annual ISP planning meeting for Individual #154, the physician looked in the record for dates of medical pre-treatment sedation as part of a discussion on diet texture and aspiration. The Dietitian looked at and discussed documents regarding diet texture. On the other hand, there was discussion about when to do a MBSS. The nurse kept saying the individual's coughing was related (among other things) to recent bronchitis, but no data were reported or records checked to determine the frequency of coughing at meals prior to the beginning of bronchitis. • At the annual ISP planning meeting for Individual #547, the IDT reviewed labs and swallow study information in the record.	

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		Furthermore, in an interview of several QDDPs by the Monitoring Team using the Interview Tool for Use of the Records, one example given of use of a report from another discipline specifically involved using, during an ISP meeting, an assessment by the physician and the risk rating form to change an individual's daily schedule. <u>Summary</u> Although the Facility had made a number of improvements in the use of records, and policy development and implementation Provision V4 is not yet in compliance. Improvements are needed in consistent documentation in records so that all needed information for decisions is available, timely posting of assessments, and staff use of records for daily implementation of supports and services.	

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

1. Audit all components of the Unified Record, including Individual Notebooks. This will require also developing a process to audit Master and overflow records to ensure availability of information. (Provision V3)
2. Each rating cell on the record audit form should be filled in. (Provision V3)
3. Update the BSSLC policy on CTD to match current requirements for training related to the requirements of the Settlement Agreement. (Provision V2)
4. Develop a standardized system to train staff, and ensure staff have the necessary knowledge and skills to implement the new or revised policies. To accomplish this, the Facility should define in policy or procedure the process that will be used to ensure this occurs. In developing such a policy, the following should be considered:
    a. It should incorporate mechanisms already in place, such as an email/correspondence being sent to the departments impacted by the policy.
    b. It should identify whether a process to ensure knowledge or competence needs to be established for the specific policy, whether staff in specific job categories need to document knowledge of the policy by signing off, and the list of job categories to whom training should be provided.
    c. In addition, for each policy approved, consideration should be given to defining who will be responsible for certifying that staff who need to be trained have successfully completed the training, what level of training is needed (e.g., classroom training, review of materials, competency demonstration, etc.), and what documentation will be necessary to confirm that such training has occurred. It would seem that sometimes this responsibility would be with the Competency Training Department, but often others would have responsibility.
    d. Timeframes also would need to be determined for when training needed to be completed. It would be important to define, for example, which policy revisions need immediate training, and which could be incorporated into annual or refresher training (e.g., ISP annual refresher training). (Provision V.2)
5. The process for posting documents to the Share Drive should be reviewed, streamlined and standardized to be of more

practical use to IDT members as they prepare for ISP meetings. (Provisions V3 and V4)

6. Implement actions to increase timeliness of posting to the share drive. (Provision V.4)

The following are offered as additional suggestions to the Facility:

7. The Monitoring Team suggests that, for certain policies, it might be essential to ensure the training is consistent, covers the same issues, and evaluated understanding, which would require some centralized development of the training. The Monitoring Team recommends that the policy development and implementation process address how the need for such centralized development be determined as part of approval of policies.

List of Acronyms

Brenham State Supported Living Center

January 16-20, 2012 Compliance Visit

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
APL	Active Problem List
APRN	Advanced Practice Registered Nurse
APS	Adult Protective Services
AROG	Active Record Order & Guidelines
AS	Action Step(s)
AT	Assistive Technology
BCBA	Board Certified Behavior Analyst
BIR	Behavioral Incident Report
BP	Blood Pressure
BSP	Behavior Support Plan
BSRC	Behavior Support Review Committee
CAP	Corrective Action Plan
CBC	Criminal Background Check or Complete Blood Count
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)
CWS	Client Work Station
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
DSP	Dental Support Plan
DUE	Drug Utilization Evaluation
EEG	Electroencephalogram
EKG	Electrocardiogram
ER	Emergency Room
FA	Functional Analysis or Functional Assessment
FAST	Functional Assessment Screening Tool
FBA	Functional Behavior Analysis or Functional Behavior Assessment
FFAD	Face-to-Face Assessment/Debriefing
FSA	Functional Skills Assessment
FSPI	Facility Support Performance Indicator
FTE	Full Time Equivalent
FY	Fiscal Year
GERD	Gastroesophageal reflux disease
HCG	Health Care Guidelines
HCP	Health Care Plan
HIPAA	Health Information Portability and Accountability Act
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
ICM	Integrated Clinical Meeting
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
MAS	Motivational Assessment Scale
MBSS	Modified Barium Swallow Study
MD/M.D.	Medical Doctor
MOSES	Monitoring of Side Effects Scale
MP	Medication Plan
MR	Mental Retardation
MRA/MHMRA	Mental Retardation Authority/Mental Health and Mental Retardation Authority
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant Staphylococcus Aureus
MSP	Medical Support Plan
NA	Not Applicable
NANDA	North American Nursing Diagnosis Association
NCP	Nursing Care Plan
NDC	Non Direct Care
NEO	New Employee Orientation
NMT	Nutritional Management Team
NOO	Nurse Operations Officer
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
PBMC	Psychiatric and Behavior Management Clinic
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
PFI	Personal Focus Interview
PIC	Performance Improvement Council
PMAB	Physical Management of Aggressive Behavior
PMOC	Psychiatric Medication Oversight Committee
PMR	Psychiatric Medication Review
PMT	Psychotropic Medication
PNA	Psychiatric Nursing Assistant
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, oral intake
POC	Plan of Correction
POI	Plan of Improvement
PRC	Polypharmacy Review Committee
PRN	Pro Re Nata (as needed)
PSA	Prostate Specific Antigen
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Physical Therapy/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/QDDP	Qualified Mental Retardation Professional/Qualified Developmental Disabilities Professional
QPR	Quarterly Psychiatric Review
RC	Restraint Checklist
RD	Registered Dietician
RN	Registered Nurse
r/o	Rule out
ROM	Range of Motion
SA	Settlement Agreement
SAC	Settlement Agreement Coordinator
SAM	Self-Administration of Medication
SAN	Settlement Agreement for Nursing
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
TO	Training Objective
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
WBC/wbc	White blood cell
x/o	Rule out