United States v. State of Texas

Monitoring Team Report

Brenham State Supported Living Center
July 23-27, 2012

Date of Report: October 6, 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 Director, Ms. Natalie Montalvo, was extremely supportive of the Monitoring Team's activities throughout the week of the compliance visit and also demonstrated both a commitment to improvement and a vision of priorities to address. 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, Dee Dee McWilliams (who did an exemplary job of organizing the visit and providing documents after recently taking this position), and the staff who assisted her to keep up with all our requests, especially Leah Cook, Tammy Nicewarner, Caitlin Connor, Jackie McGregor, Tammie Pavlu, Leona Sian, and Tracy Wellman. They ensured the documents requested were available before, during, and after the visit. They coordinated arrangements for all the meetings and observations. Too many other staff to mention assisted in numerous ways.

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 299 individuals.

Facility Self-Assessment. BSSLC provided a self-assessment for each section. The self-assessment for each section described activities engaged in to conduct the self-assessment, the results of the self-assessment (in some cases including data on status of processes or on outcomes), and a self-rating. This format should help guide the Facility in moving forward and help managers and clinicians develop the ways in which they assess the quality and depth of the plans and actions to meet the many items of each of the provisions of the Settlement Agreement. Although the format is consistent across sections, there was great variability in the specificity of the activities and information, in the use of data, in consistency between the activities listed and the results reported, and in how extensively the data and information used for self-assessment were taken from the regular quality assurance information the Facility gathers and uses. The Monitoring Team provides, in this report, specific reviews of the self-assessments, including recommendations to assist the Facility to select appropriate activities and measures of status and to describe reasons for discrepancies in ratings between this report and the self-assessment. The Facility should consider how it might expand use of its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes.

In addition, SSLC provided for each Section of the Settlement Agreement provisions an Action Plan listing actions to be taken to move forward toward compliance. This report also provides some comments about the action steps in order to assist the Facility to review its plans and ensure they will lead toward compliance and will provide an organized approach that can coordinate with the self-assessment.

BSSLC had begun to identify and establish overarching initiatives to address requirements of multiple provisions. For example, the Facility had established a Program Services Workgroup. This group identified data relevant to numerous compliance issues and that pointed to areas of possible improvement. The initial focus of this group will be to identify environments to meet specialized needs and who might be better supported in those environments, and then to plan those environments, identify and provide training for the staff skills needed to work in those environments, and develop plans to transition individuals who may move from current homes or day program sites to these specialized environments. This process is in a very early stage, with initial meetings having occurred in May 2012.

Specific Findings

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

Restraints

The Monitoring Team determined substantial compliance with three provisions in Section C: Provisions C.1, C.3, and C.6. The Facility's substantial decrease in restraint use, along with significant innovative training, contributed to this increased level of compliance.

- Positive Practices and Improvements Made
  - The Facility had experienced a significant decrease in the use of crisis intervention restraint, from an average of 32 times per month to an average of five times per month.
  - The Facility also experienced an impressive reduction in the use of protective mechanical restraints from 28 Individuals to 12. The use of protective mechanical restraint for behavioral reasons had been eliminated.
  - The Facility has a comprehensive and thorough system for the review of restraint episodes, including review of video surveillance tapes (with the staff who were involved in the restraint) when the restraint occurred in an area covered by the surveillance cameras.
- Improvements Needed
  - The Facility was unable to provide consistent information on the use of oral pre-treatment sedation.
  - The Facility was unable to demonstrate that for those Individuals undergoing TIVA sedation for dental treatment that the ISP for those individuals included treatments or strategies to minimize or eliminate the need for that restraint.
  - For individuals who were restrained more than three times in a thirty-day period, there was little evidence of assessment of skills or of biological, medical, or psychosocial factors, or of updating and use of information from structural or functional assessments.

Abuse, Neglect and Incident Management

Although most provisions and components of provisions were in compliance, there had been no additional improvement in meeting requirements of the Settlement Agreement, and there had been regression in the quality of reviews of investigation reports.

- Positive Practices and Improvements Made
  - Facility policies express a commitment to ensure that abuse and neglect of individuals was not tolerated, and requires staff to report abuse and/or neglect.
  - The scope of the tracking and trending of incidents had been expanded enabling more comprehensive review including potentially the identification of systemic issues.

- The staff training requirements associated with this section of the Settlement Agreement were up-to-date.
- Investigation files were well organized.

- Improvements Needed
  - The Facility had not demonstrated consistent reporting of allegations and serious incidents within the timeframes required by policy and by the Settlement Agreement.
  - The processes the Facility used to review investigation reports were not identifying basic inconsistencies in investigation methodology and conclusions or data inconsistencies. However, when recommendations were developed from the review process, they were tracked and recording in a database until satisfactory evidence was provided to the IMC and reviewed by the Incident Management Review Team.

Quality Assurance

Quality Assurance activity necessary to achieve compliance with Section E of the Settlement Agreement was still in a formative stage. The Facility had made limited progress since the last review.

- Positive Practices and Improvements Made
  - The Facility had developed a database sufficient to produce monitoring data in formats lending themselves to review by the QA/QI Council. This process was better developed for some Provisions of the Settlement Agreement than others but progress was evident to the Monitoring Team.
  - Trend reports associated with Settlement Agreement monitoring, using the State monitoring tools, were also prepared. Each section of the Settlement Agreement was subject to this monitoring.
- Improvements Needed.
  - Although trend data were provided to the Quality Assurance/Quality Improvement (QA/QI) Council, they are of limited utility for longitudinal trending. This will improve as more months of monitoring data is compiled and as the inter-rater reliability monitoring continues to improve.
  - The Facility reported it had started the process of developing key indicators and needs to progress in developing these.
  - The Facility had not as yet developed a corrective action planning process and a database to support it.

Integrated Protections, Services, Treatments and Supports

Overall, the Facility's progress had not been substantial in developing and implementing 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, although some improvements were identified. A summary of progress included some improvements in assessment process for certain disciplines and some progress toward integrated treatment. The Facility had taken some action to address significant concerns about the quality of assessments.

- Positive Practices and Improvements Made
    - BSSLC had undertaken some initiatives to improve the timeliness and strengthen the quality of its assessment practices. Department heads had been instructed to begin reviewing discipline specific assessments prior to the ISP for adequacy. This directive had not yet been fully implemented.
    - The Facility continued to devote considerable resources to training, monitoring, and coaching for QDDPs, both new and current, an effort the Monitoring Team commends.
    - There were examples of improved integration observed in planning meetings and record reviews.
    - There were some additional initiatives to provide and document competency-based training.
- Improvements Needed
    - Although a new ISP process had been recently introduced, it was still meeting with limited success specific to the requirements of this section of the SA.
    - IDT members sometimes came to planning meetings without a basic knowledge or awareness of an individual's current status or needs.
    - 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.
    - Barriers to living in the most integrated setting did not 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 skill acquisition programs to service objectives and, since the last compliance visit, from service objectives to simply scheduled activities.

<u>Integrated Clinical Services</u>

BSSLC continued to make progress toward integrated clinical planning and services. Processes to improve integrated planning both for individuals and for systemic improvements continued to evolve.

- Positive Practices and Improvements Made
    - BSSLC continued the Medical Morning Meeting. Numerous clinical disciplines participated routinely in these meetings each weekday. From observation, it was clear that both individual and systemic issues are discussed in an interdisciplinary manner and lead to actions.
    - Processes to integrate behavioral health services continued to evolve.
    - The Facility had established a Change of Status documentation and follow-up process for Sick Call. Physicians complete a Change of Status form that includes the date, reason for being seen in sick call, determinations of whether there is a change in status and whether the team needs to meet.

- Improvements Needed
    - The Facility should consider a means to ensure referrals, recommendations, and assignments made during the Medical Morning Meeting are followed and implementation or outcomes reported back.
    - There remained examples of services provided to individuals for which integration could be improved.
    - A review of recently completed HMPs found examples of lack of integrated planning were common.
    - There was a lack of attention to communication assessments in the development of skill acquisition training.
    - Regarding review by facility clinicians of consultation recommendations by non-facility clinicians, policy is not clear or comprehensive.
    - Documentation of review was done, but not all consultations resulted in an integrated progress note.

<u>Minimum Common Elements of Clinical Care</u>
The Facility was taking steps to develop more organized processes to ensure the requirements of this Section are met; many of these are in early stages.

- Positive Practices and Improvements Made
    - Diagnoses were consistent with the current versions of the DSM and ICD classification systems.
    - The Facility has made efforts to ensure that all known syndromes were appropriately diagnosed, and tracked, as well as ensuring an understanding of the prevalence of many medical conditions at the Facility; medical staff had developed a list of all the syndromes identified on campus and the individuals diagnosed as having those syndromes.
    - In order to ensure timely involvement of the Interdisciplinary Team (IDT) when there was a change of health status that might require additional assessment and treatment, BSSLC had developed a "Change of Status" form that was to be completed each time the individuals were admitted to sick call. The purpose of this form was to improve notification of the QDDP to changes in status and the need to schedule an IDT meeting for additional discussion and review. Documents provided to the Monitoring Team did not permit assessment of whether ISPA meetings were held or of the outcomes of those meetings, but the process appears to have potential for ensuring timely identification of and response to changes in health status.
- Improvements Needed
    - Adequacy and timeliness of assessments and evaluations remained variable at this visit. 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.
    - For psychiatric diagnoses, there was not always the supporting information to verify and substantiate the diagnoses.

- The Facility did not have procedures in place to ensure or monitor that treatments and interventions were implemented timely but reported a system was in draft form.
- The development of clinical indicators of health status was in early stages. The Facility had begun development of tracking sheets for several chronic conditions, including osteoporosis, diabetes mellitus, hypertension, and seizure disorder.

At-Risk Individuals

The BSSLC processes to demonstrate compliance with this section of the SA had improved since the last review. This was especially noted in Provision I.3 where compliance rates in some areas improved significantly. Perhaps due to lack of policy to guide the process, risk assessment and mitigation process works more effectively with some disciplines than others and with some interdisciplinary teams (IDTs) better than others.

- Positive Practices and Improvements Made
  - The compliance rate determined from the sample reviewed by the Monitoring Team showed an improvement in the areas of starting an assessment within five days of risk identification and implementing a plan within 14 days of its finalization.
- Improvements Needed
  - The Facility did not have a comprehensive Facility level policy or procedure to guide the risk assessment process.
  - The system used for tracking risk identification and action plans was deficient.
  - Accurate assessments of level of risk using clinical information and sound clinical judgment were not always apparent.
  - IDTs are not consistently responding to a change in status.

Psychiatric Care and Services

The Facility made progress in a number of areas. These included completion of additional psychiatric assessments and improvements in those assessments, improvements in integrated care at the level of the overall behavioral health team, and improvements in consent procedures. and in the joining together of psychology and psychiatry concerns into an integrated behavioral health entry for risk assessments. As a general matter, the clinical care provided by the Psychiatry Department was good. Nonetheless, in a number of areas the Facility is held back by deficiencies in systems to support the clinical work. In each case, multiple provision items are affected.

- Positive Practices and Improvements Made
  - Psychiatrists were all board certified.

- Psychiatrists reviewed diagnoses to make sure that they properly described known problems, and the Facility improved the tracking of psychiatric diagnoses in APLs.
- All individuals who were prescribed psychotropic medication had treatment plans, and all had working psychiatric diagnoses.
- Good integrated care was evident in the morning medical report meetings and in PTRs,
- Psychiatric assessments were provided in a timely manner for new admissions.
- Integrated care for medications prescribed for both seizures and psychiatric illness was well coordinated.

- Improvements Needed
  - Psychotropic medication plans need to include monitoring with appropriate objective/quantitative measures, to help determine whether or not the medication is effective. For purposes of longitudinal tracking, tracking graphs should be maintained that display data over time and their relationship to medication dose changes and other events.
  - Explanation/justifications for key clinical decisions (for example about clinical diagnoses or initiation/ termination of medications) need to be included in documents that will be readily accessible over time.
  - Thirty percent of individuals who received psychotropic medication had not yet received psychiatric evaluations, and there are many individuals for whom NOS diagnoses remain unresolved.
  - The Facility did not have 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.
  - There remains a need to complete psychiatric evaluations for individuals who need them.
  - Although Reiss Screens had been provided to all individuals who required them, the protocol for use of Reiss Screens needed to more fully address the use of screens when a clinical change of status occurred.
  - There needs to be a greater emphasis on reductions of unnecessary polypharmacy. When continued polypharmacy was deemed clinical necessary, more detailed justifications (or references to where the justifications were located) needed to be provided.

<u>Psychological services</u>

Based upon the information gathered, it was determined that Provision K.2 was in substantial compliance with the Settlement Agreement. Despite the lack of substantial compliance with other Provisions, the review process did reflect that the Facility had achieved progress in other areas. Nevertheless, there were several areas in which BSSLC had failed to progress or had lost previously achieved accomplishments.

- Positive Practices and Improvements Made
  - The Facility was more likely to provide individually analyzed and appropriately graphed target behaviors, as well as timely revision of PBSP than in the past.

- The Facility had increased the number of individuals for whom intellectual and adaptive assessment had been provided.

- Improvements Needed
  - Due to resignations, the Facility employed only a single BCBA.
  - Although internal peer review continued, the quality of PBSPs reflected that the peer review process was not effective in improving assessments or interventions.
  - The monitoring of treatment benefit from PBSPs was less likely to reflect evidence-based decisions than during the previous site visit.
  - Structural and Functional Assessments (SFAs) were less likely to contain the necessary historical information and direct assessment procedures, as well as less likely to identify specific functions for the target behaviors.
  - Non-PBSP interventions continued to lack evidence-based assessment and treatment monitoring procedures.

Medical Care

The Monitoring Team compliments the Facility for ensuring adequate medical staff to support individuals served by the Facility. Because of recent leadership change with the medical director, and recent hire of two new practicing medical clinicians, the Facility has yet to have had an opportunity to assertively address Provisions L1 through L4.The current medical director has been in position for six months, and has begun the process of developing strategies to address requirements of the Settlement Agreement, which includes an associate that will help implement and track efforts towards compliance. The Monitoring Team would like to highlight the efforts made to ensure that all known syndromes were appropriately diagnosed, and tracked, as well as ensuring an understanding of the prevalence of many medical conditions at the Facility.

- Positive Practices and Improvements Made
  - The Facility had developed an impressive morning meeting process that includes all major clinical disciplines, and reviews all medical incidences that occurred during the previous evening, current hospitalizations, and unusual incidences. During attendance of the morning medical rounds, the Monitoring Team was impressed by the frank, and insightful discussion by its participants.
- Improvements Needed
  - The Facility needs to enhance the management of chronic care conditions. It has begun to address that through development of a syndromes database.
  - The Facility must improve medical clinician communication with hospitals.
  - The Facility must ensure follow-up to resolution of all acute medical conditions.
  - Medical provider quality assurance audits do not assess the medical clinicians' clinical performance.
  - The mortality review process must be improved to provide effective improvement strategies for health care.

- Medical policies must be developed and revised, and procedures put in place to ensure they are implemented consistently.

Nursing Care

Overall the most notable improvements were found in Provision M.1 and M.6. The Facility had hired a much needed RN Case Manager Supervisor and their emergency response system complied with the Emergency Response Policy. The Facility had done an exceptionally good job with complying with the Medication Variance Policy and in meeting other generally accepted standard of practice for medication administration; to achieve compliance, there must be demonstration over a period of time that the improved accuracy of identification and reporting of variances continues, and that practices to reduce recently-identified medication variances are continued and are effective. The remaining Provisions M.2, M.3, M.4, and M.5 showed only minimal improvement since the last compliance review.

- Positive Practices and Improvements Made
  - The Nursing Department had continued to maintain a stable and motivated Administrative and Management staff. A new position RN Case Manager Supervisor and was filled. Some realignment of nursing positions were made since the last review that included the appointment of a RN Case Manager to serve as the Hospital Liaison Nurse, and another RN Case Manager had been appointed as a Nurse Manager for the Cottages. Staffing patterns and evaluated/analyzed staffing ratios continued to be monitored daily on each shift, monthly and longitudinally.
  - Significant progress was found with the Facility's Emergency Response System.
  - Annual and Comprehensive Nursing Assessments showed improvement in the actual assessments which was probably related to the Physical Assessment Class the RN Case Mangers and RNs were required to take.
  - Health Maintenance Plans and Acute Care Plans were more individualized and appropriate to meet individuals' needs, and extraneous information was removed from the care plan template.
  - A Change of Status Form was developed and implemented to inform the Interdisciplinary Team of the need to meet and review.
  - The Nursing Department had fully implemented all aspects of the Medication Variance Policy, 053. There was evidence that all nursing staff were trained on the policy. A comprehensive Medication Database was in place, using the root cause method, to track, analyze, and trend all medication variances reports. Medication Data was presented in tabular, graphic, and narrative form. A review of the data and the Medication Variance Committee and Pharmacy and Therapeutic meeting minutes showed that the Nursing Department was using the data to make decisions and to develop plans of correction.
- Improvements Needed
  - The Infection Control Program had continued to put various infectious/communicable disease data in the Infection Control Database; however, the data was not analyzed and trended to identify what infectious trends were present

or emerging. The Infection Control Committee needs to take a more proactive role in and analyzing and trending the infection control data.
    - The Skin Integrity Nurse was maintaining a Skin Integrity Database and began chairing a Skin Integrity Committee. Participation by all relevant disciplines, and reporting of potential or actual pressure ulcers to the Skin Integrity Nurse, need to improve.
    - Minimal improvement was found in the nurses' ability to succinctly summarize raw clinical data to adequately describe individuals' health status progress or lack of progress toward identified nursing diagnoses/problems and risk ratings.
    - Although there was evidence that the required training was compliant, the Facility had not yet demonstrated in actual clinical practice implementation of the nursing assessment and reporting protocols sufficient to address the health status of individuals served.

<u>Pharmacy Services and Safe Medication Practices</u>
There has been continued and significant improvement with regard to working toward substantial compliance. The Monitoring Team is pleased to be rating substantial compliance for five Provisions that were previously noncompliant.

- Positive Practices and Improvements Made
    - The Pharmacy provided excellent review of new medication orders, and documentation of single patient drug interactions.
    - The Monitoring Team noted exceptional quality of the QDRRs reviewed, and based on discussion with the pharmacy director and clinical pharmacist, the QDRR process was current at the time of this review.
    - The Facility provides excellent review, and assessment of the use of benzodiazepines, anticholinergics, polypharmacy, and metabolic syndrome.
    - The Facility provided assertive follow-up, reporting, and tracking of adverse drug reactions.
- Improvements Needed
    - Although the quality of drug utilization reviews is adequate, the Facility needs to provide unscheduled DUEs for advisories issued by the FDA on serious medical concerns.
    - There remains a need for the Facility to improve the medical providers' participation in assessing and reporting on medical providers' medication variances.

<u>Physical and Nutritional Management</u>
Overall, there has been improvement regarding the comprehensiveness of the discussions occurring at the PNMT level. There has also been an improvement in BSSLC's ability to accurately identify individuals who are at an increased risk of physical and/or nutritional decline. BSSLC continued to show progress across areas that required direct clinical skill such as PNMT

meetings or assessments but systems components such as implementation of PNM related strategies continue to show slow and limited improvement.

- Positive Practices and Improvements Made
    - A localized policy had been developed that outlined the roles and responsibilities of the Physical and Nutritional Management Team (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.
- Improvements Needed
    - There was no evidence the IDT or PNMT was reviewing data to better identify system issues. There was also lack of participation by the registered dietitian as a standing member of the PNMT.
    - Individuals were not provided with a comprehensive assessment by the PNM team or IDT in response to a change in status.
    - Physical and Nutritional Management Plans (PNMPs) lacked detailed information regarding oral care and Head of Bed (HOB) elevation.
    - Although PNMPs 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.
    - 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.
    - For people receiving enteral nutrition, the assessment of the medical necessity of the tube has shown much improvement but the identification of potential pathways to resume intake remained absent.

<u>Physical and Occupational Therapy</u>

Overall, there was noted improvement with the Occupational Therapy (OT) and Physical Therapy (PT) services provided at BSSLC. Assessments were much improved and did a respectable job in providing a comprehensive review of the individual. The Facility must continue to work toward obtaining full staffing levels.

- Positive Practices and Improvements Made.
    - Assessments were completed in accordance to the schedule set forth by BSSLC and contained the components necessary to identify issues with functional mobility as well as other therapy needs.
- Improvements Needed

- Individuals were not consistently provided with interventions to minimize regression and/or enhance current abilities and skills.
- Plans were not implemented as written and staff was not knowledgeable of the OT/PT plans.

Dental Services

During the period since the prior compliance visit, the newly hired dental director left the Facility for another position. The Facility hired a new dental director, who just recently assumed the role of dental director and full time dentist. This slowed the progress that had begun at the time of the last compliance visit.

- Positive Practices and Improvements Made
  - Dental emergency cases were assessed and provided treatment.
- Improvements Needed
  - The Facility did not have a mechanism to determine if an individual's treatment for restorative care was complete, unless it reviewed the individual's dental record, and because this information was not documented in the IPNs.
  - The Facility enabled only two TIVA days per month, and a total of about 40 individuals were provided dental service by TIVA during the reporting period. The dental office staff reported that many individuals who did not receive TIVA for their dental services were unable to have their assessment and treatments completed because of maladaptive behaviors, which leads to concern over the limited availability of TIVA services at the Facility.
  - Appointment failures, and tracking of appointment failures remains problematic for the Facility. The Facility must develop strategies to help mitigate appointment failures, and better track the reason for appointment failures.

Communication

The assessment process had shown significant improvement. Outside of the assessment process, there has been little progress in this section. Due to staffing issues, many communication/speech related duties were given lesser priority and therefore were often not provided in a timely manner or at times not at all.

- Positive Practices and Improvements Made
  - BSSLC has filled all of their positions.
  - Individuals identified as having decreased communication were being provided with the needed assessments. Assessments had continued to show significant improvement. Assessments were noted to be comprehensive and provided clear details and strategies to improve the individuals' level of communicative functioning.
- 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.

- While the comprehensive assessments were detailed and met all the requirements of the SA, recommendations provided as a result of the assessments had become more vague and did not clearly identify the pathway (goals and objectives) to expanded communication.
- 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.

Habilitation, Training, Education, and Skill Acquisition Programs

Based upon information obtained during the site visit, it was evident that BSSLC had achieved minimal progress in regard to Section S of the Settlement Agreement. Although information provided by the Facility in the Self-Assessment suggested that improvements had been implemented, staff reports and reviewed documents reflected only minimal changes over conditions observed 18 months ago.

- Improvements Needed
  - Skill acquisition programs continued to rely primarily upon templates from the Murdoch Center Program Library without modification for individualization.
  - Formal task analyses were not completed as part of skill acquisition program development.
  - The ISP, Personal Focus Assessment, and other documents were not routinely used to identify personal needs or guide the development of skill acquisition programs.
  - Apart from vocational settings, minimal functional engagement for individuals living at the Facility was observed.
  - Community-based employment had not expanded and community activities had decreased substantially.

Most Integrated Setting

The Facility had continued improvement in this area. A summary of noted progress included the concerted effort with the families of many children, who had previously expressed opposition to community living, to work toward movement to a more appropriate and integrated setting. Additional progress was noted in the implementation of the CLDP and PMM processes, although these did not yet rise to the status of substantial compliance. 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 15 active referrals.
  - Identification of staff responsible for transition activities had been established.
  - CLDPs were completed and reviewed with the individual and LAR to facilitate their decision-making regarding supports and services needed for community living.
  - PMM Checklists were completed in a timely manner.

- The Facility reported two Alternate Discharges during the past six months and both appeared to have been completed in compliance with CMS discharge planning requirements and DADS policy.

- Improvements Needed
  - BSSLC must adequately assess, plan for, and implement a plan for each person's needs for education and awareness about community living options.
  - There were 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.
  - The Facility did not consistently identify 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.
  - Although there had been improvement, BSSLC did not yet consistently provide an adequate assessment of the presence of supports called for in the CLDP.

<u>Consent</u>

A summary of noted progress included the issuance of statewide policies on guardianship and self-advocacy. The Facility had begun to take some beginning steps toward implementing the requirements of the policy, such as recruitment of members for the Guardianship Committee, and the development of materials to be used for staff training. The Facility continued to provide support for self-advocacy and had begun using some formal choice-making materials as a part of its self-advocacy activities.

- Positive Practices and Improvements Made
  - The Facility also continued to develop its capacity to provide advocates for individuals as an alternative to guardianship.
  - DADS State Office had issued a new policy, DADS Policy 019: Guardianship, effective 3/7/2012, with five Exhibits, that provided some guidance to the Facility in the development and maintenance of a prioritized list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision.
  - The Facility maintained a prioritized list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision.
  - A new DADS policy on Self-Advocacy had recently been issued, and BSSLC did continue to provide support for self-advocacy, including incorporation of the use of some formal choice-making curriculum as had been recommended in the past.
- Improvements Needed

- Neither the Facility nor the new Guardianship policy identify guidelines or tools for assessing capacity to make decisions.
- The Facility had not yet developed a local Guardianship policy to implement the DADS policy.
- The Facility had completed recruitment of members for its Guardianship Committee, as called for in the DADS Policy, but had not yet held its first meeting.

Recordkeeping and General Plan Implementation

Although no provisions were found in compliance, the Monitoring Team found improvements in the records.

- Positive Practices and Improvements Made
  - Although records continue not to meet all requirements of Appendix A of the Settlement Agreement, but they are not as widespread as in the past. This indicates the audit and corrective action processes are leading to improvement.
- Improvements Needed
  - The Recordkeeping Policy revision should be completed as quickly as possible to improve consistency with requirements.
  - The Facility should also identify areas for systemic improvement actions rather than only corrective actions for individual records.

The comments in this executive summary were meant to highlight some of the more salient aspects of this status review of the Facility. The Monitoring Team hopes the comments throughout this report are useful to the Facility as it continues to work toward meeting the requirements of the Settlement Agreement.

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. BSSLC Self-Assessment (7/12/12) 2. BSSLC Action Plan (7/6/12) 3. Section C Presentation Book (undated) 4. DADS Policy 001 Use of Restraint (8/31/09) 5. DADS Policy 001.1 Use of Restraint (4/10/12) and related training materials 6. DADS SSLC Nursing Protocol: Pretreatment and Post-Sedation Monitoring (February 2011) 7. BSSLC Restraint for Behavioral Crisis Policy (6/8/11) 8. BSSLC Medical and Dental Restraint Policy (6/18/11) 9. BSSLC Restraint Debriefing Form 10. BSSLC Restraint Video Surveillance Review Form 11. List of crisis intervention restraints 1/23/12 to 7/23/12 12. List of protective restraint 1/23/12 to 7/23/12 13. List of medical restraint 1/23/12 to 7/23/12 14. List of Individuals with more than three restraints in a rolling 30 day period (6/28/12) 15. For Individuals #130, #173, and #460, the following documents were reviewed, if available: • Facility report of restraint applications • ISPs • ISP addenda • ISP Quarterly Notes • PBSPs • PBSP progress notes • Safety Plans • Restraint documentation • Psychological Evaluations and Updates 16. List of Individuals with a Safety Plan (6/20/12) 17. Sample of crisis intervention restraint records (Sample C.1): Individuals #173 3/21/12, #130 5/6/12, #460 5/21/12, #185 6/10/12, #11 4/29/12, #381 4/14/12, #399 6/10/12, #167 2/21/12, #479 4/12/12, and #403 5/30/12 18. Other restraint records: Individuals #38, #360, #392,#460 and #467 19. Sample of medical restraints for medical procedures (Sample C.2): Individuals #43, #221, #233, #238, and #380 20. Documentation of protective mechanical restraint for self-injurious behavior (use of new restraint policy) Individual #392 21. BSSLC "Do Not Restrain" list (undated)

	22. Sample of 25 direct care professionals' training records (Sample C.3) 23. Staff training records for sample of staff designated as restraint monitors 24. DADS report "Percent of All Employees Completing Courses of Training Programs" 7/3/12 25. DADS report "Course Due/Delinquent for BSSLC" for various required courses 6/28/12 26. Restraint Competency Exam (4/27/11) 27. Staff training material developed by BSSLC for restraint monitoring (Class RMT2011) 28. Minutes of Restraint Reduction Committee 4/26/12 29. Log of restraint related injuries since the last review. 30. Checklist for 3/30 Meetings/Reports (undated) 31. BSSLC Restraint Trend Report 6/30/12 32. TIVA records (Sample C.3) for Individuals #38 (04/11/12), #370 (03/08/12), #417 (01/04/12), and #445 (02/09/12). **People Interviewed:** 1. Terry Hancock, PhD, BCBA, Chief Psychologist 2. Shawn Cureton, M.S., Psychology Manager 3. Dr. Victoria Morgan, Lead Psychiatrist 4. Deanna Otts, Dental Hygienist **Meeting Attended/Observations:** 1. QA/QI Council meeting 7/25/12 2. Restraint Reduction Committee meeting 7/26/12
	Facility Self-Assessment: The BSSLC Plan of Improvement reported substantial compliance with one of the eight provisions of Section C of the Settlement Agreement (SA) - Provision C.6. The Monitoring Team determined substantial compliance with four provisions: C.1, C.2, C.3, and C.6. At the last review it was noted that documentation had improved compared to that observed at the earlier monitoring reviews. Documentation provided to the Monitoring Team during this review was much improved which led to improved compliance. The Facility's Action Plan that accompanied the self-assessment included steps to improve processes that were intended to lead to compliance with the Settlement Agreement. Revising the Facility restraint policy to reflect the substantive changes in the State restraint policy was an important element of the Action Plan. Many Action Plans in each provision were a continuation of plans previously developed and were reported as "in process." Action Plans need to be specific and targeted to Settlement Agreement requirements and should be adjusted as appropriate when circumstances associated with implementation (and effectiveness) are presented.
	Summary of Monitor's Assessment: The Monitoring Team determined substantial compliance with four provisions in Section C: Provisions C.1, C.2, C.3, and C.6. The Facility's substantial decrease in restraint use, along with significant innovative training, contributed to this increased level of compliance. The Facility had experienced a significant decrease in the use of crisis intervention restraint, from an average of 32 times per month to an average of

	five times per month. The Facility also experienced an impressive reduction in the use of protective mechanical restraints from 28 Individuals to 12. The use of protective mechanical restraint for behavioral reasons had been eliminated. The Facility reported they expect remaining use of protective mechanical restraint for medical reasons to continue to decline. The Facility has a comprehensive and thorough system for the review of restraint episodes, including review of video surveillance tapes (with the staff who were involved in the restraint) when the restraint occurred in an area covered by the surveillance cameras. 100% of restraints are reviewed by Psychology Department staff. The Facility use of available video surveillance tape to review restraint episodes is commendable. The Facility's restraint review process accurately identified any areas of noncompliance with written policies, procedures, and plans governing restraint use and demonstrated appropriate follow-up to any such identification. The quality and correctness of restraint documentation had improved significantly from that observed at the last review.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed a random sample of Restraint Checklists and Face to Face Assessments/Debriefings to determine compliance with the requirements of this provision. 2. Reviewed all videos of restraint on camera to determine compliance with the requirements of this provision. From its self-assessment the Facility determined that: 1. The review of five restraint checklists in June showed that there was one instance where it appeared the individual was placed in a restraint (chemical) without all lesser interventions being attempted (four of five equals 80% compliance). In this instance, the psychologist was on the phone with Direct Care Professionals (DCPs) reviewing that all lesser interventions had been attempted. A nurse called the psychiatrist directly for approval for a chemical bypassing the information the psychologist was collecting on lesser interventions attempted. This nurse had not yet been retrained on the correct procedure of ensuring all lesser interventions have been attempted because she had been out on sick leave. The Facility stated if she returns to work she will be retrained. Review of 20 restraint checklists in May showed there were no instances of an individual being placed in a prone restraint (100%) but on review of the videos (see #2 below) it was found that one of those 20 had been briefly in a prone restraint. The checklist was corrected to reflect an individual in a prone restraint (19/20 – compliance rate of 95%) and the DCP and restraint monitors were immediately retrained on appropriate PMAB	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		procedures and accurate reporting of restraints. Total sample of restraint checklists reviewed to date shows that 100% (25/25) of the restraints were used in a clinically justifiable manner, for reasons other than punishment, staff convenience or an absence of or alternative to treatment. Issues were noted in one of 25 restraint checklists for approved restraints (prone restraint - 24/25 for a compliance rate of 96%) and in one of 25 restraint checklists for not using a graduated range of interventions before administering a chemical restraint (24/25 for a compliance rate of 96%). 2. Reviewed five videos in June and determined that all restraints were administered per these provisions; specifically, restraints were only used when the individual posed a risk to self or others, after a graduated range of less restrictive measures had been exhausted, 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 approved restraint techniques were used. In reviewing nine videos in May, it was found that in one of the videos, the individual was briefly placed in a prone position (8/9 - 89%). All DSP involved in the prone restraint received competency-based training regarding correct PMAB restraint techniques and monitoring of restraint. In the remaining eight videos the restraints were administered per these provisions. There is improvement seen in correct use of restraint procedures (no prone restraint) in the video samples from May (89%) to June (100%). Total sample of videos to date shows that 93% (13/14) of the restraints used correct PMAB procedures (no prone restraint). Based on the findings of the self-assessment, the Facility determined that this provision is not in substantial compliance because there was one episode of prone restraint discovered on video review and one episode of a chemical restraint being administered before all graduated ranges of interventions had been attempted on a restraint checklist review. The Facility reported that since they had not completed video reviews of all restraints previously, they would expect that percentages toward compliance may be lower in the short term but the video review process will help effectively and accurately manage restraints in the long term. <u>Monitoring Team Findings</u> The Monitoring Team reviewed the documentation associated with the two restraints described in the Facility self-assessment and determined that the conclusions drawn from the Facility review were accurate. The Facility has a comprehensive and thorough system for the review of restraint episodes, including review of video surveillance tapes (with the staff who were involved in the restraint) when the restraint occurred in an area covered by the surveillance cameras. (Note: these cameras are not in private areas of the Facility such as individual's bedrooms and home bathrooms.) The Facility had demonstrated the ability through its system of restraint monitoring to identify errors in restraint	

#	Provision	Assessment of Status	Compliance
		application and/or documentation and take immediate appropriate corrective actions. This is described in more detail below. As a result, the Monitoring Team finds this Provision in substantial compliance. Following all restraints (100%), Psychology Department staff interview the staff involved in the restraint episode and record these data on the Facility's Restraint Debriefing Form. Video tapes of 100% of the restraints recorded by the video surveillance cameras are additionally reviewed by Psychology Department staff and that data is recorded on the Facility's Video Restraint Review Form. The comprehensive review of each restraint episode enabled the Facility to identify any instance in which written policies, procedures, and plans governing restraint use were not followed and to initiate corrective measures, most typically immediate retraining of specific staff. In the last review the Monitoring Team noted a significant increase in use of crisis intervention restraint at the Facility. Since then the Facility experienced a significant decrease in the use of crisis intervention restraint. For example, during the six-month period from September, 2011 through February, 2012 the Facility used crisis intervention restraint 192 times, or an average of 32 times per month. Since February, the Facility had used crisis intervention restraint an average of five times per month. The Facility attributed this significant decrease in large measure to increased staff training, particularly in the context of restraint review activity. The Facility engaged in two types of post restraint review activity that served the purpose of not only reviewing the restraint episode but also providing learning opportunities for the staff involved in the restraint. These are described more fully in Provision C.8.	

Type of Restraint	**Date range**
	1/23/12 to 7/23/12.
Personal restraints (physical holds) during a behavioral crisis	47
Chemical restraints during a behavioral crisis	2
Mechanical restraints during a behavioral crisis	0
TOTAL restraints used in behavioral crisis	49
TOTAL individuals restrained in behavioral crisis	13

#	Provision	Assessment of Status	Compliance
		Of the above individuals, those restrained pursuant to a Safety Plan: 8	

The Facility also experienced an impressive reduction in the use of protective mechanical restraints since the last review. At the time of the last review, seven Individuals regularly used protective mechanical restraint for behavioral reasons. This has been reduced and at the time of this review no Individuals used protective mechanical restraint for behavioral reasons. A similar impressive reduction in the use of protective mechanical restraint for medical reasons had occurred. At the time of the last review, 21 Individuals regularly used protective mechanical restraint for medical reasons. This had been reduced and at the time of this review 12 Individuals used protective mechanical restraint for medical reasons. The Facility reported they expect the use of protective mechanical restraint for medical reasons to continue to decline. The Facility attributed this decrease in use of protective restraints to aggressive implementation of behavior support plans that included multiple fading trials with commensurate staff training that ensured the ongoing safety of Individuals without the need for restrictive mechanical restraint.

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. DADS issued a new restraint policy in April 2012 and the Facility is in the process of implementing the new State policy. All staff had been trained as of July 1, 2012 and the restraint documentation associated with the revised State policy was being used. The Facility still needs to revise its Facility based restraint policy to reflect the State policy.

<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 prohibited. As described in the Facility self-assessment, one instance of brief prone restraint was identified in a post-restraint review of video surveillance tape. The Facility use of available video surveillance tape to review restraint episodes is commendable.

<u>Restraint Samples</u>
Two 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: Crisis Intervention 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

#	Provision	Assessment of Status	Compliance
		restrained and ensured the type of restraint used in the sampled episodes included both physical and chemical restraint. The sample also included the one instance of off-campus restraint. The sample included Individuals #173 3/21/12, #130 5/6/12, #460 5/21/12, #185 6/10/12, #11 4/29/12, #381 4/14/12, #399 6/10/12, #167 2/21/12, #479 4/12/12, and #403 5/30/12. Seven restraints involved individuals with a Safety Plan. Files prepared by the Facility for these 10 restraints were to contain the restraint checklist (RC), 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. • TIVA records for Sample C.3, Individuals #38 (04/11/12), #370 (03/08/12), #417 (01/04/12), and #445 ((02/09/12) and oral pretreatment-sedation reviews were for Individuals #43, #221, #233, #238, and #380. <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 10 of 10 records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others. This was presented on both the restraint checklist (RC) and the debriefing form (FFAD). ▪ For 10 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 10 (100%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. ▪ In nine of 10 records (90%), there was documentation that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. The one that did not document this was identified by the Facility as part of its post restraint review process. In this instance, this issue was identified through review of the video surveillance tape. ▪ All 10 restraint checklists (100%) indicated use of many pre-restraint interventions. including prompted replacement behavior, prompted coping skills, interventions in PBSP, interventions in Safety Plan, verbal prompt, redirection,	

#	Provision	Assessment of Status	Compliance
		PMAB protection skills, moved others away, traded out staff, and moved furniture. ▪ Facility policies identify a list of approved restraints. Based on the review of the sample of 10 restraints, 10 (100%) were approved restraints although one horizontal side-lying restraint resulted in a brief prone restraint. The Facility use of available video surveillance tape to review restraint episodes is commendable. The quality and correctness of restraint documentation had improved significantly from that observed at the last review (please note, however, that the documentation in records reviewed for Provision C.7 for individuals who experienced more than three restraints in a 30 day period was not improved). Four of 10 (40%) documentation files were error free. Another three (30%) contained only minor non-substantive errors, such as the recorded time of restraint on the RC being two minutes before or after the recorded time on the FFAD. The Psychology Department reported it regularly reviews 100% of restraint documentation to ensure accuracy and consistency between data reported on the RC, data recorded on the FFAD, and data recorded during the restraint debriefing conducted by the Psychology Department with the restraint monitor and the staff directly involved in the restraint episode. Additionally, since the last review, the Psychology Department initiated a process whereby each restraint episode that is recorded by the video surveillance cameras is reviewed with the restraint monitor and the staff involved in the restraint. This provided additional opportunities to ensure the data recorded on the RC and FFAD was accurate, and if not, corrected. The Facility's restraint review process accurately identified any areas of noncompliance with written policies, procedures, and plans governing restraint use and demonstrated appropriate follow-up to any such identification. This included correcting data on the restraint checklist and face-to-face debriefing document and retraining staff. The frequency of documented restraint practice and procedure that is inconsistent with written policy and procedure is extremely low. Because the Facility has demonstrated an effective process for reviewing each restraint episode and accurately identifying deviations from written policy and procedure, and has procedures in place to correct and document these deviations, including immediate retraining of staff, the Monitoring Team finds the Facility in substantial compliance with this provision.	
C2	Effective immediately, restraints shall be terminated as soon as the	<u>Facility Self-Assessment:</u> The Facility reported it had engaged in the following activities in conducting its self-	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	individual is no longer a danger to him/herself or others.	assessment: 1. Reviewed a random sample of Restraint Checklists and Face to Face Assessments/Debriefing to determine that restraint was terminated as soon as individual was no longer a danger to self or others. 2. Reviewed video of all restraints on camera to ensure that restraint was terminated as soon as individual was no longer a danger to self or others. 3. Reviewed monthly Section C monitoring tools to determine that the restraint was terminated as soon as the person was no longer a danger to self or others. From its self-assessment the Facility determined that: 1. Five restraints were reviewed on 6/15/12. The review determined that all restraints were terminated as soon as the individual was no longer a danger to self or others (5/5; 100%). Twenty restraints were reviewed on 5/22/12. This review determined that in all 20 restraint checklists sampled the restraint was terminated as soon as the individual was no longer a danger to self or others (100%). On review of the video of these restraints (see #2 below) though, one restraint in this sample should have been terminated earlier than it was because the individual was no longer a danger to self or others. The checklist associated with this restraint was corrected so it accurately reflected that the restraint was not terminated appropriately (19/20; 95%). The DSP staff involved in this one restraint was retrained on appropriate restraint procedures, especially terminating as soon as the individual is no longer a danger to self or others and the monitors were retrained on appropriate reporting procedures. Review of total sampled restraints to date found that in 96% of checklists (24/25) the restraint was terminated as soon as individual was no longer a danger. The review from May to June found overall improvement in restraints being terminated as soon as the individual is no longer a danger (May – 95%; June – 100%). 2. Review of five videos in June found that all five restraints were terminated as soon as the individual was no longer a danger to self (100%). Review of 9 videos in May found that one restraint with an individual was not terminated as soon as the individual was no longer a danger to self or others (8/9; 89%). The DSP staff involved in this one restraint was retrained on appropriate restraint procedures, especially terminating as soon as the individual is no longer a danger to self or others. Review of all videos to date found that 93% (13/14) of restraints were terminated when individual was no longer a danger to self or others. The video review from May to June found overall improvement in restraints being terminated as soon as the individual is no longer a danger to self (May -89%; June - 100%). 3. Review of the monthly Section C monitoring tools (review period from 03/01/2012 through 5/31/12; n=8) showed a 78% compliance rate on termination of restraints; paperwork reviewed found clear reporting of restraint being terminated when the individual was no longer a danger to self or others.	

#	Provision	Assessment of Status	Compliance
		Based on the findings of the self-assessment, the Facility determined that it is not yet in substantial compliance on this provision. The Facility reported it will need several months of review with consistent data between the checklist and video and 100% of restraints terminated as soon as the individual is no longer a danger to self or others as evidenced in the restraint checklist review, video review and section C monitoring. The Facility reported that since they had not completed video reviews of all restraints previously, they would expect that percentages toward compliance may be lower in the short term but the video review process will help effectively and accurately manage restraints in the long term. <u>Monitoring Team Findings</u> The 10 restraint records in Sample C.1 were reviewed. Two were chemical restraint. Of the remaining eight, 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. As reported in Provision C.1 the Facility had discontinued all use of protective restraint for behavioral reasons. From the documentation presented associated with the restraints chosen to sample, 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. The Facility's restraint review process included a 100% review of each episode of restraint. In instances where the restraint episode was video-recorded by a surveillance camera the Facility review included a review of that data. The review process is comprehensive, thorough, and in the opinion of the Monitoring Team would correctly identify any instance where restraint was not terminated as soon as the individual was no longer a danger to him/herself or others. The frequency of compliance reported in the Facility self-assessment (21 of 23 restraints reviewed by the psychology department for a 91% compliance rate), the presence of a process to review all restraints and to identify whether termination occurred as required, and the absence of noncompliance in the sample reviewed by the Monitoring Team is encouraging, and the Monitoring Team will find substantial compliance with this Provision. Nevertheless, the data reported from the	

#	Provision	Assessment of Status	Compliance
		Facility use of the Quality Assurance (QA) monitoring tool (78% compliance) demonstrates a need for continued improvement.	
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.	Facility self-assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed polices/procedures to ensure they are accurate and current in regards to restraint. 2. Reviewed training records to ensure Direct Support Professionals are current on the required training on restraint- related topics; specifically are current in PBS0100 (Positive Behavior Support), PMA0320 (PMAB 3.2: Intermediate Protection), PMA0400(PMAB 4: Restraint), PMA0700 (PMAB: Prevent), and RES0105 (Restraint: Prevention and Rules for Use at MR Facilities). 3. Reviewed a random sample of Restraint Checklists and Face to Face Assessments/Debriefings to determine that no individual was placed in prone restraint, lesser interventions were attempted, and restraint was justifiable. From its self-assessment the Facility determined that: 1. The local polices/ procedures for restraint are not currently consistent with the newly approved state policy. The Facility had trained staff on the new state policy and those procedures and forms are in place as of July 1, 2012. Still need to write a local policy that is consistent with the state policy. 2. Review of Central Training Department (CTD) training records for Direct Support Professionals showed that 99.3% (482/485) are current on PBS0100 (Positive Behavior Support) and RES0105 (Restraint: Prevention and Rules for Use at MR Facilities) while 98.9% (480/485) are current on PMA0320 (PMAB 3.2: Intermediate Protection), PMA0400 (PMAB 4: Restraint), and PMA0700 (PMAB: Prevent). 3. Review of five checklists in June showed one instance where it appeared the individual was placed in a restraint (chemical) without all lesser interventions being attempted (4/5; 80%). In this instance, the psychologist was on the phone with DSP reviewing that all lesser interventions had been attempted. A nurse called the psychiatrist directly for approval for a chemical bypassing the information the psychologist was collecting on lesser interventions attempted. This nurse has not yet been retrained on the correct procedure of ensuring all lesser interventions have been attempted because she has been out on sick leave. If she returns to work she will be retrained. Review of 20 checklists in May showed that there were no instances of an individual being placed in a prone restraint (100%) but on review of the videos, it was found that one of those 20 had been placed in a prone restraint. The checklist was corrected to reflect an individual in a prone restraint (19/20; 95%) and the DSP and restraint monitors were retrained on appropriate PMAB procedures and accurate reporting of restraints. Total sample of	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		checklists to date shows that 100% (25/25) of the restraints were used in a clinically justifiable manner, for reasons other than punishment, staff convenience or an absence of or alternative to treatment. Issues were noted in one of 25 checklists for approved restraints (prone restraint; 24/25; 96% compliant) and in one of 25 checklists for not using graduated range of interventions before administering a chemical restraint (24/25; 96%) From its self-assessment the Facility determined that this provision is not yet in substantial compliance since there has been one instance of a prone restraint discovered and one restraint that did not first use all lesser interventions before the restraint. In the future, we will need video and checklist monitoring to be consistent and 100% of the restraints whether reviewed by video or by checklist to meet all of the provisions. Additionally, while a high percentage of DSP are currently trained, to achieve compliance in this area we need 100% of staff to be current in their restraint related training and a process in place to remove DSP from working with individuals when they are not current in their training. <u>Monitoring Team Findings</u> In its self-assessment the Facility correctly reports it had not as yet revised the Facility restraint policy to comport with the revised State policy, which was issued in April, 2012. The State Office written guidance that accompanied the new policy and related training material did not specify a firm implementation date. In fact, State Office encouraged facilities to proceed in training and implementation of the new policy in manner that afforded an orderly and logical transition period. As a result, the Monitoring Team review occurred while this transition was occurring. Facility staff had been trained on the new policy and this training was completed by July 1, 2012. The restraint sample drawn by the Monitoring Team did not include any restraints that occurred in the time period since the new policy had been in effect at the BSSLC. Consequently, this review applied the policies and procedures in place at the time the restraint occurred. The Facility's policies related to restraint are discussed, in part, in Section C.1. The Restraint for Behavioral Crisis Policy (6/8/11) addresses the requirements of the SA associated with behavioral crisis restraint use. The BSSLC had sufficient policies to govern restraint. 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.	

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		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) • RES0105 (Restraint: Prevention and Rules for Use at MR Facilities) 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 24 of 25 (96%) staff had completed required training. One of the 25 was overdue in completing the PMAB training annually. 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 100% • PMA0400 100% • PMA0700 100% • RES0105 100% 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: • PMA0320 7 • PMA0400 6 • PMA0700 6 • RES0105 6 The three data sources noted above confirm substantial completion of required training and substantial compliance for the training components of this provision of the SA. The Monitoring Team has determined that the restraint policy in use at the BSSLC during this review included the elements required under this provision of the SA, and, that staff had been trained in the policy. As a result, this Provision is in substantial compliance. The Facility will need to develop and implement local policy that is consistent with DADS policy and local implementation of restraint procedures as trained.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one	<u>Facility Self-Assessment:</u> The Facility reported it had engaged in the following activities in conducting its self-assessment:	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	1. Reviewed a random sample of Restraint Checklists and Face to Face Assessments/Debriefings to determine that restraint was only used for crisis intervention except in case of medical procedures. 2. Reviewed a random sample of Restraint Checklists and compared them to the Individuals medical orders and the Do Not Restrain list. From its self-assessment the Facility determined that: 1. Review of 20 out of 20 checklists in May and 5 out of 5 checklists in June showed that each use of restraint was for crisis intervention and no individual was placed in a restraint for other reasons (100%). 2. Review of 20 out of 20 checklists in May and 5 out of 5 restraint records in June showed that no restraint used was in contradiction to the individual's medical orders. From its self-assessment the Facility determined that it was not in substantial compliance with this provision. The Facility reported it needed additional samples to ensure that procedures are consistent across time with restraint used only for crisis intervention and not used if contraindicated in an individual's medical orders. Additionally, the Facility reported it needed to develop a system to track whether the IDT has a plan in place for all individuals who require treatments or strategies to minimize or eliminate the need for restraint. <u>Monitoring Team Finding</u> Based on a review of 10 crisis intervention restraint records (Sample C.1), 10 (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 10 crisis intervention restraint records (Sample C.1), 10 (100%) 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 had a current 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. Additionally 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.	

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		Medical Restraints and Pre-Treatment Sedation In response to the pre-visit document request the Facility was unable to produce an accurate list of individuals who had pre-treatment oral sedation for a medical procedure. During the review, the Pharmacy Director provided a list of individuals who were prescribed medications used for pre-treatment sedation. Facility staff responsible for Section C of the Settlement Agreement could not independently verify the accuracy of this list. Nevertheless, from this list a sample of five (20%) was used to assess compliance with relevant requirements of Provision C.4. The Facility reported no instances of use of oral pre-treatment sedation for dental procedures. This was attributed to the Facility Dentist not having the appropriate credentials to prescribe such medicine. As a result, TIVA was used for those individuals who may otherwise have needed only oral pre-treatment sedation to facilitate dental treatment. The Facility was unable to demonstrate that for those Individuals undergoing TIVA for dental treatment that the ISP for those individuals included treatments or strategies to minimize or eliminate the need for that restraint. Development and deployment of plans to use pre-treatment sedation, and treatments or strategies to minimize the need for the sedation: For dental procedures steps to initiate the use of medical sedation for dental procedures were started when difficulties were encountered during an individual's appointment that was not preceded by the use of pre-treatment sedation. If repeated attempts on different days were not successful, the dental clinic requested that the IDT meet to 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. Items 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 individuals taking psychotropic medications • Monitoring procedures to be used • Consent status (person contacted for consent) The ISPA shells were also used when pre-treatment sedation was deemed necessary for medical procedure like eye appointments, imaging studies, diagnostic studies and more challenging/intrusive medical examinations. ISPA shells were the basis for the development of plans to use pre-treatment sedation. The plan was reviewed by the	

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		guardian who provided appropriate consent. The HRC then reviewed the plans to use pretreatment sedation. The provision required that if pre-treatment sedation was indicated, the individual needed to be provided with treatments or strategies to minimize or eliminate the need for the sedation. This would address the requirement that restraint not be used in the absence of treatment. The Facility reported that programs to do so were developed by different professionals, depending on the individual's needs. When appropriate, the Psychology Department developed "desensitization skill acquisition programs" (the term used by the Facility). Other programs were developed by QDDPs, with appropriate input from various IDT members, including psychology. The Facility reported that since Jan 1, 2012 there had been 39 episodes of dental restraint with sedation. During the visit the Facility clarified that all use of sedation in the dental clinic was related to TIVA; oral pretreatment was not used since the dentist was not properly credentialed to prescribe such medication. For the same period of time, the Facility reported that oral pre-treatment sedation was used 32 times for routine medical procedures. The Psychology Department reported that there were eight individuals with desensitization skill acquisition programs. The QDDP Department reported that there were 52 individuals who had non-skill acquisition programs to minimize the need for pre-treatment sedation. The Monitoring Team reviewed records for particular procedures, to see if each individual who received pre-treatment sedation had an appropriate program. The Facility reported that some kind of behavioral plan was in place for 12 of 39 (31%) of the episodes of dental pre-treatment sedation. No data was provided for medical pre-treatment sedation. The Monitoring Team next reviewed a sample of individuals who had received TIVA or oral procedures during the past six months (Sample J2). The sample was selected by choosing every sixth individual on the list of procedures provided by the Facility. TIVA reviews were for Individuals #38, #370, #417, #445. Oral pretreatment-sedation reviews were for Individuals #43, #221, #233, #238, and #380. For TIVA sedation, reviews of plans to minimize use of TIVA were as follows: **Individual # | ISPA shell date | Title of plan | Implementation of program | Monitoring Team comments** 38 | | | | No materials received	

#	Provision	Assessment of Status					Compliance
		370	2/22	When interacting with Dental Hygienist (the individual) will respond positively when touched on the hand for one of 4 sessions for two month	April: One session completed, two attempts refused	The plan did not address or clarify thinking on whether or how the skill learned will address the need for TIVA	
		417	12/29/11	Desensitization skill acquisition plan	Detailed notes provided documenting thoughtful application of the plan, and that progress was made	Well designed, described and executed	
		445	01/09/12	(The individual) will reduce the need for sedation for dental exams and improve his oral hygiene within one year Tooth brushing program- twice daily for two consecutive months	Data sheets provided for each month that document that the program was carried out	Good implementation of the plan but the plan itself did not address or clarify thinking on whether or how the skill learned would address the need for TIVA	

Plans were not in place to reduce the need for pre-treatment sedation for general medical procedures.

<u>Monitoring for safety during pre-treatment sedation:</u> Some progress was made in this area: Protocols for medical monitoring for safety by nursing had been clarified, and nursing protocol cards that summarized what was needed for safety monitoring were made available. The procedures used were as follows:

- Prior to departure from the home unit, nurses assessed vital signs,

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		gait/balance/coordination. Nursing 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. • Following completion of the procedure and the treatment provider had determined that the individual was stable, the BSSLS nurse resumed care and assessed the individual with vital signs every 15 minutes for one hour and then every 30 minutes for one hour until a REACT (a measure of depth of anesthesia) score of 8 was achieved, at which point the individual was released to the home. • Monitoring (including vital signs) was continued at the home every 30 minutes x2, then every two hoursx2, then every 4 hours for a minimum of 24 hours. All above guidelines were minimal requirements, and more frequent/higher level of care interventions were expected if they were clinically warranted. The Monitoring Team reviewed the safety monitoring that took place during the following pre-treatment procedures: TIVA reviews were for Individuals #38 (04/11/12), #370 (03/08/12), #417 (01/04/12), and #445 ((02/09/12). Oral pretreatment sedation reviews were for Individuals #43 (02/23/12), #221 (06/01/12), #233 (03/23/12), #238 (01/13/2012), and #380 (05/11/12). For TIVA reviews the results were as follows: For Individual #370, medical and dental orders for medication were received but not the nursing monitoring for safety. Medical, dental and nursing data were not received for Individuals #38, #417, and # 445. For oral pre-treatment reviews the results were as follows: For Individual #380 the planned procedure (ophthalmology exam) could not be completed, but the sedation was given and appropriate monitoring was provided. Vital signs were done prior to administration of the sedation every half hour until the appointment, and then every half hour x2, two hours x2 and every 4 hours for the remainder of the 24 hour period since the sedation was given. For Individuals #43, #221, #233, and #238, medication and medical monitoring data were not provided. During the last two reviews the Monitoring Team expressed concern over the lack of readily available and accurate data with respect to use of medical restraint. Without this the Monitoring Team cannot adequately review compliance with this provision. This concern remains and needs to be addressed. At the last review the Facility reported it had formed a special workgroup to develop a	

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		work plan that can lead to compliance with the medical restraint aspects of the SA. The Monitoring Team saw very limited progress in this regard and looks forward to seeing observable progress at its next review. At this time, the Monitoring Team was unable to confidently conduct a comprehensive review of this element of this Provision and was not able to confirm compliance with this provision.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed a random sample of Restraint Checklists and Face to Face Assessments/Debriefings to determine if restraint monitor met the required response time (< 15 minutes). 2. Reviewed a random sample of Restraint Checklists and Face to Face Assessments/Debriefings to determine if a licensed health care professional met the required response time (< 30 minutes). 3. Reviewed a random sample of Restraint Checklists and Face to Face Assessments/Debriefings to determine if the physician ordered an alternative monitoring schedule. 4. Reviewed all Restraint Checklists and Face to Face Assessments/Debriefings when a restraint occurred off-site to determine if nursing (30 minutes within return to facility) and restraint monitor (15 minutes within return to facility) documented within allotted time frame. 5. Reviewed monthly section C monitoring tools to determine if restraint monitor and health care professional met the required response time. From its self-assessment the Facility determined that: 1. The review of five of five checklists in June found that that the restraint monitor arrived within 15 minutes of restraint start (100%). The review of 20 out of 20 checklists in May found that the restraint monitor arrived within 15 minutes of restraint start (100%). The review of total sampled restraints to date found that in 100% of checklists (25/25) the restraint monitor arrived within 15 minutes of restraint start. 2. The review of five of five checklists in June found that that the licensed health care professional arrived within 30 minutes from start of restraint (100%). The review of 20 out of 20 checklists in May found that the health care professional arrived within 30 minutes of restraint start (100%). The review of total sampled restraints to date found that in 100% of checklists (25/25) the health care professional arrived within 30 minutes of restraint start. 3. The review of five of five checklists in June and 20 out of 20 checklists in May showed that no physician ordered an alternative monitoring schedule (100%). 4. The review of the Restraint Checklist and Face to Face Assessment/Debriefing for the one restraint that occurred off-site found that the protocol was not followed by the	Noncompliance

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		psychologist involved. (0% compliance). According to the restraint documentation, no contact was made with the Restraint Monitor or Nurse within the allotted time frame. Retraining was completed with this psychologist and from notes entered in the individual's chart it was clear that the Restraint Monitor and Nurse had been contacted upon return to the facility within the allotted time frames but the psychologist had not documented this accurately in the restraint paperwork. 5. The review of the monthly section C monitoring tools (review period from 03/01/2012 through 05/31/2012; n=8) found a 92% compliance rate with restraint monitors responding within the allotted time frame (Section C Monitoring tool, "Monitoring of Restraint," 1b), but a 65% compliance rate with a licensed health care provider beginning vital signs within 30 minutes of the start of restraint (Section C Monitoring took, "Monitoring of Restraint," 2a) and 65% compliant with health care professional completing mental status at least every 30 minutes from the start of the restraint(Section C Monitoring took, "Monitoring of Restraint," 2b). Based on the findings of the self-assessment, the Facility determined that this provision is not in substantial compliance. The Facility reported it was making good progress toward meeting the time requirements for the restraint monitors, but according to the Section C monitoring there are still issues with health care professionals meeting the time requirements (65% compliance). It also appeared there are issues with restraints that occur off-site as far as following the proper procedures. Additionally, the entire facility has just recently been trained on the new restraint policy/procedures and these have only been in place since July 1, 2012. More reviews will need to occur to ensure that there is the same level of compliance with the new state policy and procedures. <u>Monitoring Team Findings</u> 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 and had been updated to reflect the revised State Office Policy. The current version is labeled RMT2012. 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 10 Restraint Checklists. The staff person noted as the restraint monitor on the Restraint Checklist matched the list of restraint monitors provided by the Facility in each instance (100%). The Monitoring Team reviewed the training transcripts for the restraint monitors that monitored restraints in Sample C.1 in order to validate completion of the following classes: • PMA320 (PMAB Basic)	

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		• 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 10 of 10 instances (100%) for Sample C.1 the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint, or in the one case of an off-campus restraint, within 15 minutes of arrival back to the Facility. For some restraint episodes the restraint monitor was onsite when restraint began because he or she had been called earlier to assist in de-escalation efforts. In 10 instances (100%), the documentation on the FFAD showed that an assessment was completed of the application of the restraint. In 10 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 10 non-medical restraint records in the sample indicated an alternative physician-ordered monitoring schedule. Based on a review of ten 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 for physical restraints and every 15 minutes for chemical restraints from the initiation of the restraint in 10 (100%) of the instances of restraint. ▪ Monitored and documented vital signs in 10 (100%). However, there was documentation on the Restraint Checklists that the individuals listed below refused to allow the nurses to monitor all required vital signs every 30 and/or 15 minutes. o Individual #130: On 5/6/12 at 6:37 a.m., Individual #130 refused to allow the nurse to monitor one of four (25%) of the required vital signs. o Individual #460: On 5/21/12 at 2:53 p.m., Individual #460 refused to allow the nurse to monitor two of three (66%) of the required vital signs.	

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		o Individual #185: On 6/10/12 at 4:54 p.m. and 4:57 p.m., refused to allow the nurse to monitor one of four (25%) of the required vital signs. ▪ Monitored and documented mental status in 10 (100%). Based on documentation provided by the Facility, one restraint had occurred off the grounds of the Facility in the last six months. 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%). However, there was documentation on the Restraint Checklist that the individual listed below refused to allow the nurse to monitor all required vital signs every 30 minutes. ▪ Individual #479: On 4/12/12 at 9:41 p.m., there was documentation that Individual #479 refused to allow the nurse to monitor one of five (20%) of the required vital signs. ▪ Monitored and documented mental status in one 100%). The Monitoring Team noted documentation on the Restraint Checklists of numerous refusals by the Individuals to allow the nurses to complete the required vital signs 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 PSP, skill acquisition plan, or safety plan. The Facility must address this issue and provide guidelines to nurses regarding what actions to take when there is a refusal and to IDTs about the need to address consistent refusals. The Facility is close to achieving substantial compliance with this Provision. The healthcare restraint monitoring data reported from the Facility use of the Quality Assurance (QA) monitoring tool (65% compliance) demonstrates a need for continued improvement. While this provision is close to substantial compliance, consistent validation of compliance as demonstrated through use of the QA Monitoring Tool and a necessary.	
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	Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed a random sample of Restraint Checklists and Face to Face Assessments/Debriefings to determine compliance with the requirements of this provision. From its self-assessment the Facility determined that: 1. The review of five of five checklists in June and 20 of 20 checklists in May showed that the nurse checked for restraint-related injury in every restraint and there were no	Substantial Compliance

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	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.	injuries documented as a result of the restraint (100%). Supervision was documented as one-to-one as required and there were no instances of alternate levels of supervision requiring authorization by the Director. None of the restraints sampled occurred at meal time. There were no instances where an individual was denied an opportunity to exercise, use a toilet/bed pan or receive liquids. Since most restraints were very short in duration (< 2 minutes) these requirements would not likely be applicable. Based on the findings of the self-assessment, the Facility determined that this provision is in substantial compliance. <u>Monitoring Team Findings</u> Sample C.1 of 10 crisis intervention restraints was reviewed using the Restraint Checklist and Face-to-Face Assessment Debriefing as the primary source of documentation. The following compliance rates were identified for each of the elements required to comply with Appendix A: • In 10(100%), continuous one-to-one supervision was documented. • In 10 (100%), the date and time restraint was begun was documented; • In 10 (100%), the location of the restraint was documented; • In 10 (100%), information about what happened before, including the change in the behavior that led to the use of restraint was documented. • In 10 (100%), the interventions taken by staff prior to the use of restraint were documented and are adequate for post restraint review. • In 10(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 10(100%), the names of staff involved in the restraint episode were indicated on the restraint checklist. • The Restraint Checklist documented observations of the individual and actions taken by staff (where applicable)while the individual was in restraint, including: o In 10(100%), the observations documented at least every 15 minutes and at release. All restraints in the sample were of short duration. None exceeded 15 minutes. • In 10(100%), the specific behaviors of the individual that required continuing restraint were noted; and • Most restraints were of short duration (one-three minutes) which did not require opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, or to use a toilet or bed pan. Three restraints were	

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		reported to last 10 minutes and the documentation reviewed did not indicate any need to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, or to use a toilet or bed pan. • In 10(100%), the level of supervision provided during the restraint episode was recorded on the restraint checklist. • In 10 (100%), the date and time the individual was released from restraint was recorded on the restraint checklist. In nine (90%), the results of assessment by a licensed health care professional were documented as to whether there were any restraint-related injuries or other negative health effects. In 10 (100%) the FFAD restraint debriefing forms were present. In nine (90%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects were present. For Individual #167, the Post-Restraint Assessment Section of the Restraint Checklist did not document whether or not Individual #167 sustained injury related to the use of chemical restraint. The restraint sample reviewed by the Monitoring Team included two individuals who were the subject of a chemical restraint. In one (50%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the psychologist, who assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met. Refer to Provision C.1 for additional detail. The BSSLC had an additional restraint debriefing process where a psychologist interviewed staff involved in the restraint episode, including the Restraint Monitor. This process, viewed by the Monitoring Team as a positive practice, often produced useful information the IDT used to develop strategies to decrease the likelihood of need for restraint in the future. This restraint debriefing process probes the following which is documented on the Facility's Restraint Debriefing Form: 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	

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		displaying the precursors of the challenging behaviors that led to restraint, how did staff try to calm the resident? What interventions were tried prior to restraint, and how did the resident respond? 4. How can we prevent the need for restraining this resident in the future? If a similar situation develops, is there anything we can do instead of restraining the resident? Is there anything we can change in the environment where the restraint occurred that might make it less likely that the resident will again need to be restrained there? The files produced pursuant to Sample C.1 included this facility specific restraint review process in all 10 (100%) restraint episodes. Restraint documentation at the Facility was exemplary. The Monitoring Team has determined this Provision is in substantial compliance.	
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:	Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed the Restraint report for BSSLC to identify cases for which there were three restraints in any 30 day period. 2. Reviewed records of individuals identified as having three restraints in any 30 day period to determine if there was an IDT review through an ISPA. 3. Reviewed ISPAs to determine if the content and analysis requirements of this provision were met. From its self-assessment the Facility determined that: 1. The review of the Restraint report in June revealed that one case met the criteria requiring an IDT review of three restraints in a 30 day period. The review of the Restraint report in May revealed that there four cases that met the criteria requiring an IDT review of three restraints in 30 days. 2. Review of IDT minutes found that the one case in June and the four cases in May all resulted in a review through an ISPA (5/5; 100%). 3. Information provided in the ISPA for the one case in June met all criteria for "a" through "e." (100%). The IDT determined from this review that the PBSP did not need to be revised. Information provided in the ISPA for the four cases in May showed that criteria "a" through "e" were met for three of the four cases (75%). The IDT determined in all four cases that the PBSP did not need to be revised. Based on the findings of the self-assessment, the Facility determined that this provision is not in substantial compliance because all review criteria required by this provision was not thoroughly discussed by the applicable IDT.	

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		Monitoring Team Findings: According to Facility documentation, during the six-month period prior to the on-site review, a total of three individuals were placed in restraint more than three times in any rolling thirty-day period. A sample of three of these individuals (100%) was selected for review to determine if the requirements of the Settlement Agreement were met. The following documents were reviewed, if available. • Facility report of restraint applications • ISPs • ISP addenda • ISP Quarterly Notes • PBSPs • PBSP progress notes • Safety Plans • 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. Based upon the information obtained from BSSLC as part of the current site visit, it was not evident that the Facility had implemented a consistent and coherent process for monitoring the utilization of restraints. As documented elsewhere in Section C, the Facility had indicated a substantial decrease in the use of restraints since the previous site visit. Records associated with restraint utilization and monitoring for these individuals, however, were replete with instances in which the Facility failed to follow expected practices and respond to the use of restraint appropriately. • For Individual #130, the record included documentation that the IDT reviewed restraint use on 1/25/2012, but only for restraints applied on January 17 and 22. Restraints were also used for Individual #130 on 1/23, 1/26, 1/28, 2/23 (3 applications), 2/26, 4/11, 4/26, and 5/6. The record for Individual #130 did not reflect any review of restraints after 1/25/2012. No documentation suggested, either by timing or rationale, that any changes in ISP or PBSP resulted from review of restraints. • For Individual #173, the record reflected only one instance during which the IDT reviewed restraints. This review was documented in the ISP Quarterly Review, which covered the first three months of 2012. The record did not reflect any timely review of more than 3 applications of restraint in any 30 day period, although the Facility report of restraint applications reflected restraints had been	

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		applied on 1/7, 1/9 (2 applications), 1/12, 1/16, 1/17, 1/27, 2/1, 2/6 (2 applications), 2/13, 2/22, 2/28, 3/1 (3 applications), 3/5, and 3/21. • Individual #460 was admitted to BSSLC on 1/3/2012. Restraints were used for this Individual on 1/5 (2 applications), 1/8 (2 applications), 1/11, 1/14, 1/23 (3 applications), 1/31, 5/4 (2 applications), and 5/21. Documentation reflected that the IDT conducted a review of restraints on 1/5, 1/12, and 1/17, with no further reviews prior to the site visit. Due to the recent admission of Individual #460 to BSSLC, little was known about the Individual's behavior. None of the documentation of restraint reviews included in the record, however, reflected an in-depth consideration of the reasons for restraint or a specific plan for further investigation. A full Structural and Functional Assessment was not completed until late June. Due to the lack of necessary reviews, comprehensive assessments, PBSP revisions and follow-up, it was not evident that the Facility had made adequate attempts to identify the reason for restraint use for the three individuals with more than three applications of restraint in any rolling 30-day period. As a result, the Facility lacked the information necessary to avoid the use of restraints for these individuals.	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	According to Facility documentation, during the six-month period prior to the on-site review, a total of three individuals were placed in restraint more than three times in any rolling thirty-day period. A sample of three of these individuals (100%) was selected for review to determine if the requirements of the Settlement Agreement were met. The following documents were reviewed, if available. • Facility report of restraint applications • ISPs • ISP addenda • ISP Quarterly Notes • PBSPs • PBSP progress notes • Safety Plans • 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. Based upon the information obtained from BSSLC as part of the current site visit, it was not evident that the Facility had implemented a consistent and coherent process for	Noncompliance

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		monitoring the utilization of restraints that occur more than three times in a rolling 30-day period. Provision C7 has several requirements for what must be reviewed and what actions to take based on the reviews; documentation provided as part of the site visit reflected repeated instances where the Facility failed to consistently follow expected practices outlined in Provision C7 and did not provide evidence that all necessary reviews were completed. A consistent and coherent process would provide guidance, and possibly a checklist, of actions to be taken, and timelines for those actions that would trigger monitoring and accountability. As documented elsewhere in Section C, the Facility had indicated a substantial decrease in the use of restraints since the previous site visit. Records associated with restraint utilization and monitoring for these individuals, however, were replete with instances in which the Facility failed to follow expected practices and respond to the use of restraint appropriately. • For Individual #130, the record included documentation that the IDT reviewed restraint use on 1/25/2012, but only for restraints applied on January 17 and 22. Restraints were also used for Individual #130 on 1/23, 1/26, 1/28, 2/23 (3 applications), 2/26, 4/11, 4/26, and 5/6. The record for Individual #130 did not reflect any review of restraints after 1/25/2012. No documentation suggested, either by timing or rationale, that any changes in ISP or PBSP resulted from review of restraints. • For Individual #173, the record reflected only one instance during which the IDT reviewed restraints. This review was documented in the ISP Quarterly Review, which covered the first three months of 2012. The record did not reflect any timely review of more than 3 applications of restraint in any 30 day period, although the Facility report of restraint applications reflected restraints had been applied on 1/7, 1/9 (2 applications), 1/12, 1/16, 1/17, 1/27, 2/1, 2/6 (2 applications), 2/13, 2/22, 2/28, 3/1 (3 applications), 3/5, and 3/21. • Individual #460 was admitted to BSSLC on 1/3/2012. Restraints were used for this Individual on 1/5 (2 applications), 1/8 (2 applications), 1/11, 1/14, 1/23 (3 applications), 1/31, 5/4 (2 applications), and 5/21. Documentation reflected that the IDT conducted a review of restraints on 1/5, 1/12, and 1/17, with no further reviews prior to the site visit. Due to the recent admission of Individual #460 to BSSLC, little was known about the Individual's behavior. None of the documentation of restraint reviews included in the record, however, reflected an in-depth consideration of the reasons for restraint or a specific plan for further investigation. A full Structural and Functional Assessment was not completed until late June. Due to the lack of necessary reviews, comprehensive assessments, PBSP revisions and	

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		follow-up, it was not evident that the Facility had made adequate attempts to identify the reason for restraint use for the three individuals with more than three applications of restraint in any rolling 30-day period. As a result, the Facility lacked the information necessary to avoid the use of restraints for these individuals.	
	(b) review possibly contributing environmental conditions;	For three of the individuals/instances reviewed (100%), there was no documentation that individuals' teams reviewed the possibly contributing environmental conditions.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	For none of the individuals/instances reviewed (0%), individuals' teams reviewed and/or performed structural assessments of the behavior provoking restraints. The following are examples of where teams failed to do this adequately: • For Individual #130, the most recent Structural and Functional Assessment (SFA) was completed in October 2011. Although a 30-day behavior history was presented as part of the IDT review on 1/25/2012, documentation did not relate the history to the previous SFA or reasons for restraint. • For Individual #173, the most recent SFA was completed 8/20/2011. Documentation did not address the consideration of information from that SFA in relation to more recent applications of restraint. • For Individual #460, the restraint review conducted by the IDT on 1/5/2012 included a narrative of events surrounding the applications of restraint up to that date. No interpretation of those events was provided and a full SFA was not completed until late June.	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	For none of the individuals/instances reviewed (0%), individuals' teams reviewed and/or performed functional assessments of the behavior provoking restraints. The following are examples of where teams failed to do this adequately: • For Individual #130, the most recent Structural and Functional Assessment (SFA) was completed in October 2011. Although a 30-day behavior history was presented as part of the IDT review on 1/25/2012, documentation did not relate the history to the previous SFA or reasons for restraint. • For Individual #173, the most recent SFA was completed 8/20/2011. Documentation did not address consideration of information from that SFA in relation to more recent applications of restraint. • For Individual #460, the restraint review conducted by the IDT on 1/5/2012 included a narrative of events surrounding the applications of restraint up to that date. No interpretation of those events was provided and a full SFA was not completed until late June.	Noncompliance

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	(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 three of the individuals reviewed (100%), individual had a PBSP at the time of the restraint applications. Of the three individuals in the sample who had PBSPs, the following was found: • None (0%) were based on the individual's strengths; • None (0%) specified the objectively defined behavior to be treated that led to the use of the restraint; • None (0%) specified the alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint; and • None (0%) specified, as appropriate, the use of other programs to reduce or eliminate the use of such restraint. The following are examples of individuals had inadequate PBSPs. The development of an adequate PBSP requires an adequate SFA. For none of the three individuals was documentation of an adequate SFA provided. • For Individual #130, the most recent Structural and Functional Assessment (SFA) was completed in October 2011. No effort to establish the validity of the existing SFA or to append the SFA with information regarding recent restraint applications was documented. • For Individual #173, the most recent SFA was completed 8/20/2011. Documentation did not address the validity of that SFA in relation to more recent applications of restraint. • For Individual #460, the restraint review conducted by the IDT on 1/5/2012 included a narrative of events surrounding the applications of restraint up to that date. No interpretation of those events was provided and a full SFA was not completed until late June. The Safety Plans of the individuals in the sample were reviewed. The following represents the results: • In three out of three of the Safety Plans reviewed (100%), the type of restraint authorized was delineated; • In three (100%), the maximum duration of restraint authorized was specified; • In three (100%), the designated approved restraint situation was specified; and • In three (100%), the criteria for terminating the use of the restraint were specified.	Noncompliance
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment	For none of the individuals reviewed (0%), the individual's behavioral data and/or treatment integrity checks showed that the PBSP was implemented with a high level of treatment integrity.	Noncompliance

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	integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	The following are examples of where the Facility failed to do this adequately: • For Individual #130, no treatment integrity checks were conducted or interobserver agreement (IOA) data collected during January and February 2012, the months of in which restraints were applied with the greatest frequency. Therefore, there was no evidence that treatment was being provided as designed in the ISP and PBSP. • For Individual #173, the highest frequency of restraint application was in January, February, and March. Documentation revealed treatment integrity checks were conducted no times in January, three times in February and three times in March. Documentation reflected that for four of the six treatment integrity checks, the Facility reported that staff had no opportunity to respond to at least half of the relevant items, substantially limiting the value of those data. No IOA observations were conducted until 6/28/2012. • For Individual #460, the highest frequency of restraint application was in January and May. Documentation revealed treatment integrity checks were conducted two times in January and four times in May. Documentation reflected that for six of the six treatment integrity checks, staff had no opportunity to respond to at least half of the relevant items, substantially limiting the value of those data. No IOA observations were conducted.	
	(g) as necessary, assess and revise the PBSP.	In none of the records reviewed (0%), was there adequate documentation to determine that the individual's PBSP had been revised as appropriate. • Although the PBSP was revised in March 2012, no effort to establish the validity of the existing SFA or to append the SFA with information regarding recent restraint applications was documented. Documentation by the IDT did not reflect a reason for a revision to the PBSP. For Individual #130, the most recent Structural and Functional Assessment (SFA) was completed in October 2011. A review of the relevant treatment data reflected a decline in the display of behavior resulting in restraint, as well as other undesired behavior. • According to the record, the PBSP for Individual #173 had been revised in July 2011. Although self-injury and physical aggression had substantially increased beginning in January 2012, no additional revisions to the PBSP were documented. • For Individual #460, the PBSP was revised in March 2012. As a complete SFA had not been completed at the time of the revision, it was not clear from the record that the revised PBSP reflected relevant issues or addressed the circumstances associated with restraint applications.	Noncompliance
C8	Each Facility shall review each use of restraint, other than medical	Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment:	Noncompliance

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	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.	1. Conducted a retrospective review of all physical and chemical as well as programmatic restraints since 1/22/12. 2. Conducted a monthly review of Restraint Checklists and Face to Face Assessments/Debriefings starting in April 2012 to determine if the required facility level reviews were completed within the prescribed time limit. 3. Conducted a review of the most recent section C monitoring results to determine if the required reviews were completed within the prescribed time period. From its self-assessment the Facility determined that: 1. All emergency physical and chemical restraints as well as programmatic restraints were reviewed from 1/22/12-6/10/12. The review found that 48 restraints were reviewed within three business days of the start of the restraint (100%). One restraint was incorrectly coded as an early start of prescribed medication rather than a chemical restraint. After consulting with State Office regarding coding, the restraint was coded as an emergency chemical restraint. 2. Twenty restraints were reviewed on 5/22/12. The review found that all restraints were reviewed within three business days of the start of the restraint (20/20; 100%). 3. Review of the monthly section C monitoring tools (review period from 03/1/12 through 5/31/12; n=8) found a 50% compliance rate with the required reviews being documented on the checklists as occurring within three business days. Based on the findings of the self-assessment, the Facility determined that this provision is not in substantial compliance because the review of restraint checklist data was not consistent with the findings of section C monitoring tool data. The Facility reported it will need to have consistent findings between the checklist review and the section C monitoring tool to be in compliance with this provision. <u>Monitoring Team Findings</u> The Monitoring Team selected a 20% sample of crisis intervention restraints (Sample C.1) that occurred from the time of the last review to the time of document preparation, a five-month period. During this time period the Facility reported 49 crisis intervention restraints involving 13 different people. The sample consisted of 10 restraints involving 10 different individuals. The BSSLC process for reviewing each episode of restraint began with a FFAD done by the restraint monitor immediately after the restraint episode. The restraint episode is reviewed in the unit morning meeting the next business day with whatever information has been prepared by the time of the meeting. This often consisted of verbal reports from staff. It is usually reviewed that same day by the Incident Management Review Team (IMRT), again usually based on verbal reports from staff, either the Unit Director,	

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		behavioral services staff, or both. The restraint use is also reviewed by the Individual's IDT within three days of occurrence. Two additional levels of restraint review occurred at the Facility. 1. First, as reported in Provision C.6, the BSSLC had a 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 produced useful information the IDT used to develop strategies to decrease the likelihood of need for restraint in the future. Please refer to the complete description of this process reported in Provision C.6 The files produced pursuant to Sample C.1 included this facility specific restraint review process in all 10 (100%) restraint episodes. Second, as reported in Provision C.1, the Psychology Department initiated a process whereby each restraint episode that is recorded by the video surveillance cameras is reviewed with the restraint monitor and the staff involved in the restraint. This provided additional opportunities for staff training and to ensure data recorded on the RC and FFAD was accurate, and if not, corrected. The Monitoring Team reviewed documentation related to 10 incidents of crisis intervention restraint (Sample C.1). This documentation included the FFAD, Unit Morning meeting minutes, IMRT minutes, the Behavioral Services staff debriefing report, and ISP addendums resulting from the review process. Sample C.1 documentation reviewed by the Monitoring Team showed that: ▪ In 10 (100%), the review by the Unit IDT occurred within three business days of the restraint episode and this review was documented by an ISP Addendum. ▪ In 10 (100%), the review by the Unit IMRT occurred within three business days of the restraint episode and this review was documented by signature on the Restraint Checklist and FFAD and in Unit IMRT meeting minutes. ▪ In 10 (100%), the review by the Facility IMRT occurred within three business days of the restraint episode and this review was documented on the FFAD and in Facility IMRT minutes. ▪ In 10 (100%), the circumstances under which restraint was used was determined and was documented on the Face-to-Face Assessment Debriefing including the signature of the staff responsible (restraint monitor) for the review. A further review was completed by staff from the Psychology Department and documented on the Facility specific Debriefing Form. When appropriate this review included	

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		review of video surveillance recordings which was documented on a supplementary review form. ▪ In 10(100%), the review conducted by the Unit IMRT and IDT, the Facility IMRT, and the Psychology Department was sufficient in scope and detail to determine if the application of restraint was justified, if the restraint was applied correctly, and to determine if factors existed that if modified might prevent future use of restraint with the individual, including adequate review of alternative interventions that were either attempted and were unsuccessful, or were not attempted because of the emergency nature of the behavior that resulted in restraint. ▪ In 10 (100%) of Sample C.1, the review conducted by the Unit IMRT and the Facility IMRT resulted in referral to the IDT for review and consideration of possible changes in active treatment plans, positive behavior plans, and other aspects of the ISP that effect the behavior of the individual; and ▪ Of the 10 referred to the team, ten (100 %) resulted in documentation of substantive review which either resulted in a team decision to continue the current course of action, or in the initiation of changes to the individuals' ISP. In each case these follow-up courses of action appeared appropriate to the circumstances. Restraint review of nursing related requirements was not as extensive and thorough as that noted in other areas. For example, ▪ Individual #130: the Restraint Checklist's Post-Restraint Assessment Section stated, "Bit self to right wrist". It checked the box indicating that the injury was from behavior. The nurse's physical assessment was inadequate. The description of the injury sustained by the bite was not documented nor whether treatment was required. There was no documentation in the Post-Restraint Assessment check box indicating that the Provider was notified. ▪ Individual #381: the Restraint Checklist's Post-Restraint Assessment Section stated, "Doing usual activities with staff and peers". The check box was marked indicating there was an injury related to behavior. This conflicted with the statement written in the Post-Restraint Assessment section. The nurse's physical assessment was inadequate. If an injury was indicated in the check box there should have been a description of the injury and documentation whether or not treatment was required. There was no documentation indicating that the Provider was notified of the Post-Restraint Assessment. ▪ Two of 10 (20%) Restraint Checklists' Post-Restraint Assessment Sections documented whether or not Providers were notified of the Post-Restraint Assessments.	

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		Restraint procedures used across the Facility were also reviewed at the monthly Restraint Reduction and Behavior Support Committees. The meetings of each group observed by the Monitoring Team (and a review of previous meeting minutes) confirmed that meetings were substantive in nature and included both policy and procedural discussions. Meetings were well attended and discussions were interdisciplinary. It was evident these committees engage in substantive review, problem solving, and the development of specific recommendations. Meetings sometimes included a case study, which was typically the most difficult behavioral/restraint case at the time of the meeting. Additionally, the Quality Assurance/Quality Improvement Council included a review of SA Section C compliance on its agenda on a rotating basis. This would typically not include any discussion of an individual episode of restraint but did ensure a broader base of general review of restraint data and restraint practices at the BSSLC. The data reviewed by the Monitoring Team reported substantially different compliance rates than that reported via the Facility's use of the Section C Monitoring Tool. The data reviewed by the Psychology Department also reported substantially different compliance rates. The Facility correctly points out in its self-assessment that a higher, and more consistent, degree of compliance rates between restraints reviewed through the Monitoring Tool, and those reviewed as part of the Psychology Departments self-assessment must be present in order for this Provision to be in substantial compliance. The Monitoring Team concurs. Additionally, improvement is needed in the restraint review process to ensure the nursing requirements associated with restraint are properly documented.	

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

1. The Facility needs to revise its restraint policy to comport with the revised State policy (Provision C.1)
2. The Facility needs to reconcile differences in compliance assessments conducted using the Monitoring Tool compared with those conducted by Psychology staff (Provisions C.2, C.5., and C.8).
3. The Facility needs to determine if the inability to prescribe oral pre-treatment sedation by the dentist impairs the ability to deliver needed dental services or results in use of a more restrictive sedation procedure than would otherwise be required and if so develop alternative strategies to overcome this problem (Provision C.4)
4. The Facility needs to develop and maintain accurate information regarding the use of medical restraint (Provision C.4).
5. 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).
6. The Facility should ensure that the nursing staff complete and document thorough assessments and descriptions of injuries sustained during restraint use and indicate whether treatment was required. If so, the treatment should also be documented.
7. The Facility should ensure that the Restraint Checklist's Post-Restraint Assessment Section is completed for the Provider Notification and the RN/LVN signature and date.

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 Self-Assessment (7/12/12) 2. BSSLC Action Plan (7/6/12) 3. Section D Presentation Book (undated) 4. DADS Policy 021 – Protection From Harm – Abuse, Neglect, and Exploitation (5/11/11) 5. DADS Policy 023 Incident Management (1/31/11) 6. BSSLC Policy Protection from Harm-Abuse, Neglect, and Incident Management (4/14/11) 7. BSSLC Policy D.2: Maintaining and Providing ANE Resource Guide (1/25/12) 8. BSSLC Policy D.3: Participating in and Completing Incident Management UIR Committee (1/25/12) 9. BSSLC Policy DD.2: Injury Reporting – Semi-Annual Under Reporting Audits (1/25/12) 10. BSSLC Policy DD.3: Incident Management Executive Duty Officer (2/8/12) 11. BSSLC Draft Policy DD.4: Incident Management Duty Officer (5/24/12) 12. Form 1020 for sample of 25 employees 13. Your Rights and Zero Tolerance posters 14. Training materials used by BSSLC Abuse/Neglect classes April, 2012 15. Abuse/Neglect/Exploitation Competency Exam dated 12/12/11 16. Log of Department of Family and Protective Services (DFPS) cases 1/23/12 to 7/23/12 17. Data Report prepared by the BSSLC summarizing Abuse & Neglect allegations, and case disposition, from 1/1/12 to 6/30/12 18. Log of Office of Inspector General (OIG) cases 1/23/12 to 7/23/12 19. Log of serious injuries 1/23/12 to 7/23/12 20. Log of serious incidents 1/23/12 to 7/23/12 21. Log of witnessed injuries 1/23/12 to 7/23/12 22. Log of discovered injuries 1/23/12 to 7/23/12 23. DFPS investigation reports and related materials selected for Sample D.1: 42347535, 42321872, 42309712, 42295412, 42132393, 42104954, 41884875, and 42016072. (Note: all eight selected cases were also investigated by OIG) 24. Other OIG case reports: 8886-12 and 8357-12 25. Other DFPS case reports: 40941456, 41799274, and 42297632 26. BSSLC investigations selected for Sample D.2: UIRs 127, 148, 169, and 175 27. Other BSSLC investigations: UIRs 079, 138, 142, 160, 168, and 172 28. BSSLC Investigator Recommendation Log 7/23/12 29. Injury Packets for a sample of discovered non-serious injuries 30. Incident Management Team meeting minutes 6/8/12, 6/22/12, and 6/29/12 31. List of the ten most injured individuals since the last review 32. List of peers who caused the most injuries since the last review 33. BSSLC Unusual Incident Reports Trend Report 6/30/12

	34. BSSLC Abuse, Neglect, Exploitation Trend Report 6/30/12 35. BSSLC Injury Trend Report 6/30/12 36. Training transcripts for Facility Investigators 37. Training transcripts for DFPS Investigators 38. Minutes of DFPS/OIG/BSSLC meeting 5/24/12 39. Minutes of Self-Advocacy group 2/27/12, 3/26/12, 4/23/12, and 6/25/12 40. List of BSSLC employees 6/25/12 41. DADS spreadsheet documenting background checks 9/10/11 42. DADS report MHMR0102 Percent of All Employees Completing Course of Training 7/3/12 43. Course/Due Delinquent reports for ABU0100 and UNU011 7/3/12 **People Interviewed:** 1. Natalie Montalvo, Facility Director 2. Kim Littleton, Assistant Director of Programs 3. Susie Johnson, Director of Residential Services 4. Daniel Dickson, Quality Assurance (QA) Director 5. Michael Appling, Incident Management Coordinator 6. D'eandra Polk, Facility Investigator 7. Mary Anne Brett, MD, Medical Director 8. Debbie Williams, RN, Chief Nurse Executive 9. Jill Quimby, RN, QA **Meetings Attended/Observations**: 1. Childress IDT meeting 7/23/12 2. Self-advocates meeting 7/24/12 3. Childress Unit Incident Management Team meeting 7/24/12 4. QA/QI Council meeting 7/25/12 5. Restraint Reduction Committee meeting 7/26/12
	Facility Self-Assessment: The BSSLC self-assessment reported substantial compliance with three (D.1, D.4 and D.5) of the five provisions of Section D. The Monitoring Team determined substantial compliance with these same three provisions. The BSSLC self-assessment reported substantial compliance with 14 components of SA provisions. The Monitoring Team found BSSLC to be in substantial compliance with 12 of those 14 components but disagreed with the finding for two others. The two components self-assessed as in compliance but found to be not in compliance by the Monitoring Team both addressed the need for the Facility to be more thorough and thoughtful when reviewing of investigations of serious incidents. For example, the Facility reviews of DFPS reports were not always thorough and successful in identifying substantive issues with investigatory methodology. Also, the Facility review of unusual incidents did not always detect important issues related to investigation methodology and conclusions. As a result, reports generated pursuant to this Provision were deficient. The Facility's self-assessment included use of data, where appropriate, and for the most part identified

	compliance ratings consistent with that determined by this review by the Monitoring Team. The Facility's Action Plan that accompanied the self-assessment included steps to improve processes that were intended to lead to compliance with the Settlement Agreement. Most Action Plans in each provision were nearly identical focusing on "analyze data," "develop a corrective action plan," "develop a tracking system," and "monitor the corrective action plan." This provided a broad framework for action planning but Action Plans that are much more specific and targeted to Settlement Agreement requirements are needed.
	Summary of Monitor's Assessment: In the last review the Monitoring Team noted that to achieve full compliance with Section D of the Settlement Agreement the Facility needed to achieve compliance with only five addition components of two provisions. These were D2.a, D2.e, D2.i, D3.e, and D3.f. Compliance with these components remains problematic. Unfortunately, the Facility had not experienced observable movement towards compliance in these five components during the last two reviews. This review identified two additional components requiring substantive attention: D.3.g and D.3.h. Facility policies express a commitment to ensure that abuse and neglect of individuals was not tolerated, and requires staff to report abuse and/or neglect. Nevertheless, the Facility had not demonstrated consistent reporting of allegations and serious incidents within the timeframes required by policy and by the Settlement Agreement. The processes the Facility used to review investigation reports (primarily the staff review by the Incident Management Coordinator's (IMC) office, reviews by the Facility Incident Management Review Team, and the reviews conducted by the UIR Review Committee) were not identifying basic inconsistencies in investigation methodology and conclusions or data inconsistencies. Recommendations coming from the review process were tracked and recording in a database until satisfactory evidence was provided to the IMC and reviewed by the Incident Management Review Team. The scope of the tracking and trending of incidents had been expanded enabling more comprehensive review including potentially the identification of systemic issues. Timely reporting of serious injuries needs improvement and the process of reviewing investigations of non-serious discovered injuries to rule out abuse and neglect needs improvement. The staff training requirements associated with this section of the Settlement Agreement were up-to-date. Investigation files were well organized.

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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.	Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment: Reviewed local policies that address ANE to determine if zero tolerance commitment and staff reporting responsibilities are included. From its self-assessment the Facility determined that the local policies clearly include the Center's commitment to zero tolerance of ANE. Based on the findings of the self-assessment, the Facility determined that this provision remains in substantial compliance because the local policies address the commitment of zero tolerance of ANE. Monitoring Team Findings: The Facility's policies and procedures did: • Include a commitment that abuse and neglect of individuals will not be tolerated, • Require that staff report abuse and/or neglect of individuals. The state policy stated that SSLCs would demonstrate a commitment of zero tolerance for abuse, neglect, or exploitation of individuals. The Facility policy stated that all employees who suspect or have knowledge of, or who are involved in an allegation of abuse, neglect, or exploitation, must report allegations immediately (within one hour) to DFPS and to the director or designee. In practice, the Facility appeared committed to ensure that abuse and neglect of individuals was not tolerated, and encouraged staff to report abuse and/or neglect, as illustrated by examples provided throughout this section D of the report. The criterion for substantial compliance for this provision is the presence and dissemination of appropriate state and facility policies. Implementation of these policies on a day to day basis is monitored throughout the remaining items of section D of this report.	Substantial Compliance
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies,		

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	procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.	Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment: Conducted a review of Departmental monitoring for Section D reporting of serious incidents, injuries, and death investigations. From its self-assessment the Facility determined that the monitoring tool data for May 2012 indicated that 50% of the cases were not reported within the timeframes specified in Center Policy. Based on the findings of the self-assessment, the Facility determined this provision is not in substantial compliance because not all unusual incidents of this nature are reported timely to the Center's Director or Designee or initiation of investigation. Monitoring Team Findings BSSLC policy required staff 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. In its last review the Monitoring Team noted that with regard to serious incidents, the BSSLC policy Protection from Harm – Abuse, Neglect, and Incident Management (4/14/11) did 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. During this review the Monitoring Team specifically asked to see the Facility's policy directed at injury reporting and none was provided. The Facility had a process to review and update key facility policies. The Abuse, Neglect, and Incident Management policy should be updated or another policy developed that includes requirements for reporting all types of serious incidents. From a response to a document request asking for the total number of abuse and neglect allegations and disposition/status for the six month period from 1/1/12 through 6/30/12, the following data were provided by the Facility. These data are provided for information purposes only:	Noncompliance

#	Provision	Assessment of Status	Compliance
		Total Number of Abuse Allegations: 60 (Note: in the prior six-month period there were 153 abuse allegations). Confirmed 0 Unconfirmed 34 Inconclusive 0 Administrative Referral 4 Disposition Pending 19 Other (unfounded) 3 Total Number of Neglect Allegations: 48 (Note: in the prior six-month period there were 29 neglect allegations). Confirmed 2 Unconfirmed 10 Inconclusive 1 Administrative Referral 20 Disposition Pending 5 Other (1 unfounded, 1 outside investigation) Total Number of Exploitation Allegations: 5, all of which were unconfirmed BSSLC provided a log of serious injuries during the period from 1/23/12 through 7/23/12, a six month period. From this report the Monitoring Team was able to determine the BSSLC had 18 serious injuries during this time period. This is an average of three per month, a decrease from the 4.2 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 eight (20% of the 42 investigations between 1/23/12 and 6/25/12) investigations was selected from the list of DFPS cases provided by the Facility. This sample included the following DFPS cases: 42347535, 42321872, 42309712, 42295412, 42132393, 42104954, 41884875, and 42016072 (Note: all eight selected cases were also investigated by OIG). These eight cases included three cases of unconfirmed abuse, one case of confirmed neglect, two cases of unconfirmed neglect, and two cases administratively referred back to the Facility. • Sample D.2: Facility Investigations. A sample of four serious injury investigations (20% of the 18 serious injuries between 1/23/12 and 6/27/12) was selected from the facility log of serious injuries. This sample consisted of the following UIRs: 12-127, 148, 169, and 175.	

#	Provision	Assessment of Status	Compliance
		Based on a review of the eight investigation reports included in Sample D.1, six reported a date and time of the alleged incident. Of these six, two (33%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by Facility policy. Those that did not include DFPS cases 42347535, 42321872, 42104954, and41884875. Serious injuries were not always reported to the Facility Director according to policy (within one hour). In reviewing the four serious injuries in Sample D.2 two (50%) were not reported timely, including: • UIR 12-169: The UIR indicates the incident occurred at 2:40pm and was reported at 4:10pm • UIR 12-127: The UIR indicates the incident occurred on 3/1/12 and was reported on 3/2/12 The Facility had a standardized reporting format, the Unusual Incident Report (UIR). Based on a review of the 12 investigation reports included in Sample D.1 and Sample D.2, 12 (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 and process 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 an "injury packet." In the last report by the Monitoring Team it was noted that injury packets did not regularly undergo any formal quality assurance review outside the residential unit from which they originate. This is still the case. 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. This is necessary to ensure that when a probable cause is assigned to a discovered injury it is evidence-based and not solely conjecture. The Monitoring Team did identify examples of injury packets that were sent to the Incident Management Coordinator by the Unit Director. This occurred when the Unit could not establish a "probable cause." These injuries were subsequently reviewed by a Facility investigator. As a matter of good practice, at least on a sample basis, the IMC office should review Unit investigations of non-serious discovered injuries for which the Unit established a probable cause. Such a process should detect obvious inconsistencies in data reviewed at the Unit level. For	

#	Provision	Assessment of Status	Compliance
		example, the Monitoring Team reviewed the discovered injury of Individual #316 ((3/29/12). The Unit review reported a probable cause of "from leg brace and shoes." This may have been part of a probable cause but the statement was not complete. Additionally, the Injury Report identifies the cause as ""self-caused hit". An investigation should identify and reconcile inconsistent data and include this in the investigation documentation. Finally, the Witness Statement identifies the shift the injury was discovered on but not the specific time. The specific time should be reported so that the investigation protocol can work back from that time in reviewing information that may help in identifying cause, such as what the Individual was doing, where they were, and what staff was responsible for their supervision.. Through the course of reviewing investigations the Monitoring Team noted that the video surveillance cameras had been helpful in ascertaining the facts associated with many allegations. Because the Facility has not demonstrated consistent reporting of allegations and serious incidents within the required timeframe, this Provision is not in substantial compliance.	
	(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.	<u>Facility Self-Assessment:</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Conducted a review to determine if all alleged perpetrators were placed on non-direct care status immediately once they have been identified. 2. Conducted a review to determine if all DFPS final reports and serious injury final reports are reviewed by the Unusual Incident Review Committee. From its self-assessment the Facility determined that: 1. Alleged perpetrators were removed from direct contact and were not returned to direct contact status until the Unusual Incident Review Committee had met to review the report. 2. Alleged perpetrators were tracked through a data base that includes the date and time placed on non-direct care and when returned to work. Based on the findings of the self-assessment, the Facility determined that this provision remains in compliance. <u>Monitoring Team Findings</u> BSSLC policy directs facility staff 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	Substantial Compliance

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		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 eight investigation reports in Sample D.1, alleged perpetrators (AP) were identified in four investigations. Documentation showed that the alleged perpetrators were placed in non-direct care (NDC) status in each case; however, it was not always clear if this occurred on a timely basis. For example, for case 42309712 the UIR reports the date the AP was placed in NDC status but not the time. For case 42321872 the UIR reports the date and time the AP was placed in NDC status which was at 10:30 am the day following the report of the allegation. It is unclear if the AP worked the morning shift until 10:30am or what specific circumstances may have been present. For case 42104954 the UIR reports the date and time the AP was placed in NDC status, which was at 9:35 pm even though the incident occurred at 10 am and was reported at 4:29 pm. It is unclear if the AP worked the morning and/or afternoon on the day in question. In the last report by the Monitoring Team, it was noted that UIRs and DFPS reports undergo a significant amount of review at BSSLC and that the Monitoring Team would expect these review processes to detect, and correct, data inconsistencies like those referenced in the previous paragraph that directly affect SA compliance. Review activity is still deficient in this regard. In reviewing the eight investigations in Sample D.1, there were not any instances in which a staff person who had been removed from direct contact was 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 eight 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.	

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		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 and reconcile data inconsistently such as that 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.	Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment: Conducted a review to determine if all new and current employees receive ANE training before they are released from the Training Department to their work assignment and during annual ANE Refresher. From its self-assessment the Facility determined that in its review of 50 new and current employees that were required to attend new and annual ANE training 100% of staff sampled have received ANE training prior to being released to their work assignment. Based on the findings of the self-assessment, the Facility determined that this provision remains in compliance. Monitoring Team Findings BSSLC policy 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 training transcripts showed that 25 (100%) of those staff had completed competency-based training on abuse and neglect and 25 (100%) had completed unusual incidents within the last 12 months. The Monitoring Team also reviewed DADS report MHMR0102 Percent of All Employees	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Completing Course of Training which reported a 99% completion rate for ABU0100 and a 100% completion rate for UNU0100. The Monitoring Team has determined this Provision is in substantial compliance.	
	(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.	Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment: Reviewed a sample of 50 current employees. From its self-assessment the Facility determined that the review showed that 50 of 50 (100%) had signed the Form 1020 acknowledging their obligation to report ANE. Based on the findings of the self-assessment, the Facility determined that this provision remains in substantial compliance. Monitoring Team Findings BSSLC policy 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 was randomly selected to determine if annual acknowledgements had been signed. Twenty-five of 25(100%) had signed annual acknowledgments form 1020. Through the course of its investigations and review of DFPS investigations the Facility did not report any instances of failure to report or of late reporting of abuse or neglect that could be linked directly to specific Facility staff. The Monitoring Team has determined this Provision is in substantial compliance.	Substantial Compliance
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person,	Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment:	Noncompliance

#	Provision	Assessment of Status	Compliance
	identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	Conducted a review of Departmental Monitoring for Section D mechanisms to educate individuals and LARs on identifying and reporting unusual incidents including ANE. From its self-assessment the Facility determined that: The review of Departmental Monitoring of four sample investigations for Section D2.e of the monitoring tool for the time period of May 2012 indicated that 50% of the individuals were educated on identifying and reporting while 100% of the LAR's were educated on identifying and reporting and 100% of the LAR education was referenced in the annual ISP. Based on the findings of the self-assessment, the Facility determined that this provision is not in substantial compliance at this time as there is no consistent method of documenting in the annual ISP of the education of the LAR and individual of identifying and reporting ANE. <u>Monitoring Team Findings</u> The Monitoring Team review of ISPs associated with other Sections of the Settlement Agreement confirmed the Facility self-assessment that there is no consistent method of documenting in the annual ISP the education of the LAR and individual of identifying and reporting ANE. In addition, in reviewing minutes of self-advocates meetings that have occurred since the last review none included discussion of this topic. The Facility had a policy entitled "Maintaining and Providing ANE Resource Guide (1/25/12)" which described a process directed at achieving compliance and includes a QA process to ensure intended activity occurs. The Facility did not provide any documentation that could validate implementation of this policy. The Monitoring Team concurs with the Facility self-assessment that this Provision is not yet in substantial compliance.	
	(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.	<u>Facility Self-Assessment:</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: Conducted a review of walk-throughs of all homes identifying that Zero Tolerance and Rights Posters were available and posted in the home. From its self-assessment the Facility determined that the review of the walk through of	Substantial Compliance

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		all of the homes completed by the Incident Management Department indicated that 100% of the homes displayed the Zero Tolerance and Rights Poster. Based on the findings of the self-assessment, the Facility determined that provision is in substantial compliance. <u>Monitoring Team Findings</u> A review was completed of the two postings used at the Facility to demonstrate compliance with this Provision. They included brief and easily understood statements 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 program areas on campus showed that all areas reviewed had postings of individuals' rights in an area to which individuals regularly had access. Prior to the review by the Monitoring Team the Facility IMC completed a walk-through of all homes and program areas to validate compliance with this requirement. He identified 13 areas where one or both posters were missing. They were subsequently replaced. This suggests the Facility needs to implement a regular process for periodically inspecting homes and program areas to ensure continued compliance with this Provision.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	<u>Facility Self-Assessment:</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: Validated that DFPS reports all allegations to local law enforcement. From its self-assessment the Facility determined that of all reported DFPS cases since January 30, 2012, 100% were referred to local law enforcement by DFPS. Based on the findings of the self-assessment, the Facility determined that this provision remains in substantial compliance. <u>Monitoring Team Findings</u> In reviewing Sample D.1 (eight DFPS cases) no documentation was provided that would validate, as reported in the facility self-assessment, that law enforcement had been notified in 63% of the cases: 41884875, 42295412, 42016072*, 42321872*, and 42309712*. These last three cases (*) were allegations of physical abuse. This was determined by the absence of an appropriate entry on the cover page of the DFPS case report. Because all these cases were also investigated by OIG it is evident that law enforcement was notified and this Provision remains in compliance.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The Facility needs to be more thorough in its self-assessment. Based on its self-assessment the Facility expects local law enforcement notification for all DFPS cases. Based on the documentation provided to the Monitoring Team this is not consistently documented.	
	(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.	Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment: Conducted a review of reports of retaliation reported to the Director and or the Assistant Director. From its self-assessment the Facility determined that there were no reports of retaliation reported to the Director and or the Assistant Director. Based on the findings of the self-assessment, the Facility determined that this provision remains in substantial compliance. Monitoring Team Findings BSSLC policy includes specific requirements associated with this element of the SA. These are found in section V of the policy. Training provided to all staff included curricula directed at the prohibition of retaliation and how to report. Based on a review of investigation records (Sample D.1 and Sample D.2), there were no concerns noted related to potential retaliation. During this review the Monitoring Team interviewed a DFPS investigator who reported occasional (about once a year) concern of retaliation expressed by a staff person in the course of interviews. This was reported as an expressed concern, not an actual report of retaliation. The investigator reported that when this happens the concern is reported to the IMC. 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, or exploitation. The Facility reported it did not have such a list because there were no reported allegations of retaliation since the last review. The Monitoring Team concurs with the Facility self-assessment and finds this Provision in substantial compliance.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment: Reviewed a sample of 20 individuals in which the Under Reporting Monitoring Tool was completed. From its self-assessment the Facility determined that of the 20 individuals sampled there were 66 non-serious injuries in which the proper reporting procedures were not followed. Based on the findings of the self-assessment, the Facility determined that this provision is not in substantial compliance because the procedure for reporting non-serious injuries was not being followed consistently. Monitoring Team Findings The self-assessment activities reported by the Facility were inadequate to measure compliance with this Provision and were not targeted at the essential element of the SA requirement, determining whether significant resident injuries were reported for investigation. Additionally, the Facility did not provide the Monitoring Team with any documentation that would enable the Monitoring Team to assess compliance with this Provision. In the last report the Monitoring Team noted that the Facility had not experienced observable movement towards compliance in this provision. This still appears to be the case. When the Facility establishes a process to comply with this Provision that process should be able to: • Determine whether or not an issue identified by a program auditor is representative of a "significant injury". A significant injury may not necessarily be a serious injury as defined in DADS or Facility policy. For example, issues identified in the audits could involve incidents/injuries that reported coughing (i.e. aspiration issue?), cuts (i.e. blood and infection control issue?), and injury in the area of the eye (client protection issue?). All these could be considered "significant" and may merit closer review in the context of this Provision. • Determine whether or not the issue identified by a program auditor was (or should have been) reported for investigation. • Determine that if the issues identified by a program auditor should have been reported for investigation, and were not, that discovery of this fact resulted in	Noncompliance

#	Provision	Assessment of Status	Compliance
		subsequent initiation of an investigation. The Monitoring Team concurs with the Facility self-assessment that this Provision is not in substantial compliance.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	<u>Facility Self-Assessment:</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: Reviewed Incident Management (IM) staff training records to determine all required training was completed by staff conducting investigations per state and local policy. From its self-assessment the Facility determined that the review of all IM staff training records indicate all staff (100%) that conduct investigations are properly trained. Based on the findings of the self-assessment, the Facility determined that this provision remains in substantial compliance. <u>Monitoring Team Findings</u> State and Facility policies articulate training requirements for investigators and these are sufficient to meet the requirements of this Provision. 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:	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		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 4. Time and Stress Management In reviewing the materials associated with these modules the Monitoring Team is of the opinion that this training is competency-based. 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.	

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		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, in addition to the Incident Management Coordinator, 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. The Monitoring Team concurs with the Facility self-assessment that this Provision is in substantial compliance.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	<u>Facility Self-Assessment:</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: Conducted a quarterly DFPS/OIG/BSSLC meeting on May 24, 2012. From its self-assessment the Facility determined that DFPS and OIG both stated that they had no issues with cooperation from BSSLC staff and if any issues were to arise they would notify the Incident Management Coordinator for assistance. Based on the findings of the self-assessment, the Facility determined that this provision remains in substantial compliance. <u>Monitoring Team Findings</u> BSSLC policy includes language directed at this element of the SA including the following language in section IV.A.3.e, f, and g: e. The director or designee shall require employees and agents to cooperate with DFPS investigators so that they are afforded immediate access to all records and evidence as necessary to conduct an investigation in a timely manner. f. The director or designee shall assist in whatever way possible to make employees and agents who are relevant to the investigation available in an expeditious manner. g. Employees who fail to cooperate with an investigation are subject to disciplinary action.	Substantial Compliance

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		As described earlier in this report, two samples of investigation files were selected for review. These included Sample D.1 and Sample D.2, which consisted of DFPS investigations, and Facility investigations, respectively. Review of the investigation files in Sample D.1 showed that in all eight investigations (100%), Facility staff cooperated with DFPS and OIG investigators. Additionally, the Monitoring Team interviewed a DFPS Investigator who reported a high level of cooperation from Facility staff. The Monitoring Team concurs with the Facility self-assessment that this Provision is in substantial compliance.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed the Memorandum of Understanding between DADS, HHSC, DFPS, OIG, and the SSLC's to determine policy supports the coordination of investigations. 2. Conducted a quarterly DFPS/OIG/BSSLC meeting on May 24, 2012. From its self-assessment the Facility determined that: 1. Review of the MOU shows that policy supports appropriate coordination of investigations between agencies. 2. DFPS and OIG expressed no concerns regarding the coordination of investigations. Based on the findings of the self-assessment, the Facility determined that this provision remains in substantial compliance. Monitoring Team Findings 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 eight of eight investigations (100%). The Monitoring Team concurs with the Facility self-assessment that this Provision is in substantial compliance.	
	(d) Provide for the safeguarding of evidence.	Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment: Reviewed local policy to ensure it supports the safeguarding of evidence. From its self-assessment the Facility determined that policy adequately supports the safeguarding of evidence. All case investigation evidence is maintained in a locked environment with only the IMC and facility investigators having access. Based on the findings of the self-assessment, the Facility determined that this provision remains to be insubstantial compliance. Monitoring Team Findings 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 DFPS investigator reported, when interviewed by the Monitoring Team, that she had never encountered a situation at the BSSLC where necessary evidence was unavailable or evidence handling compromised the integrity of an investigation. The Monitoring Team concurs with the Facility self-assessment that this Provision is in substantial compliance.	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	Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment: Review of Departmental Monitoring for Section D that require each investigation of a serious incident commence within 24 hours after being reported. From its self-assessment the Facility determined that:	Noncompliance

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	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.	Departmental Monitoring of four sample investigations for Section D3.e of the monitoring tool for the time period of May 2012 indicated that: • For DFPS investigations: 1 out of 2 (50%) did not commence within 24 hours • For Facility investigations: 1 of 4 (25%) did not commence within 24 hours. Based on the findings of the self-assessment, the Facility determined that this this provision is not in substantial compliance because not all investigations are initiated within the required 24 requirement <u>Monitoring Team Findings</u> 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: 1. 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). 2. Checking to assure that any known APs were placed in NDC status, 3. The identification of any collateral witnesses, 4. The Facility has (or is) gathering all relevant documentation, 5. Any physical evidence is secure, 6. A determination if there is likely video surveillance evidence to review, 7. The development and review of a preliminary investigation plan. Two of the eight cases in Sample D.1 were administrative referrals. For the other six cases there was adequate documentation to substantiate commencement of the investigation within 24 hours of the allegation being reported. None of the six cases addressed all of the subject matter noted above. All contained enough material to lead to the conclusion the investigation began within 24 hours. DFPS may wish to provide more explicit guidelines and instructions as to required information to establish that substantive investigatory activity took place within the first 24 hours of receiving an allegation. A checklist documenting whether or not specific actions were taken, or were not applicable, could be helpful in this regard.	

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		Onsite interviews of collateral witnesses' and APs seldom occurred within the first 24 hours of an investigation of an incident. Although other substantive investigatory activities can serve to establish initiation of an investigation, there may be investigations in which the outcome of the investigation 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. 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. Two of the six (33%) investigations were not completed within 10 calendar days of the incident and the Facility did not provide any evidence that an extension had been requested and approved by the DFPS supervisor. Because no documentation was provided by the Facility the Monitoring Team could not assess whether the SA requirement of "extraordinary circumstances" was met. The other two investigations in Sample D.2 were administrative referrals back to the Facility. Following the visit, DADS provided a statement that documented extensions were received, but the Monitoring Team had no way to verify this information; at the next compliance visit, it will be essential for the Facility to provide such information. All 12 (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 in Provision D.3.f. Where appropriate, the DFPS report included concerns and recommendations for corrective action by the Facility. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: In reviewing Sample D.2 (four serious injuries) the information in the UIR was sufficient to determine that the investigation began within 24 hours of the incident in three (75%) investigations. The Facility had initiated a new process whereby the Facility investigator writes a report separate from the UIR titled "Initiation of Investigation Summary." This very clearly documents what occurred when in the early stages of the investigation. The incident associated with UIR 127 pre-dated the implementation of this new process. In reviewing this UIR it was not possible for the Monitoring Team to determine the date and	

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		time the Investigator actually began the investigation. Facility investigations in Sample D.2 were completed within 10 calendar days of the incident, including sign-off by the IMC (supervisor). The Facility had a UIR Review Committee that reviewed DFPS cases. The Facility had recently decided this committee will review all UIR's to ensure decisions and recommendations are reviewed at an executive level within the Facility. Four of four investigations in Sample D.2 (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 in Provision D.3.f. 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. Because not all investigations were completed within 10 days (and the Facility did not provide documentation addressing an extension request), and because documentation was insufficient to demonstrate that all Facility investigations commenced within 24 hours, this Provision is not in substantial compliance. The Monitoring Team concurs with the Facility self-assessment that this Provision is not in substantial compliance.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person	Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment: Reviewed Departmental Monitoring for Section D for this provision. From its self-assessment the Facility determined that: Departmental Monitoring of four sample investigations for Section D3.f of the monitoring tool for the time period of May 2012 indicated that: • For each person interviewed, includes a summary of the topics discussed and questions posed: 0 out of 4 investigations • Reasons for the conclusions by the investigator: 3 out of 4 (75%) did provide a clear basis for the conclusions Based on the findings of the self-assessment, the Facility determined that this provision	Noncompliance

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	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.	is not in substantial compliance because not all investigations include a summary of the topics discussed and questions posed. Monitoring Team Findings This Provision was rated in noncompliance in the last two reviews. No documentation was provided to the Monitoring Team which would indicate that measures to correct the deficient practices noted in the last two reports had been initiated. In order to highlight the deficiencies reported in the last two reports by the Monitoring Team the following is taken from the previous report: "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 Provision 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 are to utilize 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	

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		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 investigations and Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of Sample D.1 DFPS investigations: In all eight investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. While report content was always clear in presenting the Investigator's rationale for their conclusions there were instances where the conclusions reached were questionable. For example, case 42016072 was an allegation of physical abuse which was administratively referred back to the Facility. The alleged victim reportedly had a V-shaped bruise on the back of her thigh. The DFPS investigator interviewed a BSSLC physician who reported she "does not suspect abuse…cause of the injury is most likely from bumping into something or flopping down on an object." The investigator accepted this statement as fact and referred the case back to the Facility as an administrative issue. The Monitoring Team questions this decision and believes because of the nature of the injury and location of the injury DFPS should have conducted a complete investigation. The preliminary investigation should have been more thorough and should not have relied on the opinion of one Facility staff person. Case 42321872 was an allegation of physical abuse which was administratively referred back to the Facility. The alleged victim was reported to have been repeatedly pushed into a chair by the AP. The incident was recorded by the video surveillance camera. The DFPS investigator determined the staff action was appropriate and consistent with the Individual's behavior support plan and PMAB training even though the investigator did not confer with psychology staff or a PMAB trainer to confirm this. The matter was referred back to the Facility as a possible training issue. (This incident was subsequently	

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		investigated by OIG which confirmed physical abuse). DFPS should have been more thorough in its investigation of this allegation. Case 42132393 was an allegation of physical abuse (unconfirmed) by an unknown staff at an unknown date and time which was investigated by DFPS. The alleged victim was reported to be on 1:1 or 2:1 Level of Supervision at all times during the time period preceding the report of the allegation. No staff was interviewed as part of this investigation. No explanation for not interviewing staff was noted in the case report. DFPS should have been more thorough in its investigation of this allegation. The Monitoring Team is of the opinion that in three of eight (38%) investigations conducted by DFPS, the investigation methodology was insufficient to draw a reasonable conclusion. The DFPS case report utilized a standardized format that set forth explicitly and separately ▪ In eight (100%), each serious incident or allegations of wrongdoing; ▪ In eight (100%), the name(s) of all witnesses interviewed; however, in five (62%), witnesses were not identified that should have been, as noted above. ▪ In eight (100%), the name(s) of all alleged victims and perpetrators;; ▪ In eight (100%), the names of all persons interviewed during the investigation; ▪ In eight(100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; ▪ In eight (100%), all documents reviewed during the investigation; ▪ In eight(100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; ▪ In eight (100%), the investigator's findings; and ▪ In eight (100%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of Sample D.2 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; ▪ 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 four (100%), the name(s) of all witnesses; o In four (100%), the name(s) of all alleged victims and perpetrators; o In four (100%), the names of all persons interviewed during the	

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		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 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. In addition to the Facility investigations in Sample D.2 the Monitoring Team also reviewed the Facility investigation of the DFPS Administrative Referral for case 42016072. This was an allegation of physical abuse. It was reported the alleged victim had a V-shaped bruise on the back of her thigh. The DFPS investigator interviewed a BSSLC physician who reported she "does not suspect abuse…cause of the injury is most likely from bumping into something or flopping down on an object." The investigator accepted this statement as fact and referred the case back to the Facility. The Facility investigation of this incident was deficient because: 1. The Facility should have questioned DFPS's decision to not investigate what was a patterned bruise to an area of the body not likely to be self-inflicted, and, for accepting the statement of the physician who expressed an opinion (i.e. "most likely") without further review regarding the cause of the injury. DFPS's decision should have been viewed as unacceptable by the Facility. 2. The Facility investigation consisted only of interviews with two DSPs. It did not include an interview of the physician interviewed by DFPS. 3. From the chronology of events presented in the UIR, and the two staff interviews, it seemed likely the injury occurred while the Individual was at school. No staff at the school was interviewed and the investigator did not conduct an environmental review at the school to assess potential hazards that could have contributed to the cause of the injury (for example, whether it was possible to identify any hazard that might have cause a bruise with the shape and location described). The Monitoring Team concurs with the Facility self-assessment that this Provision is not in substantial compliance.	
	(g) Require that the written report, together with any other relevant documentation, shall	Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment:	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	Reviewed Departmental Monitoring for Section D for this provision. From its self-assessment the Facility determined that of four sample investigations for Section D3.g of the monitoring tool for the time period of May 2012 that 100% of the investigations were reviewed by supervisory staff. Based on the findings of the self-assessment, the Facility determined that this provision is in substantial compliance. <u>Monitoring Team Findings</u> BSSLC policy 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. As reported below this does not always happen. 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: ▪ The six investigation files reviewed by the Monitoring Team contained evidence that the DFPS supervisor had conducted a review of the investigation report. The two administrative referral reports reviewed by the Monitoring Team did not. ▪ The person supervising investigations at BSSLC had reviewed case reports in each instance. As reported in Provision D.3.f, issues identified by the Monitoring Team were not identified by the Facility review process and therefore were not reported back to DFPS for 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.	

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		The review of DFPS investigation reports conducted by the Facility was not always thorough and adequate. Please refer to case 42016072 described in Provision D.3.f. In the last report the Monitoring Team recommended that the Facility should consider including Facility investigations of serious injuries within the scope of administrative review conducted by the UIR Review Committee. The Facility had implemented this recommendation. The Monitoring Team does not concur with the Facility self-assessment of substantial compliance. The Facility had experienced regression in performance associated with this Provision. As reported in Provision D.3.f Facility reviews of DFPS reports were not always thorough and successful in identifying substantive issues with investigatory methodology and Facility reviews of Facility investigations were not always discovering obvious and apparent issues with investigation methodology.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment: Reviewed Departmental Monitoring for Section D for this provision. From its self-assessment the Facility determined that: Departmental Monitoring of four sample investigations for Section D3.h of the monitoring tool for the time period of May 2012 indicated that 100% of the investigations contained a written final report based on subparagraph g. Based on the findings of the self-assessment, the Facility determined that this provision is in substantial compliance. Monitoring Team Findings BSSLC has a UIR Review Committee and uses a report titled "UIR Committee Report" to address this Provision. This report documents review of each DFPS investigation report, any issues the committee may have with the report, any recommendations as to follow-up action with DFPS, and concerns either DFPS had identified in the report, or the review group identifies, that require follow-up action by the Facility. This report becomes part of the official file for each investigation. 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. Recently, this committee has expanded its scope to include review of all UIRs.	Noncompliance

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		This committee did not appear to have reviewed all DFPS reports. For example, documentation was not provided that would validate committee review of DFPS case 42016072. As reported in Provision D.2.f this case was particularly problematic. The Facility had experienced regression in performance associated with this Provision. Two of eight (25%) investigations reviewed did not contain documentation of review (i.e. the required written report) by the UIR Review Committee (cases 42016072 and 42321872). Additionally, for case 42016072 no evidence of IMRT review was provided. Two other cases had not been reviewed by the UIR Committee even though the Facility had the DFPS report for approximately three weeks (cases 42309712 and42347535). It was reported they had not been reviewed by the UIR Review Committee because the Facility was still waiting to hear from OIG as to its disposition. The Facility should at least conduct a preliminary review of DFPS case reports so after they are received to determine administrative and programmatic steps that might be necessary to take even before receiving final disposition from OIG. The committee did not always examine investigation reports in sufficient detail to detect issues which require attention. For example, the case file for DFPS case 42132393 includes two injury reports both reporting an injury which occurred on 5/19 at 10:40am. One injury report describes two reddish purple bruises to the back; the other describes bruises to the arm and leg. The text in the UIR also describes this conflicting data. The UIR committee did not identify this inconsistent data and attempt to reconcile it. The DFPS case report indicates the Individual had no discovered injuries in the recent past but the unit investigation report indicates the Individual frequently has discovered injuries. The UIR committee did not identify this discrepancy and attempt to reconcile it. Please refer to other issues presented in D.2.f regarding this case. The UIR Committee did not identify these issues in its review of this case. As a result its written report was incomplete. The Facility had received a compliance rating of substantial compliance in the last review. Because of regression in performance this Provision is no longer in 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	<u>Facility Self-Assessment:</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: Review the UIR Recommendation Log to ensure that required actions are completed promptly and thoroughly. From its self-assessment the Facility determined that the UIR Recommendation Log	Substantial Compliance

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	track and document such actions and the corresponding outcomes.	showed that all recommendations from the UIR Final Reports are tracked to completion using the UIR Recommendation Log, and these recommendations are completed promptly and thoroughly. Based on the findings of the self-assessment, the Facility determined that this provision remains in substantial compliance. <u>Monitoring Team Findings</u> BSSLC policy 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 occurred through the incident management review process that included daily unit meetings and the facility-wide daily IMRT meeting. The IMC maintained 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 Provision. The Monitoring Team randomly selected eight entries from the Investigator Recommendation Log and reviewed the documentation that validated completion of each recommended action. The Monitoring Team concurs with the Facility self-assessment that this Provision is in substantial compliance.	
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	<u>Facility Self-Assessment:</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed storage procedures to determine all investigators have easy access to investigative files. 2. Reviewed the location of investigative files to determine investigators have easy access to all files. From its self-assessment the Facility determined that: 1. The review of storage procedures indicates that all investigative files are stored within the IM suite. 2. The review of all case files stored in the IM suite indicates that they are easily and readily accessible.	Substantial Compliance

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		Based on the findings of the self-assessment, the Facility determined that this provision remains in substantial compliance. Monitoring Team Findings 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. The investigation files were well-organized and up-to-date. The Monitoring Team concurs with the Facility self-assessment that this Provision is in substantial compliance.	
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment: Reviewed the process in which unusual incident and investigation data is tracked and trended. From its self-assessment the Facility determined that data is tracked and trended and presented to the QA/QI Counsel on a monthly basis to determine any trends in which Corrective Action Plans may be needed. Based on the findings of the self-assessment, the Facility determined that this provision remains in substantial compliance. Monitoring Team Findings 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	Substantial Compliance

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		Unusual Incident Reports. The trend report for UIRs could be improved in the tracking of serious injuries. The report tracks "undetermined cause" and "determined cause." The determined cause category includes discovered injuries for which a probable cause (as opposed to an injury that was witnessed) was established as part of the investigation process. It may be useful for analysis purposes to have two subcategories under determined cause: delineating those that were "witnessed" and those that were "discovered but for whom the facility investigation established a probable cause." Although information required in this provision was collected and made available in a report, there was not evidence provided to the Monitoring Team that the Facility regularly evaluated this information and identified and addressed systemic issues. Information collected by the Facility should be used to address systemic problems that are barriers to protecting individuals from harm. As the Facility continues to develop its system of quality improvement, these reports will be critical in evaluating progress. Evaluation of the trend information is a necessary component of a process to use these data to protect individuals served and will need to be provided to and reviewed by the Monitoring Team at the next compliance visit. The Monitoring Team concurs with the Facility self-assessment that this Provision is in substantial compliance.	
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	<u>Facility Self-Assessment:</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: Validated that initial and annual checks with Employee Misconduct Registry, the Nurse Aide Registry, the Client Abuse and Neglect Reporting System, and the Federal Bureau of Investigation for employee fingerprints are conducted for 100% of applicants, employees, and volunteers. This occurs during the initial involvement with the SSLC and annually thereafter. From its self-assessment the Facility determined that all of the 1073 current employees and volunteers do not have, as a result of any of the checks performed, any permanent bars to employment. Since the last monitoring review, there have been no people who had discretionary bars to employment. The Director has exercised a decision making process to determine if they may continue with employment or volunteering. Based on the findings of the self-assessment, the Facility determined that this provision is in substantial compliance because 100% of the current employees and volunteers do	Substantial Compliance

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	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.	not have a criminal history that would preclude them from working or volunteering in an SSLC. Monitoring Team Findings 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. In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. The Monitoring Team concurs with the Facility self-assessment that this Provision is in substantial compliance.	

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

1. All incidents must be reported timely, in accordance with State and Facility policy (Provision D.2.a).
2. Education of guardians and Individuals on abuse/neglect must be routinely documented in the ISP per policy (Provision D.2.e).
3. A process for regular audits to determine whether significant resident injuries are reported for investigation needs to be established and implemented (Provision D.2.i).
4. Investigations of serious incidents need to begin within 24 hours of being reported (Provision D.3.e).
5. The facility investigatory process needs to improve to ensure staff statements and staff interviews are regularly completed and documented as

required by the SA (Provision D.3.f).

6. Investigation reports need to reflect conclusions based on a thorough investigation that considers all evidence and explores, where applicable, multiple hypotheses (Provision D.3.f).
7. The organization of information related to facility investigations (the UIR document) needs to improve to be in alignment with data required by the SA (Provision 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.
8. The thoroughness of Facility review of investigation needs to improve (Provision D.3.g and D.3.h).

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.

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 Self-Assessment 7/12/12 2. BSSLC Action Plan 7/6/12 3. Section E Presentation Book (undated) 4. DADS Policy 003.1 Quality Assurance 1/26/12 5. BSSLC Policy Quality Assurance Process 11/22/10 6. BSSLC Policy Quality Assurance/Quality Improvement Council 9/30/10 7. BSSLC Quality Assurance Plan 12/12/11 8. BSSLC Policy E.3 – Developing, Implementing, & Tracking Corrective Action Plans 5/9/12 9. Quality Assurance/Quality Improvement (QA/QI) Council meeting minutes 3/28/12, 4/18/12, 4/25/12, 5/23/12, and 6/27/12 10. QA/QI meeting agenda and meeting handouts 7/25/12 11. Facility Trend Reports 6/30/12 12. Monitoring tools and related reports currently in use by the QA department **People Interviewed:** 1. Daniel Dickson, QA Director 2. Natalie Montalvo, Facility Director 3. Kim Littleton, Assistant Director of Programs **Meetings Attended/Observations**: 1. QA/QI Council meeting 7/25/12
	Facility Self-Assessment: The self-assessment provided by the BSSLC reported it was not in compliance with any provision of this section of the SA. The Facility self-assessment consisted of a review of data organization and a review of QA/QI Council minutes to determine if the Council is reviewing data quarterly as expected and if this review resulted in the identification of the need for corrective actions. Future self-assessments need to be much more comprehensive in order to measure compliance with this Section of the Settlement Agreement. The Monitoring Team concurred with the Facility self-assessment that it was not in compliance with any Provision in Section E.. The Facility provided the Monitoring Team with a comprehensive Action Plan which included actions, that when completed, should move the Facility in the direction of compliance. Some of these action plans addressed the development of policies and procedures to measure trends across all areas of care, continued development of inter-rater reliability in monitoring, development of a tracking system for the identification of issues across all components of protections, supports, and services for Individuals living at the Facility, development of a reporting system for use with reporting trends both monthly and quarterly in order to provide analysis of issues identified from trends to the QA/QI Council, and development of a corrective action planning process and the necessary implementation and monitoring tracking system.

	Summary of Monitor's Assessment: Quality Assurance activity necessary to achieve compliance with Section E of the Settlement Agreement was still in a formative stage. The Facility had made limited progress since the last review. For example, the Facility still had not revised its Quality Assurance Process policy (11/22/10) or its Quality Assurance/Quality Improvement Council policy (9/30/10) to reflect current expectations and requirements of both the Settlement Agreement and the new State QA policy which was issued in January. Written policies and procedures are essential to establish operational parameters of a QA system. The Facility had developed a database sufficient to produce monitoring data in formats lending themselves to review by the QA/QI Council. This process was better developed for some Provisions of the Settlement Agreement than others but progress was evident to the Monitoring Team. For example, the trend reports required by DADS (noted below) had been in place for a considerable period of time which enabled longitudinal trending and tracking. Trend reports associated with the monitoring tools had been in place in most cases only a few months which limited their utility for longitudinal tracking and trending. 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 Trend reports associated with Settlement Agreement monitoring, using the State monitoring tools, were also prepared. Each section of the Settlement Agreement was subject to this monitoring. These data were regularly presented to the QA/QI Council although as noted above, at least for now they are of limited utility for longitudinal trending. This will improve as more months of monitoring data is compiled and as the inter-rater reliability monitoring continues to improve. The Facility reported it had started the process of developing key indicators as required by State policy and expected to have these developed, with data collection and analysis, by the time of the next Monitoring Team review. The Facility had not as yet developed a corrective action planning process and a data base to support it. As a result it had only made minimal progress towards achieving compliance with Provisions E.2, E.3, E.4, and E.5.

#	Provision	Assessment of Status	Compliance
E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living	Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed longitudinal data. 2. Reviewed the Quality Assurance/Quality Improvement (QAQI) Council meeting	Noncompliance

#	Provision	Assessment of Status	Compliance
	units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	minutes to determine if the Council meets at least monthly. 3. Reviewed QAQI Council meeting minutes to determine if the Council is reviewing the incident management data quarterly. 4. Reviewed the QAQI Council meeting minutes to determine if the Council is reviewing the restraint data quarterly. 5. Reviewed the QAQI Council meeting minutes to determine if the Council is reviewing the POI section monitoring quarterly. 6. Reviewed the QAQI Council meeting minutes to determine if corrective actions are needed and/or identified. 7. Reviewed of the QA Plan to determine that it accurately reflects ongoing monitoring. 8. Review of QA Policy and CAP tracking Policy From its self-assessment the Facility determined that: The QA Dept. has developed a QA Data Report to display data collected and the analysis of the data through the various monitoring systems to be reviewed at the QA/QI Data meeting. This will form the basis of the development of corrective action plans. Based on the findings of the self-assessment, the Facility determined that this provision is not in substantial compliance because some Facility disciplines are still in the beginning stages of developing internal Quality Assurance Monitoring processes and analysis. <u>Monitoring Team Findings</u> Quality Assurance activity necessary to achieve compliance with Section E of the Settlement Agreement was still in a formative stage. The Facility still had not revised its Quality Assurance Process policy (11/22/10) or its Quality Assurance/Quality Improvement Council policy (9/30/10) to reflect current expectations and requirements of both the Settlement Agreement and the new State QA policy which was issued in January. Written policies and procedures are essential to establish operational parameters of a QA system. During the last review the QA Director reported on the status of several initiatives including: • Revision of the QA Plan to include two levels of inter-rater reliability formats to begin validating monitoring data. This had not, as yet, resulted in a formal revision to the QA Plan. Additionally, the QA Plan consisted only of a matrix displaying what was expected to be monitored, by whom, at what frequency, and administrative responsibility assignments. It did not contain any narrative which would typically include a two or three page overall description of how QA is	

#	Provision	Assessment of Status	Compliance
		conducted at the Facility; a description of the comprehensive inventory listing of all data that are collected across the facility; a description of the QA matrix and how those data are managed, reviewed, trended, and analyzed by the QA department; the role of any QA databases; the way that the QA/QI Council meetings work; and the overall expectation and processes for data analysis, corrective action planning, and corrective action management. • Revision of the facility QA/QI Council meeting format to include two monthly meetings. The first of the monthly meetings was to focus on data review and analysis. The process for this would consist of: the QA department sending out the prior month's data collection results with data reports and trend analysis summaries. The section leads preparing discussion topics and draft corrective action plans based on the data reports. The QA/QI Council discussing, reviewing, and approving corrective action plans. The Monitoring Team was able to observe most of this activity during the QA/QI Council meeting held during the review week with one notable exception. The Facility had not as yet implemented a Corrective Action Planning (CAP) process. The second meeting each month would focus on information sharing. Monitoring Team review of meeting minutes confirmed regular meetings of the QA/QI Council had occurred. • The Facility had developed a policy and procedure for the development of Corrective Action Plans to address problematic trends that arise from the various systemic monitoring processes. This policy was not approved until 5/9/12, and the procedures called for in the policy were not yet implemented. • The Facility had developed a policy and procedure to measure trends across all areas of care as identified in the self-assessment. This policy had not been formalized and in the Action Plan it is noted as "in process" with a projected completion date of 8/30/12. These procedures were not yet implemented. • 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 being developed. The tracking system reviewed by the Monitoring Team presented considerable data but had not as yet been regularly used to identify issues for correction or improvement. • 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 place. The system of reporting trends was in place; however, the analysis of issues identified from the data was, at this point, informal. At the QA/QI Council meeting the section lead for each section of the Settlement Agreement verbally reported their interpretation (i.e. the analysis) of the data. This was not presented in a manner that generated substantive discussion and typically did not result in any decision-making by the QA/QI Council	

#	Provision	Assessment of Status	Compliance
		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. During this review the QA Director reported the development of quality indicators ("key indicators" per State policy) had only recently started. Key indicators should monitor a wide range of supports the Facility provides, including areas such at-risk individuals; medical, psychiatric, and nursing issues; infection control; physical and nutritional supports; residential and vocational supports; habilitation and skill acquisition; and outcomes related to transition to the most integrated setting. The data should be used to determine if the Facility is actually reaching and maintaining clearly delineated benchmarks related to health, safety, and integration. If not, then analysis needs to occur to determine the changes that should be instituted to assist the Facility and, most importantly, the individuals in reaching the desired outcomes. Although these initiatives all appear to have value in developing a quality assurance and improvement system that can identify areas of correction and improvement needed, the Facility must move much more quickly toward implementation. The Monitoring Team looks forward to reviewing progress resulting from these initiatives at its next review. The Facility had developed a database sufficient to produce monitoring data in formats lending themselves to review by Facility leadership and the QA/QI Council. This process was better developed for some Provisions of the Settlement Agreement than others but progress was evident to the Monitoring Team. For example, the trend reports required by DADS (noted below) had been in place for a considerable period of time which enabled longitudinal trending and tracking. Trend reports associated with the monitoring tools had been in place in most cases only a few months which limited their utility for longitudinal tracking and trending. 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 Trend reports associated with Settlement Agreement monitoring, using the State monitoring tools, were also prepared for each section of the Settlement Agreement. These data were regularly presented to the QA/QI Council although as noted above they are of limited utility for longitudinal trending. This will improve as more months of monitoring data is compiled and as inter-rater reliability monitoring continues to improve. As reported above, the development of key indicators is an important next step in the maturation of the QA process at the BSSLC.	

#	Provision	Assessment of Status	Compliance
		Some trend data could be further delineated to produce useful analysis and decision-making For example, the Allegations Trend Report reports the day of the week, shift, and hour of the day for allegations for the report month. It may be useful to track these data over an extended period of time as it could have implications for staffing, supervision, and activity levels of individuals. For example, if allegations are disproportionally represented on certain days of the week, certain shifts, or in clearly delineated time windows, it is conceivable that activity schedules, staffing ratios, or supervisory presence may need to be examined. At a minimum these data, when reviewed longitudinally, can give clues as to administrative and programmatic processes that may contribute to outcomes, positively or negatively. The Monitoring Team concurs with the Facility self-assessment that this Provision is not yet in substantial compliance.	
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.	Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed longitudinal data. 2. Reviewed the Quality Assurance/Quality Improvement (QAQI) Council meeting minutes to determine if the Council meets at least monthly. 3. Reviewed QAQI Council meeting minutes to determine if the Council is reviewing the incident management data quarterly. 4. Reviewed the QAQI Council meeting minutes to determine if the Council is reviewing the restraint data quarterly. 5. Reviewed the QAQI Council meeting minutes to determine if the Council is reviewing the POI section monitoring quarterly. 6. Reviewed the QAQI Council meeting minutes to determine if corrective actions are needed and/or identified. 7. Review of the QA Plan to determine that it accurately reflects ongoing monitoring. From its self-assessment the Facility determined that: 1. The QA Dept. has developed a QA Data Report to display data collected and the analysis of the data through the various monitoring systems to be reviewed at the QA/QI Data meeting. This will form the basis of the development of corrective action plans. 2. Currently no corrective action plans are in place as this system is still in draft. Based on the findings of the self-assessment, the Facility determined that this provision this provision is not in substantial compliance as disciplines are currently in the beginning stages of developing internal Quality Assurance Monitoring processes and	Noncompliance

#	Provision	Assessment of Status	Compliance
		analysis. <u>Monitoring Team Findings</u> The Facility had developed a data base sufficient to produce monitoring data in formats lending themselves to review by Facility leadership and the QA/QI Council. This process was better developed for some Provisions of the Settlement Agreement than others but progress was evident to the Monitoring Team. For example, the trend reports required by DADS (noted below) had been in place for a considerable period of time which enabled longitudinal trending and tracking. Trend reports associated with the monitoring tools had been in place in most cases only a few months, which limited their utility for longitudinal tracking and trending. While a system of reporting trends was in place the analysis of issues identified from the data was, at this point, informal. At the QA/QI Council meeting the section lead for each section of the Settlement Agreement verbally reported their interpretation (i.e. the analysis) of the data. This was not presented in a manner that generated substantive discussion and typically did not result in any decision-making by the QA/QI Council Presumably review and analysis of monitoring data would lead to identification of a need for one or more corrective action plans. The Facility reported it had not as yet developed a corrective action planning process and a data base to support it. As a result it had only made minimal progress towards achieving compliance with this provision. While the Monitoring Team confirmed the Facility reported lack of a formal Corrective Action Plans managed through the QA Department, it was evident that some discipline departments had informal corrective action planning occurring. For example, the significant improvements in the management of restraints reported in Section C presumably were attributed to the Psychology Department identifying a set of problem and consciously developing a set of strategies and actions to address the problems. The Monitoring Team observed similar activity with respect to the Nursing Department and the Habilitation Therapies Department. As noted in previous reports, the Monitoring Team believes a Quality Assurance (QA) and Corrective Action Planning (CAP)process should include two sets of activities and strategies for outcomes: 1. Development of specific actions necessary to correct specific problems discovered through monitoring and auditing conducted by residential units and facility departments, and by staff 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	

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		and trending data described in E1; regulatory reports (CMS 2567's); reports (anecdotal and written) coming from DADS subject matter experts, outside consultants, DFPS, OIG, and others; and, data collected from self-advocacy group meetings, family member meetings, and other stakeholders. The Monitoring Team did not observe any evidence that the Facility had as yet engaged in substantive activity directed at this second point. The Monitoring Team concurs with the Facility self-assessment that this Provision is not yet in substantial compliance.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment: Review of QA Policy and CAP tracking Policy From its self-assessment the Facility determined that currently no corrective action plans are in place as this system is still in draft. Based on the findings of the self-assessment, the Facility determined that this provision is not in substantial compliance as disciplines are currently in the beginning stages of developing internal Quality Assurance Monitoring processes and analysis. Monitoring Team Findings The Facility had not as yet developed a corrective action planning process and a database to support it and assign and track responsibility for implementation. As a result it had not made any progress towards achieving compliance with this provision. The Monitoring Team concurs with the Facility self-assessment that this Provision is not yet in substantial compliance.	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.	Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment: Review of QA Policy and CAP tracking Policy From its self-assessment the Facility determined that currently no corrective action plans are in place as this system is still in draft. Based on the findings of the self-assessment, the Facility determined that this provision	Noncompliance

#	Provision	Assessment of Status	Compliance
		is not in substantial compliance as disciplines are currently in the beginning stages of developing internal Quality Assurance Monitoring processes and analysis. Monitoring Team Findings The Facility had not as yet developed a corrective action planning process and a data base to support it. As a result it had not made any progress towards achieving compliance with this provision. The Monitoring Team concurs with the Facility self-assessment that this Provision is not yet in substantial compliance.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment: Review of QA Policy and CAP tracking Policy From its self-assessment the Facility determined that currently no corrective action plans are in place as this system is still in draft. Based on the findings of the self-assessment, the Facility determined that this provision is not in substantial compliance as disciplines are currently in the beginning stages of developing internal Quality Assurance Monitoring processes and analysis. Monitoring Team Findings The Facility had not as yet developed a corrective action planning process and a database to support it and track implementation and effectiveness of corrective action plans. As a result it had not made any progress towards achieving compliance with this provision. The Monitoring Team concurs with the Facility self-assessment that this Provision is not yet in substantial compliance.	Noncompliance

Recommendations: The following recommendations are offered for consideration by the State and the Facility:
1. Make an appropriate facility-specific policy that correctly reflects the January 2012 state policy (Provision E1).
2. Provide training to QA staff, and senior management and clinical staff on the new state policy and any
3. QA-related facility-specific policies (Provision E.1).
4. Continue to refine the type of data tracked and trended longitudinally (Provision E.1).
5. Use data to proactively identify potential systemic issues requiring attention whether
6. these improvements need to occur Facility-wide or be targeted to specific homes/shifts, day/vocational programs,
7. and/or departments (Provision E.1).

8. Develop and implement a corrective action planning process (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) Self-Assessment, updated 07/12/2012 2. BSSLC Action Plans, dated 07/06/2012 3. Brenham State Supported Living Center Presentation for July 2012 for Settlement Agreement Monitoring Team Visit 4. Section F Presentation Book materials 5. DADS Policy 004: Individual Support Plan Process, dated 09/01/11 6. Draft DADS Policy 017: Habilitation, Training, Education and Skill Acquisition Programs, effective 5/10/12 7. PSP ISP Attendance-PSP's only 5/1/12 – 6/26/12 document 8. Monthly Attendance by Discipline 5/1/12 – 6/26/12 document 9. IDT Quarterlies Pilot Project, undated 10. Individual Support Plans (ISPs), Personal Focus Assessment (PFAs), Preferences and Strengths Inventories (PSIs) and related documentation for Individuals #68, #185, #226, #260, #288, #334, #422, #446, #548, and #576 11. 30-Day Individual Support Plans (ISPs) Personal Focus Assessments (PFAs), Preferences and Strengths Inventories (PSIs) and related documentation for Individuals #423, #501, and #539 12. Annual ISP Assessments in S Drive for Individuals #258, #264, and #406 13. Draft ISP and ISP assessments for Individual #86 **People Interviewed:** 1. Pam Boehnemann, QDDP Coordinator 2. Kim Littleton, Assistant Director of Programs 3. Crystal Chavez, QDDP Educator 4. Natalie Montalvo, Facility Director 5. Daniel Dickson, Quality Assurance Director **Meeting Attended/Observations:** 1. ISP annual planning meeting for Individual #86 2. CLDP for Individual #242
	Facility Self-Assessment: The Monitoring Team reviewed the BSSLC Self-Assessment and accompanying Action Plans. BSSLC reported it was not in compliance with any of the provisions of this section of the SA. The Monitoring Team concurred. The Facility had in some instances attempted to couple the self-assessment with its internal quality assurance processes to assess ongoing progress toward actual outcomes, in that it reviewed the results of internal Section F Monitoring Tools as a part of its self-assessment processes. The Self-Assessment relied to a great extent on the data obtained from the Section F Monitoring tools. These data were based on limited samples to this point and the Facility noted concerns with inter-rater reliability, so it

	was not yet likely this information provided a sound basis for evaluation. Many of the activities to be engaged in to complete the Self-Assessment were subjective, such as making a determination of whether an ISP provided interventions that were practical and functional in a community setting, so that the skill of the rater would be a key factor in the accuracy of the finding. It may also be necessary to identify some more discrete and objective indicators within the broader SA requirements that could be made more readily measurable. Still, it was deemed progress that the Facility had intentions of more fully using its internal quality assurance processes to assess ongoing progress toward completion and the actual outcomes. The Monitoring Team also noted in the Action Plans that some needed to be re-evaluated and updated to ensure that new processes were considered. For example, the Action Steps related to the PFA all indicated they had been completed on 9/15/2011 and did not take into account the changes made in the PSI process. These Action Steps also did not specifically address the findings from previous Monitoring Reports that attributed some level of noncompliance to a failure to effectively use the PFA/PSI to identify preferences and strengths. This reflected a larger concern that the Self-Assessment and Action Steps did not consistently or adequately address noncompliant findings. For example, for Provision F2g, the Facility indicated it was not in compliance due to not having a monitoring tool in place. This was a significant oversimplification of the need to develop an overall QA plan.
	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. Overall, the Facility's progress had not been substantial in developing and implementing 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, although some improvements were identified. A summary of progress included some improvements in assessment process for certain disciplines and some progress toward integrated treatment. The Facility had taken some action to address significant concerns about the quality of assessments. For example, it was reported that Department heads had been instructed to begin reviewing discipline specific assessments prior to the ISP for adequacy. This directive had not yet been fully implemented. Other findings are described below. **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 and incorporated into a draft DADS Policy 004: Individual Support Plan Process. This ISP process was still meeting with limited success specific to the requirements of this section of the SA. There was still no meaningful preparation provided to ensure the PFA/PSI 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. IDTs often failed to conduct comprehensive assessments of sufficient quality to reliably identify the

	individual's strengths, preferences and needs. As noted in its Self-Assessment, BSSLC had undertaken some initiatives to improve the timeliness and strengthen the quality of its assessment practices. Department heads had been instructed to begin reviewing discipline specific assessments prior to the ISP for adequacy. This directive had not yet been fully implemented. The Monitoring Team commended the Facility for devising a strategy that designated managers with a specific role for ensuring quality assurance within their areas of responsibility, but noted this initiative had met with limited success thus far. The Facility continued to devote considerable resources to training, monitoring, and coaching for QDDPs, both new and current, an effort the Monitoring Team commends. **Provision F2:** The Monitoring Team found there were some examples of improved integration observed in planning meetings and record reviews, and some additional initiatives to provide and document competency-based training. 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. Skill acquisition programs were not well-written or implemented correctly and/or routinely. The Monitoring Team also found ISP strategies did not reflect encouragement of community participation in any meaningful or purposeful manner. In the previous monitoring visit, the Monitoring Team identified a troubling trend toward elimination of many skill acquisition programs (SAPs) and the replacement of these with service objectives (SSOs) in individuals' ISPs. Many of these SSOs were related to community integration activities. During this monitoring visit there was an equally troubling trend toward the elimination of many SSOs and simply replacing them with a place on the individual's schedule.

#	Provision	Assessment of Status	Compliance
F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
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 it had a Q Coordinator, a Q Educator and 20 QDDP positions, with two current vacancies. It was also reported the Q Educator carried a caseload as QDDP as well. 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 ongoing Q Construction facilitation training. The Facility reported	Noncompliance

#	Provision	Assessment of Status	Compliance
		it had six QDDP staff who were certified trainers and therefore deemed competent in the Q Construction facilitation skills. Otherwise, it was reported that none of the QDDPs had yet been certified as competent in facilitation skills. Additional training initiatives are described in more detail in Provision F2e below. 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.	
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.	<u>Composition and Participation of IDT:</u> In response to the Monitoring Team's pre-visit document request the Facility submitted a document labeled "PSP Attendance-PSP's only 5/1/12 – 6/26/12" and a document labeled "Monthly Attendance by Discipline 5/1/12 – 6/26/12". These documents were intended to display, by discipline, the frequency of discipline attendance at ISP meetings. The documents contained inconsistent and conflicting data such that it was not useful to the Monitoring Team in assessing compliance with this Provision. For example, the documents reported 35 Individuals attended ISP meetings. Presumably this would be interpreted to mean the report reflected 35 ISP meetings. Neither report actually displayed the number of ISP meetings from which attendance percentages could be calculated. The number of ISP meetings attended by particular disciplines appeared to be low. For example, according to these reports QDDPs attended only 32 (91%), DCPs attended only 21 (60%) , a physician attended only 15 (42%) and a psychologist attended only 20 (57%) . When the Monitoring Team reviewed these documents with the QDDP Coordinator she agreed it was difficult to interpret the data on the reports and she would try and get more accurate reports later in the week. None were provided. <u>Extent of Individual participation in ISP:</u> 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 Preferences and Strengths Inventory (PSI) process, as described in DADS Policy 004: Individual Support Plan Process, was not robust enough to facilitate an individual's real	Noncompliance

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		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 PSI 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 PSI areas with the individual. The portfolio could then be revised for the ISP meeting based on the PSI results. This would make the ISP a much more comprehensible, participatory and positive experience. It was noted the Facility was making some attempt to implement this recommendation by posting a list of preferences at the annual meeting, but these were not used to effectively develop an optimistic living vision. Conclusion: This provision was fund 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: Assessments for the ISP were often not completed on a timely basis. The expectations remained that 1) the PSI 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 Facility reported it had begun using an Assessment Tracking Database to help ensure timely completion of assessments. In May 2012, QDDPs were trained as to the placement and organization of the assessments in the shared drive. The Monitoring Team found this training had not yet produced the desired outcomes. A review of the assessments available on the shared drive for ISPs upcoming over the next ten days revealed that zero of three (0%) had all required assessments available. The Monitoring Team found that the process for posting the assessments to the shared drive remained erratic. It remained necessary to search through multiple folders in order to locate all the available assessments.	Noncompliance

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		Extent to which assessments are conducted in response to significant changes: The Monitoring Team found that there were some instances in which assessments were being updated in response to significant changes. For example, as reported in Provision O1, there was improvement since the last compliance visit in the comparative analysis and oral motor portions of the assessments. These areas were found to be more comprehensive and provided more clarity regarding status changes over the past year. There were still instances in which in which assessments were not being conducted or updated in response to significant changes. For example, as reported in Provision M3, the Comprehensive Nursing Assessments were not updated when there was a significant change in health status. Extent to which to which assessments are of sufficient quality to reliably identify the individual's strengths, preferences and needs: 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. For Individual #86, the Monitoring Team found numerous instances of inaccuracies and/or missing information in the assessments used in the IRR and ISP held during the site visit. Examples included: • The Annual Medical Summary, dated 7/18/12, detailed diagnostic colonoscopies in 2007 and 2009 and indicated a repeat needed to be completed this year. A colonoscopy had already been completed on 5/23/12, but was not referenced in the Medical Summary. • The Nursing Summary indicated the individual had a "few missing teeth"; the individual is edentulous. • The Habilitation Therapies Annual Assessment indicated the individual had a diagnosis of diabetes; no such diagnosis exists nor is there any history of diabetes. • The Habilitation Therapies Annual Assessment, completed on various dates in June and July 2012, did not provide data regarding the individual's ABI, which is used to assist in the evaluation of an existing diagnosis of peripheral vascular disease. Habilitation therapy staff reported at the ISP meeting that the individual was not cooperative "on that day." The most recent data available was from 7/12/11. This lack of data was particularly significant because there was question during the ISP as to the accuracy of the diagnosis. • The individual's guardian asked the IDT whether the individual was still having sleep difficulties. Team members reported the individual probably sleeps one	

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		out of three nights and about four hours at a time. This was not referenced in any of the assessments developed for the ISP. The Nursing Summary stated "(t)here are no sleep problems known." Other examples included: • As documented in Provision S1, there was little indication that the Facility had provided adequate assessment in relation to skill acquisition training. • For ten recent ISPs, the FSA provided no (0%) information about functional community living skills and no recommendations. • As reported in Provision R2, generally accepted clinical standards for a comprehensive assessment should contain certain components. Based on review of 26 assessments (Samples #1, #2, and #3 in Section R), four of 26 (15%) individuals had comprehensive assessments that contained each of these elements. The Facility had taken some action to address this significant problem. For example, it was reported that Department heads had been instructed to begin reviewing discipline specific assessments prior to the ISP for adequacy. This directive had not yet been fully implemented in that not all departments were yet actively engaged in the process, while others had begun the reviews but were not yet confident in their purpose or approach. The Monitoring Team commended the Facility for devising a strategy that designated managers with a specific role for ensuring quality assurance within their areas of responsibility. The Monitoring Team remained concerned, however, that not all individual IDT members were yet taking personal responsibility for the quality, accuracy and thoroughness of their reports. In theory and in policy, the QDDP and all IDT members should be reviewing each other's work in the S drive prior to any ISP meeting, and this should provide a vehicle for corrections and clarification. As described earlier in this provision, however, assessments are often not available for IDT review in sufficient time prior to the meeting. It was recommended that, at a minimum, each QDDP should complete a careful review of the ISP assessments before the meeting in order to discover the discrepancies and have them corrected beforehand. The Facility undertook a new process during the monitoring visit in which the IDT reviewed all current assessments during the Preparation Meeting as a team process. This immediate and thoughtful response to the concern was to be commended. It remained to be seen whether this process would have a long term positive impact on the quality of assessments, but it was reported that the IDT in question did in fact identify several discrepancies that were to be addressed before the ISP annual planning meeting.	

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		Conclusion: 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.	Extent to which assessment results are used to develop ISPs: 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. For example, as reported in Provision S1, in none of the ISPs or SPOs/SAPs reviewed (0%) were there FSA findings discussed in the ISP that corresponded with the specific skills targeted by the SPOs/SAPs. Other examples found in Section S of failure to incorporate assessment findings in the development of the plan included: • For Individual #21, the ISP indicated the individual had hearing difficulties and might not be able to hear spoken speech. The SPOs/SAPs included verbal instructions as well as reinforcement in the form of verbal praise. These SPOs/SAPs did not include any instructions or guidance addressing the hearing limitations. • For Individual #423, the communication assessment information presented in the ISP recommended that efforts to verbally communicate with the individual be simple, involve choices, and be supported by frequent prompts redirecting the individual back to the topic being communicated. Although the SPOs/SAPs for the individual involved verbal instruction and verbal praise, the instructions did not address the communication recommendations. Conclusion: This provision was found to be not in compliance. The Monitoring Team found there continued to be a substantial 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 continues to be a pervasive issue that merits immediate attention on the part of the Facility.	Noncompliance
F1e	Develop each ISP in accordance with the Americans with	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	Noncompliance

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	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).	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. 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. Zero of ten (0%) recent ISPs demonstrated overall compliance with this guidance. The only disciplines for which the directive was consistently implemented were habilitation therapies and nursing. While the former typically included specific recommendations related to supports and services needed in the most integrated setting, the latter rarely did so. The Monitoring Team attended one ISP annual planning meeting and reviewed ten recent ISPs as measures of how this process may have affected the IDTs' implementation of this requirement of the SA. The IDT was expected to indicate the most integrated setting appropriate to an individual's and, if they chose not to make a referral, indicate the reason(s) for that choice. The new ISP format had been re-designed to force this determination, and the Monitoring Team found those ISPs completed in the updated process were more likely to provide it. Overall, however, the Monitoring Team found the IDTs still failed to fully understand their roles and responsibilities in making a professional determination as to the most integrated setting appropriate to an individual's needs. In ten of ten (100%) recent ISPs, the IDT determined that there were no barriers to the individual living in a community setting. In all but one of instances, however, the IDT determined at the conclusion of the plan that the individual would remain at BSSLC. Other than the one individual who was referred for community living, none of the other nine (0%) had the identified barriers to living in the most integrated setting adequately addressed in a manner consistent with the Olmstead decision. Examples included: • For Individual #288, the IDT identified no barriers to community living, but agreed to defer to LAR wishes that the individual remain at BSSLC until the LAR could determine the individual would not suffer from an environmental change. There were no strategies or Action Plans developed to assist the LAR in this regard.	

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		• For Individual #185, the IDT indicated twice in ISP narrative that it wished to continue to educate the individual on community living options, but no strategies or Action Plans to do so were developed. • For Individual #422, the ISP documented no barriers to community living, but determined the goal for the living environment was to continue to live in a safe environment where all needs could be met. The living option determination stated the individual should continue to live at BSSLC; this determination was said to be based on "the team decision." Conclusion: This provision was found to be not in compliance. It appeared the IDTs continued to confuse 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:		
	1. Addresses, in a manner	The Facility had very recently begun to implement another revision to the ISP process,	Noncompliance

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	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;	which had been incorporated into a draft DADS Policy 004: Individual Support Plan Process. Training had been provided to QDDPs on the use of this updated format. 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. The following concerns were noted with regard to the identification and incorporation of preferences and strengths into ISPs: • Little, if any, information about individuals' specific strengths was discussed in ten recent ISP documents. Strengths were not regularly built upon to address other need areas. This was true for all of those reviewed regardless of whether the "updated" format was used. • The revised PSI process had had no substantial positive impact on the extent to which the IDTs documented preferences or analyzed how they might be used to develop an optimistic living vision for an individual. Examples of preferences listed in the ISPs on occasion included such things as twirling string, tearing pages from a magazine and manipulating objects such as a "rubber ducky." In a few instances, the ISP provided a narrative summary of an individual's daily routine that included some preferences; this was an improvement, but not yet adequate to facilitate the development of a meaningful optimistic living vision or a plan to achieve it. • As described in the Provision S1 review of a sample of skill acquisition plans, 0% were related to the individual's preferences. <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 ten (0%) ISPs reviewed/attended were priorities clearly	

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		defined and addressed, nor barriers identified and addressed. Extent to which ISP encourages community participation: IDTs did not consistently encourage community participation. As reported in Provision S3b, data presented by BSSLC reflected a substantial decrease in the provision of community outings since the previous monitoring visit. No information regarding this decrease in community services was provided by the Facility; however, this may be an unintended consequence of a decision that had been made to eliminate SSOs and simply place community outings on the individuals' schedules as a general item. The rationale was that these outings were an ongoing activity that would be provided as a matter of routine. The actual impact of this would more likely be that community integration activities would provide even less structured and goal-oriented community education and awareness related to community living options. This evidence of a substantial decrease in community outings would indicate the negative effects of this decision were even more far-reaching, The Facility recognized this unintended effect, and was taking action to resume community outing SSOs, but should also take action to review the eliminated SSOs, even expanding upon them to incorporate community education and awareness needs and objectives. In many, if not most, instances, a structured SAP would actually be more appropriate than an SSO in order to effectively promote community integration and the learning of skills that would facilitate community participation. 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 to be employed, and the necessary supports to: attain identified outcomes related	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 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	Noncompliance

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	to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	adequately presented. BSSLC failed to conduct individual task analyses. As a result, SPOs/SAPs were not tailored to the unique learning needs, current skills, or physical condition of each person. Another example of the lack of individualization was reported in Section R. Twenty-two of 26 individuals had comprehensive assessments that provided recommendations for direct interventions and/or skill acquisition programs for individuals with identified communication deficits and/or the manner in which strategies, interventions, and programs should be utilized throughout the day. Although recommendations were provided, they were often generic and were not specific to the individual. An example of this was the recommendation to utilize the home communication board and to provide choices without offering specifics regarding how staff should utilize the boards and activities in which it would be appropriate. In the previous monitoring visit, the Monitoring Team identified a troubling trend toward elimination of many skill acquisition programs (SAPs) and the replacement of these with service objectives (SSOs) in individuals' ISPs. Many of these SSOs were related to community integration activities. During this monitoring visit there was an equally troubling trend toward the elimination of many SSOs, including community integration activities, and simply replacing these with notations on the individual's schedule. This is further described in Provision F2a1. <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> The Monitoring Team found the IDT still 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 Provisions F1e and T1b3. Barriers to living in the most integrated setting that were identified did not always lead to goals, objectives, or service strategies. Examples may be found in Provision F1. The Facility often did not have an adequate basis for determining the preferences of individuals for living arrangements. As described in Provision T1b2 below, a small proportion of individuals living at BSSLC had opportunities to tour community living options and the annual CLOIP process was not meaningful for most. The PFAs/PSIs reviewed during this compliance visit provided little in the way of a visioning of an individual's ideal living arrangement. See Provisions F1b and F1c for further discussion regarding the Facility's processes for identifying and supporting individuals' preferences.	

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		These processes continued to need considerable enhancement. Preferences of LARs and families for living arrangement were more often understood and documented. The Facility was providing some opportunities for families and LARs to learn more about community options, but these were limited, as described in Provision T1b2 below, and many families were not interested in participating in them. The annual ISP process typically did not appear to lend itself to a comfortable discussion of community living opportunities. Overall, the Monitoring Team found that obstacles to transition were not yet consistently appropriately identified or addressed by the IDTs. Zero of nine (0%) recent ISPs in which transition was not recommended evidenced proficiency in this regard. Examples of issues related to identification and addressing of barriers are described in Provision F1e. <u>Conclusion:</u> 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;	<u>Extent to which ISP integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions:</u> The Facility demonstrated some progress toward integrated treatment. These include the continuation of a number of processes designed to support integration through interdisciplinary collaboration reported during the last monitoring site visit, including a peer review process for the Integrated Risk Rating assessment, a joint case formulation process between Psychiatry and Psychology to support integration of the impact of environmental variables on mental illness, and a daily Medical Staff meeting 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. 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 Provision M3, zero of five (0%) HMPs were integrated with other relevant disciplines. • As reported in Provision O3, there was no evidence that IDT members had discussed the efficacy of the interventions and integrated PNMP strategies into other plans and activities (e.g., action plans, skill acquisition programs, behavior support plans, nursing/health management care plans, and/or daily schedules). • As reported in Provision R3, zero of 29 ISPs reviewed (0 %) included how communication interventions were to be integrated into the individual's daily	Noncompliance

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		routine. • As reported in Provision R2, three of eight communication assessments and PBSPs reviewed (37%) addressed the connection between the PBSP and the recommendations contained in the communication assessment.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Extent to which ISP identifies: • Methods for implementation: As reported in Provision S1, BSSLC failed to conduct individual task analyses; rather it continued to use 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. 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. For example, in 73% of the skill acquisition programs reviewed, the operational definitions of training targets consisted of general statements such as bathing, turning on water, or complying with a request. In the majority of skill acquisition programs reviewed at BSSLC, teaching trials were provided at a rate of one per day or less. A single trial per day is not usually sufficient to develop a new behavior or skill. The SPOs/SAPs also often lacked instructions of sufficient specificity to ensure that training was conducted consistently. • 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: The ISP format called for the identification of the "Person(s) Responsible for Plan Development/Monitoring" and "Persons Responsible for Plan Implementation." These were both identified by position, such as DSP or QDDP. SPOs and SSOs typically indicated only the "Documenting Shift" under a section titled "Data Collection Location." Conclusion: This provision was found to be not in compliance.	Noncompliance
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	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. Data collection sheets and monthly and quarterly reviews demonstrated the failure of the Facility to routinely implement these services and supports. Extent to which interventions, strategies, and supports are practical and functional: In many instances, the interventions, strategies, and supports prescribed in the ISP were	Noncompliance

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		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. A review of eleven ISPs for Section S revealed the following: • Zero of eleven (0%) individuals were provided with training in the community that appropriately addressed his/her needs and preferences. • Zero of eleven (0%) individuals' ISPs contained a specific plan for regular community activities (e.g., leisure, work, skills. • Two of eleven (18%) ISPs evidenced strategies that were practical and functional for community settings. <u>Conclusion:</u> This provision was found to be not in compliance.	
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.	<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> The ISP did not consistently identify the data and/or documentation and frequency of data collection that would permit the objective analysis of an individual's progress. In addition to evidence provided in Section S, Provision M3, documented that one of five (20%) HMPs indicated the frequency of routine monitoring of the individual's problem, but even that one did not include where the monitoring would be documented. <u>Extent to which ISP identifies the person(s) responsible for the data collection, and the person(s) responsible for the data review:</u> 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. <u>Conclusion:</u> This provision was found to be not in compliance.	Noncompliance
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.	<u>Extent to which goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP:</u> 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	Noncompliance

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		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. <u>Conclusion:</u> 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.	<u>Extent to which ISP is accessible to staff:</u> 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. <u>Extent to which ISP is comprehensible to staff:</u> There was some evidence of progress in the ISP being comprehensible to staff. For example, five of five (100%) HMPs contained instructions for the DSP staff that were easily understood. This was not the rule, however. 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. The majority of SPOs/SAPs at BSSLC lacked adequate instructions for staff that would render them comprehensible to staff. 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 in Provision S1, the Monitoring Team conducted observations in a variety of settings across the BSSLC campus. These revealed that across all settings only 28% of observed individuals were functionally engaged. Furthermore, only slightly more than one third (36%) of all environments observed reflected at least 50% engagement. It follows that a lack of engagement by individuals also indicates staff were not engaged in implementing any ISP related activities such as SAPs, Service Objectives or generalization strategies, as these all require engagement as a prerequisite. The Monitoring Team could not determine whether this meant ISPs were not comprehensible, did not contain adequate instructions for the activities and training to be conducted, or just were not implemented. • As reported in Provision S3, during these same observations, not a single circumstance was noted in which an employee was conducting formal training. Circumstances were noted, however, in which staff demonstrated an inability to	Noncompliance

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		conduct informal training. 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. Examples included: • The Monitoring Team found that Monthly/Quarterly Reviews were often not completed in a timely fashion nor in a way that provided for meaningful evaluation of progress or program revision. They provided little evaluative analysis; instead, they made general reports such as "service provided" or "no data provided." • Documentation of the Speech/Language Pathologist (SLP) review for zero of three individuals (0%) contained information regarding whether the individual showed progress with the stated goal. • As reported in Provision O7, for a review of 17 individual records (sample #1 and #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. • As reported in Provision R3, quarterly documentation for zero of two individuals (0%) contained information regarding whether the individual showed progress with the stated goal(s). 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. Many of the data collection sheets for SPOs reviewed had missing data. Other examples of inadequate data included: • As reported in Provision O6, a review of Facility monitoring reports from January 2012 to June 2012 documented that staff and individuals were not being monitored in all aspects in which the individual was determined to be at increased risk. Without adequate monitoring, it would be difficult to determine whether monitoring is needed for ISPs or for implementation of those ISPs. For example, for monitoring forms completed in the past 6 months: o 60.4% of the monitoring forms focused on oral intake (meals and snacks) o 13.52 % of the monitoring forms focused on bathing o 7.12% of the monitoring forms focused on medication administration	Noncompliance

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		o 11.47% of the monitoring forms focused on Oral Care. o 2.28% of the monitoring forms focused on positioning • As reported in Provision R3, quarterly documentation for zero of two individuals (0%) identified recommendations/revisions to the program as indicated and related to the individual's progress or lack of progress. • As reported in Provision K4, of 30 PBSPs reviewed, 14 (47%) reflected timely changes in PBSPs. For the remainder of the PBSPs, the treatment decisions, even when evidence-based, were delayed or did not occur. The Facility was engaged in a pilot project that began in May 2012 to improve its Quarterly Review process. It was reported that the pilot quarterlies were well attended and resulted in some changes being made to behavior programs and in some needed orders being written. The Monitoring Team appreciated the initiative of the Facility in this regard, but the Quarterly Review process must serve to augment the ongoing monthly review and any appropriate modification by the responsible IDT member. <u>Conclusion:</u> This provision was found to be not in compliance. It is recommended the Facility consider how it might pilot a quality improvement project for monitoring the required monthly review.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals'	<u>Extent and adequacy of competency-based training for staff responsible for development of ISPs:</u> As reported in previous reports, training on ISPs had been standardized across the SSLCs. Supporting Visions: Personal Support Planning was the standard training curriculum for personal supports planning. Since the last review, additional training sessions and resources had been initiated. These included: • The Facility had hired a QDDP Educator to assist with training and competency-testing. • The APC had provided training to QDDPs and Social Workers on identification of obstacles and on the community referral process. • IDTs had received training on the updated ISP process in June 2012. Additional training continued to be needed 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.	Noncompliance

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	plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	<u>Extent and adequacy of competency-based training for staff responsible for implementation of ISPs:</u> There was some evidence of progress in some areas toward providing adequate competency-based training for staff responsible for implementation of ISPs. Examples reported throughout this report included: • As reported in Provision O5, staff were provided person-specific training of the PNMP by the appropriate trained personnel. Habilitation Therapies staff reportedly provided competency-based training for PNMP coordinators (PNMPCs). 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. • Also reported in Provision O5, 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. Despite these improvements, the Monitoring Team found staff were still not adequately provided with competency-based training overall. This finding was made by the lack of active treatment and engagement observed, a lack of documentation of training completed 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. • As reported in Provision M3, zero of five (0%) HMPs contained documentation that the DSP staff were trained on the plans. Since copies of functional care plans were kept in notebooks in the homes, with the original care plans filed in individuals' active records, any training or revisions to the care plans might not have been documented on the original care plan in the active record. • As reported in Provision O4, staff were not implementing interventions and recommendations outlined in the PNMP and/or Dining Plan. Observations on Driscoll, Fannin, Childress, and Bowie 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, increased risk of aspiration, or contractures and skin breakdown. Staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan and 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. • As reported in Provision O5, per report by the Director of Habilitation Therapies,	

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		pulled staff were not allowed to work with individuals with specialized training needs or those who were identified as high risk. Per interview with Home leaders, however, this process was inconsistently implemented as the Monitoring Team was told that pulled staff were considered trained after they were oriented to the welcome book by the home leader, thus allowing the pulled staff to work with all individuals. This was a concern since review of the welcome book did not ensure competence nor did it consistently contain the PNMP. Conclusion: This provision was found to be not in compliance.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	Extent to which ISPs are developed within 30 days of admission: BSSLC reported three admissions in the last six months and each had been residing in the Facility for more than 30 days. For two of three (67%), the 30-day ISP meeting was completed within 30 days. For the third, for Individual #501, the ISP date was entered as being three days before the admission date, so it was unclear as to when the meeting may have actually occurred; the ISP date was listed as 5/26/2012, and the admission date was 5/29/12. Extent to which ISPs are revised annually and as needed: In some cases ISP meetings did not occur within one year of the prior ISP date , but overall compliance with this requirement was achieved. . In assessing this Provision the Monitoring Team relied primarily on a list provided by the Facility that included each individual in residence, the date of their most recent ISP meeting, the date of the previous ISP meeting, and the date the most recent ISP was put into effect. From this list the Monitoring Team was able to determine: that twelve of 294 (4%) ISP meetings did not occur with 365 days of the previous ISP meeting. (Note: Seven additional Individuals had not been living at the Facility for a full year so they were not subject to this assessment of timeliness.) Extent to which ISPs are put into effect within thirty days of preparation: A review of the same list indicated that 71of 279 (25%) individuals did not have their ISP put into effect within 30 days of the ISP meeting. Several were extremely delinquent. For example, the list provided by the Facility showed that Individual #361's ISP meeting was on 7/11/11 and was not put into effect until 11/30/11. Individual #206's ISP meeting was on 3/7/12 and was not put into effect until 6/20/12. (Twenty-two additional Individuals had recent ISP meetings and had not reached the 30 day threshold. As a result they were not subject to this assessment.) This same deficiency held true for 30-day ISPs. Two of the three (67%) ISPs referenced	Noncompliance

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		above, dated in May and June 2012) had not yet been completed or implemented as of the date of this monitoring visit. In order to assist in addressing this problem, the Facility had instituted a policy effective 6/14/12, that the QDDP would be allowed an entire work day on the day following the ISP meeting to complete the ISP Summary the Action Plans and programming, with no other duties required. The ISP schedule had also been revamped to ensure that QDDPs did not have ISPs scheduled on consecutive days. It remained to be seen whether this strategy would have the desired outcome. The Monitoring Team requested the most recent version of the plan for Individual #86, whose meeting was held on 7/23/12, on 7/25/12. Much of the plan, including the majority of the Action Plans and the Living Option Recommendation section, was not yet completed. <u>Conclusion:</u> 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 continued to be limited. Some quality assurance activities were underway, but these were not yet organized into a system that would assist BSSLC to that identify and remediate problems to ensure that the ISPs. Examples of activities that were taking place included: • The Facility had been implementing the Section F Monitoring Tool since March 2012. Each month the three lead QDDPs and the QDDP Coordinator completed a tool for an ISP completed 60 days prior. A QA Auditor then completed an inter-rater audit of each of the four. It was reported that there remained considerable discrepancy in inter-rater findings in the Section F Monitoring Tools and that the next step in the process was to attempt to reconcile that disparity. The current process also only displayed the aggregate data without any accompanying analysis. The QA Director reported DADS State Office was going to be providing training for the QA Directors statewide on how to complete a statistical data analysis in October 2012. • The Facility continued to implement a peer review process for the Integrated Risk Rating assessment as documented in the previous monitoring report. <u>Conclusion:</u> 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 analyzing the data.	Noncompliance

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

1. Each QDDP should complete a careful review of the ISP assessments before the meeting in order to discover the discrepancies and have them corrected beforehand. (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 consider developing 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. The Facility should consider implementing a quality improvement project for ensuring the required monthly review is completed. (Provision F2d)
5. 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)
6. Clear performance goals and outcome measures should be defined for Section F, along with appropriate methodology for analyzing the data. (Provision F2g)

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 Self-Assessment (7/12/12) 2. BSSLC Action Plan (7/6/12) 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. IDT Quarterlies Pilot Project description blank minutes form; schedule for May and June 2012; attendance sheets of quarterlies for Individuals #57, #61, #144, , #152, #158, #184, #253, #309, #408, #483. #568, and #579; Integrated Risk Rating Form (IRRF) for Individuals #27, #152, #184, #381, and #593 6. G2: Review of non-SSLC Clinician Recommendations ACTION PLANS with projected completion date of 8/01/2012 7. Guidelines for reviewing non-SSLC clinician's recommendations 11/2/11 8. Physical Nutritional Management Team Weekly Summary 7/24/12 9. PNMT attendance sheets for May, June, and July 2012 10. Change in Status blank form 11. Change in Status completed form for Individual #395 7/2/12 and ISP Addendum 7/11/12 12. Statement from BSSLC in response to document request for policy or procedure guiding integrated clinical services: "No Evidence" 13. Statement from BSSLC in response to document request for forms used to document review and response to recommendations from non-Facility clinicians: "No Evidence" 14. Guidelines for reviewing non-SSLC clinician's recommendations 11/2/11 15. Sample of medical consultation reports for Individuals #27, #118, #133, #253, #434, #446, and #593,and MBSS consultation reports for Individuals #88, #96, #377, and #519 **People Interviewed:** 1. Group interview of Mary Ann Brett, MD, Director of Medical Services, Arthur Austin, MD, Adolfo Carvajal, MD, Malcolm Lochiel, MD, Martha Hare, APRN, and Penny Foerster, RN 2. Kim Littleton, Assistant Director of Programs **Meeting Attended/Observations:** 1. Medical Morning Meeting 7/25/12 and 7/26/12
	Facility Self-Assessment: BSSLC provided a self-assessment that described activities taken to review status, the results of the self-assessment, and a rating for each provision. For Provision G1, the Facility listed activities of Morning Medical Debriefing Meeting, IDT referrals to IDT from Morning Medical Debriefing sent when appropriate, and piloted Interdisciplinary Quarterly Review for risk changes and consult follow ups. However, the only result reported on was that there is no process for IDT referral follow-up (but that one is being developed). The Facility will also need to identify how it

	will asses the Morning Medical Meeting. Per interviews at the Facility, the Monitoring Team also learned that the pilot of the Interdisciplinary Quarterly Review was to be assessed in August. The Facility determined this provision was not in compliance, and the Monitoring Team concurs. For Provision G2, the Facility stated, "We are developing a tracking system to monitor non-BSSLC clinician recommendation follow up" and stated a monitoring system needed to be developed. The Facility determined this provision was not in compliance, and the Monitoring Team concurs. The Facility also provided an Action Plan of steps to progress toward compliance with this Section. For Provision G1, these steps included development of the Medical Morning Meeting and referrals to the IDT (which it accurately identified as completed) and of a tracking system for IDT responses to referrals (which was in process). The Facility also listed the Interdisciplinary Quarterly Review and the development of an Integrated Clinical Care policy as in process. For Provision G2, the steps of developing, training staff on, and monitoring guidelines for reviewing non-BSSLC clinicians' recommendations as in process. It would be helpful if, as these are developed, they are integrated into the Morning Medical Meeting system for review and referral to the IDT. Nevertheless, it was interesting that the Action Plan identified development of these guidelines as in process, although at the last review, a set of guidelines was already in place and being used. The Facility should determine what objective information should be included in monitoring and what of that should be integrated into the Facility quality assurance system.
	Summary of Monitor's Assessment: BSSLC continued to make progress toward integrated clinical planning and services. Processes to improve integrated planning both for individuals and for systemic improvements continued to evolve. BSSLC piloted a new quarterly review process intended to improve integration of planning, the IDT Quarterly Meeting. BSSLC continued the Medical Morning Meeting. Numerous clinical disciplines participated routinely in these meetings each weekday. From observation, it was clear that both individual and systemic issues are discussed in an interdisciplinary manner and lead to actions. This was an example not only of a process to promote integration, but also of a well-practiced approach that involved real participation and planning as a team using the knowledge and skills of all participants. The Facility should consider a means to ensure referrals, recommendations, and assignments made during the Medical Morning Meeting are followed and implementation or outcomes reported back. Other examples of actions include: • Processes to integrate behavioral health services continued to evolve. • The Physical and Nutritional Management Team (PNMT) continued to review individual cases including assessing individuals hospitalized with aspiration pneumonia upon return from the hospital.

	• The Facility had established a Change of Status documentation and follow-up process for Sick Call. Physicians complete a Change of Status form that includes the date, reason for being seen in sick call, determinations of whether there is a change in status and whether the team needs to meet. Although the Monitoring Team found good examples of integrated clinical services noted throughout this report, there were also examples in which such integration could and should improve. • The number of ISP meetings attended by particular disciplines appeared to be low. • The Skin Integrity Nurse was maintaining a Skin Integrity Database and began chairing a Skin Integrity Committee. However, all relevant disciplines did not consistently attend the committee meeting. • A review of recently completed HMPs found examples of lack of integrated planning were common. • There was a lack of attention to communication assessments in the development of skill acquisition training. Regarding review by facility clinicians of consultation recommendations by non-facility clinicians, policy is not clear or comprehensive. Although there was a document with guidelines, the Monitoring Team could not determine whether it had been implemented. Documentation of review was done, but not all consultations resulted in an integrated progress note.

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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 steps taken by the Facility to move toward compliance. Processes to improve integrated planning both for individuals and for systemic improvements continued to evolve. BSSLC piloted a new quarterly review process intended to improve integration of planning, the IDT Quarterly Meeting. BSSLC continued the Medical Morning Meeting. Numerous clinical disciplines participated routinely in these meetings each weekday; at the meetings observed, participants included physicians and APRN, the director of pharmacy, the director of habilitation services, the CNE, the hospital liaison nurse, the RN Case Manager Supervisor, and both psychiatrists. The physician on call reported information regarding the last 24 hours, and the hospital liaison nurse provided information on individuals who were in hospital or had returned in the last day; these were not simply report, though, as many of them led to discussion about the circumstances and about actions that needed to be taken. From observation, it was clear that both individual and systemic issues are discussed in an interdisciplinary manner and lead to actions. For example, when discussing an individual who requires nebulizer treatment, the director of habilitation services asked how long to wait after nebulizer treatment to provide regular or enteral feeding. Good discussion was held about this issue and about how it would affect the schedule of enteral feeding for the individual. The pharmacy director offered to do a	Noncompliance

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		literature review of practices, and there was a decision to bring this back for further discussion and to determine whether the Facility should establish guidelines. This was an excellent example of how integrated planning can lead to improved services for individuals as well as trigger review of Facility practices to identify proactively improvements that can be made in services. The Facility should consider whether it would be useful for a psychologist also to attend this meeting regularly to identify and address issues in which behavioral and medical concerns interact (such as difficulty in compliance with medication, or identification of medical issues that may be exacerbating target behaviors) and to enhance psychiatric and behavioral integration. The Facility should also consider a means to ensure referrals, recommendations, and assignments made during the Medical Morning Meeting are followed and implementation or outcomes reported back. Furthermore, although the observed meetings focused on acute medical care, there too were exchanges of information that contributed meaningfully to the psychiatric understanding of the individual under review. Examples are provided in Provision J8 of this report. There were several areas of clinical services in which integrated planning is essential and for which the Facility had taken action since the baseline visit. Examples include: • Behavioral Health Services: As reported in Provisions J1and J8, processes to integrate behavioral health services continued to evolve. Psychiatric Treatment Reviews (PTRs), the setting where most of the routine psychiatric care was provided, were well attended, typically by psychiatry, psychology, nursing, QDDPs, DSPs and other disciplines. Psychology and psychiatry integration was also strong at the higher level of review in the PBSC. The Monitoring Team attended the committee meeting on 07/23/12 and was impressed by the degree of interdisciplinary exchange. While the discussion was appropriately focused on the care provided by psychology, pertinent issues to psychiatry were raised and discussed meaningfully. Additionally, there was appropriate discussion on general medical issues that could have impact on behavioral issues. Evidence of thoughtful integrated care was also present in a redesign of the risk assessment tool. Previously, there were separate entries for "challenging behavior" and "psychiatry." They were combined into a single category for "behavioral healthcare." The Monitoring Team concurred that the combined assessment was clinically beneficial. • Physical and Nutritional Management: The Physical and Nutritional Management Team (PNMT) continued to review individual cases including assessing individuals hospitalized with aspiration pneumonia upon return from the hospital (although, as reported in Provision O1, there was a need to improve	

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		the discussion to mitigate future risk). However, attendance of members had declined since the last compliance visit., as reported in Provision O1 and noted in review of attendance sheets from May, June, and July 2012. The PNMT review of Individual #132 was an example of integrated review and planning. Individual #132 had been followed by PNMT and had received a comprehensive PNMT evaluation that included medical, pharmacy, nursing, and habilitation components in response to a diagnosis of aspiration. • The Facility had established a Change of Status documentation and follow-up process for Sick Call. Physicians complete a Change of Status form that includes the date, reason for being seen in sick call, determinations of whether there is a change in status and whether the team needs to meet, a description of the change of status, and a follow-up to be completed by the QDDP that states the date an ISPA meeting was held. The Monitoring Team reviewed a completed Change of Status form and ISP Addendum (ISPA) for Individual #395 provided by the Facility. The ISPA documented the disciplines that attended the ISPA meeting, the purpose, a record of the discussion, and the decision or recommendations. In addition, as reported in Provision M5, review of a larger sample of Change of Status reports found most were referred to the IDT, but information on whether ISPA meetings were held or the outcomes of these meetings was not provided. The Change of Status form prompts the physician to identify issues that should be referred to the IDT; it would be good for the Facility to develop a process to track these and ensure IDTs review whenever the physician refers to the IDT. • As reported in Provision M1, a Skin Integrity Committee Membership was comprised of members from several disciplines, including nursing, medical services, habilitation therapy, residential services, QDDPs, and psychology. However, the Skin Integrity Committee Meeting Minutes found no quarterly meetings had been conducted from December 2011 until June 1, 2012. The Sign-in Roster for the June 2012 meeting did not include the attendance of several key disciplines. In an effort to improve the efficiency and integration of quarterly reviews, BSSLC initiated an IDT Quarterly Review pilot project. The Facility selected the Cottages unit to implement this project in May and June 2012. Medical and QDDP quarterly reviews were combined, and several individuals were scheduled for each session. For some individuals, this was the first quarterly, for others it was the second quarterly, and for others the third quarterly review. Six sessions were held reviewing a total of 37 individuals. The Facility had drafted a form for minutes that covered clinical areas, program issues, and updating of risks; the only documentation of content of the reviews provided to the Monitoring Team was the IRRFs for several individuals reviewed on May	

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		8, 2012. It was not possible from that information to determine whether the discussion and decision-making at these quarterly reviews was integrated. The attendance signature sheets were provided. The Monitoring Team did not review ISPs to determine which IDT members were needed based on services provided and the preferences of the individuals. Attendance ranged from six to nine staff; the QDDP, physician, psychologist/behavior analyst, and nurse attended all reviews. Some who might have been expected to participate for some individuals (such as activity or vocational staff and a dietitian/nutritionist) attended no reviews, and DSPs also were never present. The Facility planned to review the outcome of the pilot during August 2012 and determine whether to revise the process and expand it to other living units. If the Facility chooses to continue and expand this process, the Monitoring Team would be pleased to observe sessions and review minutes and documentation of follow-up actions taken. Through observations, interviews, and reviews of documentation, the Monitoring Team identified examples of both integration of clinical services and opportunities for greater integration. A few examples follow: • The number of ISP meetings attended by particular disciplines appeared to be low. For example, according to these reports QDDPs attended only 32 (91%), DCPs attended only 21 (60%) , a physician attended only 15 (42%) and a psychologist attended only 20 (57%) . • The recently appointed Hospital Liaison Nurse was making routine visits to hospitalized individuals, keeping the Interdisciplinary Team apprised of their health status, and actively participating at individuals' pre and post hospitalization Individual Support Plan Addendum meetings. There was general improvement in adherence to Nursing Protocol for Hospitalizations, Emergency Room Visits, Transfers and Discharges. • The Skin Integrity Nurse was maintaining a Skin Integrity Database and began chairing a Skin Integrity Committee. However, all relevant disciplines did not consistently attend the committee meeting. It is important for all relevant disciplines to attend and actively participate in the committee meeting and take a proactive role in analyzing and trending Skin Integrity data, particularly data for decubitus pressure ulcers, in order to put measures in place to prevent or minimize the incidents of decubitus. • As reported in Provision M3, a review of recently completed HMPs found examples of lack of integrated planning. Zero of five (0%) HMPs were integrated with other relevant disciplines. Individual #264's HMP stated there would be collaboration with the behavioral therapist to integrate strategies into the care plan. No such strategies were included in the care plan. The plan also stated there would be collaboration with the physician regarding psychiatric/behavioral analyst consults and would follow-up on	

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		recommendations. No such recommendations were added to the plan. • For Individual #61, the same hospitalization and follow-up identified both good integration and areas in which integration could have been improved and might have avoided problems. This individual, who had complex behavioral needs, went to the hospital for a colonoscopy. After the colonoscopy, her oxygen saturation level dropped down to the mid to high 70's and she was coughing up a small amount of blood. Consequently Individual #61 was admitted to ICU. The hospital physician ordered a chest x-ray, which revealed infiltration of the left lung. The hospital attending physician believed Individual #61 had aspirated during the colonoscopy. After the Hospital Liaison Nurse's visit to the hospital, the IDT met to explore possible contributing factors that could have caused Individual #61 to aspirate. The team discussed the fact that Individual #61 had a Modified Barium Study in 2006 that showed she was at risk for aspirating solid foods due to a narrowing of the posterior pharynx. During the colonoscopy, the individual was anesthetized using a procedure that does not ensure absolute protection against aspiration. The IDT review of the of the active medical problem list found that it did not include a diagnosis of aspiration/dysphagia. The nursing assessment completed by the nurse prior to sending Individual #61 to the hospital did not include information regarding risk of aspiration. It was of concern to the Monitoring Team that the low risk rating for the diagnosis of aspiration/ dysphagia might have caused this information to be overlooked on the active medical problem list and nursing assessment reports sent to the hospital. It was further discussed by the Monitoring Team's physician, perhaps had the anesthesiologist been aware of the risk for aspiration, a more protective means of delivering anesthesia might have been used, which could have protected the airway against aspiration during the procedure. This demonstrated the necessity for the team to carefully and accurately assess individuals risk ratings and to integrate the risk ratings and risk actions plans into individuals overall care. Still, the interdisciplinary review following her admission identified issues that should be addressed to minimize the reoccurrence of similar problems. • A nurse notified the Habilitation Therapist that Individual #39 had been coughing and spitting out medication during medication administration and requested a change on his PNMP to crush medications. The speech pathologist reviewed the medication orders and found the individual was on a ground diet with pureed meat. Because whole pills did not fit the criteria for his current diet, the speech pathologist asked the PCP to change the medication orders to crush all medications or administer in liquid forms and mix medication in pudding/pureed textures. Consequently, a temporary PNMP was put in place to crush all medications until the PCP orders were clarified/changed. This	

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		provides an example of the need for medication administration instructions to be consistent with the PNMP and for the PNMP to be filed in the Medication Administration Record (MAR). Nevertheless, it provides an example in which a nurse identified a problem and involved other clinicians in a collaborative process to resolve the concern rapidly. • As reported in Provision J1, discussion at Psychiatric Treatment Reviews (PTRs) was integrated, because it tied together the clinical observations about side effects that the nurse had rated, with the various blood tests and information about drug interactions, serum levels and the like, that could explain why the side effects might have occurred. • As discussed in Provision P1, annual assessments/updates were completed by Occupational Therapists (OT) and Physical Therapists (PT) collaboratively. • Although there was some involvement of Speech and Language Pathologists (SLPs) in ensuring that PBSPs and skill acquisition plans (SAPs) took into account communication patterns, skills, and preferences, this involvement was not consistent. Three of eight communication assessments and PBSPs reviewed (37%) addressed the connection between the PBSP and the recommendations contained in the communication assessment. Furthermore, Individual #160's communication assessments stated the individual responds negatively to touching his hands, while the PBSP instructed staff to use hand over hand prompts. • Similarly, there was a lack of attention to communication assessments in the development of skill acquisition training. For example, three individuals included in the sample for Provision S1 experienced receptive communication limitations related to hearing. For none of these individuals were accommodations made in the SPOs for hearing or communication limitations. For Individual #21, the ISP indicated the individual had hearing difficulties and might not be able to hear spoken speech. The SPOs/SAPs included verbal instructions as well as reinforcement in the form of verbal praise. These SPOs/SAPs did not include any instructions or guidance addressing the hearing limitations. For Individual #167, the adaptive behavior assessment identified motor skills as a weakness. This individual had been provided an SPO for manipulating a radio. It was unclear whether the individual possessed the motor skills to perform the training procedures and documentation reflected no effort to address the issue. For Individual #288, there were discrepancies noted between assessments. The Vocational Assessment indicated only that the person "Verbally speaks clearly." The Speech-Language Assessment, however, reflected problems with perseveration and other verbal behavior issues. Conclusion: The Facility has made strides toward ensuring planning of services is	

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		integrated across clinical disciplines. Examples occur in which integrated planning needs to improve.	
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.	In response to a document request for policy or procedure guiding integrated clinical services, the Facility stated, "No Evidence." Nevertheless, 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. In response to a document request for forms used to document review and response to recommendations from non-Facility clinicians, the Facility state, "No Evidence." However, the Facility did have a set of guidelines revised in November 2011. During this compliance visit, the Facility provided a document called "G2: Review of non-SSLC Clinician Recommendations ACTION PLANS:"; these had a start date of 10/1/11 and a projected completion date of 8/1/12. It was not clear whether this was a draft or whether the Facility meant all consultations would comply by the completion date. This document provided a great deal more detail than the prior guidelines. The prior guidelines related only to medical consultations, whereas these newer guidelines include all clinical recommendations from non-SSLC clinicians. The new guidelines include procedures that had been reported to be in place at the last compliance visit. These included the following: 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. These guidelines appear to provide clear guidance, except that it would be helpful to provide timelines for how long can pass between receipt of the recommendations and documentation of review, entry into the IPN, and IDT meetings when appropriate; also, it would be useful to have a tracking system, such as review of ISPAs when IDT meetings are held. As reported in the self-assessment, the Facility is developing a tracking system to monitor follow up, and this was identified in the Action Plans as having a projected completion date of 12/31/12. The Monitoring Team reviewed 16 consultations by non-Facility clinicians for 12 individuals. Twelve consultations were medical consultations, and four were MBSS consultation recommendations. For all 16 (100%), there was documentation of review	Noncompliance

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		on the consultation report. For 10 of these (63%), an IPN had been written addressing the recommendations. For all (100%), the Facility clinician documented agreement on either the consultation report or in an IPN. It would have been helpful in preparing this report if the Facility had clarified whether these guidelines have or have not been implemented, and whether clinicians are expected to comply with them. Because the guidelines were not provided until midway through the compliance visit, the Monitoring Team did not have the opportunity to evaluate levels of compliance with the requirements. The Monitoring Team looks forward to seeing an approved policy and/or set of guidelines and to evaluating levels of compliance at the next compliance visit.	

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

1. Consider whether it would be useful for a psychologist also to attend the Morning Medical meeting regularly to identify and address issues in which behavioral and medical concerns interact (such as difficulty in compliance with medication, or identification of medical issues that may be exacerbating target behaviors) and to enhance psychiatric and behavioral integration. (Provision G1)
2. Develop a process to track referrals to the IDT from Sick Call and ensure IDTs review whenever the physician refers to the IDT. (Provision G1)
3. Consider developing a means to ensure referrals, recommendations, and assignments made during the Medical Morning Meeting are followed and implementation or outcomes reported back. (Provision G1)
4. The Guidelines for review of recommendations by non-SSLC consultants should provide timelines for how long can pass between receipt of the recommendations and documentation of review, entry into the IPN, an IDT meetings when appropriate. (Provision G2)
5. Complete development of, and implement, a process or tool to monitor follow up to recommendations from non-SSLC clinicians. (Provision G2)

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. BSSLC Self-Assessment (7/12/12) 2. BSSLC Action Plan (7/6/12) 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. Change in Status blank form 6. Draft Tracking Sheets for osteoporosis, diabetes mellitus, hypertension, lipid disorders, seizure disorder, and constipation, with cover notes providing numbers of individuals with those diagnoses 7. ISPs, CLDPs, and other documents reviewed by the Monitoring Team **People Interviewed:** 1. Group interview of Mary Ann Brett, MD, Director of Medical Services, Arthur Austin, MD, Adolfo Carvajal, MD, Malcolm Lochiel, MD, Martha Hare, APRN, and Penny Foerster, RN **Meeting Attended/Observations:** 1. ISP annual planning meeting for Individual #86 2. Medical Morning Meeting 7/25/12 and 7/26/12
	Facility Self-Assessment: BSSLC provided a self-assessment that described activities taken to review status, the results of the self-assessment, and a rating for each provision. For Provision H1, the Facility listed activities of monitoring assessments for various disciplines for timeliness; reporting change of status at Morning Medical Debriefing, and making informal referrals to the IDT; and assessing individuals seen at Sick Call for change of status, and making recommendations with respect to the need for the IDT to meet. The results stated there was a system in draft form to track timeliness (but did not mention the current database used to do such tracking), and that a monitoring mechanism to ensure the IDT responds to referrals is being developed. The results did state that the Primary Care Physician (PCP) completes a form at Sick Call, and the QDDP acts if there is a recommendation for an IDT meeting, but no data were provided on implementation; this is confusing because the Facility already stated there is not a mechanism in place to track response to referrals. For Provisions H2 and H3, the Facility again provided activities to be done but stated it did not have a system in place to ensure these are being done consistently. For the remainder of the provisions, the Facility either indicated there are no formal systems in place to monitor or else indicated not all requirements were being met. The Facility needs to ensure all requirements of each provision are assessed. For example, Provision H3 requires that treatments and interventions be timely and clinically appropriate based upon assessments and diagnoses, but the Self-Assessment only mentions timeliness.

	The Facility also provided an Action Plan of steps to progress toward compliance with this Section. Actions focused on developing tracking, as well as referring to other Sections for actions related to Medical Debriefing, Peer Review, and risk management. It was not clear that there was a comprehensive and coordinated plan to meet the requirements of this Section.
	Summary of Monitor's Assessment: Adequacy and timeliness of assessments and evaluations remained variable at this visit. 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. Diagnoses were consistent with the current versions of the DSM and ICD classification systems. Furthermore, the Monitoring Team would like to highlight the efforts made to ensure that all known syndromes were appropriately diagnosed, and tracked, as well as ensuring an understanding of the prevalence of many medical conditions at the Facility. For psychiatric diagnoses, there was not always the supporting information to verify and substantiate the diagnoses; although there were examples of this for medical services also, medical diagnoses were generally supported by assessments and evaluations. The Facility did not have procedures in place to ensure or monitor that treatments and interventions were implemented timely but reported a system was in draft form. Several provisions of this report provide examples in which treatments and interventions were not provided timely or were not clinically appropriate based upon assessments and diagnoses. In order to ensure timely involvement of the Interdisciplinary Team (IDT) when there was a change of health status that might require additional assessment and treatment, BSSLC had developed a "Change of Status" form that was to be completed each time the individuals were admitted to sick call. The purpose of this form was to improve notification of the QDDP to changes in status and the need to schedule an IDT meeting for additional discussion and review. Documents provided to the Monitoring Team did not permit assessment of whether ISPA meetings were held or of the outcomes of those meetings, but the process appears to have potential for ensuring timely identification of and response to changes in health status. Although the development and use of clinical indicators to assess the Facility's health care was still in early stages, the Facility had begun development of tracking sheets for several chronic conditions, including osteoporosis, diabetes mellitus, hypertension, and seizure disorder. Also, the medical staff had developed a list of all the syndromes identified on campus and the individuals diagnosed as having those syndromes. The Morning Medical Meeting provided a forum to review care of individuals. Given the open discussion of the Medical Morning meetings, it would be useful to provide data on relevant clinical indicators when discussing chronic conditions of individuals or possible systemic initiatives, and when holding follow-up discussions about the effectiveness of treatments and improvement actions.

	The Facility reported it had not yet developed a comprehensive integrated interdisciplinary set of procedures, policies, and guidelines. A draft DADS state policy addressed provisions G and H together. The policy was not yet completed or disseminated.

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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 and timeliness of assessments and evaluations remained variable at this visit. Throughout this report, there are examples in which assessments were, or 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. <u>Timeliness and Comprehensiveness of Regular Assessments</u> The Facility reported there is only a system in draft form to track timeliness. The Monitoring Team noted improvements in timeliness and comprehensiveness of assessments in a number of areas, Including: • Individuals identified as having decreased communication were being provided with the needed assessments. Assessments had continued to show significant improvement. Assessments were noted to be comprehensive and provided clear details and strategies to improve the individuals' level of communicative functioning. At the time of the review, 49 new assessments had been completed. As of this review, 232 individuals had received the new SLP assessment. Additionally, BSSLC presented a plan that would ensure all individuals would receive the new comprehensive assessments by the end of 2013. • A new comprehensive assessment format was in use at the facility and included assessment by OT and PT. All recent assessments (completed since January 2012) were noted to be comprehensive and address all generalized standards of a comprehensive assessment. The individuals who did not have a comprehensive assessment in the new format had received at a minimum an assessment that exceeded the requirements of this provision for a screening although it was not determined to be a comprehensive assessment. • As reported in Provision K5, all individuals had a current intellectual assessment at the time of the compliance visit; although only 23% of individuals had an adaptive behavior assessment completed in the last year, this was a modest	Noncompliance

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		improvement. Need for improvement still remained in a number of areas: • As reported in Provisions F1c and V4, annual assessments and updates were not consistently posted to the Share Drive 10 days prior to the ISP annual planning meeting for review by IDT members. • As reported in Provision S1, the Functional Skills Assessment did not provide the comprehensive and precise understanding of an individual's abilities needed for development of skill acquisition programs. Programs reviewed did not provide evidence that additional assessment was done to ensure the needed information about the individual's skills was available for decision-making and program development. • Although annual medical assessments are being provided, and there was generally further assessment following hospitalizations, Provision M1 documents numerous examples in which conditions were not noted in the reports of the annual medical assessments, or there was not complete follow up to resolution following hospitalizations. • As reported in Provision K5, there was frequent reliance on the use of abbreviated Structural and Functional Assessments (SFAs) that did not typically require direct assessment of behavior, and SFAs often did not indicate the date, setting, or respondents used for indirect assessments (making it difficult to determine whether these were current). • A minority of communication assessments contained all the elements that should be covered in a comprehensive assessment. Although recommendations were provided, they were often generic and were not specific to the individual. <u>Timeliness of Assessments for New Admissions</u> Assessments for newly admitted individuals were generally timely. For example: • 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. • Communication assessments were consistently done within 30 days of admission. <u>Assessments and Evaluations in Response to Changes in Status</u> The Monitoring Team found that there were some instances in which assessments were being updated in response to significant changes. For example, as reported in Provision O1, there was Improvement since the last compliance visit in the comparative analysis and oral motor portions of the assessments.	

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		However, assessments were not consistently done in response to a change in status, as the following examples demonstrate: • As reported in Provisions M1 and M3, the Comprehensive Nursing Assessments were not updated when there was a significant change in health status. • Provision C7 notes that no evidence was provided that individuals restrained more than three times in a thirty-day period received reassessment of skills or of biological, medical, or psychosocial factors, or updating and use of information from structural or functional assessments. <u>Use of Information From Assessments</u> Further, although there had been improvement in completion of assessments, information from the assessments was not always used in planning services and supports or provided unresolved conflicting information. For example: • As reported in Provision S1, although 64% of the individuals (seven of 11) had been provided intellectual and adaptive behavior assessments within the past year. Of those seven, however, only the record for one individual included evidence that the findings of the intellectual and adaptive behavior assessments were considered in the development of a skill acquisition training program. • For Individual #288, there were discrepancies noted between assessments. The Vocational Assessment indicated only that the person "Verbally speaks clearly." The Speech-Language Assessment, however, reflected problems with perseveration and other verbal behavior issues. • All of the individuals in the sample had a completed Functional Skills Assessment (FSA) included in the permanent record. For none of the ISPs or SPOs reviewed, however, were there FSA findings discussed in the ISP that corresponded with the specific skills targeted by the SPOs.	
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. Furthermore, the Monitoring Team would like to highlight the efforts made to ensure that all known syndromes were appropriately diagnosed, and tracked, as well as ensuring an understanding of the prevalence of many medical conditions at the Facility. Although much work remains, including implementation of clinical pathways that clarify the signs and symptoms to be reviewed (and, thus, ensure assessments needed to make and support diagnoses are performed), the Facility has taken important steps and plans to continue to move forward to identify, diagnose, and track syndromes. For both medical and psychiatric diagnoses, there was not always the supporting information to verify and substantiate the diagnoses.	Noncompliance

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		• Although, as reported in Provision J1, the Monitoring Team was impressed that practices for psychiatric formulations and diagnoses were embedded in high quality day-to-day clinical practices, there remained issues that need to be addressed, including: o Thirty percent of the individuals who require a comprehensive psychiatric evaluation had not yet received those. Therefore, diagnosis was not yet based on the needed assessments. o There remained 36 individuals who had one or more unresolved NOS (not otherwise specified) diagnoses. The Facility needs to evaluate or re-evaluate these individuals to determine whether these diagnoses can be resolved. o Clinical justification for psychiatric diagnoses had improved, as noted in Provision J6, but there remained a number of cases in which diagnoses were cited or rejected without clarification of the rationale or differential diagnosis. • In general medical diagnoses were supported by the assessments and evaluations, with some exceptions. o The annual medical assessment, dated 12/9/11, documented that the Individual had an "epidermal inclusion cyst right neck"; however, the physical exam component of the annual medical assessment indicated that the neck, and skin were "normal". The current health status documented on the annual medical assessment noted that the Individual was non-ambulatory, and that the Individual was not able to maintain tone of the neck and torso; however, the physical assessment component of the annual medical assessment documented "normal" motor function. Given the Individual's non-ambulatory state, diagnosis of diplegia, and observational assessment, the Monitoring Team questions the physical assessment of normal motor function.	
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 procedures in place to ensure or monitor that treatments and interventions were implemented timely but reported a system was in draft form. Several provisions of this report provide examples in which treatments and interventions were not provided timely or were not clinically appropriate based upon assessments and diagnoses. Several examples were provided in Provision L.1 showing lack of adequate and timely follow-up to diagnostic findings. For example, there were numerous cases 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.	Noncompliance

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		As reported in Provisions O1 and O2, individuals were provided with an annual comprehensive assessment by the PNMT or IDT that focused on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning during the course of the day and during nutritional intake. Improved since the last compliance visit were the comparative analysis and oral motor portions of the assessments. These areas were found to be more comprehensive and provided more clarity regarding status changes over the past year. However, PNMPs were not comprehensive as information regarding oral care remained vague at times and was lacking the detail needed to ensure safe consistent delivery of service. This included lack of staff positioning and specificity regarding HOB elevation. As a result, plans lacked the comprehensiveness needed to ensure consistent implementation. Furthermore, a primary role of the PNMT RN was to assess all individuals who returned from the hospital with a PNM related issues (i.e., aspiration, choking). The PNMT RN's responsibility was to alert the PNMT or Habilitation Therapists of individual cases of aspiration pneumonia and changes in health status that were pertinent to the PNMT and/or Habilitation Therapists. As reported in Provisions C7g and K4, there were examples in which changes in treatments and interventions did not occur when behavioral data indicated a need. For example: • As reported in Provision C7g, According to the record, the PBSP for Individual #173 had been revised in July 2011. Although self-injury and physical aggression had substantially increased beginning in January 2012, no additional revisions to the PBSP were documented. • As reported in Provision K4, of the 30 PBSPs reviewed, 14 (47%) reflected timely changes in PBSPs. This was an improvement over the 33% noted during the previous site visit. For the remainder of the PBSPs, the treatment decisions, even when evidence-based, were delayed or did not occur. o For Individual #481, the treatment expectations included in the PBSP had been met. The PBSP continued despite the successful reduction in the target behaviors. o For Individual #51, replacement behaviors were documented as increasing but later fell to zero. The PBSP continued for four months without revision despite the lack of replacement skill development. In order to ensure timely involvement of the Interdisciplinary Team (IDT) when there was a change of health status that might require additional assessment and treatment,	

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		BSSLC had developed a "Change of Status" form that was to be completed each time the individuals were admitted to sick call. The purpose of this form was to improve notification of the QDDP to changes in status and the need to schedule an IDT meeting for additional discussion and review. The physicians who saw individuals in sick call decided if a change of status had occurred and if the individuals' team needed to meet. The physicians' then signed the forms and gave them to the nurses. If individuals had a change of status, the nurse forwarded the forms to the individuals' QDDPs and the Lead QDDPs on their units. The QDDPs conducted ISPA meetings, documented the results of the meetings the change of status in the QDDPs' individual folder. Documents provided to the Monitoring Team did not permit assessment of whether ISPA meetings were held or of the outcomes of those meetings, but the process appears to have potential for ensuring timely identification of and response to changes in health status.	
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.	Although the development and use of clinical indicators to assess the Facility's health care was still in early stages, the Facility had begun development of tracking sheets for several chronic conditions, including osteoporosis, diabetes mellitus, hypertension, and seizure disorder. These tracking sheets will include data on clinical indicators, such as HgbA1C for diabetes mellitus. As these are developed, a core set of clinical indicators should be available and usable to evaluate the efficacy of treatments and interventions. Dr. Brett stated the medical staff review the clinical pathways provided by DADS as they are developing clinical indicators for the Facility. The medical staff had developed a list of all the syndromes identified on campus and the individuals diagnosed as having those syndromes. Refer to Section L for more detailed information. Dr. Brett reported this list of syndromes and individuals will be used for three purposes: 1. To prompt physicians to ensure appropriate assessments are done as recommended for these syndromes and to provide a tracking system physicians can use. 2. To educate clinicians by discussing specific syndromes at the Morning Medical meeting. 3. Relevant to this provision, to establish priorities for identifying clinical indicators for syndromes that involve a large number of people. As indicated in several sections of this report, use of clinical indicators of health status could be expanded for both care of individuals and for systemic changes. Some issues identified include: • As reported in Provision M1, while improvement was found in the content of discussions and dispositions of the minutes, there was no formalized trend	Noncompliance

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		analyses of infection control data included that would have alerted the committed if local or systemic infectious/communicable diseases were occurring so that preventative intervention could be put in place to prevent or minimize their spread. • As reported in Provision M2, the baseline data in Health Maintenance Plans (HMPs) frequently consisted of the diagnosis and/or treatment prescribed and did not include clinical indicators/data that lead to the necessity for the HMPs. • While PNMPs are reviewed at the ISP, 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.	
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 to monitor health status of individuals had been continued. • The Morning Medical Meeting 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. As stated in several sections of this report, this meeting was interdisciplinary, discussion was open, and outcomes included actions specific to individuals and also systemic in nature. • The Incident Management Review Team (IMRT) agenda includes review of injuries and causes, reports from the hospital liaison nurse, and restraints. As reported in Provision J1, the Psychiatric Treatment Reviews (PTRs) were conducted monthly for all individuals supported by psychiatry and were well attended, typically by psychiatry, psychology, nursing, QDDPs, DSPs and other disciplines, and sometimes by family members/guardians (via telephone). Clinical discussions included review of changes in status 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. Although the development and use of clinical indicators to assess the Facility's health care was still in early stages, development had begun of tracking sheets, as described in Provision H4, for several chronic conditions, including osteoporosis, diabetes mellitus, hypertension, and seizure disorder. These tracking sheets, along with guidelines for assessment and treatment, may provide a means to ensure timely and effective monitoring of health status; the Monitoring Team looks forward to reviewing the	Noncompliance

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		implementation of this process.	
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 provision will require demonstration of a functional system that is both integrated and ensures all clinical services make decisions on treatments and interventions timely in response to clinical indicators. The development of clinical indicators and tracking sheets at the Facility level could provide an organized way to provide clinicians with needed information and a means to identify when modifications are needed. This would need to be expanded not only to additional health and medical conditions, but also to other clinical services and supports. The various protocols developed by the State Office represent an initial framework, but there needs to be evidence these are put into action, support and are supported by appropriate clinical indicators, and lead to treatment that reflects that interventions and changes in interventions are based on identified clinical indicators and criteria that are appropriate for the individual. Given the open discussion of the Medical Morning meetings, it would be useful to provide data on relevant clinical indicators when discussing chronic conditions of individuals or possible systemic initiatives, and when holding follow-up discussions about the effectiveness of treatments and improvement actions. As noted in Provision H3, there were examples in which treatments and interventions were not modified in response to clinical indicators. The Facility will need to put systems in place to identify such examples and determine whether there are trends or problematic areas for which systemic improvement actions should be considered.	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. As this section requires all clinical departments, not just the Medical Department, to establish and implement policies, procedures, and guidelines, the policy needs to address the broad area of clinical services, such as PNMT, communication, and behavioral healthcare including psychiatry and psychology services. The Facility reported it had not yet developed a comprehensive integrated interdisciplinary set of procedures, policies, and guidelines. No policies relevant to this provision had been implemented since the last compliance visit.	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 monthly, quarterly, or annually as required and in response to changes in an individual's status. Where tracking indicates assessments and evaluations are not completed timely, the Facility must develop systemic improvement actions to improve timeliness.(Provision H1)
2. Ensure assessments are completed and posted to the Share Drive as required by policy. (Provision H1)
3. Identify and implement processes to review clinical assessments for comprehensiveness and quality. (Provision H1)
4. When developing the tracking sheets for health conditions, ensure they include measurement of clinical indicators and include in the related guidelines relevant treatment to be provided by medical staff and also other disciplines.
5. Given the open discussion of the Medical Morning meetings, it would be useful to provide data on relevant clinical indicators when discussing chronic conditions of individuals or possible systemic initiatives, and when holding follow-up discussions about the effectiveness of treatments and improvement actions. (Provision H6)

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 Self-Assessment (7/12/12) 2. BSSLC Action Plan (7/6/12) 3. Section I Presentation Book (undated) 4. DADS Policy 006.1 At Risk Individuals (2/18/11) 5. List of risk ratings for Individuals (undated) 6. Record reviews of Individuals #25, #31, #56, #86, #151, #159, #167, #195, #259, #276, #283, #284, #305, #318, #366, #371, #377, #413, #460, #527, #547, and #576 **People Interviewed:** 1. Kori Kelm, Director of Habilitation Therapies 2. Tracy Searle, Physical Therapist Assistant 3. Connie Horton, RN/FNP, DADS Office **Meetings Attended/Observations**: 1. Quality Assurance/Quality Improvement Council 7/25/12 2. Restraint Reduction Committee 7/26/12 3. Presentation meeting on At Risk changes (DADS) 7/25/12 4. ISP annual planning meeting for Individual #86
	Facility Self-Assessment: The Facility's self-assessment reported the BSSLC was in substantial compliance with Provision I.1 which addresses the requirement that the Facility has a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk. The Monitoring Team did not find this to be the case and did not concur with the Facility's self-assessment. The Facility did not have a Facility specific policy to guide its work effort directed at compliance with Section I. Additionally, the facility had not reviewed its risk rating tracking list to determine either accuracy or whether risks were being addressed. The Facility self-assessment determined that it was not in substantial compliance with Provision I.2 and I.3 and this was consistent with the findings of the Monitoring Team. The Facility also included in its self-assessment an Action Plan intended to describe a series of actions leading to compliance. The Action Plan did not include the development of a comprehensive Facility-specific policy directed at the risk assessment process. Without this the Facility's work efforts directed at compliance with this Section of the SA did not appear to be coordinated and integrated across disciplines.
	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 in Provision I.3 where compliance rates in some areas improved significantly. For example, the compliance rate determined from the sample reviewed by the Monitoring

	Team showed an improvement from 46% compliant to 67% compliant in the area of starting an assessment within five days of risk identification, and an improvement from 38% to 67% in the area of implementing a plan within 14 days of its finalization. The Facility did not have a comprehensive Facility level policy or procedure to guide the risk assessment process, and the system used for tracking risk identification and action plans was deficient. It was apparent to the Monitoring Team that the risk assessment and mitigation process works more effectively with some disciplines than others and with some interdisciplinary teams (IDTs) better than others. The lack of written policy and procedural direction may be a significant contributory cause to the lack of consistent performance across the Facility and to the types of issues enumerated in this report. Accurate assessments of level of risk using clinical information and sound clinical judgment were not always apparent. Although the Monitoring Team observed IDT participation and discussion during the risk discussion at the ISP meeting it attended, the risk levels assigned to the individual during the meeting could not be considered accurate due to these types of issues. Risk ratings were not always accurate or timely. The IDTs are not consistently responding to a change in status. There is a lack of integration of various risk factors into the ISP and inconsistent team member monitoring of the action plan.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	Facility Self-Assessment: The Facility reported it had engaged in the following activities in conducting its self-assessment: Section I Monitoring Tools 1. Reviewed risk data for the time period January 1, 2012 through May 31, 2012 to determine if all individuals have had an updated or annual risk assessment completed. 2. Reviewed Departmental Monitoring for Section I to determine overall compliance percentage for the review period of March 2012 through May 2012. 3. Reviewed Inter-rater reliability data to determine validity of overall compliance percentages for Section I monitoring conducted by the department and Quality Assurance (QA) for the review period of March 2012 through May 2012. From its self-assessment the Facility determined that: 1. In reviewing the risk database for the time period it was indicated that 165 individuals out of 301 have received an updated or annual integrated risk rating for all categories identified. The At Risk Performance Evaluation Team (PET) is currently developing a	Noncompliance

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		process to ensure that the Risk Rating has been integrated. 2. Review of Departmental Monitoring for Section I for the time period of March 2012 through May 2012 overall compliance is 51%. 3. Section I monitoring inter-rater reliability results for the review period of March 2012 through May 2012 indicates an overall rating of 52%. Currently between the raters it has been determined that there are some noted differences in the scoring of the tools. The Section I PET is currently reviewing the IRR process. Based on the findings of the self-assessment, the Facility reported this provision is in substantial compliance because the risks screening, assessments, and management system to identify an individual's needs when at risk is completed. There have been problems identified with the different monitors that utilize the tool which is currently being reviewed by the Section I PET along with problems with IRR. <u>Monitoring Team Findings:</u> The Monitoring Team does not concur with the Facility self-assessment. This Provision is not in substantial compliance. The statewide risk assessment procedure, with guidelines for rating risk, was in use at the Facility. Considerable training of staff involved in risk identification activity and IDTs responsible for the development of risk action plans had occurred, yet, as reported in Provisions I.2 and I.3, there were continuing issues with accurate risk identification, thorough assessments, and effective risk action plans. Additionally, a representative from DADS State Office provided the Monitoring Team with an overview of recently initiated training on the At-Risk process. A key component of this training was to ensure all IDT members had completed assessments timely and placed them in a shared drive for review by other team members prior to meeting, with instructions on developing their individual views on risk prior to the meeting. This was intended to lead to a shorter, more integrated, more interdisciplinary, and more productive risk discussion at an ISP meeting. This revised process had not as yet been implemented at the BSSLC. As described below the Facility did not have a comprehensive interdisciplinary Facility level policy or procedure to guide the risk assessment process. Additionally, the system used for tracking risk identification and action plans was deficient. The lack of written policy and procedural direction may be a significant contributory cause to the types of issues presented in this section of this report. For example, the Facility self-assessment reported compliance rates of just over 50% suggesting the need for stronger policy and procedural guidance and performance related accountability. The Facility's management system for tracking risk levels and determining whether or not Action Plans were in place was inaccurate. For example, the report prepared for the Monitoring Team visit and presented to the Monitoring Team reported 131 instances	

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		where an individual was rated as high risk in one or more categories and did not have a plan in place to address the high risk. Additionally, there were multiple examples in the report where the risk level was reported as "none" rather than high, medium, or low. The Monitoring Team provided the Facility with an opportunity to review the report to ensure its accuracy. The annotated report returned to the Monitoring Team contained over 50 corrected entries. Even with the corrections there were many instances where an individual was rated at high risk and did not, according to this report, have a plan to manage or mitigate the identified risk. The Monitoring Team observed one ISP meeting specifically to assess the risk assessment process. Staff present at the ISP were the actual staff who worked with the individual and were very knowledgeable about the individual. The individual was present at the meeting. The IDT used the Risk Level Guidelines required by State policy. The ISP meeting observed by the Monitoring Team included an open discussion among IDT members including presentation and discussion of clinical data but not all data was adequately evaluated, assessed, and discussed, for example: • The nursing assessment stated the individual sleeps seven to eight hours per night. The DSP present at the meeting reported the individual only sleeps four hours per night. This discrepancy in reported data was not explored in detail by the IDT. The psychiatrist immediately said she will change the administration of risperidone to night to help with sleep. There was no further discussion regarding other contributing factors that might affect sleep, such as napping during the day, or how lack of sleep might affect risks. Such a discussion could possibly shed light on how sleep patterns may affect areas of risk, such as falls and behavioral health—two areas of risk for the individual. • .The IDT mentioned the individual throws food. This was not explored. There was no discussion of taking data for incidents of throwing food. This behavior was not included in clinical data or in her PBSP.The IDT discussed lack of appetite. Contributing factors to cause a lack of appetite were not explored. She is offered liquids every hour, including ensure supplement. No consideration was given to exploring if the frequent intake of fluids and ensure could interfere with appetite at meals. The level of discussion related to throwing food, appetite, and supplement intake was insufficient to determine if risk mitigation plans were adequately addressing identified risk. Based on the Individual's medical history and diagnoses several diagnostic exams should have been completed before her annual meeting to provide an accurate status, e.g., Dexa Scan for osteoporosis, and Ankle-Brachial (ABI) test for circulation.	

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		Although the Monitoring Team observed IDT participation and discussion during the risk discussion at the PSP meeting, the risk levels assigned to the individual during the meeting could not be presumed to be accurate due to the lack of thorough discussion of specific risks and the absence of important diagnostic tests. Risk ratings were not always accurate or timely. For example, an aspiration trigger sheet was implemented for all individuals with physical and nutritional management needs. Issues were noted regarding the frequency in which professionals outside of nursing and the primary care physician were notified. A guideline was developed that stated the team should consider a referral to habitation therapy to assess for individualized triggers when the following occurs: • More than one pneumonia in a year and the individual is on an altered diet texture of liquid consistency • Any individual with a downgrade in texture or liquid consistency • Any new enteral feed • A choking incident requiring the Heimlich maneuver • Anyone labeled high risk and has a diagnosis of aspiration pneumonia and has no or few triggers recorded for three months who hasn't received recommendations from habilitation therapy • Recurrent aspiration or choking triggers without resolution While the above guidelines were a positive step, the guidelines were not consistently implemented as several individuals experienced triggers without consultation with the Habilitation Therapies Department to assist with determining the etiology of the trigger. For example: • Individual #318 who experienced multiple triggers for consecutive months but was never referred to Habilitation Therapies until the individual was hospitalized. Additional issues with data reported in the aspiration trigger sheet are presented in Section O of this report. Finally, the Facility did not have a comprehensive facility-level policy or procedure that addressed the risk assessment and management process and a system to ensure implementation is consistent (and to take corrective action when implementation does not occur or is inaccurate). Furthermore, the effective use of the existing process remains problematic as described in Provision I.2 and I.3.	
I2	Commencing within six months of	Facility Self-Assessment: The Facility reported it had engaged in the following activities	Noncompliance

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	the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	in conducting its self-assessment: 1. Reviewed Departmental Monitoring for Section I question I.2.1.C to determine if assessment occurred within 5 days of being determined at risk. 2. Reviewed Inter-rater reliability data to determine validity of current compliance percentages for Section I question I.2.1.C. 3. Conducted a comparison of facility high risk data for aspiration and BSSLC pneumonia report to ensure accurate and timely assessment of risk by Interdisciplinary Teams (IDT). The results of the self-assessment: 1. Review of Departmental Monitoring of 12 samples for Section I for the time period of March 2012 through May 2012 for I.2.1.C indicates an overall compliance of 61% indicating that the determined assessments began within 5 days of being determined at risk. 2. Section I monitoring of 12 samples of inter-rater reliability results for the review period of March 2012 through May 2012 for I.2.1.C indicates that QA monitoring rated this provision at 56%. Section I monitoring conducted by the department and Quality Assurance (QA) for the same time period indicates an overall IRR score of 52% for this provision. 3. Review of data indicates that 100% of people diagnosed with aspiration pneumonia between March 2012 and May 2012 were rated at a high risk. Based on the findings of the self-assessment, the Facility determined that this provision is not in substantial compliance because the IDT is not consistently responding to a change in status. <u>Monitoring Team Findings:</u> Review of 12 records (Individuals #31, #56, #159, #167, #284, #318, #371, #377, #413, #527, #547, and #576) 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 eight (67%) individuals. Records that did not contain documentation of this requirement included: Individuals #56, #377, #167, and #159. This was an improvement from what was reported (46% compliant) in the last monitoring report. The records of these 12 individuals were reviewed to determine if changes in circumstance should have resulted in changes to an at-risk assessment, rating, and plan. For five Individuals the IDT determined through review that the changes in circumstance did not require changes in the at-risk rating, and mitigation plan. There were seven	

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		examples of risk events or changes in status that warranted further assessment. 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 #167 and #159. Based on a review of records of six individuals (Individuals #31, #284, #371, #527, #547, and #576) for whom assessments had been completed to address the individuals' at risk conditions, all (100 %) included an adequate nursing assessment to assist the team in developing an appropriate plan. The following provides an example of an assessment that was comprehensive: Individual #547's Integrated Risk Rating Form demonstrated significant improvement in the use of substantive clinical data in developing rationale to support risk ratings than that noted in previous visits by the Monitoring Team. Based on a review of records of three individuals (Individuals #159, #318, and #413) for whom assessments had been completed to address the individuals' physical and nutritional management at risk conditions, two (Individuals #159 and #413) included an adequate physical and nutritional management and/or OT/PT assessment to assist the team in developing an appropriate plan. The following provides an example of an assessment that was not comprehensive: Individual #318 upon return from a hospitalization had his risk level revised; however, no formal assessments were completed to be used by the IDT in supporting the revised risk level and to address the risk. The following provides an example of an assessment that was comprehensive: For all three individuals the Physical Nutrition Management Nurse had been doing an adequate job of assessing people when they return from the hospital. This did not occur in an interdisciplinary manner which could have an effect on the development of the most optimal risk mitigation plans. Based on a review of records of three individuals (Individuals #56, #167, and #377) for whom assessments had been completed to address the individuals' behavioral health at risk conditions, none (0%) 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	

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		of this report. This Provision is not in substantial compliance because the IDT is not consistently responding to a change in status and adjusting risk action plans accordingly.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.	<u>Facility Self-Assessment:</u> The Facility reported it had engaged in the following activities in conducting its self-assessment: 1. Reviewed Departmental Monitoring for Section I to determine current monthly compliance percentages regarding plan integration into the ISP and clinical indicators and frequency of monitoring (section I.3 of the monitoring tool). 2. Reviewed Inter-rater reliability data for Section I.3 to determine validity of current compliance percentages conducted by the department and Quality Assurance (QA). From its self-assessment the Facility determined that: 1. Review of Departmental Monitoring of 12 samples for Section I for the time period of March 2012 through May 2012 with a sample of 12 ISPs for I.3 indicates an overall compliance for: • Includes prevention intervention to minimize the condition of Risk: 55% • Is integrated into the ISP: 55% • Includes clinical indicators to be monitored: 50% • Identifies the frequency of monitoring: 60% 2. Section I monitoring 12 samples of inter-rater reliability results for the review period of March 2012 through May 2012 indicates an overall rating of 52%. Currently between the raters it has been determined that there some noted differences in the scoring of the tools. The Section I PET is currently reviewing the IRR process. Based on the findings of the self-assessment, the Facility determined that this provision is not in substantial compliance because there is a lack of integration into the ISP and inconsistent team member monitoring of the action plan. <u>Monitoring Team Findings:</u> Based on a review of 12 records for individuals determined to be at risk (Individuals, #31, #56, #159, #167, #284, #318, #371, #377, #413, #527, #547, and #576), 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 eight (67%)) cases. Records that did not contain documentation of this included Individuals #56, #167, #377, and #413. The Facility had demonstrated improved compliance. In the last	Noncompliance

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		review compliance was 38%. ▪ Implemented a plan that met the needs identified by the IDT assessments in seven (58%) cases. Records that did not contain documentation of this included Individuals #56, #167, #371, #377, and #576. The Facility had demonstrated improved compliance. In the last review compliance was 38%. ▪ Included preventative interventions in the plan to minimize the condition of risk in six (50%) cases. Records that did not contain documentation of this included Individuals #56, #167, #371, #377, #413, and #576. ▪ When the risk to the individual warranted (eight cases), the Facility took immediate action in four (50%) cases. Records that did not contain documentation of this included #56, #167, #377, and # 318. ▪ Integrated the plans into the ISPs in eight (75%) cases. Records that did not contain documentation of this included Individuals #56, #167, #377, and #413. ▪ In five (42%), 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 #413, #576, #371, #31, #167, #377, and #56. The Facility had demonstrated improved compliance. In the last review compliance was 23%. ▪ In six (50%) appropriate functional and measurable objectives were incorporated into the ISP to allow the team to measure the efficacy of the plan. Records that did not contain documentation of this included Individuals #159, #413, #167, #377, #318, and #56. ▪ Included the clinical indicators to be monitored and the frequency of monitoring in four (25%) cases. Records that did not contain documentation of this included Individuals #318, #159, #413, #167, #377, #56, #576, and #371. Compliance rates from a low of 25% to a high of 75% are insufficient to demonstrate substantial compliance with this provision.	

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

1. Develop a Facility specific policy and a set of comprehensive procedures to guide the implementation of the risk assessment and risk mitigation process.
2. Develop an accurate methodology for tracking risk related data.
3. 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. QDDPs/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.
4. 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: Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. BSSLC Self-Assessment (07/12/12) and Action Plans (07/06/12) 2. Presentation Book for Section J, including all information on actions taken to reach compliance, forms and procedures for monitoring status of the Facility relevant to this section, and other information to document compliance or progress 3. DADS Policy and Procedures 007.2 Psychiatry Services (08/30/11) 4. DADS Policy and Procedures 001.1 Use of Restraint (04/10/12) 5. BSSLC Procedure III1.b Medical and Dental Restraint, updated on 12/10/11 and including a. Exhibit A – Restraint Checklist b. Exhibit B – Pre/Active/Post Sedation Checklist c. Exhibit C – Medical/Dental Cooperation Procedures 6. BSSLC Protocol for Reiss Screen Use (undated) 7. BSSLC Form: Administration of Chemical Restraint Consult 8. BSSLC Flow sheet: BSSLC Pre-Treatment Sedation Process (revised 07/26/11) 9. BSSLC ISPA shells for pre-treatment sedation, and for new psychotropic medications 10. A list of 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 11. A list of 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) 12. A list of completed combined case formulations for psychology and psychiatry (undated) 13. Psychology Department spreadsheet with details of all Reiss Screen administrations (01/2011) 14. Minutes of the Pharmacy and Therapeutics Committee (P&TC) and the Psychotropic Medication Oversight Committee (PMOC),since the last compliance visit 15. Minutes of the Sedation Workgroup, since the last compliance visit 16. A list of individuals prescribed intraclass polypharmacy and interclass polypharmacy, including the names of medications prescribed and each medication's start date 17. A tabulation that compared rates of Facility use of polypharmacy over the period from January 2010 until the present 18. A separate list of individuals, 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 19. A list of individuals who had medical support plans and dental support plans, to reduce the need for pre-treatment sedation 20. The number and percentage of individuals who had dental procedures, who also received pre-treatment sedation - oral or total intravenous sedation (TIVA) 21. A list of all individuals screened for tardive dyskinesia with DISCUS evaluations 22. A list of all individuals screened with MOSES side effects evaluations 23. DISCUS forms done over the past year that were rated "5" or higher 24. A list of individuals diagnosed with tardive dyskinesia and the Active Problem List (APL) for each of those individuals 25. A list of neurology clinic appointment for individual with both psychiatric and neurological problems, and psychiatrist participation in the neurology clinic appointments 26. Sample J1: Record Reviews for Individuals #20, #187, #270, #276, #288, #293, #390, #467, #517, #588 (selected by the Facility and considered to be clinically stable on their psychotropic medications), Individuals #423, #460, #501, and #517(new admissions), and Individual #86 (ISP during the visit,). 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 Behavior Assessment 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 (QDRRs) 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 (ISP 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 p. The most recent Human Right Committee (HRC) review for each psychotropic medication prescribed to the individual 27. Sample J2: Episodes of pre-treatment sedation: Oral pre-treatment sedations: Individuals #43 (02/23/12), #221 (06/01/12), #233 (03/23/12), #238 (01/13/2012), and #380 (05/11/12). TIVA

	sedations: Individuals #38 (04/11/12), #370 (03/08/12), #417 (01/04/12), and #445 (02/09/12).– Documents reviewed included the restraint checklist, face to face debriefing documents, medical orders, physician specified monitoring schedule, 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, evidence related to all steps of the facility restraint review process including administrative and programmatic follow-up 28. Sample J3: Information on psychotropic medications approved by HRC in 2012. These were 25 medications for Individuals #61, #75, #121, #152, #167, #181, #184, #185, #193, #308, #411, #488, #493, #511 #536. Materials reviewed included: a. Information from the clinical record (e.g., progress notes, psychiatric treatment reviews, ISPAs) relevant to understanding the reasons/clinical rationales for choice of the medication b. Integrated Progress Notes (IPNs), Psychiatric Treatment Reviews (PTR)s and other psychiatric notes that clarified the reasons the new medications were proposed c. Consent for use of the Psychotropic Medication d. Positive Behavior Support Committee (PBSC) and HRC review of the psychotropic medication proposals e. Revised Positive Behavior Support Plan (PBSP) 29. Sample J4: 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 #56, #167, and #377. 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 ISP change of status documentation c. Documentation of assessments and other steps taken to develop an action plan to reduce the risk (either ISPA or new ISP) d. The action plan (AP) to address the risk (either ISPA or new ISP) 30. Sample J5: For episodes of chemical restraint, materials reviewed included physician orders and nurses notes associated with the incident, psychiatry notes associated with the incident, documentation of any IDT meeting associated with the incident. Individual #167 (2/21/12); Individual 403 (5/30/12); Individual #316 01/02/2012 31. Sample J6: Documents related to psychiatric and neurological care for individuals who took seizure medication for both neurological and psychiatric indications. These were Individuals #159, #185, #377, #510, and #588. 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 32. Sample J7: Annual psychiatric updates for Individuals #130, #181, #471, #545, and #576 33. A list of all meetings and rounds that were typically attended by the psychiatrist, and which categories of staff always attend or might attend 34. A list and copy of any new forms used by the psychiatrists 35. 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 36. Description of administrative support offered to psychiatrists (e.g. secretarial and administrative scheduling of psychiatric consultations **People Interviewed:** 1. Reeba Chacko, MD, Staff Psychiatrist 2. Terry Hancock, PhD, Department Head, Psychology 3. Trey Knittel, PharmD, RPh, Department Head, Pharmacy 4. Victoria Morgan, MD, Department Head, Psychiatry **Meetings Attended/Observations:** 1. Psychiatric Treatment Review (PTR) 07/23/12, 07/25/12 2. Positive Behavior Support meeting (PBSP) 07/23/12 3. ISP meeting, Individual #86, 07/23/12 4. PMOC meeting 07/24/12 5. Medical Morning Report 07/24/12 and 07/25/12
	Facility Self-Assessment: BSSLC had made considerable revisions to the Self-Assessment. In the new format, the Facility described for each provision item (1) the activities the Facility engaged in to conduct the Self-Assessment of that provision item, (2) the results and findings from these self-assessment activities, and (3) a self-rating of substantial compliance or noncompliance. The new format was an improvement in the Facility self-assessment activity. For the Self-Assessment section, the Facility provided responses that drew from the Facility's tracking of pertinent clinical data. These included tracking for completion of psychiatric evaluations (J2 and J6), lists maintained by the QDDP and psychology departments for plans to reduce the need for pretreatment sedation (J4), tracking of polypharmacy by the PMOC (J11), lists of individuals who received MOSES and DISCUS evaluations (J12), tracking of psychiatrist participation in neurology clinic (J15), and a list of Reiss Screen that had been completed (J7). The Psychiatric Department had also conducted an audit, to determine if ISPAs for new medication were completed and to compare psychiatry and psychology tracking of psychiatric symptoms for psychotropic medications. The results of the Self-Assessment section were presented in a clear and straightforward manner. This was helpful, and laid the groundwork for understanding the basis for the Self-Rating that followed. Overall, the Facility's response in the Plan of Improvement showed responsiveness to the requests and suggestions of the Monitoring Team. It indicated that there was a common understanding of what is required to achieve substantial compliance with the Settlement Agreement (SA). As indicated below, the Facility and Monitoring Team were in agreement about the status of most of the provision items, and differed only on the status of provision J11 and J14. For Provision J11 the Monitoring Team assessed that a more aggressive effort to reduce unnecessary polypharmacy was needed. When continued polypharmacy was deemed clinically necessary, more detailed justifications were needed. For Provision J14 the Monitoring Team

	assessed that to achieve compliance the Facility needed to improve the risk vs. risk discussion for new medications, and to improve presentation of that information to the HRC. As a result of these matters, the Monitoring Team found noncompliance for these provisions. Overall, the quantitative data that the above analyses provided was helpful. However, there was also a need for the Facility to review the quality of the data provided. If it is not already doing so, the Psychiatry Department should (1) seek assistance from the Quality Assurance (QA) Department to develop methods to review performance for the requirements of the various elements required by the provision items, and to develop a program for review of document for quality. The Facility Action Plan (AP) addressed many of the issues that are the focus of the Monitoring Team comments for this compliance visit. However, some of the action steps were in early stages of implementation. In addition, more detailed actions plan steps were needed for the items mentioned in the preceding paragraph regarding Provisions J11 and J14. The AP should also be modified to address improvements needed for Provisions J7 (regarding use of the Reiss Screen when a change of status occurs), J8 (psychiatric information in the ISP), and J10 (risk vs. risk and treatment alternatives). For Provision J2 the Monitoring Team noted the need to implement a system to incorporate information about key developments into the permanent records. This item was not addressed in the AP for Provision J2, but it was addressed under the AP for provision P6. This is not a problem, since the requirements for Provisions J2 and J6 overlap.
	Summary of Monitor's Assessment: The Facility made progress in a number of areas. These included completion of additional psychiatric assessments and improvements in those assessments, improvements in integrated care at the level of the overall behavioral health team, and improvements in consent procedures. Psychiatrists reviewed diagnoses to make sure that they properly described known problems, and the Facility improved the tracking of psychiatric diagnoses in APLs. Good integrated care was evident in the morning medical report meetings and in PTRs, and in the joining together of psychology and psychiatry concerns into an integrated behavioral health entry for risk assessments. Psychiatric assessments were provided in a timely manner for new admissions. As a general matter, the clinical care provided by the Psychiatry Department was good. Nonetheless, in a number of areas the Facility is held back by deficiencies in systems to support the clinical work. In each case, multiple provision items are affected. • Psychotropic medication plans need to include monitoring with appropriate objective/quantitative measures, to help determine whether or not the medication is effective. These measures need be applied properly, and the results brought to the PTRs and other places where decisions about psychotropic medication management are made. For purposes of longitudinal tracking, tracking graphs should be maintained that display data over time and their relationship to medication dose changes and other events. Such graphs were in place for measures of challenging behavior, but typically not for psychiatric measures. The resulting difficulties impacted not only provision items that directly address medication management (J3, J13), but also provisions that relate to

integrated care (J8) and Facility level reviews of psychotropic medication management (J11).

- Explanation/justifications for key clinical decisions (for example about clinical diagnoses or initiation/ termination of medications) need to be included in documents that will be readily accessible over time. Difficulties in this area are affecting provision items J2, J6, J8, and J11.
- Some systems for integrated care that require collaboration from diverse Facility departments are not yet fully in place to support needed clinical functions. In particular, this is true for efforts to minimize the need for pre-treatment sedation
- While efforts have been made to provide QA/QE for psychiatry, there is still no psychiatry monitoring tool in place, nor is there a system for physician peer review of key documents such as psychiatric assessments.

Comments on specific provision items:

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. Thirty percent of individuals who received psychotropic medication had not yet received psychiatric evaluations, and there are many individuals for whom NOS diagnoses remain unresolved. Evaluations for newly admitted individuals were done in a timely manner. The Facility needs to complete and implement a system to incorporate information about key developments into the permanent records, for example by implementation of annual psychiatric updates by all psychiatrists.

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, but data-based monitoring of psychiatric symptoms was not sufficient.

For Provision J4: The provision was determined to be not in compliance. Systems to provide coordination between psychology, psychiatry, dental, QA, pharmacy and others are a current focus for the Facility Sedation Workgroup, but the efforts had proceeded only to the level of an action plan.

For Provision J5: The provision was determined to be not in substantial compliance, due to the loss of a psychiatrist and overall decrease in psychiatry staffing from 2.5 to 2.0 FTEs. The Facility did not have 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. Seventy percent of the individuals who needed psychiatric evaluations had received them. Improvements were needed in the areas of diagnostic justifications and case formulations.

	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, many individuals seen by psychiatry did not yet have psychiatric evaluations in place. The protocol for use of Reiss Screens needed to more fully address the use of screens when a clinical change of status occurred. **For Provision J8:** The provision was determined to be not in compliance. Significant progress has been made toward integration of behavioral healthcare, and combined case formulations are now part of the Functional Assessment (FA) document. However, further progress was needed for integrated care at the level of the ISP. As individuals leave the Facility for the community, input is needed from the behavioral healthcare team, to guide provision of appropriate supports for the individuals. **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. Procedures were in place for presentation of risk vs. risk and treatment alternatives for new medications, in ISPAs for new medications. However, the forms were rarely used and when they were, they were not used correctly. **For Provision J11:** The provision was determined to be not in substantial compliance. There appeared to be a small reduction in rates of polypharmacy over the past six months, but there needed to be a greater emphasis on reductions of unnecessary polypharmacy. When continued polypharmacy was deemed clinical necessary, more detailed justifications (or references to where the justifications were located) needed to be provided by PMOC. **For Provision J12:** The provision was determined to be not in substantial compliance. Adequate procedures for screening when there was a change in medication dose had just been started and results could not yet be assessed. **For Provision J13** The provision was determined to be not in substantial compliance. There were difficulties in the identification of measures to assess treatment efficacy and better systems needed to be in place to track data on medication efficacy. **For Provision J14:** The provision was determined to be not in substantial compliance. There were improvements to the consent process but failure to complete needed documentation from IDTs regarding discussion of risk/benefit analysis for new medication meant that the Monitoring Team could not confirm that the needed discussions took place at the IDT level. **For Provision J15:** The provision was determined to be in substantial compliance. Integrated care for medications prescribed for both seizures and psychiatric illness was well coordinated.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	The psychiatric staffing at the Facility dropped from 2.5 FTEs to 2 FTEs. This was the result of the resignation in April of Dr. Luna, who had been employed in a full time position. While efforts are underway to recruit a replacement for Dr. Luna, Dr. Morgan has agreed to increase her level of effort from 20 hours per week to 40 hours per week. As a result of the changes, psychiatric services at the Facility at the time of the compliance visit were provided by two full-time psychiatrists, Drs. Morgan and Chacko. As reviewed during previous visits of the Monitoring Team, Drs. Morgan and Chacko were both board certified psychiatrists with extensive experience in the psychiatric care of individuals who have intellectual disabilities. Drs. Morgan and Chacko actively and appropriately participated in interdisciplinary processes, including IDT and ISP meetings. They also participated in Medical Department activities such as the Medical Morning Report, and Facility wide oversight activities such as PBSC, POMC and P&TC. The Monitoring Team reviewed Drs. Morgan and Chacko's licensure documents, and they are all up to date.	Substantial Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	The Monitoring Team first reviewed the process that was in place for psychiatric evaluation and diagnosis. To do so, the Monitoring Team observed the psychiatrists' day-to-day work in the various settings and meetings where individuals were seen and their care discussed. The Monitoring Team attended two PTRs, the setting where most of the routine psychiatric care was provided. PTRs were conducted monthly for all individuals supported by psychiatry. They were well attended, typically by psychiatry, psychology, nursing, QDDPs, DSPs and other disciplines, and sometimes by family members/guardians (via telephone). Individuals were seen by the psychiatrist either during the PTR, or earlier in the day. The general format for PTRs was that the nurse case manager presented information on physical health and side effect screens (MOSES and DISCUS). QDRR information was reviewed from the pharmacy's written (quarterly) report, the psychologist presented behavioral data, DSPs presented information from the home, and a general discussion followed. PTR reviews lasted about 30 minutes, sometimes longer. In many PTR reviews, there were clinical discussions that contributed to the diagnostic understanding of the individual under review. For example, in the review for Individual #144 the IDT reviewed the possible command hallucinations that the individual had experienced the previous day. The initial focus was on the quality of the risk evaluation that had been done when the symptoms occurred. Broader discussion then considered	Noncompliance

		the diagnostic implications of the symptoms. Discussion focused on whether the symptoms were learned behaviors that were intended to evoke a particular response from the staff, or whether they were symptoms of psychosis. The conclusion was that behavioral elements were present, but that the individual also had true psychosis. As part of the ensuing discussion, the diagnosis of schizoaffective disorder was re-affirmed. Other discussions that related to the psychiatrist's formulation and diagnosis were for Individual #408, about symptoms that were the basis of the diagnosis of a Pervasive Developmental Disability (PDD), and for Individual #61, about symptoms that were the basis for the diagnosis of Schizoaffective Disorder. The Monitoring Team also observed the ISP for Individual #86, on 07/24/12. Psychiatry participated in the overall discussion and contributed to the overall care plan for the coming year. Among other things, the psychiatrist drew the attention of the IDT to the importance of meaningful inclusion of the individual's guardian in the day-to-day decision making on her behalf. Discussions about psychiatric diagnoses were also part of the PBSC committee meeting on 7/24/12: The meeting was attended by the department heads of psychiatry and psychology, and the IDT psychologists of individuals under review. The focus of PBSC was the review and approval of new or modified PBSPs, and for several individuals a clinical discussion about diagnosis was part of that discussion. The Monitoring Team also observed the Medical Morning meetings on 7/24/12 and 7/25/12. The meeting was a fast-paced work meeting that focused on acute medical care, but there too were exchanges of information that contributed meaningfully to the psychiatric understanding of the individual under review. More details on each of these meetings are provided under provision item J8. Overall, the Monitoring Team was again impressed that practices for psychiatric formulations and diagnoses at the Facility were embedded in high quality day- to- day clinical practices, and that there were good interdisciplinary exchanges between psychiatrists and colleagues from other disciplines. During the visit, the Monitoring Team also revisited items that had been a focus during the previous compliance visit and that resulted in specific comments and suggestions in the report for that visit. To do so, the Monitoring Team drew from (1) observations made during the visit, (2) review of department databases on diagnoses and medications provided to individuals under the care of psychiatry, (3) record reviews for 15 individuals in Sample J1, and from (4) annual psychiatric updates for the five individuals in Sample J7. Items reviewed were: <u>The need to complete CPEs for individuals who did not have them:</u> At the time of the last	

		compliance visit, Appendix B CPEs were in place for 86/149 (57%) of the individuals who needed them. Despite the staffing shortage, BSSLC psychiatrists continued to compile additional evaluations. Since the last visit, CPEs were completed for an additional 12 individuals. That brought the total number of evaluations up to 98/139 (70%) of the individuals who needed them. A review of the quality of the Appendix B evaluations is provided under provision item J6. <u>The large number of individuals who had NOS diagnoses:</u> In the report for the last compliance visit, the Monitoring Team found that 36/149 (24%) of individuals followed by psychiatry had one or more unresolved NOS diagnoses. The Monitoring Team noted that the percentage was high. Unfortunately, there has been no progress in this matter: At the time of the current tour, NOS diagnoses were present for 37/139 (26%) of the individuals followed by psychiatry. To explore the Facility's efforts to resolve NOS diagnoses, the Monitoring Team examined records the Facility provided for all changes made in diagnoses during 2012. There were 19 such changes, and four involved the resolution of NOS diagnoses. Each was examined: • Individual #120: The psychiatrist concluded that the diagnosis of disruptive behavior NOS was unnecessary. In the PTR note of 1/10/12 the psychiatrist noted that his psychiatric symptoms were consistent with the diagnosis of bipolar disorder. The full CPE has not yet been done, but the record review demonstrated the clear presence of a psychotic disorder, and the Monitoring Team agreed with the conclusion of the psychiatrist regarding the additional NOS diagnosis. • Individual #130: The diagnosis of psychosis NOS was removed, and Autism and Reactive Attachment Disorder were added. There was a detailed note from the PTR of 03/06/12 about the symptoms that supported the new diagnoses. The note provided adequate justification for attribution of the symptoms to a pervasive developmental disorder and not a psychotic disorder. Although the issue of the NOS diagnosis was adequately addressed, it was replaced by a different matter that needed diagnostic justification: In the new formulation, the psychiatrist diagnosed the individual with both Reactive Attachment Disorder (RAD) and a pervasive developmental disorder. However, the Guidance of the Diagnostic and Statistical Manual (DSM) has been that pervasive developmental disorders should be differentiated from RAD. Given that, the psychiatrist should have clarified the reasons for the use of both diagnoses. The PTR discussion about Individual #130 also illustrated the need to capture key information from PTR notes for the permanent record, before the notes in question are deleted from the record (see comments that follow about management of key information.) • Individual #490: The individual had a CPE of 03/06/12 and the diagnosis of	

		Psychosis NOS was deleted. The psychiatrist gave a detailed explanation to support the diagnosis of Oppositional Defiant Disorder. However, he also stated that the individual "continued to meet the criteria for Mood Disorder NOS" without further discussion. The matter should have been addressed in the CPE. The care of the individual was later transferred to another psychiatrist, after the first psychiatrist left the Facility. The record then showed a hand written correction of the diagnosis on the APL, on 6/28/12 changing the Mood Disorder NOS diagnosis to Cyclothymia. The overall change appeared clinically reasonable, but the Monitoring Team was not provided a note that explained the thinking of the psychiatrist and the support for the new diagnosis. • Individual #484: The diagnosis of Mood Disorder NOS was changed to Anxiety due to Smith-Lemli- Opitz syndrome. This was an excellent resolution. The syndrome in question has a strong behavioral phenotype which includes temperament dysregulation. Also, the citation of the phenotype was appropriate, since it helped provide an integrated understanding of the individual. In addition, NOS diagnoses were either introduced or left unaddressed in a number of other diagnostic reviews. Examples were Individuals #27 and #539. In discussion with the Facility, the Monitoring Team noted that Appendix B of the SA stated explicitly (Item XII iii) that diagnoses listed as NOS should be addressed within 60 days through clinically appropriate assessments, and resolved in a clinically justifiable manner. As a general principle, NOS should be used only when there is no other viable clinical diagnosis available. Should the psychiatrist believe that an NOS diagnosis is nonetheless necessary, a detailed justification should be provided to explain pertinent details. It may be helpful in some situations to include information from the psychologist's functional assessment. That might help provide another perspective for understanding the challenging behaviors/symptoms that underlie the NOS diagnosis. <u>Adequacy of the process to track diagnoses and diagnostic updates:</u> During the last compliance visit the Monitoring Team found that in 6/17 cases reviewed (35%) there were discrepancies between the information contained in the departmental database and the Active Problem List (APL). As a response of that finding, the Psychiatry Department developed a detailed process ("Axis 1 Diagnostic Change Process") to assure changes in diagnosis made by the psychiatrist were reflected in the APL and elsewhere in the record. The new process contained a flow chart for actions that involved the psychiatrist, psychiatry assistant, administrative support, AVATAR clerk and psychologist. The new system was intended to assure that data systems for (1) psychology department files, (2) psychiatry department files, and (3) the AVATAR system will all contain the same information. The psychiatry assistant was also tasked to follow-up and make sure that	

		updates were completed. During the current visit, the Monitoring Team examined the 15 records in Sample J1. In all cases, the APLs, medical summaries, psychiatry department listings all contained the same information. This represented good progress. The Psychiatry Department's review of data management also helped make sure that the departmental database and APLs contained complete information. In addition to the five changes in NOS diagnoses noted above, there were an additional 14 instances of changes in diagnoses of other kinds. Many of these were additions of diagnoses not previous listed but which described problems that were not new. For example, for five individuals the diagnosis of pica was added. This diagnosis may not have been previously included, since pica is typically not a focus for pharmacotherapy. The addition of these diagnoses facilitated more integrated and coordinated behavioral and general healthcare. That too was an example of progress. In the case of Individual #86, a long-standing diagnosis of dyskinesia was not listed in the APL. That suggested that perhaps there was further work to be done. <u>Timeliness of psychiatric evaluations for new admissions:</u> Since the beginning of 2012, there were four admissions to the Facility. These were Individuals #423, #460, #501, and #539. All were admitted on psychotropic medications, and all received services from psychiatry. Each individual was seen by a psychiatrist within 30 days, baseline MOSES and DISCUS evaluations were completed, and each individual was seen on a monthly basis in PTR. CPEs were in place for the four new admissions. For Individual #501 (admitted on 5/29), a preliminary psychiatric consultation was completed on 6/6/12. Overall, the evaluations were done in a timely manner. That was positive. <u>Were the Facility's documents adequate to capture relevant information on psychiatric evaluation and diagnosis?</u> At the last compliance visit, the Monitoring Team commented on the need to improve the way key clinical information was summarized and included in documents that were either not thinned from the record or were (more) readily accessible. Part of the Facility's response to that need was a plan to have Psychiatric Treatment Plans. These would contain pertinent psychiatric information needed for the long term record. PTPs would have been updated annually and also when new medications or diagnoses were introduced. The Facility also shared plans to do annual updates to the Appendix B CPEs. The Monitoring Team discussed with the Facility the status of these plans. At the time of the visit, annual evaluations were being done by one of the psychiatrists but not the	

		other. The Monitoring Team also learned that the Facility was reconsidering the use of PTPs. Overall, the Monitoring Team understands the need for the Facility to be careful and deliberate in the design of the overall plans for annual documentation. At the same time, this remains an area of need that should receive appropriate emphasis. Since the use of annual reviews is one of the possible ways to capture needed key information for the permanent record, the Monitoring Team requested and reviewed examples of annual reviews (Sample J7) that had been completed. The annual reviews provided detailed summaries of the care provided during the year. However, greater effort should be placed around clinical explanation/justification of key issues. For example, Individual #130 was admitted on four psychotropics and initial plans were to taper the medications slowly. The psychiatrist wrote that the individual had adjustment difficulties, and that only two of the medications had been tapered. The individual was now treated with five medications. The psychiatrist wrote that in the coming year the team may attempt to challenge one of the medications. The psychiatrist should have offered her assessment as to whether ongoing management with the remaining four medicines was needed, and if so why. In conclusion, the Monitoring Team confirmed the good overall quality of day to day psychiatric clinical practice at the Facility. The Facility was approaching substantial compliance. To do so, the Facility needs to (1) continue to complete CPEs for individuals who do not have one, (2) address the matter of clinically unnecessary NOS diagnoses, (3) to complete the design and implement a system to incorporate information about key developments into the permanent record. The first two issues also contribute to the Facility's current failure to achieve compliance with provision item J6, and the third issue contributes to the Facility's current failure to achieve compliance with provision items J6, J8, J11, J12, and J13.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	The key requirement of the provision was that medications should not be used as a substitute for a treatment program. In the Facility, the treatment program was the Positive Behavior Support Plan (PBSP), supported by a Functional Assessment (FA). These were in place for all individuals who took psychotropic medications. At the time of the visit there were 139 individuals who received psychotropic medications (for some reports, the number was 140, a number that was correct when the document was prepared). All individuals who were treated with psychotropic medications had PBSPs. PBSPs were shorter than in the past, and they were more transparent and easier to follow in regard to psychiatric information. Although, as noted in Provision K9, there remained a need to provide psychiatric information in PBSPs, PTRs attended by the Monitoring Teams showed that greater clarity about the role of medication in the overall treatment plan facilitated better communication between the clinical staff, and that	Noncompliance

contributed to clearer and more focused decision making.

Specific areas where FA/PBSPs had improved were:

- New/revised PBSPs had combined case assessments that outlined whether and how psychiatric symptoms and learned behaviors (and at times other factors) were interrelated. As of June 1, 2012, combined psychiatry- psychology case formulations were reported to be in place for 92 of 139 (66%) of individuals who needed them. For individuals in Sample J1, three of eight (38%) long-term Facility residents had case formulations in place. Case formulations were not yet in place for the newly admitted individuals, since they did not yet have full SFAs. A more detailed analysis of combined case formulations is presented under provision J8, which focused on integrated care.
- In the current format of the PBSP, the reader was directed to psychiatric documents such as the medication consent for details about side effects. That was a satisfactory resolution of the problem of different information being provided by the PBSP and the psychiatrist.
- In 04/12, the Psychiatry department had audited the records of all individuals who took psychotropic medication and found that in many cases there were differences between PTR and PBSP information about the symptoms that were the focus of the medication treatment. The audit found that the percentage of symptoms/target behaviors that did not match varied from 13.5% to 50%, depending on the unit, for a campus wide average of 19.6%. This was an example of a good QA effort. At the time of the visit, efforts were underway to resolve the differences.
- Efforts were underway to update the PBSPs table of information about psychotropic medications, so that it would present the same information that was presented to the IDT during PTRs. For each psychotropic medication, psychologists are now instructed to report the following information:

Axis I Psychiatric Diagnosis	Psychiatric Symptom	Rating Scale	Psychoactive Medication and Current Dose	Medication Change

The items selected were appropriate and the uniform presentation will facilitate communication between psychiatrists and psychologists.

While the new format is an important improvement, implementation appeared to be slow. The new format was not present in PBSPs in any of the records of individuals in Sample J1, and even for the records reviewed by PBSC on 07/24/12, only 2/6 (33%) records presented information in the required form. Dr. Hancock indicated to the Monitoring Team that she knows that implementation needs to improve, and she

		reported that plans that do not contain the information in the required format were being returned to their authors for correction. Provision item J3 mandated that psychotropic medications should not be used for staff convenience or for punishment. To explore that area, the Monitoring Team reviewed each use of the four episodes of chemical restraints that occurred in 2012. These were for Individuals #167 (twice of 2/21/12), #316 (1/2/12) and #403 (5/30/12). On each occasion psychiatry was consulted about the use of the restraint, and psychiatry was involved in the review for the need for restraint. In each there was an IDT review of the circumstances. There was no suggestion that chemical restraints were used for staff convenience or punishment. Overall, considerable progress had been made on this provision, and the Facility was close to the level required for substantial compliance. To achieve that status further progress is need on the matters noted above, and also to the matter of medication monitoring practices. This matter is relevant to provision item J13, as well as J3. For Monitoring Team comments about that area, see provision item J13.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	<u>Development and deployment of plans to use pre-treatment sedation, and treatments or strategies to minimize the need for the sedation:</u> For dental procedures (oral pretreatment sedation and TIVA) steps to initiate the use of medical sedation for dental procedures were taken when difficulties were encountered during an individual's appointment that was not preceded by the use of pre-treatment sedation. If repeated attempts on different days were not successful, the dental clinic requested that the IDT meet to 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. 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 individuals taking psychotropics • Monitoring procedures to be used • Consent status (person contacted for consent) The ISPA shells were also used when pre-treatment sedation was deemed necessary for medical procedure like eye appointments, imaging studies, diagnostic studies and more challenging/intrusive medical examinations. ISPA shells were the basis for the development plans to use pre-treatment sedation. The plan was reviewed by the	Noncompliance

		guardian who provided appropriate consent. The HRC then reviewed the plans to use pretreatment sedation. The provision required that if pre-treatment sedation was indicated, the individual needed to be provided with treatments or strategies to minimize or eliminate the need for the sedation. The Facility reported that programs to do so were developed by different professionals, depending on the individual's needs. When appropriate, the Psychology Department developed "desensitization skill acquisition programs" (the term used by the Facility). When broader non-skill acquisition programs to minimize the need for pre-treatment sedation were needed, they were developed by QDDPs, with appropriate input from various IDT members, including psychology. The Facility reported that since Jan 1, 2012 there had been 39 episodes of dental restraint with sedation. During the visit the Facility clarified that all use of sedation in the dental clinic was related to TIVA; oral pretreatment was not used since the dentist was not properly credentialed to prescribe such medication. For the same period of time, the Facility reported that oral pre-treatment sedation was used 32 times for routine medical *procedures*. Dental staff informed the Monitoring Team that no significant progress was made with regards to implementing its dental pilot desensitization skill acquisition program, as a joint venture between the dental and psychology departments that began in January 2012. The Psychology Department reported that there were eight individuals with desensitization skill acquisition programs. The QDDP Department reported that there were 52 additional individuals who had programs to minimize the need for pre-treatment sedation. The Monitoring Team reviewed records for particular procedures, to see if each individual who received pre-treatment sedation had an appropriate program. The Facility reported that some kind of behavioral plan was in place for 12 of 39 (31%) of the episodes of dental pre-treatment sedation. Additional information reported by the dental staff may be found in Provision Q2; this information provides detail about seven individuals introduced to programs to reduce need for sedation since January 2012. The Monitoring Team next reviewed a sample of individuals who had received TIVA or oral procedures during the past six months (Sample J2). The sample was selected by choosing every six individual on the list of procedures provided by the Facility. TIVA reviews were for Individuals #38, #370, #417, #445. Oral pretreatment-sedation reviews were for Individuals #43, #221, #233, #238, and #380. For TIVA sedation, reviews to minimize the plans were as follows:	

Individual #	ISPA shell date	Title of plan	Implementation of program	Monitoring Team comments
38				No materials received
370	2/22	When interacting with Dental Hygienist (the individual) will respond positively when touched on the hand for one of 4 sessions for two month	April: One session completed, two attempts refused	The plan did not address or clarify thinking on whether or how the skill learned will address the need for TIVA
417	12/29/11	Desensitization skill acquisition plan	Detailed notes provided documenting thoughtful application of the plan, and that progress was made	Well designed, described and executed
445	01/09/12	(The individual) will reduce the need for sedation for dental exams and improve his oral hygiene within one year Tooth brushing program- twice daily for two consecutive months	Data sheets provided for each month that document that the program was carried out	Good implementation of the plan but the plan itself did not address or clarify thinking on whether or how the skill learned would address the need for TIVA

Plans were not in place to reduce the need for pre-treatment sedation for general medical procedures.

<u>Monitoring for safety during pre-treatment sedation:</u>
Some progress was made in this area: Protocols for medical monitoring for safety by

		nursing had been clarified, and nursing protocol cards that summarized what was needed for safety monitoring were made available. The procedures used were as follows: • Prior to departure from the home unit, nurses assessed vital signs, gait/balance/coordination Nursing 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. • Following completion of the procedure and the treatment provider had determined that the individual was stable, the BSSLS nurse resumed care and assessed the individual with vital signs every 15 minutes for one hour and then every 30 minutes for one hour until a REACT (a measure of depth of anesthesia) score of 8 was achieved, at which point the individual was released to the home. • Monitoring (including vital signs) were continued on the home every 30 minutes x2, then every two hoursx2, the every 4 hours for a minimum of 24 hours. All above guidelines were minimal requirements, and more frequent/higher level of care interventions were expected if they were clinically warranted. The Monitoring Team reviewed the safety monitoring that took place during the following pre-treatment procedures: TIVA reviews were for Individuals #38 (04/11/12), #370 (03/08/12), #417 (01/04/12), and #445 ((02/09/12). Oral pretreatment sedation reviews were for Individuals #43 (02/23/12), #221 (06/01/12), #233 (03/23/12), #238 (01/13/2012), and #380 (05/11/12). For TIVA reviews the results were as follows: For Individual #370, medical and dental orders for medication were received but not the nursing monitoring for safety. Medical, dental and nursing data were not received for Individuals #38, #417, and # 445. For oral pre-treatment reviews the results were as follows: For Individual #380 the planned procedure (ophthalmology exam) could not be completed, but the sedation was given and appropriate monitoring was provided. Vital signs were done prior to administration of the sedation (oral valium) every half hour until the appointment, and then every half hour x2, two hours x2 and every 4 hours for the remainder of the 24 hour period since the sedation was given. For Individuals #43, #221, #233, and #238, medication and medical monitoring data were not provided. <u>Facility Sedation Workgroup:</u> The Facility had a workgroup that met to coordinate activities needed to meet SA requirements regarding medical restraints and the requirements for efforts to minimize	

		the need to use pretreatment sedation. The Monitoring Team reviewed minutes of the Facility Sedation Workgroup. The minutes clarified that when the Facility compared efforts made to date by four different sections (restraint, psychiatry, pharmacy, and dental) regarding plans to better address the issue of pre-treatment sedation, it was clear that there had been a major issue in coordinating the various efforts. As a result, a meeting was held on July 19, 2012 that led to the development of an eight-step AP. The desired outcome was "to ensure that all medical/dental appointments that require the use of pre-treatment sedation are discussed and approved by the IDT and receive due process prior to the administration of the pre-treatment sedation." A meeting with the Facility was also held during the visit. It addressed the issue raised by the IP, and also the need to have appropriate behavioral plans in place for each individual. Overall, the Monitoring Team notes that progress on this provision remained slow: 1. In regard to medical monitoring for safety, the Monitoring Team did not receive documents needed to demonstrate that the required monitoring by the nurses had been done. It is possible that monitoring records were difficult to locate on short notice. If so, the new SSLC Restraint Policy might be helpful, since it included a form to be used during medical restraint that included a place to enter vital sign data. The form was new and was not in use during the review period. 2. Further work was needed, to develop, implement, and monitor programs to reduce the need for pre-treatment sedation. Per the Facility's own report, such plans were in place for only 31% of the procedures done in the dental clinic. The percent of plans in place for medical procedures was unknown, but it was probably lower. 3. The random sample of the Monitoring Team showed wide variation in practice. One individual (Individual #417) had a detailed and well executed desensitization plan. For others there was either no plan, or it was not clear that the plan in place addressed the stated need for a plan. To achieve compliance, the Facility must develop and monitor the progress of appropriate plans per the need of the individual.	
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	At the time of the visit there were two psychiatrists at the Facility, Drs. Morgan and Chacko. Both psychiatrists worked full time, so the overall level of effort was two FTEs. In contrast, at the time of the January 2012 visit there were three psychiatrists: Dr Chacko and Luna worked full time and Dr. Morgan worked 20 hours per week. The combined level of effort was two and a half FTEs. Administrative support offered to the psychiatrists (secretarial, administrative	Noncompliance

	ensure the provision of services necessary for implementation of this section of the Agreement.	scheduling of psychiatric consultation, etc,) was one full time psychiatry assistant, one staff member for dictation transcription, and additional administrative support. There was a vacant position for an associate psychologist, who would compile needed data, manage departmental databases, and help prepare for PTR meetings. At the time of the last compliance visit the Facility determined that 2.5 FTEs of psychiatric time were needed to ensure the provision of services necessary for implementation of this section of the SA. The Monitoring Team agreed with that estimate. That determination took into account the amount of time needed to provide staffing for psychiatry clinics and other clinical responses needed across the campus, to provide admission evaluations and updates, to attend meetings such as POMC and P&TC and physician's meetings, ISPs, and ISPAs, and to respond to clinical/administrative issues that concerned psychiatry. The Facility is currently not in compliance due to shortages of psychiatrists and support staff.	
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	The rate of completion of the CPEs had slowed somewhat, likely due to the departure of one of the three staff psychiatrists. Since the last compliance visit the Psychiatry Department completed 12 additional CPEs in the Appendix B format. CPEs were in place for 98/139 (70%) of the individuals who were followed by psychiatry. The Monitoring Team reviewed psychiatric evaluations for the 15 individuals for whom record reviews were done. Eleven of these were of individuals who have lived at the Facility for some time. The other four were new admissions to the Facility. In previous reports the Monitoring Team had commented on the need to provide justification for diagnoses to assure that the individual met the relevant diagnostic criteria in the DSM IV. In a number of more recent Appendix B CPEs, the clinical justifications for the diagnoses that were made had improved. Examples of improved discussions were the CPEs for Individuals #20 and #270. Nonetheless, there were a number of cases where diagnoses were cited or rejected without clarification why. There were occasions when more was needed than an explanation of the manner in which an individual meets the DSM/DMID criteria for the diagnoses that were made. As a general matter, when there are several possibilities for diagnosis, there needed to be a discussion about differential diagnosis that included clarification about diagnoses that were accepted and rejected, and the reasons for the diagnostic preferences. Examples from the sample were: • Individual #467 was diagnosed with both pervasive developmental disorder (PDD) and Reactive Attachment Disorder (RAD). The evaluation should have commented on the reasons that both diagnoses were used, since the DSM discourages the concurrent use of both.	Noncompliance

		• Individual #20 was diagnosed with both PDD and OCD. The evaluation did not clarify why the diagnosis of OCD was needed, when the underlying symptom of stereotypy/skin picking could have been attributed to the PDD. In that situation there was nothing that prevented the clinician from using both diagnoses, but a clarification was needed for the reason why this was done: Perhaps the stereotypy was disproportionate to the other symptoms associated with PDD. If so, perhaps the OCD diagnosis was intended to emphasize that this symptom was sufficiently strong that it should not be considered part of PDD and it "deserved" to be a diagnosis of its own. It is possible that the skin picking should not be viewed as stereotypy at all and should not be considered part of the PDD. Either way, there should have been clarification on this point. Overall, the aim should be for transparency and clarity in the diagnostic process. This was not always achieved. Another area in which additional efforts were needed was that of the case formulation. As a general matter, Appendix B evaluations were very demanding in that they covered a very wide range of clinical areas of interest. The task of assembling that information (or gathering the information from evaluations done by other clinical colleagues, perhaps from other sections of the clinical record) was necessarily time consuming. The value of that work, however, was that once the information had been assembled and the bulk of the evaluation completed, the psychiatrist was then provided with a unique opportunity to pull the critical elements together in the final case formulation. That opportunity should not be missed. Successful completion of the formulation section of the Appendix B CPE required a clinical synthesis that was based in biological, psychological, social and spiritual domains; to that end what was needed in the case formulation was a selective recounting of key items of information from the broader evaluation, selected to highlight the main forces that shaped or shape the individual's current clinical presentation. When done well, case formulations provided the psychiatrists' identification and understanding of the most important clinical elements, and those should then form the basis for treatment recommendations. The quality of case formulations reviewed by the Monitoring Team varied considerably. In some formulations, for example for Individual #588, there was an attempt to differentiate between biological predisposition, environment factors, and social stressors. That lay the foundation for the treatment recommendations that followed. For that individual, the formulation was then organized by the various areas of clinical interest, and the presentation was based on the data cited earlier in the evaluation. The case formulation that was created then served as a foundation for the treatment recommendations that	

		followed. However, in many of the formulations, the psychiatrist provided a case summary rather than the needed synthesis. A good discussion of what is needed for case formulations may be found in the following article: Ross, D.E. (2000): A method for developing a biopsychosocial formulation. Journal of Child and Family Studies, 9(1), pp 1-6. To come into substantial compliance with provision J8, the Facility needs to continue to complete evaluations for those who need them, and in those evaluations to: • Improve the presentation of differential diagnosis and related diagnostic justification • Improve case formulations • Whenever possible, resolve NOS diagnoses.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	The Reiss Screen was a tool to identify individuals for whom a psychiatric evaluation should be considered, based on the results. The procedure in place at the Facility was for the Reiss Screen to be given to individuals who lived at the Facility only to individuals who were not already followed by psychiatry and treated with psychotropic medications. Individuals seen by psychiatry were not screened, since those individuals were already required to have comprehensive psychiatric evaluations (CPEs). Similarly, individuals admitted to the Facility received a Reiss Screen if they did not have a psychiatric diagnosis or took psychotropic medications. If they did, they were referred to the Psychiatry Department for a full CPE (as noted below, not all had received full CPEs at the time of the compliance visit). The psychology assistants score the Reiss and then the scoring is verified by the Chief Psychologist. For each individual, the Facility retained both the raw data sheet and the scoring sheet. 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 had psychiatric diagnoses or prescribed psychotropic medications. The Monitoring Team was given a list of individuals who had been screened that also indicated whether the screen was positive or negative. Two of the screenings were positive, and those two individuals were received full psychiatric evaluations, which did not indicate a need for ongoing psychiatric treatment. The Monitoring Team then selected a random sample of 32 individuals whose screens were reported to have been negative (20% of the total number of individuals who received the screening). For each individual selected, data and sheets were compared to the Facility list. The Monitoring Team found that the information for all 32 individuals was reported correctly.	Noncompliance

		Since the start of the screening in 2010 there have been 10 admissions to the Facility. All took psychiatric medications, and none were given the Reiss Screen. As reported under Provision J2, there were four admissions since the last compliance visit. Four of the four had received a psychiatric evaluation. In past reports the Monitoring Team has noted that many of the individuals who needed psychiatric evaluations had not received them. In 2012 the Facility continued to complete psychiatric evaluation for all those who needed them. Ninety-eight of 139 (70%) of the individuals who needed evaluations have now received them. During the last compliance visit the Monitoring Team had discussed with the Facility the need to clarify whether and how Reiss screens would be used for their intended purpose during ongoing clinical work at the Facility. During the current compliance visit the Monitoring Team was given Facility procedures for use of the completing the Reiss Screen have not been described in a BSSLC protocol "Protocol for Reiss Screen" (undated). The procedure clarified that Reiss Screens would be completed: 1. When an IDT made a referral to psychiatry to evaluate an individual who was not previously followed by psychiatry or who has not been seen by psychiatry for at least a year 2. Six months after an individual had been discharged from the psychiatry clinic 3. For newly admitted individuals who take no psychoactive medications when they arrived at the Facility Process for completing a Reiss Screen outlined in the procedure included that: 1. Only psychology staff trained to administer the Reiss Screen would do so. 2. Staff members who interviewed individuals for the purpose of Reiss Screens needed to have a working knowledge of the individuals. This was needed for the Reiss Screen to be reliable. For newly admitted individuals who were not taking psychoactive medications, all efforts would be made to complete the Reiss Screen when psychology personnel complete the preadmission screening assessment. 3. Reiss results would be forwarded to the Psychiatry Department and the individual's team. Even if the Reiss Screen did not indicate significant psychiatric issues, the psychiatrist may complete a psychiatric consultation or CPE for any individual referred by the IDT for psychiatric services. 4. Reiss results will be included in the Structural Functional Assessment for that individual. The Monitoring Team found that the protocol addressed some but not all of expected needs. One situation left unaddressed was that of an individual who lived at the Facility who had experienced a change in clinical status that might lead to the need for a mental	

		health evaluation. Examples might be a major brain illness like stroke, a major interpersonal loss, a stressful event like a move, or the onset of major medical illness or dementia. For such individuals, screening for pathology could be useful even if overt symptoms did not rise to a level of severity that would prompt IDT to ask for full evaluation (item #1, above). The Facility should also consider periodic administration of the Reiss Screen to all individuals who were not followed by psychiatry, perhaps in the form of a campus wide screening every number of years. The Facility is close to achieving substantial compliance on this provision. Completion of the remaining CPEs will be required for compliance. The Monitoring Team looks forward to reviewing and verifying at the next compliance visit that the new protocol addresses the need to screen individuals who experience a change in clinical status and that the protocol is fully implemented.	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	The development of the combined case formulation has been a focus for psychology and psychiatry at the Facility for some time. The case formulations are now an expected part of the Functional Assessment (FA). Case formulations were in place for 92/139 (66%) individuals. For the most part the case formulations were concise, focused, balanced, and informative. As a rule, the formulations presented the general clinical understanding of psychology and psychiatry side by side, accompanied by a brief statement of how they interrelate. With the help of the case formulations it was much easier to understand the many details about behavioral health care that were included in the Positive Behavior Support Plans (PBSPs), ISPs, and elsewhere. The Monitoring Team reviewed the records for 15 individuals (Sample J1). There were two combined case formulations for Individuals #20 and #270. Both were good. Further improvement in the combined case formulation process would be achieved if input could be obtained, as appropriate to the particular clinical circumstances, from additional disciplines such as social work and habilitation. Psychology and psychiatry integration was also strong at the higher level of review in the PBSC. The Monitoring Team attended the committee meeting on 07/23/12 and was impressed by the degree of interdisciplinary exchange. While the discussion was appropriately focused on the care provided by psychology, pertinent issues to psychiatry were raised and discussed meaningfully. Additionally, there was appropriate discussion on general medical issues that could have impact on behavioral issues. Examples of good discussions were those for Individuals #276 and #321. Integrated care was also apparent at the level of the PTR. Conversations were based on data that was presented by psychology. Conversations included input from families; medicine and nursing were also well represented. Improvements were needed in the	Noncompliance

		area of data presentation for psychiatric treatment plans. Until such data is obtained and presented, it will be difficult to have truly integrated discussion about key psychiatric matters, and it will be difficult to provide higher level integrated reviews, as for example the treatment justifications needed for PMOC. Good interdisciplinary discussions that contributed meaningfully to integrated care were evident at the morning medical meetings, attended by the Monitoring Team on 07/24/12 and 07/25/12. Many individuals' status were reviewed, and time was set aside for a substantive and integrated exchange of information between the various medical, nursing, speech and language and other clinical disciplines that were present. There was also follow up regarding the status of individuals who were in the post crisis stage. Examples were: • Individual #61 was discussed due to her hospitalization as the result of complications of a medical procedure. She was also an individual who had complex behavioral needs. The conference received input from the psychiatrist regarding how her care could be best provided while she was in the hospital. Of note, one of the few episodes of chemical restraint that took place in 2012 (for Individual #167, on 2/21/12), happened soon after that individual's return to the Facility following hospital treatment for pneumonia. Inquiry by the IDT for Individual #167 revealed that she had not received her psychotropic medication for five days while she was in the hospital; it was a likely cause for the agitation she experienced on her return to the Facility. These events were mentioned during the discussion on 07/24/12 about ongoing efforts for improved liaison with medical hospitals. • Individual #316 was discussed as a follow-up. His care after the medical hospitalization had been uneventful, in part because psychiatric needs were prioritized; in his case that meant that priority was given to getting him back to his home unit quickly where he was surrounded by individuals he knew and trusted. • Individual #75 was discussed due to difficulties obtaining an appropriate sitter while he was in the hospital for medical concerns. The absence of good support resulted in acute behavioral issues. The discussion led to active problem-solving to try to minimize the likelihood that the problem would recur. Evidence of thoughtful integrated care was also present in a redesign of the risk assessment tool. Previously, there were separate entries for "challenging behavior" and "psychiatry." They were combined into a single category for "behavioral healthcare." The Monitoring Team concurred that the combined assessment was clinically beneficial. Although much progress was noted in the area of combined case formulations and overall integrated care, there were five areas that related to integrated care that needed	

		continued attention: Bio-psycho-social case formulations in CPE: The main focus of psychiatric care in the Facility is bio/pharmacotherapy. The psychiatric case formulation needed to be broader, and was strongest when it touched on many areas of functioning, including psychological and social variables. The case formulation in the CPE was an opportunity to bring together different perspectives to support a comprehensive and interdisciplinary formulation. As discussed under provision J6, some improvement is needed in this area. Coordination of behavioral and pharmacological care: Necessarily, the efficacy of psychiatric treatments needed to be validated by the use of quantifiable measures. Psychiatric care lagged in this area. As discussed under provision J13, there were no formal medication treatment plans in use. In practice many of the needed elements such as the related psychiatric diagnosis, clinical rationale, symptoms/behavioral characteristics could be derived from the medication consent and medication response profile. However, these did not provide measures to assess efficacy. Sometimes, efficacy measures were identified in the course of clinical work – several examples of that were listed in the medication table in the PBSP and in the PTR template. Yet even then, no procedures were in place for rater training, and tables or graphs were rarely generated for measures of interest. In PTRs observed by the Monitoring Team graphs of rating for behavioral data were provided for ratings of challenging behaviors over time, but often not for psychiatry. During the PTR attended by the Monitoring Team there were many examples where psychiatric ratings - for example Connor's Scores for Attention Deficit Disorder - were available for only the current and previous month. As a result, while the discussion on psychiatric issues was clinically strong and interdisciplinary, it was not based on objective assessment tools and was therefore not data driven. Objective instruments must be incorporated into clinical use to determine the presence of symptoms, and to monitor the response to medications. For further discussion on this matter, see provision item J13. Facility level review of pharmacotherapy: The relative absence of objective assessments also impacted Facility level reviews. As discussed under provision J11, psychiatrists needed to defend/justify the need for particular pharmacotherapy before POMC. It was difficult to do so absent data from objective assessments. Integrated care at the level of the ISP: Integrated care at the ISP also remained an area of relative weakness. The natural flow of	

		behavioral data is from discipline-based assessments (for example, within psychology and psychiatry) to integrated behavioral health discussions and presentations (for example at IDT meetings and at PBSC) and from there to the overarching level of the annual ISP. Input from behavioral healthcare was needed in the ISP, not only to report on the individual's status, but also to help guide the discussion toward actions needed during the coming year. As individuals leave the Facility for the community, input is needed from behavioral healthcare to guide the provision of appropriate supports for individuals. <u>Integrated care to minimize the need for medical restraint/ pretreatment sedation:</u> This area was reviewed in detail under provision J4 and the details need not be repeated here. The difficulty identified by the Facility just prior to the compliance tour and discussed during the tour was that the overall focus is on the need to minimize unnecessary use of medications. The interventions need to come from many different disciplines - psychology provides desensitization programs when they are needed, the IDT under the guidance of the QDDP plans for broader support plans to reduce anxiety around the procedure, and dental, pharmacy, psychiatry, habilitation and others are also needed as potential full participants in the efforts to provide integrated planning for the individual's needs. To date the process has been lagging; as reviewed under provision J4, an action plan has just been written to address this issue. Overall, the Facility has made steady progress across the campus to enhance integrated care, particularly in the area of combined case assessment and case formulation. The Facility is encouraged to complete deployment of the case formulations over the coming annual cycle, so that they will be in place for all individuals. The Facility is also encouraged to focus on the five areas cited above.	
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	This provision item required that specific clinical issues need to be discussed and decided by the IDT/PST before the implementation of a proposed PBSP. As described under provision J2, one of the strengths of the clinical process in place at the Facility was the PTR that included psychiatry, psychology, QDDP, nursing and other disciplines. Primary care physicians attended often, and were readily available for input at other times. When a new medication was proposed, a meeting was also convened to address key issues around the proposed treatment. The meeting was led by the QDDP, and the discussion was guided by an ISPA "shell" that identified the issues that needed to be covered, which were: 1. Behavioral status 2. History, previous interventions and results 3. Health status 4. Medical pathology	Noncompliance

	interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	5. Psychosocial and environmental conditions 6. Functional Assessment 7. Psychiatric summary 8. Current medications 9. Risk assessment 10. Decisions/recommendations The Monitoring Team reviewed PTR and ISPA documents for all 25 new medication proposals made in 2012. The results are reviewed for each of the three requirements of this provision. <u>The PST and psychiatrist should determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition:</u> The discussion was documented in item #2 of the ISPA shell. However, there were two problems. First, ISPAs for new medications were often not completed. The psychiatry department reported that in an audit of medication proposals from February to April only five of 19 (26%)medication proposals were completed by the QDDP with the specific ISPA shell. Among the 25 medication proposals reviewed by the Monitoring Team, only seven of 25 (28%) had an ISPA for new medications. A second problem was that even when the ISPA was completed, the discussion only covered pharmacological alternatives. There was also a need to review non-pharmacological treatments to establish that medication interventions were appropriate and necessary. In five of seven (71%) of the ISPAs, the discussion addressed only previous medication treatment. Two of seven (29%) ISPAs, for Individuals #367(Depakote) and #536 (Ambien) did address prior (failed) non-pharmacological interventions. For those two individuals, it was clear that the medication was the least intrusive treatment available. <u>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:</u> Each of the 25 medications were for individuals who had a PBSP in place. And all had behavioral supports of some kind in place. <u>The PST and psychiatrist should determine whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone</u>: The requirement here was for the IDT to make meaningful determinations of appropriate modalities of treatment, including "other interventions." This requirement was an opportunity for the psychiatrist and psychologist to comment on whether verbal therapy, speech and language intervention, and other modalities of treatment have -or might be - helpful to the individual. Such information was not provided in the seven ISPAs that	

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At the time of the last review the Monitoring Team commented that the Facility needed to improve the way that deliberations about less restrictive alternatives were guided. Per the data above, some progress has been made, but more is needed. Accordingly, the provision must remain in noncompliance.</td><td></td></tr>
<tr><td>J10</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.</td><td><u>Risk vs. Risk:</u>
Per the language of the provision, for any non emergency administration of the psychotropic medication, there needed to be a discussion about the risks associated with providing the treatment vs. the risks of not providing the treatment.

The Monitoring Team determined compliance for this requirement by examining documentation provided for 25 non-emergency medications approved for use since January 2012. This risk assessment was part of the ISPA for new medications. As outlined in the discussion for provision item J9, ISPA's for new medication were in place for only seven of 25 of the medication requests (28%). For the ISPAs that were in place, the discussion did not provide information that was specific to the medication in question.

<u>Alternative treatments (including no medication):</u>
Starting in May 2012 the Facility added language to the MRP that indicated what the treatment alternatives were. This indicated that the discussions now took place (likely at the ISPA meeting) and need to be documented.</td><td>Noncompliance</td></tr>
<tr><td>J11</td><td>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</td><td>POMC met on a monthly basis, and it was the principal venue for facility wide review of medication practices and polypharmacy. Participation in the POMC included psychiatry, medicine, nursing, psychology, and quality assurance. Polypharmacy was also reviewed at PTRs, during which quarterly QDRRs were reviewed.

During the last compliance tour the Monitoring Team noted that overall rates of polypharmacy had not changed since tracking began in late 2010 and in some respects medication use had perhaps increased. To review progress, the Monitoring Team reviewed longitudinal data on overall rates of polypharmacy.

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<tr><td></td><td>11-2007</td><td>11-2008</td><td>11-2009</td><td>11-2010</td><td>11-2011 (Facility Census 310)</td><td>06-2012 (Facility census 299)</td></tr>
<tr><td>Rate of</td><td></td><td></td><td></td><td></td><td>140/310</td><td>140/299</td></tr>
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	medications that are not clinically justified are eliminated.						

psychotropic use					(45%)	(46%)
Interclass polypharmacy	18	21	25	21	25/140 (17%)	23/ 140 (16%)
Intraclass polypharmacy				58	58/140 (41%)	51/140 (36%)
Total number of individuals with polypharmacy						53/140 (38%)

The data provided showed that the overall percentage of individuals treated with medication was essentially unchanged, and there was a small decrease in the rate of interclass polypharmacy (from 17% to 16%) and a slightly larger decrease in the rate of intraclass polypharmacy, (from 41% to 36%).

The Facility also reported that since late 2008 there have been no individuals treated with seven or more psychotropics, and that since November 2009 there have been no individuals treated with six or more psychotropics. Over the same period of time the number of individuals taking three psychotropics increased. That suggested that there had been a shift toward interclass polypharmacy with fewer medications per individual.

The Facility also provided data on use patterns for various medications. Some of that data appeared to reflect the preference by the psychiatrists for one medication over another (for example, a shift toward Aripiprazole and away from Risperidone). The data also demonstrated short- term and long- term reductions in the use of Reglan. That reduced the overall risk for movement disorders.

The Monitoring Team reviewed the system under which POMC reviewed intraclass and interclass polypharmacy. This was done by periodic review of individuals and prescriptions for various classes of medication. Each month, there was a review of the Facility database for polypharmacy and report for tracking and trending of items included. Entries included rates of polypharmacy, and Facility-wide data on patterns of use of particular medications and doses (for example atypical antipsychotics, anticholinergics, benzodiazepines and Reglan). This was followed by reports on organization planning, for example staffing deployments intended to coordinate the work of QA/QI and PMOC). Group and individual data was then reviewed for particular clinical groups that were of interest to PMOC, for example individuals with high risk polypharmacy, individuals with intraclass polypharmacy for mood stabilizers, antidepressants, and antipsychotics, individuals with tardive dyskinesia, and all individuals taking particular medications, for example benzodiazepines. The agenda that

		determined which groups would be reviewed was set several months in advance. The final monthly item for POMC was new business, such as updates on the SA and discussion of different ways to present data to committee. The Monitoring Team reviewed how POMC reviewed the particular clinical groups reviewed above. The method used by POMC was that group data was reviewed, followed by case-by case review of each individual in the group. POMC then provided feedback or suggestions, on a form that was retained and provided to the clinician For the most part that system for clinical review of various clinical groups seemed adequate; however, not much detail was provided for each individual and the Monitoring Team could not tell if the Committee had adequately reviewed the clinical justification for the actions taken by the clinician. For example, for Individual #381 the comments were "clozapine is not the preferred medication for her age but has been effective. Challenged Geodon last year but had to increase dose back." In situations like that where the psychiatrist appears to have stated that continued antipsychotic polypharmacy is needed, it is best that one of the summary documents (annual review, PTP, etc) provide a more detailed justification, supported by data. Such a statement could be provided or referenced and it should be carefully reviewed. The situation for review of individuals who had tardive dyskinesia was similar, and is reviewed under provision J12 that follows. Overall the Monitoring Team found some evidence of progress over the past six months, but the rate of polypharmacy remained high. Clinical justifications needed to be in place when psychiatrists determined that continued polypharmacy was needed.	
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.	MOSES and DISCUS examinations were done by individuals' nurse case managers. The nurse case manager then presented the forms for review and signature to psychiatrist and/or primary care physician, as appropriate. MOSES screens were done every six months and DISCUS screens were done every three months. The Facility acknowledged that there was not a process in place to ensure that side effect monitoring was done in response to the individual's changing needs. However, during the tour the Facility informed the Monitoring Team that a decision had been made to perform MOSES (and when appropriate, also DISCUS) exams following a change in the dose of psychotropic medication. The 07/06/12 Facility Action Plan also stated that DADS psychiatry policy will be revised to increase the frequency of side effect exams in response to medication changes. Three processes were in place to assure that administration of side effects was taking place and that there was proper clinical follow-up in response to the results. The	Noncompliance

		Monitoring Team reviewed each of these: • The Facility maintained lists of all individuals who were screened with MOSES and DISCUS exams. To make sure that the correct individuals were being screened with MOSES and DISCUS exams, the Monitoring team compared these lists to other lists provided by the Facility that identified who was treated with the various psychotropic medications that required the screenings. The Monitoring Team confirmed that the appropriate individuals were screened, including individuals who took Reglan, a medication given for non-psychiatric purposes that nonetheless can cause dyskinesia and for that reason required screenings. All individuals given Reglan were included in the list of individuals being screened. During previous visits the Monitoring Team had examined the actual screenings of individuals who took Reglan and found that they were being done correctly. • Periodically, PMOC provided clinical oversight regarding follow-up for individuals with current diagnoses of tardive dyskinesia or elevated scores of the DISCUS, which suggested the possibility of that diagnosis. The most recent review was done in June 2012. The Committee identified five such individuals, four of whom were treated with atypical antipsychotics at the time of the review. The comment/recommendation section of the report mentioned changes made in medication treatment over the past year, and in two cases recommended review/clarification of the diagnosis of record (probable dyskinesia for one, masked dyskinesia for the other). The Monitoring Team found that it was very positive that the Committee had selected out this group of individuals for clinical review. That said, the key clinical question at hand was left seemingly unaddressed: In each case one presumes that the IDT and psychiatrist had carefully reviewed the individual's circumstances and had concluded that the benefits of continued antipsychotic treatment outweighed the risks. But that was not mentioned in the Committee minutes and a detailed justification for the need for continued treatment was not provided. At minimum, the Committee should identify where that review/justification was documented (perhaps in a PTR note), and should mention whether the committee concurred with the psychiatrist's assessment, and why. If annual psychiatric reviews or Psychiatric Treatment Plans are put in place, this is the kind of item that should be discussed. Also, the diagnosis of dyskinesia was not present in the APL for individual #86 (see discussion under provision J2). • As part of QA efforts, the Facility stated that in March and May it had conducted a small (n=5) audit of individuals for the presence of needed MOSES evaluations. In that sample 100% of MOSES exams were signed by both the PCP and psychiatrist. There was no mention of the length of time between test administration by the nurse case manager and the review by the PCP and psychiatrist. During the visit, the Monitoring Team reviewed records of the 15	

		individuals in Sample J1 for presence of required MOSES and DISCUS forms. The required screenings had been done and they were reviewed by the prescribing physician. but not always in a timely manner. In one case (individual #467) close to a month lapsed before the screen was reviewed. The Monitoring Team attended PTRs on 07/23/12 and 07/25/12, and observed how information about side effects were integrated into the IDT/PTR processes. Information about side effect screening was presented by the nurse during the part of the discussion that was dedicated to objective medical data and review of that data. That section also included information from the pharmacy provided via the QDRRs (please note examples below). Information presented included laboratory data, drug/drug interactions, and pharmacy recommendations for clinical information that were derived from that data. The Monitoring Team observed good clinical discussion between the psychiatrist, nurse and other IDT members on these matters The discussion was integrated, because it tied together the clinical observations about side effects that the nurse had rated, with the various blood tests and information about drug interactions, serum levels and the like, that could explain why the side effects might have occurred. QDRRs were done well and the clinical pharmacist made treatment recommendations. For example, Individual #276 had drug induced elevations of a hormone that had implications about choice of medication; Individual #270 commented on possible management for a medication side effect. Overall, the Monitoring Team observed that the process of timely MOSES and DISCUS reviews by clinicians and the IDT had improved, and noted positively the plans to provide additional screenings when medication doses changed. POMC review and/or documentation could improve, around the issue of Facility wide monitoring for medication use of individuals with tardive dyskinesia. Implementation of the action planned for further screening following change in dose, along with accurate listing of dyskinesia in the APL and more complete documentation of rationales for decisions about treatment could result in a finding of substantial compliance at the next compliance visit.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic	At the time of the tour, the Facility did not have the Medication Treatment Plans in place. Nonetheless, many of the elements required by the provision were contained in one of several documents that were completed when a medication was proposed. This was the "Medication Response Profile" (MRP) that was attached to the informed consent form, the ISPA for psychotropic medications that was completed during an IDT meeting about the new medication, and the revised PBSP that included a table for the new medication. Ongoing assessment of medication efficacy was done in the PTR.	Noncompliance

	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.	The Monitoring Team examined the plans for all 25 medications that were approved for use during 2012, and results were as follows: <u>Diagnosis and symptoms:</u> For each of the 25 medications, an MRP was provided. This provided information about both the psychiatric diagnosis and psychiatric symptoms that were related to the medication. <u>Expected timeline for the therapeutic effects of the medication to occur:</u> For each of the 25 medications, this information was provided in the MRP. <u>Plan designates by whom, when, and how the monitoring will occur:</u> The MRP for each medication contained standard language that indicated that "treatment response will be evaluated during PTRs or as clinically warranted." Depending on the measure, more specific information might be needed. For example, whether the rating was to be done by DSPs, by a psychologist, by observation during the clinic, or something else; whether the proposed measure was a standard rating scale or a measure that was developed for the particular individual's topography; whether the data reported was a raw frequency measure or a judgment guided by defined criteria (and if so what those criteria were), and so forth. <u>Objective monitoring (rating scale or other measure):</u> The Facility had a standardized format for the table of information about each psychotropic medication (see description under provision J3). The table was located in the (revised) PBSP that contained information about the new medication, and which was reviewed by the PBRC and HRC. One of the four entries was the rating scale (or other measure) that would be used to assess treatment efficacy. However, little beyond a format for information entry existed at the time of the visit. The new format was not yet used consistently, and when it was used, the information about the selected measure was often absent. Overall, a measure for treatment monitoring was provided for only four of 25 medication plans (16%), for Individuals (#61 and #121). <u>Ongoing monitoring of the treatment plan:</u> PTR's reviewed by the Monitoring Team showed that measures for treatment efficacy were listed for about 20% of the medications, new and old. Input of graphs that provided quantitative data had just started. During the visit the Monitoring Team reviewed with the Facility plans for graphing data for longitudinal tracking. The Facility intends to provide graphs of data for psychiatry, similar to the manner that such graphs are provided to support psychology in addressing "challenging behavior" data. There has been a pilot for such graphing, and the Monitoring Team was informed that it was going well. In one PTR reviewed by the Monitoring Team there was one case (Individual #185)	

		where PTR graphing of psychiatric data was present. The initiation of medication treatment planning and monitoring with object measures had just started at the Facility. It was a key element that will allow psychiatrists to further improve the quality of care, and it will provide a needed basis for assessment of compliance with many SA provision items, including J3, J8, and J13.	
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 25 new medications approved by PBSC and HRC during the six months prior to the visit of the Monitoring Team. The consents for all 25 medications were obtained using the form "*Consent for Use of Psychoactive Medication for Behavior Support.*" The front of the form contained information on the medication and the prescribing physician (check boxes were provided for the staff psychiatrist's name or for the PCP's name,) followed by the clarification that the PCP was following the recommendation of the (named) BSSLC contract psychiatrist. The back of the form included spaces for the brand and generic names of the medication, psychiatric (axis 1) diagnoses, targeted symptoms, the expected drug response, common side effects, and a medication dose chart (adult or child). The form clarified that a Patient Education Monograph for the medication 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. Results of the review confirmed that the following items were present for each medication: Medication Name, DSM psychiatric diagnosis, Target symptoms and behaviors, FDA indications, dose range information, common side effects, and guardian signature. PBSC/HRC approval was provided in all cases. The process by which informed consent was obtained was greatly improved. Consent was obtained by the psychiatrist directly, and the guardian was provided the opportunity to ask questions about the medication and to dialogue with the psychiatrist. Nonetheless, at the time of the last visit, the Monitoring Team noted several items that needed to be addressed: 1. The Monitoring Team noted that there was insufficient information about risk/benefit for the new medication. The documentation about risk of taking the medication vs. the risk of not taking the medication was an item on the ISPA for new medications. However, these were completed for only 7/25 (28%) of medication consent forms. Also, IDTs appear not to have been informed	Noncompliance

		correctly as to the discussion that was needed. Instead of a risk/benefit analysis of the new medication, IDTs did an update of the overall risk associated with the psychiatric condition (now risk assessment for behavioral healthcare). IDTs should be informed about the need to address risk/benefit for the new medication. 2. Many of the consent forms reviewed did not include information about treatment alternatives. The Facility responded to this issue. As of 05/01/12, the Facility consents for psychoactive medication included a section which indicated the other treatment alternatives, as part of the informed consent document. The new language was included in consent forms that had been completed after 05/01, for example consents for Individuals # 167 (Klonopin) and #425 (Zoloft). It is likely that information on treatment alternatives was discussed in the ISPA for new medications. If so, the discussion should be referenced in that ISPA. 3. The Monitoring Team noted that in many instances, the HRC was not provided with the appropriate information for risk vs. risk evaluations. The HRC form required information about risks of providing the medication under review, risks of not providing the medication, and an analysis to confirm that the risk of not providing the medication was higher. In many presentations information was provided for the medications as a group. Such presentations were not sufficiently specific. Other times, risk information was given for the overall behavioral program, not for the medication. That was also too broad. Sometimes there was no analysis of the risk. The Facility is close to substantial compliance on the provision item. To achieve compliance the Facility needs to improve the risk vs. risk discussion for new medications, and improve presentation of information to the HRC.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	The main focus of provision was to assure coordination between psychiatry and neurology, for individuals who receive medications to treat both seizures and mental health disorders. To help track the manner in which anticonvulsant medications were used, the Facility classified the indication for which anticonvulsant medications were used as follows: 1. The number of anticonvulsants prescribed for psychiatric disorders was 69 at the time of the visit. 2. The number of anticonvulsants prescribed only for neurological indications was 283 at the time of the visit. 3. The number of anticonvulsants prescribed for both psychiatric and neurological indications was 9 at the time of the visit.	Substantial Compliance

		PTR and neurology clinic notes were compared for five individuals who were prescribed anticonvulsants for both psychiatric and neurological indications. These were Individuals #159, #185, #377, #510, and #588. For those individuals, the notes from both the neurology and psychiatry clinics correctly identified the medications that were used by both disciplines, and the information was reported correctly in the above Facility wide listings for uses of anticonvulsant medication. The Monitoring Team reviewed recent psychiatry and neurology clinic notes. The notes for both neurology and psychiatry referred to use for the medication by the other discipline and the discussion was relevant – for example drug levels, drug interactions and patterns of use. • For Individual #588 Depakote was used for dual purpose. • Individual #185 there was active discussion about the change from use of Tegretol to Topamax as a dual purpose medication. In this case there were psychiatric data graphs included with the PTR note. The tracking in this case was for aggression related to intermittent explosive disorder. This was not a particularly good measure, since it was simply a renaming of aggression. An alternative measure could have been one where some assessment was made to determine whether the behavioral response was disproportionate to the circumstances, and whether the functional assessment demonstrated a functional purpose to that behavior. • Individual #377 the neurologist noted that the individual had not had a seizure since 2002 and probably did not need the medication (Valproic Acid) for seizures. If so, the medication should be re-designated as being used for psychiatric purposes only. • For Individual #510, Tegretol use for dual purpose was discussed. • For individual #159, use of Tegretol for dual purpose was discussed, by both disciplines. Overall, the working relationships between neurology and psychiatry remained productive and coordinated care was provided.	

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

1. NOS diagnoses should be resolved whenever possible. (Provisions J2, and 6)
2. Better systems need to be in place to record key psychiatric data in documents that are retained in the permanent record. (Provisions J2, J6, J8, J11, J13, and J15)
3. Differences in tables that describe details of psychiatric medication treatment in PBSP and PTR should be resolved. (Provisions J3, and J13)
4. Medication proposals should include objective measures that will be used to assess medication efficacy. (Provisions J3 and J13)
5. Elective reviews of medication management should be supported by longitudinal data, preferably including graphic display. The presentation should be in format that will be useful for decision-making about psychotropic medications (for example, including information about dose

changes, specific stressors, etc). (Provisions J3 and J13).

6. Differences between PBSP and PTRs in information about medications should be resolved. (Provision J3)
7. Develop a tracking system to assure that all individuals who need plans to reduce the need for pre-treatment sedation have them. Facility plans must include consideration of pre-treatment sedation for medical procedures as well as dental. (Provision J4)
8. Develop methods to assess efficacy of programs to reduce the need for pre-treatment. (Provision J4).
9. Provide clearer discussion of psychiatric differential diagnosis and choice of diagnoses selected. (Provision J6)
10. Improve case formulations in Appendix B assessments to provide needed case syntheses. (Provision J6)
11. Consider the use of Reiss Screen when individuals experience a change in clinical status that could lead to changes in mental health status, for example the onset of a brain illness like stroke or dementia, the onset of a major medical illness, a major interpersonal loss, or a stressful event like a move.. (Provision J7)
12. Consider periodic administration of the Reiss Screen to all individuals not followed by psychiatry, perhaps every number of years. (Provision J7)
13. Combined case formulations done to date rely on information from psychology and psychiatry. When appropriate, include input from additional clinical disciplines such as speech and language, and habilitation. (Provision J8)
14. Improve documentation of IDT discussions about risk/benefit for medication treatment proposals. (Provision J10)
15. On annual re-consents for ongoing medications, the risk/benefit analyses should be based not only on general comments regarding the potential of various side effects, but also on the individual's experience to date with the medication. (Provisions J10 and J14)
16. Implement plans to provide side effect monitoring (MOSES and, for medications that can cause dyskinesia, DISCUS) following change of medication dose. (Provision J12)
17. POMC should review the clinical justification for continued use of psychotropic medications that can worsen existing dyskinesia. (Provision J12)
18. Implement quality assurance monitoring (e.g. chart review and peer review) for psychiatry. (Provisions J2, J4, J6, J8, J9, J10, J11, J12, J13, J14, and J15)

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. BSSLC Self-Assessment (7/12/12) 2. BSSLC Action Plan (7/6/12) 3. BSSLC July 2012 Presentation notes 4. Minutes for the Positive Behavior Support Committee (1/9/2012 – 6/18/2012) 5. 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 BSSLC Self-Assessment and Action Plan. 6. A sample of records for review of behavior assessment and intervention practices included 20 records identified by BSSLC as reflecting the most recent PBSPs (Individuals #50, #61, #65, #88, #130, #167, #169, #173, #231, #242, #260, #273, #304, #314, #321, #372, #399, #417, #422, and #493) 7. A sample of records for review of PBSP efficacy and monitoring included 10 records where a PBSP had been continued following success and maintenance (Individuals #62, #95, #101, #126, #172, #230, #260, #314, #412, and #532), 10 records where a PBSP had been continued due to progress (Individuals #7, #51, #60, #181, #314, #332, #367, #460, #481, and #490), and 10 records where a PBSP had been revised due to lack of progress (Individuals #86, #130, #231, #308, #316, #403, #417, #425, #460, and #590) 8. A sample of records for review of non-PBSP intervention practices included 7 records identified by BSSLC as reflecting all individuals participating in non-PBSP interventions. (Individuals #011, #020, #185, #321, #399, #467, and #479). **People Interviewed:** 1. Terry Hancock, PhD – Chief Psychologist 2. Shawn Cureton, MS – Psychology Manager 3. Donna Bradley·Schrick, MA, LPC – Associate Psychologist V 4. Jana Lehrman, MA – Associate Psychologist III 5. Victoria Morgan, MD – Psychiatrist 6. Kim Littleton – ADOP 7. Cheryl Powell – Human Rights Committee Chair 8. Direct Support Professionals: approximately 35 individuals in Adult Program Services; Bowie Springs; Brenham Production Services; Childress Terrace; Cottages A, B, C and F; Driscoll Gardens; and Fannin Villa. **Meetings Attended/Observations:** 1. Positive Behavior Support Committee (PBSC) (7/23/2012) 2. Behavior Services/BCBA Meeting (7/23/2012) 3. Human Rights Committee (HRC) (7/26/2012)

	4. Restraint Reduction Committee (7/26/2012) 5. Adult Program Services; Bowie Springs; Brenham Production Services; Childress Terrace; Cottages A, B, C and F; Driscoll Gardens; and Fannin Villa.
	Facility Self-Assessment: At the time of the site visit, BSSLC reported that only Provisions K.2 was in substantial compliance with the SA. The Monitoring Team was in agreement with the Facility in relation to Provision K.2. Although substantial limitations existed in the other Provisions in Section K, it was important to note that BSSLC had attempted to progress toward compliance with the Settlement Agreement. Although efforts were not always successful, the Monitoring Team recognized that the Facility had attempted to improve behavior assessment and intervention and expand upon previous achievements. In the documents provided by BSSLC, it was apparent that the Facility was focused upon satisfying discrete elements of the Settlement Agreement rather than achieving more systemic or global improvements. For example, much of the Self-Assessment provided by the Facility emphasized the completion of specific tasks such as the development of training curriculum or completing a targeted number of assessments or reports. Similarly, the Action Plan submitted by the Facility did not reflect specific actions to increase the quality of services, but only steps intended to ensure that a specific quantity of tasks were completed. While the completion of such discrete tasks was likely to be of importance, it was unclear how each task contributed to the development and implementation of a comprehensive system that supported evidence-based practices and services. Furthermore, the Self-Assessment often determined successful completion of tasks in terms of quantitative measures, such as whether a set number of documents was completed by a specific date, rather than in terms of whether tasks or actions provided a meaningful improvement in services. For self-assessment to be effective in guiding decisions, BSSLC must focus more upon qualitative rather than quantitative measures. In addition, the Facility must attend to whether necessary systems are being developed, as well as whether those systems ensure that individuals living at the Facility are provided with individualized and evidence-based services that result in greater independence and an improved quality of life.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at BSSLC from 7/23/2012 through 7/27/2012. Record reviews continued off-site for several days following the site visit. Based upon the information gathered, it was determined that Provision K.2 was in substantial compliance with the Settlement Agreement. Despite the lack of substantial compliance with other Provisions, the review process did reflect that the Facility had achieved progress in other areas. One area in which some improvement was achieved involved monitoring of behavior interventions. The review revealed that the Facility was more likely to provide individually analyzed and appropriately graphed target behaviors, as well as timely revision of PBSPs.

	Another area of progress involved the provision of intellectual and adaptive assessments. The Facility continued to provide such assessments and had increased the number of individuals for whom intellectual and adaptive assessment had been provided. Due to the pace of assessments and the requirement to provide annual adaptive behavior assessments, several individuals for whom adaptive assessment had been originally provided no longer had a current adaptive assessment. Despite some improvement, however, they were several areas in which BSSLC had failed to achieve progress or had actually lost previously achieved accomplishments. Some of these areas included the following. • Due to resignations, the Facility employed only a single BCBA. • Although internal peer review continued, the quality of PBSPs reflected that the peer review process was not effective in improving assessments or interventions. • The monitoring of treatment benefit from PBSPs was less likely to reflect evidence-based decisions than during the previous site visit. • Structural and Functional Assessments (SFAs) did not consistently contain the necessary historical information and direct assessment procedures or consistently identify specific functions for the target behaviors. • Non-PBSP interventions continued to lack evidence-based assessment and treatment monitoring procedures. • PBSPs were less-likely to address motivating operations and setting events, make effective use of positive reinforcement, and include specific treatment expectations. Overall, despite noted efforts, at the time of the current site visit, BSSLC was less likely to be able to provide meaningful and evidence-based behavior intervention than during the previous site visit.

#	Provision	Assessment of Status	Compliance
K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide 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,	<u>Historical Perspective</u> 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. In January 2012, only two psychologists were BCBAs as two BCBAs had left employment with the Facility. Of the remaining Behavior Services staff, 13 met the criteria for pursuing board certification; only five were pursuing board certification. <u>Current Site Visit</u>	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>At the time of the current site visit only one BCBA remained on staff at BSSLC; Dr. Terry Hancock, Chief Psychologist.

<table><tr><td></td><td>1/2010</td><td>1/2012</td><td>7/2012</td></tr><tr><td>Percent of staff who were BCBAs</td><td>0%</td><td>13%</td><td>9%</td></tr><tr><td>Percent of staff lacking BCBA who were pursuing board certification</td><td>26%</td><td>47%</td><td>60%</td></tr></table>
During the January 2012 site visit, it was noted that BSSLC had demonstrated considerable progress in regard to PBSPs. As reported in Provision K9, evidence obtained during the current site visit revealed that for several areas relating to PBSPs BSSLC had not maintained the previously noted progress. Part of the decrease in quality of the PBSPs could have resulted from the loss of BCBA staff. Due to the lack of BCBAs, PBSPs could no longer be written or monitored by a BCBA. Dr. Hancock, the sole BCBA at the Facility, did participate in peer review but could not maintain direct involvement in all PBSPs. As several other Behavior Services staff had completed some or all of the BCBA training process, however, it was likely that the lack of BCBAs was only one factor in the PBSP regression.</td><td></td></tr>
<tr><td>K2</td><td>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.</td><td>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.</td><td>Substantial Compliance</td></tr>
<tr><td>K3</td><td>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.</td><td>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</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		practices. Historical Perspective It was noted at baseline that BSSLC lacked a fully functioning internal peer review process. 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. 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. A contract had been signed with 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. During the January 2012 site visit, it was apparent that the steps taken by BSSLC since	

#	Provision	Assessment of Status	Compliance
		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 as a measure of the peer review process. A second weakness noted was the number of PBSPs that suggested that the peer review process was not resulting in substantive changes in the SFAs and PBSPs. Current Site Visit Observations and record reviews conducted during the current site visit revealed only modest improvements in the peer review process at BSSLC during the past six months. As had been noted during previous site visits, the PBSC meeting that was observed as part of the current site visit entailed rigorous review of behavior interventions and assessments, as well as open discussion of the areas in need of improvement. A review of 20 recent PBSPs, however, revealed a continuation of the deficits noted during previous site visits. Examples reflecting an inadequate peer review process included the following. • Forty percent of the reviewed PBSPs lacked a rationale for intervention due to either inadequate SFAs or the lack of justification for an intervention. • Eighty percent of PBSPs did not thoroughly review medical, health, and psychiatric issues. • Forty percent of PBSPs did not include adequate training methodologies for replacement behaviors. • Seventy percent of PBSPs lacked specific treatment expectations that included both success and failure criteria. It was reported by the Facility that a rubric had been developed and implemented since the previous site visit. As a tracking system had not been implemented, it was not possible to review ratings assigned by the Facility using the rubric. BSSLC indicated that efforts were underway to revise the rubric and to establish a tracking mechanism for peer review. Despite the quality of the PBSC meetings, the noted limitations in the sampled PBSPs suggested the peer review process remained inadequate and had failed to promote global improvements in PBSPs. Although many aspects of the peer review process reflected sound practices, the conditions noted during the site review indicated the need for substantially more aggressive efforts by BSSLC before compliance with the SA could be achieved.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and	Historical Perspective 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.	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>At the time of the second compliance site visit, BSSLC had implemented a new data collection process 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; no changes to data collection forms were reported during subsequent site visits.

In January 2012, a sample of 18 records reflected that some areas of behavior data collection at BSSLC had improved substantially. For example, data collection practices on target behaviors allowed for adequate measurement of progress in 78% of records, 89% of data graphs were reviewed at least monthly, and 100% of completed reviews were conducted by a BCBA. Efforts at IOA and treatment integrity monitoring, however, were sporadic.

It was also noted during the January 2012 site visit that the Facility was not adequately monitoring treatment outcomes. At that time, only 56% of records reflected evidence-based decisions regarding PBSPs. Furthermore, in only 33% of reviewed PBSPs was there evidence that the Facility acted in a timely manner when individuals had not shown improvement in undesired behavior.

<u>Current Site Visit</u>
Information obtained from record reviews and observations during the current site visit reflected only isolated areas of notable improvement. To assess progress, the Facility was asked to provide a sample of 30 records. Of those 30 records, 10 were to reflect PBSPs that had resulted in substantial success, 10 that had been continued due to progress, and 10 that had required revision due to a lack of progress. The table below includes information obtained from the sample of 30 records.

<table>
<tr><td></td><td>1/2010</td><td>1/2012</td><td>7/2012</td></tr>
<tr><td>Targeted behavior data collection sufficient to assess progress</td><td>0%</td><td>78%</td><td>63%</td></tr>
<tr><td>Replacement behavior data collection sufficient to assess progress</td><td>0%</td><td>28%</td><td>27%</td></tr>
<tr><td>Data reliability is assessed</td><td>0%</td><td>0%</td><td>10%</td></tr>
<tr><td>Target behaviors analyzed individually</td><td>0%</td><td>22%</td><td>50%</td></tr>
<tr><td>Targeted behaviors graphed sufficient for decision-making</td><td>0%</td><td>39%</td><td>60%</td></tr>
<tr><td>Replacement behaviors graphed sufficient for decision-making</td><td>0%</td><td>28%</td><td>17%</td></tr>
<tr><td>Graphed data are reviewed monthly or more</td><td>0%</td><td>89%</td><td>77%</td></tr>
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#	Provision	Assessment of Status	Compliance

frequently if needed, such as due to use of restraints or changes in risk level			
Review is conducted by a BCBA	0%	100%	0%
Input from direct care staff is solicited and documented	0%	0%	0%
Modifications to the PBSP reflect data-based decisions	0%	56%	47%
Criteria for revision are included in the PBSP	0%	33%	0%
Progress evident, or program modified in timely manner (3 Months)	0%	33%	47%

Based upon the available information, there were only three areas identified during the current site visit in which notable progress had been achieved. These areas involved the graphing and individual analysis of target behaviors.

Individually analyzed target behaviors. The number of PBSPs in which target behaviors were analyzed individual increased from 22% to 50%. This improvement allowed for a more clear identification of successful interventions. As 50% of PBSPs continued to lack individual target analysis, there continued to be a substantial risk that meaningful changes in behavior could be masked or skewed, rendering the determination of treatment benefits very difficult.

Targeted behaviors graphed sufficiently for decisions. All progress notes reflected only monthly graphs of data. For 18 of the PBSPs reviewed (60%), graphs were completed with adequate frequency and reflected sound measurement practices. This reflected a substantial improvement over the 39% of records noted during the previous site visit. In several records, however, the Facility had failed to ensure that data graphs were adequate.

- For Individual #51, the scale on the Y-axis of the data graphs was too great to reveal changes in low frequency behaviors.
- For Individual #425, the Psychology Progress Note stated that data collection practices had been different and suggested previous data were inaccurate. No further information was provided and no revision in the data graphs was noted.

Timely revision of PBSPs. Of the 30 PBSPs reviewed, 14 (47%) reflected either that progress was evident or timely changes had been made in PBSPs. This was an increase over the 33% noted during the previous site visit. For the remainder of the PBSPs, the treatment decisions, even when evidence-based, were delayed or did not occur.

- For Individual #481, the treatment expectations included in the PBSP had been met. The PBSP continued despite the successful reduction in the target

#	Provision	Assessment of Status	Compliance
		behaviors. There was no evidence of plans to revise the PBSP to a generalization or maintenance program, or to determine that continuation of current procedures either should be considered or could be revised to reduce intensity of intervention. • For Individual #51, replacement behaviors were documented as increasing but later fell to zero. The PBSP continued for four months without revision despite the lack of replacement skill development. 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. <u>Replacement behavior data</u>. Only 27% of records reviewed included adequate data collection and tracking of replacement behaviors. This was 1% less than had been noted during the previous site visit. 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. <u>Data Reliability</u>. The Facility reported that monthly inter-observer agreement (IOA) data collection was being conducted for 115 of 199 (58%) individuals with PBSPs. Only three records (10%) in the sample provided by BSSLC reflected at least monthly IOA data collection. <u>Input from direct support staff</u>. Nowhere in the available records was it presented that direct support staff were offered the opportunity or participated in the review of treatment data for any of the 18 PBSPs. Although this may have occurred, there was no documentation that provided evidence. <u>PBSPs reflect data-based decisions</u>. For 14 of the 30 records reviewed (47%), there were indications that treatment decisions were based upon available data. This reflected a decrease from the 56% of records during the previous site visit. In the remaining records, changes did not reflect full consideration of the available data. • For Individual #51, the PBSP was continued due to claims of success. A review of the data, however, revealed that aggression and self-injury were increasing at the time of the review and were at 487% and 4700% of baseline respectively. • For Individual #126, the PBSP was discontinued after the determination that the intervention had successful decreased the target behavior. A review of the data, however, reflected that although the actual displays of the target behavior had decreased, the attempts to engage in the target behavior were increasing.	

#	Provision	Assessment of Status	Compliance
		PBSPs include criteria for revision. Of the 30 PBSPs reviewed, all included a section to identify criteria for PBSP revision. Of those, however, none included criteria that were current or involved criteria for failure as well as success. During the previous site visit, 33% of records had adequately addressed treatment expectations. One marked decrease was noted in the PBSP review process. During the previous site visit, 100% of PBSPs had been reviewed monthly by a BCBA. During the current site visit, this fell to none of the reviewed PBSPs. The reason for this marked decline was attributed to the loss of BCBA staff. The table below reflects the breakdown of Provision K4 ratings across the subgroups of the sample.	

	Over All	Success	Progress	No Progress
Targeted behavior data collection sufficient to assess progress	63%	70%	70%	50%
Replacement behavior data collection sufficient to assess progress	27%	0%	30%	50%
Data reliability is assessed	10%	10%	10%	10%
Target behaviors analyzed individually	50%	60%	50%	40%
Targeted behaviors graphed sufficient for decision-making	60%	80%	60%	40%
Replacement behaviors graphed sufficient for decision-making	17%	0%	10%	40%
Graphed data are reviewed monthly or more frequently if needed, such as due to use of restraints or changes in risk level	77%	90%	80%	60%
Review is conducted by a BCBA	0%	0%	0%	0%

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>Input from direct support staff is solicited and documented</td><td>0%</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Modifications to the PBSP reflect data-based decisions</td><td>47%</td><td>60%</td><td>30%</td><td>50%</td></tr>
<tr><td>Criteria for revision are included in the PBSP</td><td>0%</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>Progress evident, or program modified in timely manner (3 Months)</td><td>47%</td><td>60%</td><td>40%</td><td>40%</td></tr>
</table>

Based upon the information obtained during the site visit, it was evident that data collection, presentation, and use at BSSLC remained inadequate. Although some improvement was noted, none of the individual areas reflected the degree of success necessary for a determination of substantial compliance.</td><td></td></tr>
<tr><td>K5</td><td>Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.</td><td><u>Intellectual and Adaptive Assessment</u>
Intellectual and adaptive testing results play an integral role in understanding an individual. While a functional assessment may provide vital information regarding a single behavior or functional class of behaviors, intellectual and adaptive testing can prove useful in the development of teaching programs. To be useful, however, it is important that the tests be relatively recent, within one year for adaptive testing and five years for intellectual testing. In addition, interpretation of the results of the tests must go beyond the reporting of scores and elaborate upon specific abilities and limitations, as well as how those abilities and limitations are manifested in the person's daily activities.

<u>Historical Perspective</u>
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, had been approved and that 60 intellectual and adaptive assessment reports had been completed. In January 2012, the total number of intellectual and adaptive behavior assessments had increased to 94.

<u>Current Site Visit</u>
During the current site visit, documentation provided by BSSLC reflected that 153 individuals, 39% of all individuals living at the Facility, had received intellectual and</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		adaptive behavior assessment since the beginning of the Settlement Agreement. Of the 153 persons assessed, all were considered to have a current intellectual assessment at the time of the current site visit. In regard to adaptive behavior assessment, only 90 of the 153 individuals (59%) were identified as having an adaptive behavior assessment completed in the past year; these 90 individuals represented 23% of individuals living at the Facility.	

	1/2010	1/2012	7/2012
A Psychological Assessment had been completed.	0%	15%	39%
The Psychological Assessment was less than one year old	0%	15%	23%
The Psychological Assessments contained findings from an intellectual test administered within the previous five years.	0%	15%	39%
The Psychological Assessments contained findings of adaptive assessment conducted within one year prior to the date of the Psychological Assessment.	0%	15%	23%

In addition to providing intellectual and adaptive assessments, it is crucial that the findings of those assessments be presented in a manner that goes beyond the reiteration of scores and facilitates the identification of personal strengths and limitations. A sample of 20 records were selected to determine the degree to which this was achieved.

	1/2010	1/2012	7/2012
Psychological Assessments included a narrative summary of how the results from intellectual assessments would facilitate the understanding of the individual's strengths and needs.	0%	0%	40%
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.	0%	0%	30%

Based upon information compiled during the current site visit, BSSLC continued to reflect progress in the provision of intellectual and adaptive behavior assessment. It was

#	Provision	Assessment of Status	Compliance
		important to note, however, that at the pace of current assessment completion it was unlikely that BSSLC would be able to ensure current adaptive assessments in the long-term without reassessment on an annual basis. Behavior Assessment Historical Perspective 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, including the addition to the SFA of sections for setting events, precursor behaviors, formal preference assessments, and physiological issues. In January 2012, the Facility was able to demonstrate substantial progress in regard to the SFA. Current Site Visit During the current site visit, 20 records were selected as a sample of Structural and Functional Assessments (SFAs) at BSSLC. Based upon a review of these 20 records, it was evident that the Facility had failed to maintain previously achieved progress across all elements.	

	1/2010	1/2012	7/2012
Assessment or review of biological, physical, and medical status	0%	67%	50%
Review of personal history	0%	78%	20%
A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis	0%	78%	40%
The process or tool utilizes both direct and indirect measures	0%	78%	40%
Identification of setting events and motivating operations relevant to the undesired behavior	0%	78%	10%
Identification of antecedents relevant to the undesired behavior	0%	78%	40%
Identification of consequences relevant to the undesired behavior	0%	78%	40%
Identification of functions relevant to	0%	78%	40%

#	Provision	Assessment of Status	Compliance

the undesired behavior			
Summary statement identifying the variable or variables maintaining the target behavior	0%	78%	40%
Identification of functionally equivalent replacement behaviors relevant to the undesired behavior	0%	72%	40%
Identification of preferences and reinforcers	0%	78%	90%

Several factors appeared to contribute to the overall reduction in scores. Primary among these factors was the frequent reliance upon abbreviated SFAs. The abbreviated SFA format did not typically require direct assessment of behavior. Without direct assessment, the ability to resolve ambiguous findings from indirect assessments was substantially precluded. Furthermore, as direct assessment is often necessary to identify specific motivating operations, setting events, antecedents, and consequences, the failure to conduct direct assessment allowed many pertinent issues to remain unaddressed.

In addition to the use of abbreviated SFAs, the SFAs that were reviewed often did not indicate the date, setting, or respondents used for indirect assessments, such as the Questions About Behavioral Function (QABF), or less frequently for formal preference assessments. Without complete information, it was not possible to determine whether these elements were current.

In several of the SFAs, the person completing the SFA had failed to summarize or integrate various results into the overall findings of the SFA. This was most readily apparent in regard to motivating operations and setting events. In several SFAs, these issues were included in the assessment process, at times with substantial detail. Despite the available information, no effort was reflected to summarize the findings and identify the issues pertinent to the development of a PBSP.

Specific examples of noted inadequacies are presented below.

- For Individual #65, no discussion of the Vineland Adaptive Behavior Scales (VABS) was included in the Adaptive Behavior Assessment section despite a recent VABS assessment.
- For Individual #167, no date was provided for the QABF.
- For Individual #260, the QABF resulted in very similar scores for the functions of attention and tangibles. Tangibles were selected as the function and included in the preference assessment although no rationale or evidence to support the selection was provided.

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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Individual #399 was noted to have the diagnoses of Bipolar Disorder, Pervasive Development Disorder Not Otherwise Specified, and Obsessive Compulsive Disorder. No case formulation to integrate learned behaviors and psychopathology was included in the SFA.
One area of improvement was noted in relation to assessment and the SFA. The review of the 20 SFAs revealed improvement in integrating environmentally-based behavior and the symptoms of mental illness into the assessment process. Observations of Psychiatric Treatment Review meetings (PTRs), as well as interviews with psychology and psychiatry staff, had reflected practices that were comprehensive and robust. Although the scores that resulted from the current review reflected progress, the observations and interviews had suggested that ratings would be higher. Considering the overall limitations noted in the SFAs, it was probable that factors in the SFA process suppressed ratings regarding the integration of behavioral and psychiatric assessment and intervention.
<table>
<tr><td></td><td>1/2010</td><td>1/2012</td><td>7/2012</td></tr>
<tr><td>Screening for psychopathology, emotional, and behavioral issues</td><td>0%</td><td>0%</td><td>10%</td></tr>
<tr><td>Differentiation between learned and biologically based behaviors.</td><td>0%</td><td>6%</td><td>20%</td></tr>
<tr><td>Identification of behavioral indices of psychopathology</td><td>0%</td><td>0%</td><td>20%</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>10%</td></tr>
</table>
Based upon the documentation provided by the Facility, it was evident that more thorough and aggressive efforts were required in relation to SFAs and assessment.
</td><td></td></tr>
<tr><td>K6</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.</td><td>Based upon the information presented in K5, documentation in the record continued to reflect that psychological assessments were not based upon complete clinical and behavioral data.</td><td>Noncompliance</td></tr>
<tr><td>K7</td><td>Within eighteen months of the Effective Date hereof or one month</td><td>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</td><td>Noncompliance</td></tr>
</table>

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.</td><td>current site visit. 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 changes made by the Facility reflected a diligent effort to provide assessment 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. Furthermore, due to the pace of intellectual and adaptive behavior assessments, BSSLC was unable to ensure that individuals were provided with assessment as often as needed. A total of 153 individuals living at BSSLC had received intellectual and adaptive assessment since the onset of the Settlement Agreement monitoring process. Due to the requirement that adaptive behavior assessments be completed annually, those assessments remained current for only 90 of the individuals tested.</td><td></td></tr>
<tr><td>K8</td><td>By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.</td><td>On April 1 2011, BSSLC entered into a contract with a Licensed Professional Counselor, Hazel Leigh McRae. The contract with Ms. McRae involved the provision of counseling services for individuals living at BSSLC.

At the time of the current site visit, BSSLC identified seven individuals as being involved in counseling: Individuals #11, #20, #185, #321, #399, #467, and #479. A review was conducted of the Treatment plans for each of the seven individuals involved in counseling. The results of the review are presented below.

<table>
<tr><th></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>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></tr>
<tr><td>Services are goal directed with measurable objectives and treatment expectations.</td><td>0%</td></tr>
<tr><td>Services reflect evidence-based practices.</td><td>0%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Services include documentation and review of progress. If service includes individual or group sessions, progress review includes note in record, or specific data for each session. — 0% Service plan includes "fail criteria"—criteria, such as lack of progress on objectives, or number of sessions without meeting the learning goal that will trigger review and revision of intervention. — 0% Service plan includes process to generalize skills learned or intervention techniques to living, work, leisure, and other settings, including homework or staff training as appropriate. — 0% Service is identified in ISP and, if applicable, PBSP. — 100% Staff who provide therapeutic interventions are qualified to do so through specialized training, certification, or supervised practice. — 100% Staff who assist in therapy, or who supervise homework or milieu activities, receive training and monitoring from qualified therapists. — 0% The documentation reviewed during the current site visit reflected no progress in comparison with the previous site visit. Other than individuals admitted since the previous site visit, the treatment plans provided by the Facility for individuals receiving counseling were the same plans reviewed in January 2012 and July 2011; no additional assessments, progress reviews, or treatment plan revisions had been completed. The documents reviewed reflected that BSSLC had initiated no efforts to improve the quality of non-PBSP interventions.	
K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been	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	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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>
successful
• Short-term injuries that diagnostic or treatment failures may cause
• Long-term effects of diagnostic or treatment options, favorable and unfavorable, separating probabilities from possibilities

It is the responsibility of the Facility to conduct the assessments essential for informed consent. The evidence of continued weaknesses in the SFA process, as well as difficulties noted in the treatment monitoring process, indicated that BSSLC had not achieved success in meeting the obligation of providing sufficient information to the consenter. As a result, the Facility frequently failed to obtain valid and informed consent.

<u>Historical Perspective</u>
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 limitations such as poor rationale for interventions, limited history of interventions, inadequate intervention strategies, a lack of baseline data, and limited instructions for data collection. In January 2012, documentation reflected substantial improvement in several areas of Provision K9.

<u>Current Site Visit</u>
For the current site visit, a sample of 20 individuals were selected by the Facility as a sample of PBSPs. Although progress was indicated in four areas (operational definitions of target behaviors, operational definitions of replacement behaviors, strategies to weaken undesired behavior, and a signature on the PBSP), the evidence reflected modest to substantial declines in most ratings.

<table>
<tr><td></td><td>1/2010</td><td>1/2012</td><td>7/2012</td></tr>
<tr><td>Rationale for selection of the proposed intervention.</td><td>0%</td><td>78%</td><td>60%</td></tr>
<tr><td>History of prior intervention strategies and outcomes.</td><td>0%</td><td>78%</td><td>0%</td></tr>
<tr><td>Consideration of medical, psychiatric and healthcare issues.</td><td>0%</td><td>78%</td><td>20%</td></tr>
<tr><td>Operational definitions of target behaviors.</td><td>0%</td><td>78%</td><td>90%</td></tr>
<tr><td>Operational definitions of replacement behaviors.</td><td>0%</td><td>78%</td><td>90%</td></tr>
<tr><td>Description of potential function(s) of behavior.</td><td>0%</td><td>78%</td><td>70%</td></tr>
</table>
</td><td></td></tr>
</table>

#	Provision	Assessment of Status				Compliance
		Use of positive reinforcement sufficient for strengthening desired behavior	0%	78%	30%	
		Strategies addressing setting event and motivating operation issues.	0%	78%	20%	
		Strategies addressing antecedent issues.	0%	78%	70%	
		Strategies that include the teaching of desired replacement behaviors.	0%	78%	60%	
		Strategies to weaken undesired behavior.	0%	78%	100%	
		Description of data collection procedures.	0%	6%	0%	
		Baseline or comparison data.	0%	11%	0%	
		Treatment expectations and timeframes written in objective, observable, and measureable terms.	0%	33%	30%	
		Clear, simple, precise interventions for responding to the behavior when it occurs.	0%	78%	50%	
		Plan, or considerations, to reduce intensity of intervention, if applicable.	0%	11%	0%	
		Signature of individual responsible for developing the PBSP.	0%	78%	100%	

As noted in Provision K5, the majority of SFAs reflected substantial inadequacies. Without comprehensive and thorough structural and functional assessment, it will not be possible to develop adequate behavior intervention plans. The items that reflected decreases in ratings were for the most part those that would be affected by limited SFAs.

In addition to SFA-related issues, several PBSPs reflected poor attention to detail, carelessness, and a failure to fully consider the requirements of developing a PBSP. Examples of specific weaknesses are presented below.

- For all PBSPs, no documentation was provided regarding the date for or circumstances surrounding baseline data.
- For all PBSPs, instructions for data collection consisted of concise statements directing staff to complete data collection forms but did not state the data to be collected. Although instructions for data collection may also be included on the data collection forms (which is a good practice), it is also important for a statement of the data to be collected to be in the PBSP both for information needed for consent and to provide information for the review and approval process.
- Other than psychotropic drug changes, no PBSPs included details regarding

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>intervention history.
• For Individual #61, there was no indication that opportunities for the display of replacement behavior would be sufficient to allow for frequent reinforcement or meaningful skill acquisition.
• For Individual #169, target and replacement behavior definitions do not match the SFA. In addition, the reinforcer selected to strengthen replacement behaviors was not supported by the preference assessment.
• For Individual #372, the PBSP indicated that delusional statements was a new treatment target. No assessment was provided for delusional statements. Furthermore, the PBSP indicated that baseline data had not been collected but that baseline would be established after the PBSP was implemented.
• For Individual #399, verbal praise was to be used as reinforcement. The QABF ratings indicated that attention was no more likely to be a function of the behavior than tangibles or escape. In addition, the preference assessment in the SFA did not support verbal praise or attention as being a preference.
• For Individual #493, the PBSP identified SIB as the behavioral measure of Major Depressive Disorder and the target for both Prozac and lorazepam. The SFA did not address symptoms of mental illness.
• For Individual #422, the rationale for the PBSP was that staff required instructions to address undesired behavior.

Based upon observations and record reviews conducted as part of the current site visit, it was abundantly clear that BSSLC had failed to maintain previous levels of progress.</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><u>Historical Perspective</u>
During previous site visits, BSSLC demonstrated consistent improvement in data graphing practices other than in regard to the presentation of IOA data. In January 2012, other than the lack of IOA data, the graphs were described as excellent.

<u>Current Site Visit</u>
Based upon documentation obtained during the current site visit, BSSLC had no areas in which substantial progress was achieved over previous site visits. Furthermore, ratings of compliance regarding data graphs dropped substantially for some areas.

<table>
<tr><td>Graph Element</td><td>1/2010</td><td>1/2012</td><td>7/2012</td></tr>
<tr><td>IOA for target behavior data</td><td>0%</td><td>0%</td><td>10%</td></tr>
<tr><td>IOA for replacement behavior data</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>IOA meets minimum expectations</td><td>0%</td><td>0%</td><td>10%</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

The graph is appropriate to the nature of the data.	75%	78%	60%
Horizontal axis and label	75%	100%	100%
Vertical axis and label	75%	100%	80%
Condition change lines	75%	100%	0%
Condition labels	75%	100%	0%
Data points and path	75%	100%	100%
IOA and data integrity	0%	0%	0%
Demarcation of changes in medication, health status or other events	75%	100%	80%

Despite reports by BSSLC that efforts to provide monthly IOA observations were increasing, no data graphs reflected IOA data. Additionally, although progress notes included a section at the top of the page for reported IOA data, these sections were typically blank. For those progress notes where IOA data were provided, the information did not match that included in the Facility tracking database for IOA data.

The regression in ratings regarding the appropriateness of graphs and the graph vertical axes involved issues discussed in Provision K4. Several graphs included Y axes with scales too large to reflect small changes in behavior. Additionally, there were data graphs where the vertical axes were scaled in decimals even though behavior was measured and reported in total frequency that produced only whole numbers.

An additional issue involved the lack of condition change markers. Although graphs reviewed during previous site visits included condition change information, no current graphs included such information. A means to identify changes in interventions and treatments, or other changes in conditions, should be used in order to make information for decision-making clear.

Based upon the information obtained during the current site visit, it was evident that BSSLC had failed to maintain previous achievements in regard to 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.	The Facility reported during the current site visit that Microsoft Word 2010 was used to obtain readability statistics on direct service staff instructions for all PBSPs. Based upon the BSSLC information, 150 of 187 PBSPs reflected a Flesch-Kincaid Grade Level of 8th-grade or below. In addition, direct service staff frequently reported that PBSPs were not difficult to read or comprehend. During interviews, however, direct service staff often demonstrated difficulty in locating and accurately reporting the contents of PBSPs.	Noncompliance

#	Provision	Assessment of Status	Compliance
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.	During the current site visit, BSSLC reported that Behavioral Foundations classes had been initiated, but that only a few classes in the series had been completed. Behavioral Foundations was a curriculum to provide training on the core competencies of applied behavior analysis. No data were available regarding training outcomes. 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. • On Bowie D, staff were observed attempting to address the agitation of an individual while he was receiving his meal via a tube. Staff verbally prompted him to be less agitated, not to bite, and to not tip over the pole used in the administration of nutrients. Throughout the episode, the individual demonstrated increasing aggression and excitability and staff expressed frustration in not knowing what to do. It was evident from comments that staff were unaware of the contents of the individual's PBSP. • In Program Services Training Area 4, one individual had squatted on the floor and refused to stand while a second individual was vocalizing loudly and slapping her face. Staff failed to successfully interrupt the behavior of either individual or act to strengthen replacement behaviors. In order to more fully assess staff knowledge of PBSPs, interviews were conducted with 10 staff at various locations on the BSSLC campus. Of the 10 staff interviewed, three were able to identify at least one individual in the area with a PBSP and described that PBSP in detail. One of the three staff who were successful, however, failed to recognize that the PBSP had not been appropriately implemented. The individual in question exhibited pica and the staff member explained that part of the PBSP involved clearing the room of items that could be ingested. As the staff explained the PBSP and gestured about the room, 10 items such as string and paper were observed on the floor within five feet of the individual. Seven of the staff interviewed were unable to identify individuals with a PBSP, although each location included at least one such individual. Even when individuals in the immediate area were observed engaging in agitation, self-injury, and aggression, six of the seven staff were unable to identify those individuals who required a PBSP. The seventh staff member gestured to an individual seated in a wheelchair and stated, "probably that one." The staff member was correct, but could not describe the PBSP. Based upon documentation, observations, and staff interviews, there was little indication	Noncompliance

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		that staff were routinely familiar with PBSPs or prepared to implement behavioral interventions.	
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	At the time of the site visit, BSSLC employed one staff who possessed board certification as a behavior analyst. This represented approximately one BCBA for every 300 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 8 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)

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. BSSLC Self-Assessment (7/12/12) 2. BSSLC Action Plan (7/6/12) 3. Presentation Book, July 2012 4. BSSLC policy III.2.f (4/14/11) 5. BSSLC Administrative Death Review Committee, Policy: I4.b (no date) 6. BSSLC Clinical Death Review Committee, Policy: I.4.c (no date) 7. BSSLC Death/Discharge Summaries for Deceased Individuals #192, #342, #83, #202, #98, and #79 8. BSSLC Quality Improvement Death Review of Nursing Services and recommendations for Deceased Individuals #98, #192, #60, #342, #83, #79, and #202 9. BSSLC Clinical Death Review Committee Meeting Minutes for Deceased Individuals: #202, #98, #83, and #342 10. BSSLC Administrative Death Review Committee Meeting Minutes for Deceased Individuals: #79, #83, and #342 11. BSSLC Medical Services/Infection Control Policy: 4.1.6, dated 3/16/09 12. BSSCL Policy, Physician Procedures and Best Practice Guidelines, undated 13. Department of State Health Services – Vital Statistics Unit, Death Certificates for Deceased Individuals #60, #342, #83, #202, #98, and #79 14. BSSLC Unusual Incident Report, Unusual Incident Reports for Deceased Individuals: #98, #192, #60, #342, #83, #79, and #202 15. Department of Health and Human Services Center for Medicare and Medicaid Services, Investigation Report Regarding Individual #98's Death, 5/24/2012 16. Autopsy and Pathology Services, P.A., Autopsy Report for Individual #98, 4/15/2012 17. Texas Department of Family and Protective Services Investigation Report Regarding Individual #98, 4/25/2012 18. BSSLC Death Review Tracking Tools for Deceased Individuals #98, #192, #60, #342, #83, #79, and #202 19. BSSLC Tracking of Nursing Recommendations Sheets for Deceased Individuals: #98, #192, #60, #342, #83, #79, and #202 20. BSSLC Completed Medical Emergency Code Sheet Regarding Individual #98, 4/14/2012 **People Interviewed:** 1. Mary Anne Brett, M.D., Medical Director 2. Debbie Williams, Chief Executive Nurse 3. Daniel Dickson, Director of Quality Assurance 4. Jill Quimby, RN, Quality Assurance Nurse 5. Linda Lothringer, State Office 6. Iva Benson, State Office **Meeting Attended/Observations:** 1. Meeting with the staff listed above to review and discuss the Facility' Death Review Policies and

	Processes, as well as death review information, 7/26/2012 2. Morning Medical Meeting, July 25, 2012 3. IDT meeting for Individual #61, July 24, 2012 4. Observational rounds at living area's Bowie Springs A, B, C, and D; Childress Terrace A, B, C, and D; Driscoll Gardens A, B, C, and D; and Cottage Estates Home A.
	Facility Self-Assessment: The medical director reported that its recent reorganization and hiring of two new medical clinicians, has resulted in a delay in accomplishing headway with regards to Settlement Agreement compliance. The Facility Self-Assessment reported that the Facility had conducted an internal and external medical provider quality assurance audit during the interim six-month period. It also reported that caseloads of providers have been redistributed, to better provide medical care, and enable the medical director more time to focus on the Settlement Agreement. The Facility also indicated that it had reoriented the Facility's Physician Procedures and Best Practice Guidelines policy; however, the policy has yet to be fully implemented. The Monitoring Team finds the Facility's POI is non-descripts, and continues to only delineate some action steps that were taken to achieve compliance. The POI should be a master plan, which outlines what essential processes will be developed and implemented, to ensure compliance with the Settlement Agreement.
	Summary of Monitor's Assessment: The Monitoring Team compliments the Facility for ensuring adequate medical staff to support individuals served by the Facility. The current medical director has been in position for six months, and has begun the process of developing strategies to address requirements of the Settlement Agreement, which includes an associate that will help implement and track efforts towards compliance. The Monitoring Team would like to highlight the efforts made to ensure that all known syndromes were appropriately diagnosed, and tracked, as well as ensuring an understanding of the prevalence of many medical conditions at the Facility. In addition, the Monitoring Team was made aware that medical services was in the process of developing an electronic database system to better track important clinical issues, including active diagnosis, and problem lists. The Facility had also developed an impressive morning rounds process that includes all major clinical disciplines, and reviews all medical incidences that occurred during the previous evening, current hospitalizations, and unusual incidences. During attendance of the morning medical rounds, the Monitoring Team was impressed by the frank, and insightful discussion by its participants. Because of recent leadership change with the medical director, and recent hire of two new practicing medical clinicians, the Facility has yet to have had an opportunity to assertively address Provisions L1 through L4. Provision L1: To assess compliance of Provision L1, the Monitoring Team observed individuals at their living areas, attended morning medical rounds, discussed clinical issues, and concerns with the medical staff, and reviewed clinical records. Specific issues addressed during this review period included preventative health measures; health care issues including seizure disorders, pneumonia, Down syndrome, cerebral palsy; Interdisciplinary Team (IDT) participation by physicians; mortality review process; and

	medical staff credentials and training. In addition, the Monitoring Team conducted a comprehensive review of six cases to assess for continuity of care, integration of services, and comprehensiveness of medical care provided. The Facility reported non-compliance with Provision L1, and the Monitoring Team concurred with the Facility because there remain many outstanding issues including the need to enhance the management of chronic care conditions; ensure follow-up to resolution of all acute medical conditions; improve on clinical documentations; improve on medical clinician communication with hospitals; ensure that immunization practices follow CDC guidelines; utilize more medical specialists; and ensure that medical clinicians adequately reflect all medical conditions, and necessary supports, at interdisciplinary team meetings. Provision L2: To assess the Facility's development and implementation of a review system that consists of non-facility physician case review, the Monitoring Team discussed the Facility's progress with the current medical director, reviewed the external medical provider quality assurance audits, and reviewed the Facility's mortality review process. The Facility reports noncompliance with Provision L2, and the Monitoring Team agrees with this determination because of its continued concerns that the audits do not assess the medical clinicians' clinical performance, and because the mortality review process did not offer meaningful insight into deaths, or provide effective improvement strategies for medical services. Compliance will require that the Facility ensure that medical clinician performance measures are developed, and that an improved mortality review process is developed. Provision L3: The Facility reported that it was not in compliance with Provision L3, and the Monitoring Team concurs with this assessment. Compliance will require the development of a quality assurance process that targets the outcome of clinical assessments, and treatment of clinical conditions. Provision L4: The Facility determined that it was noncompliant with Provision L4, and is corroborated by the Monitoring Team. Compliance will require that medical policies and procedures be developed to delineate medical practice at the Facility, and that the Facility fully implements and assesses efficacy of its Physician Procedures and Best Practice Guidelines Policy.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the	To assess compliance of Provision L1, the Monitoring Team observed individuals at their living areas, attended morning medical rounds, discussed clinical issues, and concerns with the medical staff, and reviewed clinical records. Specific issues addressed during this review period included preventative health measures, health care issues including: seizure disorders, pneumonia, Down syndrome, cerebral palsy; Interdisciplinary Team (IDT) participation by physicians; mortality review process; and medical staff credentials and training. In addition, the Monitoring Team conducted a comprehensive review of six cases to assess for continuity of care, integration of services, and comprehensiveness of medical care provided.	Noncompliance

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	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.	Medical Clinician Services / Medical Administration At the time of this review, under the leadership of Dr. Mary Brett, medical director, staffing for clinical services included one full time equivalent (FTE) medical director; one FTE nurse practitioner; three FTE physicians; and one FTE clerk. In addition, the Facility had assigned a nurse to assist with developing, and implementing corrective measures for the settlement agreement. The medical director reported that in her opinion, the Facility had ample medical clinicians to meet the needs of individuals at the Facility. The current ratio of clinicians-to-individuals is 1-to-75, which is an acceptable ratio. All clinicians reviewed had current licensure, and were current with continuing medical education (CME). All CME reviewed was for general medicine, and there was no specific CME provided regarding individuals with developmental disabilities. All medical clinicians had current CPR certification. A nurse practitioner agreement, and registration with the Texas Boards of Nursing and Medicine were current. Following discussion with the medical director, who reported that most physical examinations and medical treatment were delivered at the individual's home, and not in a formal examination room, and following observation of the living area, the Monitoring Team has concern that most physical examinations, and medical treatments are not provided at a specific medical examination room, which is appropriately supplied with medical equipment, and ample lighting. Summary: The Monitoring Team noted an appropriate complement of medical clinicians, who were appropriately licensed, certified in CPR, and maintained CME. Although CME was appropriate for licensure, the Monitoring Team strongly recommends that CME regarding specific issues that are common to individuals with developmental disabilities, such as chronic constipation, musculoskeletal conditions, seizure disorder, and respiratory conditions be regularly provided to the medical clinical staff. Also, it is recommended that physical examinations and treatments be provided at a clinic type room, that is appropriately maintained, has adequate lighting, and all necessary equipment, and supplies to provide medical care. Medical Clinician Participation in the Team Process To evaluate efficacy of the team process, as related to medical clinician participation, the Monitoring Team attended the morning medical meetings, and reviewed Individual Support Plans (ISP). The morning medical meetings consisted of a full complement of clinical specialists, including unit physicians, medical director, pharmacy director, psychiatrist, and lead personnel from nursing, physical therapy, and psychology services. The process included	

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		a review of all clinical incidences that occurred during the previous evening, all currently hospitalized individuals, and unusual incidences. The process was both efficient, and efficacious. The Facility did not have a policy or procedure outlining, and did not maintain a specific tracking record of issues reviewed and recommendations. The Monitoring Team requested the first ten consecutive individual support plans (ISPs) for June 2012, along with associated attendance records. A total of ten attendance records were provided, and nine ISPs were provided for review. The ISPs did not include the health management plans (HMPs). Of the ten attendance records, six (60%) demonstrated attendance by the facility clinician. In zero, out of 10 samples (0%), there was a comprehensive review of the Individual's medical needs clearly delineated in the context of the ISP. For example, the ISP noted that an Individual had a heart murmur, and a report of a history of repaired heart defect, but no comment on the importance for follow-up on this condition; also reported was an asymptomatic change in the cervical spine, with spurring, narrowing, and laxity, but no discussion on the relevance of this condition, and need for follow-up. Summary: The Monitoring Team was impressed by the complement of professionals who attend the morning meetings, and its review process. A policy, and procedures should be developed to delineate the morning meeting process, and cases all issues raised during the morning rounds should be followed up through full resolution, and result of the follow-up documented. Given the limited attendance at ISP meetings, and lack of meaningful delineation of medical issues, the Monitoring Team has concerns over the participation of facility clinicians in the team process. All known clinical issues, and associated risks, and benefits of treatments, and diagnostic evaluations, must be made well aware to team members, including the LAR. For example, when listing a medical condition, such as asymptomatic change in the cervical spine, with spurring, narrowing, and laxity, the Interdisciplinary Team (IDT) must be made aware of probable worsening, associated pain and behavioral considerations, potential for functional decline, how staff must monitor the condition, and available diagnostic and treatment options. <u>Assessment of Routine Medical Care</u> To assess the provision of routine medical care at the Facility, the Monitoring Team reviewed active clinical records, attended an IDT meeting for Individual #61, on July 24, 2012, reviewed a community living discharge planning (CDLP) packet, and requested documents on individuals with seizure disorder, pneumonia, and Down Syndrome.	

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		Pneumonia: The Monitoring Team requested all medical clinician's notes, assessments, and hospital communication records for all cases of pneumonia that occurred at the Facility in June, 2012. The Facility provided documentation request for three individuals (Individuals #303, #318, and #207), who were diagnosed with pneumonia. In addition, the Monitoring Team requested the incidence of pneumonia for the prior year, by month. The Monitoring Team was provided a raw number of pneumonia cases that occurred in January through June of 2012. Since only six months of data was provided, the Monitoring Team could not determine if the prevalence rate of pneumonia had improved, exacerbated, or remained stable. Individual #303: Individual #303 was admitted to the local hospital on 6/10/12 because of an abrupt decrease in oxygen saturation, and was diagnosed and treated at the hospital for pneumonia, and discharged back to the Facility on June 13, 2012. There was no documented evidence of a physical assessment being completed by the Facility medical clinician prior to the hospitalization, and the post hospitalization examination was completed on the day following return to the facility. There was no evidence of physician communication with the treating hospital by the facility clinician. Despite the individual requiring continued oxygen supplementation, there were no additional follow-up examinations documented by the medical clinician, except for an evaluation for emesis, which occurred on 7/12/12. Following discharge from the hospital, the individual experienced several episodes of productive coughing, and wheezing, which required nebulizer treatment, and continued oxygen supplementation; however, the medical clinician did not document a follow-up assessment on such exacerbation, and the need for continued oxygen supplementation. The medical clinician ordered a CT of the chest, which demonstrated continued resolution of inflammation, and an undefined mass lesion, which required follow-up assessments. The only documentation in the clinical record of the mass lesion was a clinician order for repeat CT in three months, and there was no summary of the findings by the CT. Summary: The Monitoring Team has concern over follow-up care of pneumonia for this Individual. There was no documented discussion by the facility medical clinician with the hospital physician; there was no documented medical impression for the individual's continued need for oxygen supplementation; there was no routine follow-up by the facility clinician to assess for resolution of pneumonia; there was no documentation indicating the cause of recurrent pneumonia; and there was no documentation regarding the CT findings of a suspicious mass lesion in the lung. Individual #318:	

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		The individual was known to have recurrent pneumonia, and during June and July 2012, had three admissions to the local hospital for pneumonia. In June, the Individual was admitted to the local hospital on 6/19/12, and discharged on 6/22/12, with a diagnosis of pneumonia. There was no evidence of a medical clinician evaluation prior to hospital admission, and no evidence that the Facility's medical clinician discussed the case with the admitting hospital. Upon return to the Facility the Facility's medical clinician evaluated the individual, and completed a SOAP note. There was no documented evidence that the physician discussed the discharge with the treating hospital. The individual was again admitted to the local hospital for worsening pneumonia on 6/29/12. During the interim, at the request of nursing staff, the medical clinician evaluated the individual on two occasions to evaluate rash, and worsening cough. On 6/25/12, the clinician noted worsening condition, and ordered a chest x-ray, and prescribed oxygen therapy. On 6/28/12 the medical clinician noted persistent cough, and attributed it to recovering from previous pneumonia. On 6/29/12 the nurse noted severe worsening, with elevated temperature, decreased blood pressure, and decreased oxygen saturation, and the Individual was re-admitted to the local hospital for pneumonia, and was discharged back to the Facility on 7/6/12. The Facility's medical clinician documented an evaluation of the Individual upon return to the facility on 7/6/12. The next evaluation by the clinician was on 7/12/12, for evaluation and treatment for rash. On 7/13/12 nurses reported worsening condition, and the Individual was again admitted to the local hospital for pneumonia, and discharged on 7/17/12. The facility clinician documented an assessment following return from the hospital on 7/18/12, and at request of the nurse, reassessed the Individual for rash on 7/20/12. Importantly, on 6/29/12, the local hospital's admitting physician documented in his notes that "notes from the state school are very sparse regarding recent event, though past medical history provided. There is one note stating that oxygen was given to keep saturations greater than 92%, but oxygen saturation at the state school recently was not known". This statement made by the hospital physician clearly delineates the Monitoring Team's concern over lack of meaningful follow-up, and documentation practice for the care of this Individual. Summary: The Monitoring Teams has significant concern over the lack of routine follow-up to assess resolution of pneumonia, documented discussion with hospital physicians, and development of a meaningful plan to address recurrent pneumonia. Individual #207: The Individual had a history of chronic obstructive lung disease (COPD), and recurrent pneumonia. The Individual was admitted to the hospital on three occasions during June 2012, for persistent pulmonary infiltrates, aspiration pneumonia, congestive heart	

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		failure, hypothermia, hypothyroidism, and lethargy. There was no documented discussion by the facility clinician with hospital physician staff for any of the hospital admissions. There was no documented evidence of pre-hospital admission evaluations being completed. All three admissions included a post discharge evaluation by the facility clinician. On 6/7/12, the Individual's LAR requested that the individual have a do not resuscitate (DNR) order, and on 6/24/12, the Individual was admitted to the local hospital in critical condition, and was placed on artificial respiration because of respiratory failure. Hospital records indicate that the Individual's LAR was upset that the DNR order was not communicated to the hospital. There was no documented evidence to support that the Facility notified the local hospital of the Individual having a DNR order. Upon discharge from the hospital on 6/29/12, and return to the facility, the facility's medical clinician documented the Individual's worsening condition, DNR status, and referred the Individual for Hospice services. The medical clinician's documentation did not lead to an understanding of the root cause of this individual's recurrent aspiration pneumonia, and severe respiratory condition. There was no documentation indicating assertive management to determine, and prevent recurrent pneumonia in this Individual. Importantly, a consultation request with a pulmonologist was initiated on 5/18/11 for follow-up for COPD, and persistent bilateral opacities, and the Individual was seen by the pulmonologist on 6/13/12, and at that time was immediately admitted to the hospital for evaluation and treatment. Summary: Based on review of clinical records, the Monitoring Team has concerns over the management of recurrent pneumonia, and progressive pulmonary deterioration without the medical clinician notes documenting assertive management of the underlying condition causing the Individual COPD, and recurrent pneumonia. The Monitoring Team has significant concern that the DNR status, which was determined on 6/7/12, per the interdisciplinary progress record, and agreed upon, by the LAR, was not communicated to the hospital, and resulted in unnecessary treatment. The noted delay in obtaining a pulmonary consultation was also of concern. Clinical Record Review: Individual #557: Significant concern of recurrent emesis was raised during an aspiration and enteral nutritional evaluation, dated December 2011 (no day indicated). Review of the clinical record indicated that the individual received four enteric tube feedings per day, with each feeding occurring over a period of approximately one hour. Additionally, a barium swallow study completed on 6/24/11 indicated that the Individual was at high risk of aspiration because of significant reflux. The report recommended that bolus feedings be	

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		reduced and given more frequently. The Monitoring Team noted that the Individual's enteral tube-feeding amount actually increased in April 2012, and emesis had exacerbated in May 2012 through June 2012. There were no documented physician or team discussion noted in the clinical record suggesting that the intermediate tube feedings, which were administered four times per day, may be precipitating the emesis. The annual medical assessment dated 7/11/12 noted a diagnosis of congenital quadriplegia, and the individual was non-ambulatory, and the individual was noted by the Monitoring Team to have congenitally abnormal upper and lower extremities. The physical component of the annual medical assessment indicated "normal" extremities and joints. Importantly, several imaging examinations, including an x-ray of the abdomen dated 3/28/12, and chest x-ray dated 7/5/12, demonstrated significant deformity of the spine. The physician's plan did not address follow-up for spine disease, or chronic management for chronic congenital quadriplegia. On the annual medical assessment dated 7/11/12, the physician noted that the Individual's blood count and iron studies were normal, and indicated that supplemental iron would be discontinued. As of 7/24/12, iron supplementation was continuing. Summary: The Monitoring Team is concerned over the lack of comprehensive care of this Individual because congenital anomalies and abnormal imaging of the spine were not addressed by the clinician, timely follow-through of medical care was not performed, and important medical assessments and recommendations were not considered in the management of this Individual. Individual #53: Observation of the Individual noted a 3 cm diameter mass lesion over the right neck region. Staff reported that the lesion had been present for years, but changes in size, and gets larger when she is sick. The annual medical assessment, dated 12/9/11, documented that the Individual had an "epidermal inclusion cyst right neck"; however, the physical exam component of the annual medical assessment indicated that the neck, and skin were "normal". The most recent active problem list in the clinical record, dated 7/15/11, documented that the lesion was a "neck mass", "?lipoma/sebaceous cyst?". The Individual was seen by a dermatologist on 8/22/11, who recommended to either observe the mass for worsening, or undergo elective removal, and if observation was decided upon to follow-up with dermatology every six months. The Individual did not undergo elective surgery to remove the mass, and there was no evidence to support that the Individual had been seen every six months by dermatology.	

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		The Individual was known to have a diagnosis of cerebral palsy, with spastic diplegia, and was observed to be wheelchair dependent. The current health status documented on the annual medical assessment noted that the Individual was non-ambulatory, and that the Individual was not able to maintain tone of the neck and torso; however, the physical assessment component of the annual medical assessment documented "normal" motor function. Given the Individual's non-ambulatory state, diagnosis of diplegia, and observational assessment, the Monitoring Team questions the physical assessment of normal motor function. Importantly, the physician indicated that consideration for physiatry evaluation for cerebral palsy would be entertained; however, there were no orders for physiatry evaluation, or other assessments to assess chronic conditions related to cerebral palsy, nor was evidence found to substantiate that routine assessment for cerebral palsy were done in the past. Summary: The Monitoring Team is concerned of the lack of efficacious care for cerebral palsy, lack of follow-up with specialists, and inaccuracy of the physical assessment on the annual medical assessment. Individual #78: The Individual was under the care of Hospice. The Monitoring Team asked the living area nurse what the indication for Hospice was, and the nurse providing nursing care to the Individual did not know what the Hospice indication was. The Monitoring Team reviewed the current clinical record, and could not determine the indication for Hospice. A "Medical Care Review Note" was completed by the physician, and was dated 2/8/12, and stated that the Individual was in Hospice since 3/5/12, while the note was actually signed and dated by the physician on 6/27/12. In addition, the note did not provide a comprehensive understanding of the Individual's health care condition or needs, pertaining to Hospice care. Summary: The Monitoring Team is concerned about the confounding dates noted on the review form, and lack of clear, and comprehensive documentation specific to the indication, and health care needs of the Individual. Importantly, the Monitoring Team is significantly concerned over the nurse not knowing what the clinical indication for Hospice care was. Individual #428: The Individual was observed to have severe torticollis of the neck, which was not documented on the active problem list, but was noted on the physical assessment	

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		component of the annual medical assessment, dated 3/21/12. There was no action plan or assessments for the torticollis. A cervical spine x-ray, dated 4/28/11, indicated moderate diffuse degenerative disc disease of the spine. This condition was not reflected on the annual medical assessment, nor was an action plan developed for this potentially serious condition. Several chest x-rays, including a chest x-ray dated 6/18/11, noted signs of cardiomegaly (enlarged heart), vascular congestion and edema secondary to congestive heart failure. The physician indicated that the individual did not have heart failure because of a normal echocardiogram report from 4/17/09. This echocardiogram report; however, indicated that the study was of poor quality, and commented that although the ejection fraction was estimated to be normal that the study was limited because of its poor quality. Mitral, tricuspid, and aortic valve regurgitation were noted to be present. A cardiology consult was obtained on 6/11/10 which stated that an additional echocardiogram, which was not in the current record, was obtained and showed a normal ejection fraction, but was also technically difficult, and the cardiologist did not have specific cardiac recommendations; however, the consult stated that other causes of fluid overload, such as renal, and hepatic causes should be evaluated. There was no documentation by the Facility's medical clinician that other causes of fluid overload were assessed, or that follow-up on known cardiac valve disease was done. Summary: The Monitoring Team is concerned over lack of meaningful follow-up on serious medical conditions, including torticollis, degenerative disc disease of the spine, indication of either heart failure or other causes of fluid overload, and cardiac valve disease. Individual #61: The Monitoring Team attended the IDT for Individual #61, on July 24, 2012, to discuss an adverse outcome following a recent screening colonoscopy. The Individual was known to be at risk for choking, and aspiration, and had a positive swallowing study for aspiration risk, as well as a documented anatomical variance of the pharynx. The most recent health risk assessment indicated that the individual was at risk for both choking and aspiration. In addition, the Individual was on a special textured diet because of risk for aspiration, and choking. The Individual underwent a scheduled colonoscopy for health risk screening. During the procedure the Individual aspirated, resulting in abnormal blood oxygenation, and the need for admission to the hospitals intensive care unit. During the ISP it was discussed that the current active problem list did not reflect	

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		aspiration risk, or anatomical variance. The hospital was not notified that the Individual was at risk for aspiration, or the abnormal pharynx. The hospital's functional screening form was not completed properly because the question specific to "problem with chewing/swallowing" was not checked on the form, which was completed by the Facility. Summary: The Monitoring Team raised significant concerns over the lack of meaningful communication of relevant health care issues to the outside health care provider. In this particular case, the Individual was known to be at risk for aspiration, and had an anatomic variance of the pharynx, which was not adequately communicated to the treating hospital, and the Individual developed aspiration pneumonia. Individual #242: A community living discharge planning (CLDP) packet was reviewed for this Individual. The following three issues were of concern to the Monitoring Team: 1. The diagnosis of pica was changed to "mouthing" behavior on the most recent annual medical assessment, and it was noted that the psychiatric review team would provide recommendations for this condition. The CLDP indicated that the Individual had pica, as a component of behavioral issues. The health maintenance nursing assessment indicated that the Individual had a "medical diagnosis" of pica, and tendency to mouth objects, and included an action plan secondary to any observed episode of pica or mouthing. The psychiatric assessment, dated 11/17/11, did not include a diagnosis of pica, but did include a statement that the Individual mouthed objects. The positive behavior support plan, dated 7/16/12, indicated that the Individual was never known to actually swallow inedible objects thus did not meet criteria for pica; however, because of severe mouthing behavior, pica would continue to be included in the behavioral plan. The specific plan for mouthing behavior did not have a teaching component, nor did it include environmental considerations, such as a pica safe environment, hence the accepting agency would not be made aware of the significance of the mouthing behavior, nor would a service objective be developed for this potentially lethal condition. 2. The CDLP indicated that the Individual was due for a mammogram; however, review of the clinical record indicated that multiple attempts of past mammograms were unsuccessful because of inability to cooperate. There was no identified documentation that discussed the risk and benefits for routine mammograms, nor strategies to enhance compliance with mammograms. The accepting agency must be made aware of this important compliance issues, and how to address the issue in the future. 3. The active problem list on the annual medical assessment indicated that the	

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		individual was "overweight", and indicated a plan of care to continue on reduced low fat calorie diet, and encourage to exercise, and review weight monthly. Within the body of the annual medical assessment it indicated that the Individual sustained weight loss, weighing 117 pounds at the time of the assessment, and there was a concern raised over the cause of the weight loss, attributing it to other then calorie restriction. The CDLP did not provide a clear picture of the Individual's nutritional status, weight, etiology of weight loss, nor the appropriateness of the prescribed 1200 calorie diet, and importantly, did not provide clear follow-up and monitoring recommendations for the significant weight loss. Summary: Following review of the CLDP process, the Monitoring Team was concerned over the continuity of care among various disciplines, and accurate reporting of important clinical issues to referring agencies. Cerebral Palsy: To assess the management of neuromotor, and musculoskeletal conditions, the Monitoring Team requested a Facility generated random list of five individuals with a diagnosis of cerebral palsy, and their associated active clinical record. Of these samples, the appropriate ICD-9 diagnosis was assigned in five, out of five samples (100%); the annual medical assessment provided a comprehensive assessment, summary, and plan for the diagnosis of cerebral palsy in zero out of five samples (0%); the nursing assessment clearly delineated a nursing assessment and nursing plan for the management of cerebral palsy in zero out of five samples (0%); the physical therapy and occupational therapy assessment clearly delineated a functional assessment, including quantitative range of motion, and appropriate therapies for the management of cerebral palsy in zero out of five samples (0%); consultations specific for the assessment, and on-going management, such as with a neurologist, orthopedic surgeon, or physiatrist were noted in zero, out of five samples (0%); and the primary care physician participated at the ISP meeting, to address important clinical issues related to cerebral palsy in zero, out of five samples (0%). Summary: Cerebral palsy is a serious medical condition that requires assertive clinical management throughout life. Issues such as progressive joint disease, contractures, spasticity, gastroesophageal reflux disease, aspiration and choking, chronic obstructive pulmonary disease, heart failure, constipation, and bowel obstruction, chronic pain and discomfort, and degenerative spine disease with progressive myelopathy, should be routinely, and systematically assessed, as part of chronic care management. Because these issues were not routinely and systematically assessed, the Monitoring Team determined that the	

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		overall care medical care for individuals with cerebral palsy was not within standard of care practice. <u>Preventive Health / Health Maintenance</u> To evaluate the Facility's provision of preventive health measure, the Monitoring Team reviewed the Facility's immunization practice; screening colonoscopy, screening mammograms, and preventive health issues related to Down Syndrome. Down Syndrome: Syndromal conditions, such as Down Syndrome, are common medical conditions for individuals who reside at developmental centers. The Facility maintained an exceptional list of all known syndromes at the facility. Specific to Down Syndrome, the Monitoring Team assessed the Facility's ability to assess, monitor, and treat common medical conditions associated with Down Syndrome, such arthritis, degenerative, and congenital spine disease, cardiac valve disease, hypothyroidism, and blood dyscrasias, as well as cognitive and physical decline. The select seven samples were derived by selecting the first name and every fifth name following for a sample from a list of all individuals with Down Syndrome. Of the seven samples, seven out of seven (100%) has a blood count and thyroid study within the past year; one out of seven (14%) had x-rays of the musculoskeletal system within the past three years; two out of seven (29%) had an EKG within the past two years; zero out of seven (0%) had pain assessments ordered as part of routine care; and zero out of seven (0%) had annual physical assessments that clearly delineated routine health maintenance for common conditions known to occur in individuals with down syndrome. Summary: The Monitoring Team determined individuals with Down syndrome were not routinely assessed, as part of the provision of routine health maintenance. Conditions such as chronic, and debilitating arthritis, and degenerative spine disease, progressive heart valve disease, and chronic pain from musculoskeletal conditions, were not assertively assessed. For example: • Individual #397 demonstrated degenerative lower spine disease, and scoliosis on an x-ray, which was not addressed by the clinician. • Individual #335 is known to have severe cardiac problems, and surgery was recommended in 2010; however, the annual physical assessment did not comment on a plan to address this serious condition or a decision on heart surgery. • Individual #101 is known to have a left leg that is shorter then the right leg, and knee joints that were lax, both of which can contribute to the development of	

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		arthritis, and the annual physical assessment did not comment on this issue. • Individual #184 had an abnormal EKG in 2010, following previous normal EKG's. In addition, the Individual had a known diagnosis of heart valve disease. No follow-up was noted for monitoring the abnormal echocardiogram from 2001, which diagnosed the heart valve disease, and no work-up was documented to evaluate the abnormal EKG from 2010, which might indicate worsening valve disease. <u>Immunization Practice</u> To assess appropriateness of the Facility's immunization practice, the Monitoring Team reviewed its current policy on infection control, and 20 immunization records randomly generated by the of a facility. The Facility's immunization practice was reflected in its medical services/infection control policy, dated 3/16/09. The policy indicated revision was needed by March 2010. The Monitoring Team noted that the policy was not comprehensive, and did not reflect current Center for Disease Control (CDC) guidelines. For example, the policy only states that "the physician will order immunizations to be administered if the individual is not current on them", and did not include a list of necessary vaccines. Importantly, the policy did not indicate what immunization records were considered acceptable when assessing childhood and previous immunization status of an individual. Given the re-emergence of many infectious diseases, including measles and pertussis, it is paramount to maintain an accurate record of immunization status. Of the 20 immunization records randomly generated by the Facility, the immunization records were incomplete in 20 out of 20 samples, and enabled a review of only tetanus, hepatitis B, pneumococcal, tuberculosis, and influenza. Twenty out of 20 (100%) of the samples were current with tetanus vaccine; 19 out of 20 (95%) of the samples were current with hepatitis B, influenza, and tuberculosis; and 17 out of 20 (85%) of the samples were current with pneumococcal vaccine. Summary: The Monitoring Team has serious concern with regards to the Facility's immunization practice. The immunization record provided for review did not conform to CDC guidelines, and did not enable an effective understanding of current immunization status of individuals. There was no information provided on the many other necessary vaccines, such as pertussis, measles, and herpes zoster. There was no evidence to support that the Facility ensures current immunization status for both childhood and adult vaccination status, per CDC guidelines. The CDC recommends specific documented evidence for immunization status, which was not evident by this review. The Monitoring	

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		Team strongly recommends updating immunization policies and practices to reflect current CDC guidelines for vaccination, documentation of immunization, and demonstrating prof of immunization status. <u>Do Not Resuscitate (DNR)</u> A list of all individuals with a current DNR orders and documentation of clinical rationale was reviewed. The Facility maintains 15 active DNR orders. Current, generally accepted practice supports DNR orders, when clinically appropriate, and following assertive ethical review. The documents reviewed provided only a brief comment delineating the clinical rationale for the DNR. For example, the rationale provided for some individuals included: "spastic diplegia," "cortical blindness," "organic encephalopathy," "uncontrolled seizures," and "progressive degenerative neurological disorder." The Monitoring Team is aware that many individuals have such diagnoses; however, having such a condition does not automatically imply a DNR is necessary. For example, many individuals having quadriplegia, and some people with progressive degenerative neurological conditions such as dementia, are still able to maintain a quality of life, and are not considered in a terminal conditione, or that the act of chest compressions would result in significant burden to the individual. Summary: The Monitoring Team requires that the clinical rational for all DNR orders be supported by evidence that clearly demonstrates a terminal condition, or that the act of CPR, and artificial respiration, would cause undue burden to the individual. <u>Colon Cancer Screening by Colonoscopy</u> The Facility provided a list of all individuals aged 50, and older, along with the date of their most recent colonoscopy, or rationale for not providing a colonoscopy. Of the 53 individuals who were age 50 or older, 27 (51%) underwent a colonoscopy within the past ten years. Of the remaining 26 individuals, the clinical rationale for not doing the procedure was documented in only one case, and there was an additional one individual whose LAR refused the procedure. Summary: Approximately 50% compliance with screening colonoscopy, without adequate clinical rationale for not providing colonoscopy, is less then optimal. All individuals 50 years of age and older, should be provided screening colonoscopy, unless clinically contraindicated or refused by the LAR. <u>Breast Cancer Screening by Mammogram</u> The Monitoring Team was provided with a list of all women 40 years, and older, along	

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		with the date of their last mammogram, or rationale for not providing a mammogram. Of the 49 individuals on the list, only one individual did not undergo mammography, or have appropriate rationale documented for not having a mammography. Summary: The Facility provides excellent preventive health screening for breast cancer in women. <u>Incidence of Decubitus Ulcers</u> In most cases, decubitus ulcers results from inadequate support by direct care, and can be exacerbated by poor nutrition, dehydration, and underlying medical conditions. The Monitoring Team requested a list of the incidents of decubitus for the prior year, by month. The Facility provided a list containing the raw number of decubitus ulcers for September 2011, through May 2012 (ten months). Thirty-eight unduplicated individuals were reported to have sustained a decubitus ulcer; Of the 55 total decubitus ulcers diagnosed, 48 (87%) were determined to have resulted at the Facility; six out of the 55 ulcers were diagnosed as stage I (11%); 37 were diagnosed as stage II (67%); five were diagnosed as stage III (10%); and seven were diagnosed at stage IV (13%). Summary: The Monitoring Team determined that the Facility did not provide adequate care and support to prevent decubitus lesions. The Facility must enhance its direct care support to prevent decubitus ulcers from developing, and ensure that all individuals who sustain a recurrent lesion, or any decubitus ulcer of stage II or greater, be evaluated by the Facility clinician. <u>Seizure Management</u> To assess the medical management of seizure disorders during this review period, the Monitoring Team assessed the use of older antiepileptic drugs, such as phenobarbital, and Dilantin, and reviewed a list of individuals who experienced status epilepticus during the previous six months, and if a vagus nerve stimulator had been considered, and the prevalence of individuals being administered more then two antiepileptic drugs (AEDs). The Facility reports only three individuals as experiencing status epilepticus since June 2011, and in three of the three cases a VNS had been implanted (100%). Of the 111 individuals who were prescribed AEDs, 28 individuals were prescribed three or more AEDs (25%); and 53 (48%) were prescribed an older antiepileptic, such as phenobarbital, Dilantin or Primidone for seizure control.	

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		Summary: The Monitoring Team is complimentary of the Facility's assertive stance with the appropriate use of VNS therapy. Data reflects low incidences of status epilepticus, which demonstrates assertive management of seizure disorder at the Facility. The Monitoring Team clearly recognizes the challenges, and potential risks associated with decreasing the use of older AEDs; however, the Monitoring Team also acknowledges the potential benefits of mitigating such drugs when ever possible. Given the significant percentage of individuals who remain on older AEDs, the Monitoring Team questions if a comprehensive clinical review, inclusive of the treating epileptologist, and discussion with the individuals LAR, has occurred for each individual prescribed an older AED. Conclusion: The Monitoring Team compliments the Facility for ensuring adequate medical staff to support individuals served by the Facility. The current medical director has been in position for six months, and has begun the process of developing strategies to address requirements of the Settlement Agreement, which includes an associate that will help implement and track efforts towards compliance. The Monitoring Team would like to highlight the efforts made to ensure that all known syndromes were appropriately diagnosed, and tracked, as well as ensuring an understanding of the prevalence of many medical conditions at the Facility. In addition, the Monitoring Team was made aware that medical services was in the process of developing an electronic database system to better track important clinical issues, including active diagnosis, and problem lists. The Facility has also developed an impressive morning meetings process that includes all major clinical disciplines, and reviews all medical incidents that occurred during the previous evening, current hospitalizations, and unusual incidences. During attendance of the morning medical meetings, the Monitoring Team was impressed by the frank, and insightful discussion by its participants. Because of recent leadership change with the medical director, and recent hire of two new practicing medical clinicians, the Facility has yet to have had an opportunity to assertively address Provision L1, and there are many outstanding issues including the need to enhanced the management of chronic care conditions; ensure follow-up to resolution of all acute medical conditions; improve on clinical documentations; improve on medical clinician communication with hospitals; ensure that immunization practices follow CDC guidelines; utilize more medical specialists; and ensure that medical clinicians adequately reflect all medical conditions, and necessary supports, at interdisciplinary team meetings.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year,	To assess the Facility's development, and implementation of a review system that consists of non-facility physician case review, and assistance to facilitate the quality of medical care and performance improvement, the Monitoring Team discussed the	Noncompliance

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	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.	Facility's progress with the current medical director, reviewed the external medical provider quality assurance audits, and reviewed the Facility's mortality review process. External Medical Provider Quality Assurance Audits The Facility had one external medical provider quality assurance audit during the last six-month period, which occurred in May 2012. A total of four medical clinicians were assessed by a chart audit conducted by external physicians. Audits were conducted on the four medical clinicians who were practicing at the Facility during May 2012. Of the four medical clinicians, four out of four (100%) attained a compliance score of 80% or greater for both essential and non-essential compliance issues. There were 31 issues identified as non-compliant, and physicians were to review, and remediate all 31 deficiencies. At the time of this review, 17 remediation actions (52%) had not been addressed. Importantly, there was no process that enabled the medical director to review, and assess results of the audits, and discuss the audit findings with medical clinical staff. Death Reviews The Monitoring Team met with Medical Director, Chief Executive Nurse, Quality Assurance Nurse, and Quality Assurance Director to review and discuss the Facility' Death Review Policies and Processes, as well as death information provided for review, 7/26/2012 . The meeting was observed by two State Office staff. The Facility had made no changes or revisions to their Administrative Death Review Committee, Policy: I.4.b and Clinical Death Review Committee, Policy: I.4.c since the last compliance review. The Quality Assurance Nurse continued to track compliance with the Facility's death review polices, including tracking recommendations resulting from the Clinical and Administrative Death Review Committees. Since the last compliance review, seven deaths had occurred at the Facility. The Monitoring Team's findings included: • Of the seven deaths, the average age was 68.1 years (ages varied from 33 to 88 years of age). Four of seven (57%) deaths had conditions leading to deaths associated with aspiration pneumonia/pneumonia. Two of seven (29%) were also associated with sepsis. There was concern regarding the high incidence of deaths associated with aspiration pneumonia/pneumonia, which was potentially preventable. • Six of seven (86%) had Department of State Health Services – Vital Statistics Unit, Death Certificates. The cause of individuals' deaths on the Death Certificates are listed in the chart below: 1. Immediate cause of death: Respiratory Failure Condition leading to the cause of death: Aspiration Pneumonia	

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		2. Immediate cause of death: Respiratory Failure Condition leading to the cause of death: Aspiration Pneumonia 3. Immediate cause of death: Respiratory Failure Condition leading to the cause of death: Pneumonia Underlying cause of death: Sepsis 4. No Death Certificate was available one recent death: Probably cause of death was listed as: Pneumonia and Hypocalcemia 5. Immediate cause of death: Atherosclerotic Vascular Disease 6. Immediate cause of death: Cardiac Arrhythmia Condition leading to the cause of death: Cardiomegaly and Left Ventricular Hypertrophy 7. Immediate cause of death: Probable Urosepsis • Four of the seven (57%) decedents resided in the Bowie Unit, respectively one in Bowie A, one in Bowie B, and in two in Bowie C. Two of seven (29%) resided in Driscoll, respectively in Driscoll A and Driscoll D. One of seven (14%) decedent resided in Childress A. • Five of seven (71%) decedents were enterally nourished. • Six of seven (86%) decedents had Medical Histories/Chronic Diagnoses of aspiration and/or dysphagia. • Six of the seven (86%) deaths occurred in the hospital. • One of seven (14%) deaths occurred at the Facility under hospice care. • Seven of seven (100%) decedents had Do Not Resuscitate (DNR) orders prior to illness/incident. • Six of seven (85%) decedents had DNR orders at the time of death. • Two of seven (29%) decedents had an autopsies performed. • Seven of seven (100%) deaths had Unusual Incident Reports completed. • Seven of seven (100%) deaths were determined due to natural causes. • The Monitoring Team's review of the death documents for compliance with the Facility's death review policies and processes related to required timelines found: o Three of the seven (43%) Death/Discharge Summaries due to be completed by the attending physicians were completed within the required five working days. However, six of seven (86%) Death/Discharge Summaries were completed after the due date. One (14%) Death/Summary was not completed. o Seven of seven (100%) Quality Improvement Death Reviews of Nursing Services Reports were completed within the required five working days. o Clinical Death Review Committee Meetings were conducted within 14 working days of the deaths for zero of the six (0%) deaths due to have a meeting. However, the Clinical Death Review Committee Meetings were	

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		conducted after the required 14 working days. One death was too recent to have had a Clinical Death Review Committee Meeting. o Three of three (100%) Clinical Death Review Committee Meeting Minutes that were due to be sent to the Administrative Death Review Committee were sent within the required 21 calendar days after receipt of the minutes from the Clinical Death Reviews. The remaining four Administrative Death Review Committee Meetings were not due at the time of the compliance review. o Zero of three (0%) decedents' death information reviewed contained documentation that copies of the Clinical and Administrative Death Review Committees' information was sent to the State Office Medical Services Coordinator within the required 14 calendar days after the Administrative Death Review Committee Meetings. The remaining four Administrative Death Review Committee Meetings were not due at the time of the compliance review. o Zero of three (0%) contained documentation that the Facility Director submitted summaries of the resulting actions taken from the Clinical and/or Administrative Death Review Committee Meetings as required within 28 calendar days following the Administrative Death Review Committee Meetings. The remaining four summaries were not due at the time of the compliance review. o The Quality Assurance Nurse continued to: ▪ Maintain a tracking sheet for each death indicating when the various timelines were due and completed for required components of the death review policies. ▪ Timely complete Quality Improvement Death Reviews of Nursing Services Reports for each death and made appropriate recommendations for nursing services. Recommendations were primarily directed to the nursing staff. ▪ Maintain an individual tracking sheet for nursing recommendations related to each death. There was documentation on the tracking sheets with accompanying training material, and training rosters, verifying that recommendations for six of six deaths were completed. Recommendations for one death were initialed for a recent death but there had not been time to complete the recommendations. • The Monitoring Team has significant concern over the number of pulmonary related deaths at the Facility. During its review of three cases of pneumonia, as delineated in L1 of this report, the Monitoring Team noted that the Facility did not assertively assess individuals for recurrent pneumonia, and as per Provision O4, maladaptive	

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		position and lack of implementation of physical and nutritional management plans remain problematic at the Facility. The etiology of causes of aspiration, choking, and recurrent pneumonia must be assertively assessed, and provide definitive treatment when clinically appropriate. Furthermore, the Facility must enhance positioning, feeding, and gastrointestinal tube feeding practices. Since the last review, there had been no significant improvements found in the Facility's overall death review process. The requirements for completing various timelines for components of the death review policies were inconsistently met. The reason for the Facility to conduct death reviews was to ensure thorough, systemic, and integrated death reviews were conducted in order to develop recommendations to improve health care. Additionally, 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. The Medical Director and Quality Assurance Director acknowledged that the death review polices and processes were not adequately adhered to and the Monitoring Team concurred. At the last compliance review, the Director presented a draft Internal Corrective Action Plan to improve the Facility's death review process; however, it had not been implemented. The Facility had not conducted a Mortality/Morbidity Review and Analysis of longitudinal data related to deaths in order to track and trend systemic issues, develop corrective action plans, or the efficacy of the corrective actions. The Medical and Nursing Departments, as well as the Quality Assurance Department should develop a list of critical questions to answer in reviewing each decedent's medical record. This could further improve the scope and depth of clinical discussions and recommendations, in addition to providing consistency among the reviewers. According to a recent discussion with the State Office Nursing Coordinator, the State was in the process of revising the Death Review Policy. When the Death Review Policy is revised it should include a thorough, systemic, and integrated process to review all aspects of an individual's care leading up to death and to make systemic recommendations for care. The Medical Department did not provide a meaningful clinical review of each death that would enable comprehensive insight into the clinical care of the individual. It is essential that a root cause analysis of each death be completed.	

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		Summary The Monitor Team complements the Facility for conducting the external medical provider quality assurance audits; however, the Monitoring Team continues to have significant concerns because the audits do not assess the medical clinicians clinical performance. It is essential that the medical director review, and assess results of the audits and discuss its outcome with the Facility's medical clinical staff. The Medical Director is not aware of any effort to enhance the current process so that it better reflects actual clinical performance of the medical clinician. Compliance will require that a formal process be established that assesses performance outcomes of the practicing medical clinicians. The mortality review process must be significantly revised to ensure that medical providers conduct a comprehensive case review of all death, and that meaningful recommendations are provided for each death, derived by a root cause analysis. The Facility must conducted periodic analysis of all deaths, and when the Death Review Policy is revised it should include a thorough, systemic, and integrated process to review all aspects of an individual's care leading up to death and to make systemic recommendations for care.	
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.	To assess compliance for Provision L3, the Monitoring Team discussed the Facility's action steps with the medical director. The Monitoring Team was informed that the only steps taken towards developing and implementing a medical quality assurance process was that of implementing its internal medical provider quality audits, which mirror the external medical provider quality audits. No other efforts have been developed or implemented; however, the medical director did comment that she would be working with the Facility's quality assurance manager to develop strategies that will assess clinical outcomes. Review of the Facility's most recent internal medical provider quality assurance audit, which was completed in May 2012, determined that four out of four medical clinicians audited achieved 80% or greater compliance in both essential and non-essential compliance issues. Of the 49 conditions found not to be in compliance, 49 out of 49 (100%) had an action plan developed, and 34 out of the 49 (69%) of the action plans were attended to and completed, while 15 action plans (31%) were not completed. Provision L3 includes a requirement to initiate outcome-related inquiries. The Facility had not developed a method to collect, analyze, and utilize outcome data to enhance medical services. Summary: The Monitoring Team determined that the Facility's internal medical provider quality assurance audit process did not enable a determination of the quality of medical care	Noncompliance

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		because it did not assess clinical outcomes, following assessment and treatment of medical conditions. Compliance will require the development of a quality assurance process that targets the outcome of clinical assessments, and treatment of clinical conditions.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The Monitoring Team discussed the Facility's policies and procedures for health care with the medical director, who reported that there has been no development of new policies or procedures that ensure provision of medical care is consistent with current, generally accepted professional standard of care. There were no up-dates on clinical pathways, and clinical pathways had yet to be implemented at the Facility. The medical director informed the Monitoring Team that the Facility's policy called Physician Procedures and Best Practice Guidelines, had not been updated, and was not being followed consistently at the Facility. The Monitoring Team requested of the Medical Director policies and procedures for many clinical practices, such as a policy for medical grand round, physician liaison with the local hospital medical staff, follow-up on acute and chronic conditions, and mortality review, and no such policies had been developed Summary: The Monitoring Team noted a serious lack with Facility policies for medical services, and strongly recommends that policies, and procedures be developed to delineate medical practice at the Facility. Importantly, the Facility's primary medical policy, Physician Procedures and Best Practice Guidelines, should be revised and implemented.	Noncompliance

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

1. Enhance CME offerings to include issues relevant to developmental disabilities, such as musculoskeletal, and neuromotor conditions.. (Provision L.1)
2. Ensure that individuals are assessed, and treatment for medical conditions at a venue that enables adequate lighting, privacy, and appropriate medical equipment. (Provision L.1)
3. Develop, and implement a policy and procedure that delineates the medical morning meeting process. (Provision L.4)
4. Ensure that a process is developed and implemented that ensures physician participation at ISPs, and that all relevant medical issues are clearly represented in the ISP. (Provision L.1)
5. The Facility must developed a process that ensure routine follow-up through resolution of all acute medical issues by the medical clinician of record. (Provision L.1)
6. The Facility must develop and implement standard documenting practices to ensure that all clinical issues addressed by the medical clinician are clearly documented. This includes all assessments, treatments, diagnostic reviews, and discussions with others about health care matters of the Individual. (Provision L.1)
7. The etiology of all recurrent medical exacerbations, and conditions, such as recurrent pneumonia, must be assessed, and when possible determined. (Provision L.1)
8. Develop a process to better communicate all relevant medical information to a hospital that has accepted an individual for treatment. It is

paramount that all requested forms by the hospital be completed accurately. (Provision L.1)

9. For continuity of care, medical clinicians must always communicate directly with hospital physicians for all admissions and discharges. Such communications must be documented. (Provision L.1)
10. Medical clinicians must document all known medical conditions on the annual medical assessment, and a meaningful plan must be clearly delineated for each condition. (Provision L.1)
11. The Facility must utilize timely medical specialist consultations when appropriate. For example, individuals with severe neuromotor conditions should be evaluated by various medical specialists, such as orthopedic spine specialists, physiatrists, and neurologist, who specialize in these conditions; individuals with recurrent pneumonia should be assessed by pulmonologists, gastroenterologists, and perhaps movement specialists, when clinically appropriate. (Provision L1)
12. There must be clear, and comprehensive documentation outlining the terminal condition, and all efforts done to reverse the condition, for all individuals who are referred for end-of-life care, such as Hospice. (Provision L.1)
13. Medical clinicians must ensure that all relevant medical information is identified and well communicated at the time of a CLDP, and that all necessary supports and services have been determined and communicated to the accepting agency. (Provision L.1)
14. The Facility must develop an interdisciplinary approach that is well integrated in the team process, to address all neuromotor, and musculoskeletal conditions. The assessment, treatment, and monitoring of individuals with these conditions must improve. (Provision L.1)
15. Individuals with known syndromes, such as Down Syndrome, must be routinely evaluated by the medical clinician for specific complications that are known to occur in such syndrome. (Provision L.1)
16. The Facility must ensure that its immunization practices meet or exceed that of the CDCs recommendations. Importantly, documentation of immunization must conform to CDC recommendations, and all childhood, and previously administered adult vaccines must be confirmed by documentation practices established by the CDC. (Provision L.1)
17. All DNR orders must be supported by a robust clinical review that documents a terminal condition, or demonstrate that chest compressions and artificial respiration would cause undue burden to the individual. Importantly, all DNR orders must conform to local laws, and ethical standards of care. (Provision L.1)
18. Strategies to prevent decubitus ulcers must be enhanced. (Provision L.1)
19. Ensure that a comprehensive review, inclusive of the treating epileptologist and LAR, is provided to each individual who remains on an older AED, determine if the risks and benefits are in favor of alternate therapy to mitigate the use of older AEDs, and ensure that such a review is well documented in the ISP. (Provision L.1)
20. All chronic medical conditions must be assessed routinely by the Facility's medical clinicians, as per standard of care practice. It is not sufficient to evaluate an individual with known chronic conditions once per year. (Provision L.1)
21. The Facility must develop and implement a process that enables the assessment of the quality of medical care and clinical outcomes. Identifying clinical indicators, and tracking them for trends analysis is essential. (Provision L.3)
22. The external medical provider clinical audit process must be enhanced to include a process to determine the medical clinician's clinical skills, and practice performance. (Provision L.2)
23. The Medical Director should review results of the medical provider quality audits with staff medical clinicians. (Provisions L2. And L.3)
24. Develop a mortality review process that ensures comprehensive case review, development of meaningful recommendations, and enables periodic trends analysis of all deaths. (Provision L.4)

The following are offered as additional suggestions to the Facility:

1. Establish a medical consulting room at each major living area. (Provision L.1)
2. Ensure all individuals with chronic medical conditions are examined, and assessed quarterly, in the context of a quarterly medical review.

(Provision L.1)

3. Make sure that assessments of all syndromes and chronic conditions address recommendations and guidelines issues by relevant associations. (Provision L.1)

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 Section M Self-Assessment, 7/12/2012 2. BSSLC Section M Action Plan, 7/6/2012 3. BSSLC Section M Presentation Book 4. BSSLC Nursing Department Organizational Chart 5. Texas Department of Aging and Disability Services (DADS), State Supported Living Center (SSLC), Procedure: Medication Administration Guidelines, Date: February 2011 6. DADS State Supported Living Centers Policy: At Risk Individuals, Policy Number: 006.1, Implemented: 1/1/2011 7. BSSLC Risk Guidelines, Date: 6/18/2012 8. DADS State Supported Living Centers: Case Manager Responsibilities, Date: 12/30/2012 9. DADS, SSLC, Policy: Medication Variance, Policy Number: 053, Effective: 9/23/2011 10. BSSLC Nursing Care: Completing/Routing Fall Evaluation Form Instruction, no date 11. BSSLC Baclofen Pump Troubleshooting Guidelines 12. BSSLC Nursing Minimums by Unit/Cottages 13. BSSLC Nursing Scheduling Process for Cottage Staffing (Pilot for Cottage Staffing) 14. BSSLC Nursing Staffing Report for the past six months 15. BSSLC RN Case Managers' Caseload by Unit/Cottages 16. BSSLC Nursing Ratios for Direct Nursing Staff by Day, Evening, and Night Shifts 17. BSSLC Utilization of Nursing Time Report for the past six months 18. BSSLC Nursing Summary of Overtime and Contract Nursing Report for the past six months 19. BSSLC RN Case Manager Supervisor's Job Description 20. BSSLC Hospital Liaison Nurse Functional Job Responsibilities 21. BSSLC Nurse Manager and Nursing Administration Meeting Minutes for the past six months 22. BSSLC RN Case Managers Meeting Minutes for the past six months 23. BSSLC RN Case Managers and Nursing Service Meeting Schedule for the week of 7/23/2012 24. BSSLC Nurse Managers Meeting Minutes for the past six months 25. BSSLC Nursing Shift Managers Meeting Minutes for past six months 26. BSSLC RN and LVN Staff Meeting Minutes for the past six months 27. BSSLC Nursing Section M Audit Process, Effective: 7/1/2012 28. BSSLC Monitoring of Protocol Cards Process 29. BSSLC Protocol Cards Audit Data, May 2012 through July 2012 30. BSSLC Section M, Nursing Care Seizure Management Monitoring Tool, no date 31. BSSLC Seizure Record Form, no date 32. BSSLC Nursing Section M Audit Tool tracking and Trend Reports for last six months 33. BSSLC RN Case Manager Supervisor's Section M Audits: Annuals, Quarterlies, and Nursing Care Plans 34. BSSLC Inter-Rater Reliability Process Instructions, Draft: January 2012 35. BSSLC Nursing Section M Inter-Rater Reliability Report for the past six months 36. BSSLC Nursing Self-Assessment Audit Instructions, Effective: 4/1/2012

	37. BSSLC Medication Administration Record (MAR) Audit Tool 38. Medication Room Checklist Tool, Dated: 3/1/2012 39. BSSLC Medication Administration Observation Tool, Dated: 1/18/2012 40. BSSLC Medication Administration Observation Schedules for Units and Cottages, Effective: 7/1/2012 41. BSSLC MAR Audit, Medication Room Checklist, and Medication Administration Observation, and Corrective Action Plan Instructions, Effective: 4/1/2012 42. BSSLC Control Drug Count Record, no date 43. BSSLC Process for MAR, Medication Room Checklist, and Medication Administration Audits, Effective: 6/1/2012 44. BSSLC Medication Variance Committee Meeting Minutes, 1/18/2012, 3/29/2012, 4/25/2012, and 5/29/2012 45. BSSLC Pharmacy and Therapeutic Committee Meeting Minutes, 1/19/2012 and 4/26/2012 46. BSSLC Medication Errors/Variances 12 Month Summary: First, Second, Third, and Fourth Quarter 2011 and to date 47. BSSLC Medication Administration Related to Physical and Nutritional Management Issues, Competency-based Training Curriculum, Date 7/23/2012 48. BSSLC Infection Control Committee Meeting Minutes, 1/27/2012 49. BSSLC Infection Control Spread Sheet for Infectious and Communicable Diseases, October 2010 through January 2012 50. BSSLC Varicella Zoster Immunoglobulin G (IGG) Spreadsheet, December 2011 through February 2012 51. BSSLC Pneumonia/Aspiration Pneumonia Spread Sheet, February 2011 through January 2012 52. BSSLC Immunization Record Spread Sheet, to date 53. BSSLC Antibiogram, 12/1/2012 through 5/31/2012 54. BSSLC Infection Control Guidelines, 12/23/2011 55. BSSLC Percentage of Individuals Current with Flu Vaccination, 6/26/2012 56. BSSLC Percentage of Employees Current with Flu Vaccination, 5/27/2012 57. BSSLC Percentage of Individuals current with Tuberculosis Bacilli (TB) Screenings, 6/23/2012 58. BSSLC Employee TB Compliance Status, 6/28/2012 59. BSSLC Hand Washing/Hand Sanitize/Glove Use Observation Procedure, Revised: 2/1/2012 60. BSSLC Analysis of Hand Washing Data, January 2012 through May 2012 61. BSSLC Infection Control Rounds/Inspections, December 2012 through May 2012 62. BSSLC "Real Time" Acute Infection Audit Instruction Sheet, Dated: 4/23/2012 63. BSSLC "Real Time" Audit Results and Plan of Action, 7/19/2012 64. BSSLC Infection Control Environmental Form Completion Instructions, Revised: 5/31/2012 65. BSSLC Trend of Employee Infection Report, 5/28/2012 66. BSSLC Competency Training and Development (CTD) Cardiopulmonary Resuscitation Training Due/Delinquent, Printed: 7/3/2012 67. BSSLC Medical Mock Emergency Drill Schedules, Completed Drill Sheets, and related Incident Management Review Team Meeting Minutes, January 2012 through May 2012 68. BSSLC Staff Responsibilities Regarding CPR Mock Medical Emergency Drills, no date 69. BSSLC CPR Mock Drill Summary, December 2011 through May 2012

	70. BSSLC Emergency Equipment Competency-based In-service Training Material, Effective: 12/1/2011 71. BSSLC Emergency Planning Committee Membership and Committee Mission, 12/13/2011 72. BSSLC CPR Response Committee Meeting Minutes, 1/17/2012, 4/4/2012, 4/18/2012, 5/21/2012, and 5/30/2012 73. BSSLC Emergency Drill Instructor Training and Emergency Curriculum, no date 74. BSSLC Competency-based CPR Heartsaver AED Instructor Lecture, 9/23/2011 75. BSSLC Location for Emergency Equipment on Campus 76. BSSLC Emergency Equipment Checklist Summary for the past six months 77. DADS Enhanced Risk – General Training (Part I – III) Agenda 78. BSSLC Interdisciplinary Quarterlies Pilot Project, Cottages – May 2012 and June 2012 79. BSSLC Hospital/Emergency Room Log, January 2012 through June 2012 80. BSSLC Hospital/Emergency Room Tracking Log, July 2012 81. BSSLC Epi-Pen Training Material and Training Rosters, 1/18/2012 82. BSSLC Avatar Pneumonia Tracking Form, AV.5-Pneumonia Tracking 83. BSSLC Aspiration Triggers Data Sheet, Direct Support Professional Instructions 84. BSSLC Enteral Feeding Clinical Guidelines for Primary Care Providers (PCPs) and Nurses 85. BSSLC Physical and Nutritional Management Teams' Monitoring and Reliability Observations Reports, June 2012 and July 2012 86. BSSLC Nursing News, Editions 1 through 7 87. Sample of 23 Recently Completed Change of Status Reports for Individuals: #337,#380, #527, #69, #269, #96, #395, #331, #259, #490, #336, #366, #151, #543, #35, #51, #254, #242, #554, and #50 (some Individuals had more than one report) 88. Glucometer Calibration Control Logs for Routine Glucose Finger Sticks for Individuals: #185, #547, #377, and #442 89. Sample of Recently Completed Seizure Records and Accompanying Integrated Progress Notes for five Individuals: #323, #26, #474, 269, and #428 90. Sample of 10 Enteral Feeding Treatment Records for June 2012 and July 2012 to date, selected across campus for Individuals: #411, #209, #392, #453, #567, #190, #93, #53, #437, and #59 91. Sample of 10 Aspiration Trigger Data Sheets for June 2012, selected across campus for Individuals: #276, #25, #283, #185, #318, #233, #59, #272, #133, and #149 92. Sample of five most recently completed Health Maintenance Plans (HMPs) selected from across campus for Individuals: #264, #493, #473 (two HMPs), and #247 93. Sample of 17 Admission, Annual, Quarterly, and Community Living Discharge Plan Comprehensive Nursing Assessments for Individuals: #527, #284, #371, #547, #31, #576, #75, #331, #318, # 207, #138, #335, #501, #423, #539, #242, and #181 **People Interviewed:** 1. Debra Williams, RN, Chief Nurse Executive (CNE) 2. Sara Colvin, RN, Nursing Operations Officer (NOO) 3. Joy Sorensen, RN, RN Case Manager Supervisor 4. Jill Quimby, RN, Quality Assurance (QA) Nurse 5. Joanne Guard, RN, Infection Control Nurse

	6. Kellie Fitch, RN, Hospital Liaison Nurse 7. Nancy Witt, RN, RN Shift Manager, Assistant Nurse Educator 8. Leona Sian, RN, RN Shift Manager/Durable Medical Equipment Nurse 9. Johnnie Johnson, RN, Nurse Manager, Childress Terrance 10. Stephanie Hintzel, RN, Nurse Manager, Driscoll Gardens 11. Jane Barnett, RN, Nurse Manager, Bowie Springs 12. Tammy Pavlu, RN, Nurse Manager Cottages Estates 13. Susan Fletcher, Lead RN Case Manager, Fannin Villa 14. Connie Horton, RN, MS, APRN, BC, State Office Consultant 15. Numerous Staff Nurses **Meeting Attended/Observations:** 1. Reviewed Section M Presentation Book with CNE, NOO, QA Nurse, 7/23/2012 2. Individual Support Plan (ISP) Annual Planning Meeting for Individual #86, 7/23/2012 3. Meeting with CNE, Risk Manager, and Shift Manager and tour to check all on campus emergency equipment, 7/23/2012 4. Morning Medical Meeting, 7/24, 2012 5. Meeting with State Office Staff Regarding the Revised Integrated Risk Rating Process, 7/24/12 6. Physical and Nutritional Management of Medication Administration Training, presented by Habilitation Therapy Staff, 7/24/2012 7. Interdisciplinary Team Addendum Meeting for Individual #61, 7/24/2012 8. Medication Variance Committee Meeting, 7/24/2012 9. Meeting with State Office Staff, 7/25, 2012 10. Tour of All Medication Rooms on Units and Cottages, 7/25/2012 11. Medication Administration Observations in Driscoll 12. Death Review Meeting, 7/26/2012 13. CPR/Emergency Response Committee Meeting, 7/26/2012 14. Pharmacy and Therapeutic Committee Meeting, 7/26/2012
	Facility Self-Assessment: The Facility stated they were not in compliance with Provision M.1, M.2, M.3, and M.5. and the Monitoring Team concurs. The Facility stated they were in compliance with Provision M.4 and M.6. The Monitoring Team did not concur with these assessments. Although there was evidence that the required training was compliant, in order for this Provision to meet compliance, not only must the State and Facility Nursing Policies, Procedures, Processes, and Protocols be established, implemented, and the nursing staff trained; they must be demonstrated through actual clinical practice sufficient to address the health status of individuals served. The new format used for the Facility Self-Assessment, 7/2012, was much improved over the format used in previous reviews. This provided useful information by the activities they had engaged in for each Provision, as well as including the data they used to validate the activities, and provided a rationale for their self-assessment of compliance toward each Provision. The action step began to include self-initiated

	activities as opposed to only including activities related to the Monitoring Teams recommendations. The information was so valuable that it was included in each of the Provisions of the report to compare their assessment findings to those of the Monitoring Team. In addition, the Action Plan was equally as useful because it provided the Monitoring Team with a status of the action steps taken for each Provision, stated which action steps were completed and/or were on going, and the projected date of completion for action steps that were in progress. The completion of these actions steps should lead the Facility forward toward reaching compliance with this Section of the Settlement Agreement.
	Summary of Monitor's Assessment: Overall the most notable improvements were found in Provision M.1 and M.6. The Facility had hired a much needed RN Case Manager Supervisor and their emergency response system complied with the Emergency Response Policy. The Facility had done an exceptionally good job with complying with the Medication Variance Policy and in meeting other generally accepted standard of practice for medication administration. The remaining Provisions M.2, M.3, M.4, and M.5 showed only minimal improvement since the last compliance review. Continuing improvements need to be made in these Provisions to meet substantial compliance. Provision M.1: The Nursing Department had continued to maintain a stable and motivated Administrative and Management staff. A new position RN Case Manager Supervisor and was filled. Some realignment of nursing positions were made since the last review that included the appointment of a RN Case Manager to serve as the Hospital Liaison Nurse, and another RN Case Manager had been appointed as a Nurse Manager for the Cottages. Staffing patterns and evaluated/analyzed staffing ratios continued to be monitored daily on each shift, monthly and longitudinally. The established minimum staff nurse ratios for all shifts were consistently met for the past six months. Agency nurses used to supplement nursing staff when nurses were on extended leave, or for vacations, or illnesses, or other unforeseen shortages. The Nursing Administrative and Management staff continued auditing the 12 Nursing Care Monitoring Tools. Four of the Nursing Care Monitoring Tools overall percentage of compliance consistently fell below 80%. The Quality Assurance Nurse completed inter-rater reliability checks on the tools monitored by the nursing staff. The Infection Control Program had continued to put various infectious/communicable disease data in the Infection Control Database; however, the data was not analyzed and trended to identify what infectious trends were present or emerging. The Infection Control Committee needs to take a more proactive role in and analyzing and trending the infection control data, particularly as diagnosed infections for pneumonia/aspiration pneumonia, urinary tract infections and cellulitis. It was rare to find documentation in the Integrated Progress Notes indicating the Infection Control Nurse that was notified of infections or that she provided consultation or technical assistance in reviewing Acute Infection Care Plans. The recently appointed Hospital Liaison Nurse was making routine visits to hospitalized individuals,

	keeping the Interdisciplinary Team apprised of their health status, and actively participating at individuals' pre and post hospitalization Individual Support Plan Addendum meetings. The Skin Integrity Nurse was maintaining a Skin Integrity Database and began chairing a Skin Integrity Committee. However, all relevant disciplines did not consistently attend the committee meeting. It is important for all relevant disciplines to attend and actively participate in the committee meeting and take a proactive role in analyzing and trending Skin Integrity data, particularly data for decubitus pressure ulcers, in order to put measures in place to prevent or minimize the incidents of decubitus. There was little documentation that the primary care physician and/or Physical and Nutritional Team and/or nursing staff consistently referred individuals with potential or actual pressure ulcers to the Skin Integrity Nurse to assist with assessments and management. Significant progress was found with the Facility's Emergency Response System. The policy is followed, checks of equipment are done, training continues to occur, drills are documented, and actions complied with all requirements of the Emergency Response Policy. In addition to the requirements of the policy, the Facility and had taken additional measures to improve their emergency response system. Provision M.2: Annual and Comprehensive Nursing Assessments showed improvement in the actual assessments which was probably related to the Physical Assessment Class the RN Case Mangers and RNs were required to take. Minimal improvement was found in the nurses' ability to succinctly summarize raw clinical data to adequately describe individuals' health status progress or lack of progress toward identified nursing diagnoses/problems and risk ratings. The format varied from Unit to Unit and among RN Case Manager, which leads to inconsistency and noncompliance with this Provision. Health Maintenance Plans were not consistently developed for all of individuals' high and medium risk ratings Provision M.3: This Provision showed minimal improvement, except Health Maintenance Plans and Acute Care Plans were more individualized and appropriate to meet individuals' needs, and extraneous information was removed from the care plan template. The nursing protocol cards' information were not consistently incorporated into the Acute Care Plans. The Nursing Department needs to develop a system for evaluating adherence to the protocol and their effectiveness in improving nursing care. The Integrated Risk Review Form and Integrated Health Plan processes was revised, and piloted in the Bowie Unit. The Health Maintenance Plan and Acute Care Plans will no longer be used once this process is fully implemented. Provision M.4: The required nursing training was tracked through to completion. The nursing staff were trained on the 18 protocol cards and all cards were issued to carry with them at all times when on duty. The Nurse Educator had recently developed and implemented an Educational Audit Tool to evaluate nurses' knowledge of the protocols: Although there was evidence that the required training was compliant, the Facility had not yet demonstrated in actual clinical practice implementation of the protocols sufficient to address the health status of individuals served.

	Provision M.5: The Nursing Department had self-initiated several promising processes to improve the integration of services. A Change of Status Form was developed and implemented to inform the Interdisciplinary Team of the need to meet and review. Improvements on the training material for the Aspiration Trigger Data Sheet were made by the dedicated Nurse Educator and the Physical and Nutritional Management Nurse. However, training data was not tracked to determine how many of the actual DSP staff were trained. There was minimal improvement found on recently completed Integrated Risk Rating Reviews and accompanying Action Plans to accurately identify risk ratings and develop an adequate plan sufficient to meet the individuals' mental/health care needs. Provision M.6: This Provision demonstrated the most significant improvements toward compliance. The Nursing Department had fully implemented all aspects of the Medication Variance Policy, 053. There was evidence that all nursing staff were trained on the policy. All Unit/Cottages were inspected using the standardized Supported Living Center Medication Room Audit Tool. The outcome of the audit found that the Units substantially complied with requirements. Medication Administration Observation found compliance with following the individuals PNMPs and followed standards of safe administration practices,. It was positive to find that the State Office Nurse practitioner in collaboration with the Chief Habilitation Therapist had developed a competency-based practicum PowerPoint Presentation on Medication Administration training for the nursing staff' training focused on helping the nursing staff understand the physiology of dysphagia and the risk associated with aspiration during medication administration and included strategies for preventing aspiration. A comprehensive Medication Database was in place, using the root cause method, to track, analyze, and trend all medication variances reports. Medication Data was presented in tabular, graphic, and narrative form. A review of the data and the Medication Variance Committee and Pharmacy and Therapeutic meeting minutes showed that the Nursing Department was using the data to make decisions and to develop plans of correction. Variances that had not been reported were identified, and reporting of these led to an increase in reported variances. To achieve compliance, there must be demonstration over a period of time that the improved accuracy of identification and reporting of variances continues, and that practices to reduce the recently identified medication variances are continued and are effective. The Monitoring Team believes that if the Facility maintains current practices, and particularly shows continuing accurate reporting and effective practices to reduce variances for which nurses are responsible, the Facility will achieve substantial compliance.

#	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	The Facility stated they had performed the following activities to conduct the self-assessment: Staffing: • At the current time with a census of 302, staffing ratios were reviewed on a monthly basis and were as follows: o Homes with individuals that require intensive medical care: Day Shift: 1 nurse to 10-13 individuals; Night shift: 1 nurse to 13-20 individuals; and Case Manager coverage: 1 Case Manager to 12-15 individuals	Noncompliance

#	Provision	Assessment of Status	Compliance
	appropriate records of the individuals' health care status sufficient to readily identify changes in status.	o Homes with individuals that require intensive behavioral/psychiatric interventions: Day Shift: 1 nurse to 15-30 individuals; Night Shift: 1-2 nurses covers the units; and Case Manager coverage: 1 Case Manager to 12-23 individuals • On June 1, 2012, Cottages nursing staff began a pilot program on self-staffing. Staff were not to be floated to or from the Cottages; they will cover the homes with their own staff. Based on the outcome of this pilot, consideration will be given to expanding self-staffing to other units. • A meeting was held with Nurse Managers to designate areas on the units where floated personnel will be assigned. Staff will have the opportunity to train on designated units if needed. Nurses in New Employee Orientation will be cross-trained in those areas. • At the current time, 112 of the 119 budget positions are filled. Openings include one RNII position on the day shift and one on the evening. Also three LVN positions on evenings and one on nights were currently open. Currently there was an opening for the Hospital Liaison Nurse position. • The current turnover rate for all nursing staff was 10.3% (unit nurses 7.21% and administrative/management staff 3.09%) based on a six month average. • Agency and overtime hours were utilized to cover vacant positions, extended sick leave, regular sick, and nurses out on non-direct contact. Also alternate 16 hour shifts were developed to help cover open shifts. These staff work 32 hours a weekend and an additional eight hours during the week. Shifts were also covered by Shift Managers or RNs on Call to maintain staffing at least at minimum staffing levels on the campus. No shifts had fallen below minimum staffing levels since last review period. • Recruitment efforts continue by having RN Bachelor Degree students from Prairie View, A and M University serve rotations at the Facility. On 7/9/12, the Nurse Recruiter visited the Zelda L. Allen School of Nursing, a Vocational Nursing Program to inform the students of employment opportunities at the Facility. These were excellent means for recruiting nurses for both levels of nurses. <u>Quality Assurance Efforts:</u> • Section M Nursing Care Monitoring Tool audits were assigned and completed by different members of the nursing team as follows: o Medication Administration - Nurse Managers o Seizure Management, Pain, and Respiratory - RN Case Managers o Acute Illness/Injury - Shift Managers o Skin Integrity/Infection Control - Infection Control Nurses o Health Care Plans - Nursing Education and RN Case Manager Supervisor o Documentation - Nurse Managers	

#	Provision	Assessment of Status	Compliance
		o Urgent Care/ER/Hospitalizations - Hospital Liaison Nurse o Prevention - Quality Assurance (QA) Nurses o Quarterly/Annual Nursing Assessments - Nurse Educator and RN Case Manager Supervisor o In April the sample size for Section M Nursing Care Monitoring Tool audits were increased to 15 with the Lead QA Nurse providing the randomly selected names for chart review. QA Nurses now only complete the Prevention Monitoring Tools. The QA Nurses provided the inter-rater reliability audits on Section M Nursing Care Monitoring Tool audits. • Self-Assessment audits were assigned and completed by different members of the nursing team as follows: o Medication Administration Records (MARs) Audits – QA Nurses/Nurse Managers o Medication Room Checklist - QA/Nurse Managers o Medication Administration Observations – QA Nurses/ Shift Managers/Nurse Managers • Documentation showed improvement in some areas as evidenced by audit results. Any areas falling below 80% on the Nursing Care Monitoring Tools were returned to the appropriate nursing administrative/management staff for follow-up and/or corrective action. • Audits were completed by all levels of the nursing team. These audits were forwarded to the Nursing Operation Officer who collected these forms and forwarded them to the QA Nurses who provided tracking, analysis, and trending. The analyzed and trended reports were returned to the Nursing Operation Officer who distributed the results to the Nurse Managers. On a monthly basis the Nurse Managers evaluated data for trends on their respective units and provided corrective actions as necessary. • On a quarterly basis the Chief Nurse Executive, Nursing Operation Officers, Nurse Educators and QA Nurses met to identify systemic trends and developed educational training and/or corrective action plans for trends identified. • The Seizure Management Monitoring Tool and the Seizure Record were both revised to make them more compatible with each other and were put in place in May 2012. The Nursing Department continued to monitor seizure data trends to evaluate for improvements and/or to identify if further corrective action was needed. <u>Assessment and Documentation of Individuals with Acute Changes in Health Status:</u> The Chief Nurse Executive, Hospital Liaison Nurse, and RN Case Manager Supervisor attended the morning medical meetings. The Hospital Liaison Nurse reported on hospitalized individuals. The RN Case Manager Supervisor reported any discussions or issues from the physician's reports that were pertinent to the RN Case Managers, such as overnight emergency room visits, and/or other medical/health related problems/issues. <u>Hospital Liaison Activities:</u> • The Hospital Liaison Nurse was integrated into IDT meetings for hospital, transition,	

#	Provision	Assessment of Status	Compliance
		and post hospital individuals, to provide input on the individual's physical condition. The Hospital Liaison Nurse shared with the team any communication from hospital staff such as case managers, social workers, and/or physicians. The Hospital Liaison Nurse also assisted with the discharge process by communicating with appropriate team members to allow a smooth transition back to their home. • The Hospital/ER Visit Log included verification of documentation for PNMT Nurse Post Hospital Assessments/Evaluations, Hospital Liaison Nurse Reports, and ISPA meeting dates. • The Hospital Liaison Nurse was vacated in February 2012 and a new Hospital Liaison Nurse started in March 2012. Unfortunately, this position became open in May 2012. The position was reposted with interviews occurring, but the position was not filled until July 1, 2012. The Hospital Liaison Nurse responsibilities were distributed to various members of the nursing administration staff until the new Hospital Liaison Nursed was hired. <u>Skin Integrity Activities:</u> • Decubitus Report was completed each month and forwarded to QA Nurses each month. No trends or patterns noted. • Skin Integrity Monitoring Tool audits were completed by the Infection Control Nurses instead of the Skin Integrity Nurse who started in March 2012. • Decubitus Reports were reviewed at the Quarterly Skin Integrity Meetings. <u>Infection Control Activities:</u> • Infection Control Databases were in place. • The Infection Control Nurses evaluated Nursing Care Plans for individuals with infectious/communicable diseases. Care Plans were forwarded to the Infection Control Nurse from the Care Plan Committee, who resubmitted them to the Committee if changes were needed. • The Infection Control Nurses and QA Nurses developed process for Real Time Audits for Infection/Communicable diseases. • Individuals' were 100% current with TB screening. • Individuals' were 95.5% current with annual flu shots; 2% of the individuals had an allergy, and 2.5% of individuals did not have family consent given. • Hand washing observations continued through this evaluation period with a total of 312 observations completed, which included direct support professional staff, Competency Training and Development (CTD) staff, Qualified Developmental Disability Professionals (QDDPs), administrative staff, nursing staff, and 168 new employees in orientation. Monitoring continued on each unit and retraining occurred as necessary. • The Lead Infection Control Nurse became a member of the Pharmacy and Therapeutics Committee to evaluate the effectiveness of antibiotic therapy	

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prescribed.
• The Lead Infection Control Nurse was actively working toward Infection Control Certification.
<u>Mock Medical Emergency Drills and Emergency Response System:</u>
• Tracking, analysis, and trending was developed for completed Emergency Mock Drills.
• The number of staff conducting Medical Emergency Mock Drills was reduced to a core group of 10, which included the Nurse Educator, Night Supervisors, and CDT staff. Training was provided to this group on the use of the emergency equipment and staff responsibilities during the Medical Emergency Mock Drills.
• Mock Medical Emergency Drill Summary:
<table>
<tr><th>First Quarter</th><th>Overall</th><th>Second Quarter</th><th>Overall</th></tr>
<tr><td>Scheduled</td><td>31</td><td>Scheduled</td><td>28</td></tr>
<tr><td>Completed</td><td>27</td><td>Completed</td><td>28</td></tr>
<tr><td>Passed</td><td>27</td><td>Passed</td><td>27</td></tr>
<tr><td>Percent Passed</td><td>100%</td><td>Percent Passed</td><td>96%</td></tr>
<tr><td>Percent completed</td><td>87%</td><td>Percent completed</td><td>100%</td></tr>
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• A process change occurred in which all drills were reviewed by Incident Management Review Team (IMRT) and presented problems to the Chief Nurse Executive. After competed drills were reviewed, if plans of correction were needed, they were sent to the Unit Director for follow up and training.
• A Medical Emergency Code Sheet was developed by the Cardiopulmonary Resuscitation Committee to record actual emergency codes. This sheet was discussed in annual refresher competency testing, but the committee felt it should be retrained again. Nurses have been retrained at approximately 90% completion. Plans were to have 100% completion by July 31, 2012.
• Emergency Equipment was checked daily by nursing staff and monthly by Risk Manager, who confirmed that all equipment was present and in working order.
<u>Other:</u>
• BSSLC was selected to pilot an electronic copy of the MOSES/DISCUS. The RN Case Manager Supervisor, a member of the records department, and a Psychiatrist, were working on developing training and were working with the State Office to make the process user friendly. Once they become familiar with the system, campus-wide training will occur with the RN Case Managers.
• Nine more nursing protocol cards were rolled out. All together there were18 protocol cards. All nurses are required to have these protocol cards in their possession when on duty. There was a 100% training completion rate on the protocol cards for incumbent nursing staff. All protocol cards were trained and provided to new nurses in New Employee Orientation.
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#	Provision	Assessment of Status	Compliance
		• The importance of documentation was incorporated at the annual competency fair. The SOAP format was being used consistently campus-wide. • <u>The results of the self-assessment:</u>	

Quarterly Results	January	April
Acute Illness and Injury	89%	89%
Documentation	76%	74%
Infection Control	80%	83%
Management of Chronic Respiratory Distress	57%	59%
Pain Management	78%	82%
Seizure Management	62%	59%
Skin Integrity	37%	74%
Urgent Care/Emergency Room and Hospitalizations	81%	89%

Any areas falling below 80% on the Nursing Care Monitoring Tools were returned to the appropriate nursing administrative/management staff for follow-up and/or corrective action.

- Inter-Rater Reliability Tracking, analysis, and trending was completed by QA Nurses starting in February 2012. The percentage of agreement between nursing's and QA Nurses' audits was recorded as follows:

Nursing/QA Nurses Percentage of Agreement	February	March	April
Acute Illness and Injury	84%	76%	N/A
Documentation	67%	N/A	58%
Infection Control	85%	88%	98%
Management of Chronic Respiratory Distress	39%	N/A	58%
Pain Management	60%	53%	77%
Seizure Management	76%	73%	68%
Skin Integrity	N/A	81%	100%
Urgent Care/Emergency Room and Hospitalizations	N/A	83%	67%

<u>Self-rating:</u>
Based on the findings from this self-assessment, this provision was not in substantial compliance because of the failure to obtain 80% or greater compliance in the areas of documentation, management of chronic respiratory, seizure management, and skin integrity.

<u>Monitoring Team Findings</u>
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

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		and emergency response system. Additional information regarding the nursing assessment, development, and implementation of health care plans is found below in Provisions 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 Provision M.1 Self-Assessment stated they were not in compliance with this provision and the Monitoring Team concurs. A review of the Provision. M.1 Self-Assessment, 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 299. The Nursing Department continued to maintain a stable and highly dedicated and motivated staff. The 119 total nursing positions remained unchanged from the last compliance visit, which consisted of 67 Registered Nurse (RN) positions of all levels and 42 Licensed Vocational Nurse (LVN) positions. At the time of the visit there was one vacant RN position and eight LVN positions. The Nursing Department's Administrative and Management staff continued to have an excellent and effective method of monitoring staffing daily on each shift and analyzing staffing patterns and utilization monthly. These activities included, but were not limited to: Monthly hours of nursing overtime worked, hours worked by agency nurses, unit and cottages shift ratios, and turnover rates. Since the last review the Chief Nurse Executive (CNE) had begun evaluating turnover rates of both the professional and floor nurses. A review of the average overall nursing turnover rate for the past six months was 10.3%, the average turnover rate for professional nurses was 3.09% and for floor nurses was 7.21%. The evaluation of nursing turnover rates showed promise in identifying issues effecting retention and recruitment. 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. When there were nursing shortages in staffing the sift Managers and/or the RN on call provided coverage. Agency nurses continued 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. Based on a review of nursing staffing documentation and interview with the CNE, the Facility appeared to have an adequate	

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		number of nursing staff. Some innovative strategies were being tried to improve staffing. In June 2012, the Cottages began a pilot project for self-scheduling. No Cottage nurse was to float off the Cottages, nor will any nurse from the Units float to the Cottages. If 'call-ins" occurred the Cottages nurses had to work out coverage themselves. If the pilot project for staffing works out in the Cottages, self-scheduling will be implemented in the Units. In addition, the Nurse Managers dedicated a home on each Unit that was assigned a float nurse. This nurse would provide coverage when there was a shortage in any other of the Unit's homes. The outcome of these strategies to improve staffing will be reviewed at the next compliance visit. There had been some realignment of nursing positions to enhance nursing services. Recently, two RN Case Managers were reassigned, one to serve as the Hospital Liaison Nurse and the other as the Nurse Manager for the Cottages. A tour of the Cottages and interview with the recently assigned Nurse Manager for the Cottages was beginning to show improvement in the overall organization and structure of nursing services. The Hospital Liaison Nurse began her new position July 1, 2012 and was beginning to assume her role and responsibilities, as described below. The new position for a RN Case Manager Supervisor was filled since the last compliance visit, and was directly responsible for supervising the Nurse Case Managers. The RN Case Manager Supervisor reports to the Nursing Operations Officer. The addition of the RN Case Manager Supervisor should improve the quality and consistency performance of the Unit RN, Case Managers, as well as freeing the Unit Nurse Managers to provide more direct supervision of the staff nurses. In addition, during the summer two high school students who were interested in pursuing a career in nursing were providing volunteer services. The students assisted the nursing staff by running errands and were paired with nurses to learn the role of Developmental Disability Nurses. 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. It was positive to find in January 2012 the Nursing Department had begun monthly publication of the BSSLC Nursing News Letter. A review of the BSSLC Nursing News Letters found them news worthy, containing motivational news, reminders, list of upcoming events, and numerous other tidbits of information. <u>Quality Assurance Efforts:</u> Since the last compliance review, in an effort to make improvements in the monitoring	

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		processes, the Nursing Department and QA Nurse had revised the auditing processes for Nursing Care Monitoring Tools and Self-Assessment Audits. The changes are listed below: • The sample list for monitoring was chosen by the Quality Assurance Department every month and given to the Nursing Operations Officer (NOO). The audit lists were distributed to the appropriate nurses for auditing. The NOO reviewed all of the completed audits. Any discrepancies identified were reported to the appropriate Nurse Manager or RN Case Manager Supervisor with copies of the audits. The Managers were expected to provide training or disciplinary action, as needed, with the respective nurse upon receipt of the information. • All original audit copies were submitted to the Quality Assurance Department for trending and analysis. The Quality Assurance Department provided the trending and analysis results to the Chief Nurse Executive (CNE) and NOO. The NOO reviewed the results with Managers who were expected to address any results lower that 80% with their unit or team. • Every quarter the CNE, NOO, Nurse Educator and QA Nurse met to review audit data for the quarter. Areas below 80% compliance on the Nursing Care Monitoring Tools were reviewed and systemic training provided. • Each month a total of 15 records were audited on Health Care Plans and Quarterly/Annual Nursing Assessments; consisting of four from Bowie and Driscoll; three from the Cottages; and two from Fannin and Childress. Each month the remaining monitoring tools included two records from each Unit, with the exception of the Cottages, for which three records were audited. Monthly the QA Nurse selects sample records for hospitalizations and infection control for audit. The QA Nurse continued to conduct inter-rater reliability checks on records audited by the nursing staff. A review of quality assurance monitoring data for the quarters of January 2012 and April 2012 was discussed with the CNE, NOO, QA Nurse, and RN Case Manager Supervisors, who indicated that they were continuing to put forth concerted efforts toward improving compliance with the Nursing Care Monitoring Tools. Several of the Nursing Monitoring Tools for the last two quarters consistently fell below 80% compliance, particularly the monitoring tools for: Documentation, Management of Chronic Respiratory Distress, Seizure Management, and Skin Integrity. The consistently low percentage of less than 60% compliance on the Nursing Care Monitoring Tool for Management of Chronic Respiratory Distress was of concern considering the Facility's high incidents of morbidity and mortality related to aspiration pneumonias/pneumonias. For this reason, it is essential that the Nursing Department in conjunction with the Physical and Nutritional Team, as well as other relevant disciplines, continue to work collaboratively to reduce the incidents of aspiration pneumonia/pneumonia, which has the potential to be mitigated	

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		with aggressive integrated monitoring and interventions. Refer to Section O and Provision M.5 of the report for efforts put forth to mitigate aspiration pneumonia/pneumonia. A review of the Nursing Department's Nursing Care Monitoring Tool process included a process whereby the Unit Nurse Managers review, develop, and implement local corrective action plans in response to the monthly audit data trend analyses for tools that fall below 80% compliance. Then, the CNE, NOO, Nurse Educator, and QA Nurse review, develop, and implement systemic corrective action plans in response to the monthly audit data trend analyses for tools that fall below 80% compliance. Although the NOO stated that the process was being followed and corrective action plans developed and implemented for local and systemic tools falling below 80% compliance, no corrective action plans were available for review. According to the Facility's Self-Assessment for Section E, they had not yet developed a corrective action planning process and a database to support it. As was found it past review, data items on the monitoring tools were not weighted by value of significance. Therefore, when preparing overall compliance reports for the tools, the most critical data item counted the same as the least significant. The Nursing Department should collaborate with the Quality Assurance Department to evaluate weighting items on the Nursing Care Monitoring Tools by value of significance. The status of developing, implementing, and formalized corrective action plans and tracking to resolution will be reviewed at the next compliance review. Refer to Section E of the report for information related to the Facility's process in developing and tracking systemic corrective action plans for all Sections of the Settlement Agreement. Since May 2012, the recently hired RN Case Manager Supervisor reported a self-initiated process for auditing Quarterly and Annual Nursing Assessments and Health Care Plans. She reported that she had identified discrepancies across campus with the RN Case Managers who have different focuses on completing these tasks. The findings were largely based on their personal training and understanding/interpretation of training in these areas. The RN Case Managers had a varied range of experience from three months to more than 20 years. They also had varied ranges of experience and training. The RN Case Manager Supervisor stated it was necessary for all RN Case Managers to have the same information for continuity of care standards. Having identified these discrepancies, several RN Case Managers have received performance coaching, performance counseling, and disciplinary performance level one. In addition, the RN Case Manager Supervisor began retraining on the individual audits and on what was needed in their documentation in the Quarterly and Annual Nursing Assessments and Health care Plans. She was also conducting monthly audits and random spot audits to monitor the effectiveness of training in these areas. More performance coaching will be utilized as appropriate; and additional training will be done to assure improvement is achieved. These efforts put	

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		forth by the RN Case Manager Supervisor appeared to be promising. The QA Nurse continued to perform inter-rater reliability checks on the same records and timeframe that the nursing staff audited. In reviewing the inter-rater reliability results for the last two quarters, there continued to be a wide disparity in agreement between the QA Nurse and the nursing staff's monitoring tools. The disparity in agreement between the two sets of auditors was discussed. The reason for the disparity was thought due to the different interpretations by different nurses on the items contained on the monitoring tools. The Nursing Department and QA Nurse should consider meeting with the nurse staff responsible for completing the monitoring tools to review, discuss, and clarify the interpretation of the Nursing Care Monitoring Tool Guidelines, and to revise and/or clarify the guidelines to ensure that all auditors come to an agreement on interpreting items on the monitoring tools. Any revisions and clarifications to the guidelines should be written so that new auditors will operate on the same definitions, and so that there will be no unrecognized drift in definitions resulting from such discussions. <u>A review of the Nursing Department's Self-Assessment processes for auditing Medication Administration Records, Medicine Room Checklists, and Medication Administration Observations</u> • Medication Administration Records (MARs): Nurse Managers complete five records from each home every week. Completed audits are submitted to the Nursing Operations Officer (NOO) at the end of the month for review. After the review, audits are submitted to the Quality Assurance Department for trending and analysis. The results of the trending and analysis are discussed with the Nurse Managers and the Medication Variance Committee. The Nurse Managers are responsible for plans of corrective or disciplinary actions. All plans of corrective or disciplinary actions are reviewed by the NOO. The CNE and NOO will review results quarterly for improvement and continued compliance above 80%. If improvement is not noted, then training will be completed systemically. However, documentation to validate that corrective action taken as a result of the CNE and NOO review was not available to the Monitoring Team for review. Therefore, compliance with these processes could not be determined. • Medication Room Checklist: Nurse Managers will check one medication room per Unit per week, with the exception of the Cottages where two medication rooms are checked per week. The completed audits are turned in monthly to the NOO; who reviews and submits the completed audits to the Quality Assurance Department for trending and analysis. The NOO reviews the trending and analysis results with the Nurse Managers. For all results below 80% compliance on the audits the Nurse Managers are responsible for plans of corrective or disciplinary actions. All plans of	

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		corrective or disciplinary actions are reviewed by the NOO. There was documentation made available for review that demonstrated that the NOO reviewed these audits and took corrective action. The corrective actions for improvement and effectiveness are reported in Provision M.6 below. • Medication Administration Observations: Medication Administration Observations are completed quarterly. Each Unit has a rotating schedule. Medication Administration Observations are completed by the Nurse Managers on the 6-2 and 6-10 shifts, while the Shift Nurse Managers completes observations on the 10-6 shifts. The completed observations are turned in monthly to the NOO. The NOO reviews and submits the completed observations to the Quality Assurance Department for trending and analysis. When indicated during the observations the nurses are provided "on the spot" retraining. The NOO reviews the trending and analysis of the observations for systemic issues and training as needed. There was documentation made available for review that demonstrated that the NOO reviewed these audits and took corrective action. The corrective actions for improvement and effectiveness are reported in Provision M.6 below. Since the changes in Self-Assessment audits are related to medication administration practices, the findings are reported in Provision M.6. <u>Availability of Pertinent Records:</u> There was no difficulty in accessing the records at this compliance review. The only problem found, as reported in previous reviews, was the illegibility of the individuals' names and demographic information printed on the records by the use of an addressograph card/machine. Either the addressograph cards were too worn to print the information clearly or the machines were out of ink. It is essential that all documents have the individuals' name and demographic information clearly printed. A review of Integrated Progress Notes found the times of the entries were often missing. The nursing staff did not consistently use the military time on the entries of the Integrated Progress Notes, as required by the nursing documentation policy. The Nursing Department reported they had revised both the Seizure Record and the Nursing Care Seizure Management Monitoring Tool to make them more compatible with each other. Neither documents indicated they were reviewed. Since the Seizure Record is part of the active record the date of the revision should have been noted one the bottom of the form to ensure the most current Seizure Record was used. Although the Nursing Care Seizure Monitoring Tool is not part of the active record, it should have also had the date of the revision noted to ensure the most current tool was used. The Nursing Department should ensure any time records/documents are revised or created that they have official numbers and dates of the creation or revision noted to ensure the most current records/documents are used. It is also important to date records/documents created or	

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		revised that are used to record health data even though they may not be part of the active record to ensure the most current records/documents are used. <u>Assessment and Documentation of Individuals with Acute Changes in Status:</u> Since the last compliance review the Nursing Department demonstrated several self-initiated efforts to improve compliance with the assessment and documentation of individuals' acute changes in status and to improve integration of services across disciplines. However, many of the recent efforts put in place did not yet show significant improvement in individuals' acute change of status, as demonstrated, particularly in Provisions M.3 and M.5. Refer to those Provisions for more information. Because of the incompatibility between the Seizure Management Monitoring Tool and Seizure Record, in May 2012, both were revised to make them more compatible with each other. A review of the revised Seizure Management Monitoring Tools and Seizure Records found that the revisions made the two documents more compatible, as well as more consistent with the Nursing Protocol for Seizure Management. This was a positive step forward. The Seizure Monitoring Tool audit results for the past two quarters showed respectively 62% and 59% compliance. A sample review of Seizure Records and accompanying seizure related nursing Integrated Progress Notes, as applicable, for five individuals (Individuals #269, #474, #26, #323, and #428) who experienced seizures since May 2012 found: • Two of the five individuals' Seizure Records had no seizures reported since May 2012. • Forty four Seizures Records were reported for three of the individuals reported to have seizures since May 2012. A review of these records found: o Twenty-six of 44 (59%) Seizure Records were completed accurately with all of the required information on the form. Most often found missing included the following requirements: ▪ Marking the blocks for the individuals had a Vagal Nerve Stimulator (VNS). ▪ Marking the blocks for use of the VNS was used. ▪ Marking the blocks for the effectiveness of the VNS. ▪ Marking the blocks for the Recovery Period (postictal) and/or Status Epilepticus and/or Physician informed. This was consistent with the Nursing Department's percentage of compliance with the Seizure Management Tools. o Thirty-eight of 44 (86%) of the Nursing Assessment/Actions on the Seizure Records were completed according to the Seizure Activity Protocol. o Six of eight (75%) Seizure Records indicating medication (Ativan 3 mg Intramuscularly) was required for seizures lasting three to five minutes	

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		noted that the physician was notified and contained accompanying Integrated Progress Notes as required describing the seizure activity, nursing assessments and actions, nursing follow up monitoring, and notification of the physician. Although there was marginal improvement found since the Seizure Record and Seizure Management Monitoring Tool were revised to become more compatible, there remains the need for the Nursing Department to further improve compliance with the Seizure Management Protocol, particularly with regard to accurately and completely filling out the Seizure Record; including retraining the nursing staff and Direct Support Professional staffto consistently complete their section of the Seizure Record. <u>Hospital Liaison Activities:</u> It was positive to find through interview, observation, and review of records of hospitalized and/or recently hospitalized individuals that the Hospital Liaison Nurse, who assumed the position in July 2, 2012, had engaged in the following activities: • Attended and participated in the Medical Morning Meetings to update the team on individuals' hospital status. • Attended and participated Interdisciplinary Team (IDT) and Interdisciplinary Team Addendum (ISTA) meetings for hospitalized and/or discharged individuals. • Served as a backup to the PNMT Nurse for Completing the PNMT Nurse Post-Hospitalization Assessments/Evaluations. • Since the last compliance review, in May 2012, the Nursing Department developed and implemented a Hospital and Emergency Room Visit Tracking Log in an effort to further ensure integration of services and to verify completion of the required documentation and follow up for information related to the Nursing Hospitalizations, Transfers, and Discharges Protocol, PNMT Nurse Post-Hospitalization Assessments/Evaluations, Hospital Liaison Reports, Support Plan Addendums (ISPAs) meeting were completed on discharged individuals, and other pertinent hospitalization/emergency room visits and discharge requirements. The Hospital Liaison Nurse was responsible for completing the log and monitoring for compliance with the items included on the log. The Hospital Liaison Nurse performed the following activities related to maintaining the Hospital and Emergency Room Visit Tracking Log: o Reviewed and updated the log daily. o Ensured that within two business days of individuals' return from the hospital that Hospital Liaison Reports, daily progress notes, and PNMT Nursing Assessments/Evaluations were completed and filed in individuals' active records. o Reviewed log for the Post Hospitalization Nursing Assessments; if not completed the RN Case Managers were contacted.	

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		o Requested the PNMT Nurse to send the copies of all PNMT Nursing Post Hospitalizations Assessments/Evaluations. If the information was not received within three business days the Hospital Liaison Nurse contacted the PNMT Nurse. o Requested the Qualified Developmental Disability Professional (QDDP) Coordinator have the individuals' QDDPs notify the Hospital Liaison Nurse of all ISP/ISPA meetings and to ensure her attendance at the meetings. o Reviewed log for inclusion of pertinent ISP information, if the information was missing the QDDPs were contacted. This was a positive step forward for ensuring that individuals' services were integrated related to hospitalizations and emergency room visits, as well as compliance with the Nursing Hospitalizations, Transfers, and Discharge Protocol, PNMT Nursing Post-Hospitalization Assessments/Evaluations, and post-hospitalization ISPA meetings. The effectiveness of the PNMT Nursing Assessments/Evaluations Hospitalization/Emergency Room Visit Tracking Log will be reviewed at the next compliance review. • Further documented evidence of the Hospital Liaison Nurse's activities included reviews of hospitalized or recently discharged individuals' records: It was positive to find improvement in compliance with the Hospital, Transfer and Discharge Nursing Policy. Records reviewed on Individuals: #61, #335, #207 and #75 who were or were currently hospitalized found: o Individual #61: The Monitoring Team attended a special called IDT meeting regarding Individual #61's sudden change of status while undergoing a routine colonoscopy where the Hospital Liaison Nurse actively participated in the meeting: On 7/24/12, after the colonoscopy Individual #61's oxygen saturation level dropped down to the mid to high 70's and was coughing up a small amount of blood. Consequently Individual #61 was admitted to the Intensive Care Unit (ICU). Upon the notification of Individual #61's aspiration and admission ICU, the Hospital Liaison Nurse visited the hospital to obtain an update on her change of status. Subsequently, after the Hospital Liaison Nurse's visit to the hospital, the IDT met to explore possible contributing factors that could have caused Individual #61 to aspirate. The Hospital Liaison Nurse will continuously keep the IDT informed of Individual #61's condition and will meet with the team upon hospital discharge to reassess her risk ratings and plan of care. o Individual #335: Individual #335 was admitted to the hospital's ICU on 4/28/12 for aspiration pneumonia and was later transferred on 5/1/12 to a Long Term Acute Care Facility's (LTAC) ICU. A review of the Hospital Liaison Nurse's Integrated Progress Notes, 7/2/12 through 7/23/12, showed that she had consistently checked on Individual #335 and kept the IDT informed of her health status.	

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		o Individual #207, who was hospitalized for respiratory distress and chronic obstructive pulmonary disease on 514/12 and discharged on 5/30/12 and was hospitalized again on 62412 and discharged on 6/29/12, found documentation that the Nursing Hospitalizations, Transfers, and Discharge Protocol, PNMT Nursing Post-Hospitalization Assessments/Evaluations, Hospital Liaison Nurse visits, and post-hospitalization ISPA meetings were completed according to policies. o Individual #75: There was documentation that the Hospital Liaison Nurse attended and participated in Individual #75's post-hospitalization ISPA meeting on 7/18/12 to reassess his Integrated Risk Rating Review and revised plan of care. <u>Infection Control Activities</u> A review of the documentation, and information gathered during the review, indicated that the Infection Control Program had made minimal progress since the last compliance review. Findings of the review included: • The Immunization Record Tracking Database was completed, which included the immunization status of all of all vaccines to date. This should be helpful to the medical staff and the RN Case Manager in having ready access to the immunization status of individuals. The database was limited because it did not include a "flag" to alert when individuals routine immunization were due for revaccination. • A Varicella Zoster Immunoglobulin G (IGG) Spreadsheet was developed and implemented that listed individuals' Varicella Zoster IGG status. • A Pneumonia Spreadsheet was made available for review but there was no explanation as to its use, nor was there trend analysis of the data available for review. • The Infection Control Spread Sheet of a running total dating back to 2010 to date for reportable infectious/communicable diseases was made available for review. However, there was no analysis or trend data included. Therefore; it was not possible to determine whether or not there were any infectious/communicable disease trends occurring at the Facility. • Reportable infections were entered into the Infection Control Database which generated quarterly analyses of Infections by Type Reports. However, no data for Infections by Type Reports were made available for review. Neither were trend analyses of data for infections/communicable diseases made available for review. Therefore; it was not possible to determine whether or not there were any infectious/communicable disease trends occurring at the Facility. • The Infection Control Nurse reported that she reviewed care plans for infection and provided consultation to the staff. However, it was rare to find documentation in the Integrated Progress Notes that this was accomplished. • An Antibiogram (oral and injectable antibiotics) specific to BSSLC was developed	

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		based on cultures and sensitivities, which included the percentage of susceptibility for all cultures for the period 12/2/2011 through 5/31/2012. The Infection Control Nurse recently began attending the Pharmacy and Therapeutic Committee Meetings to review Antibiograms regarding the effectiveness of the Facility's use of antibiotic therapy. Refer to Provision M.6 for information related to its use. • The percentage of individuals' current with Tuberculosis (TB) Screenings was reported at 100%. However, the number of individuals who had converted TB Skin Tests was not identified. It is essential that individuals who have converted are clearly identified to ensure that appropriated medical follow ups are provided. • The percentage of individuals current with annual influenza vaccinations was reported at 95.5%. Two percent of the individuals did not receive the vaccine due to egg allergies or the family refused to give consent for the influenza vaccinations. For the remaining 2.5% of the individuals, their families had not returned the consent forms. • The percentage of employees who had received annual influenza vaccinations was reported at 26%. Influenza vaccinations were not a requirement to work at the Facility. Although influenza vaccination are not a requirement for employees it is an excellent means to prevent the spread of influenza to a medically complex and fragile population and should be strongly encouraged. • The CTD's Delinquent and Due list of employees was not available for review to determine the status of incumbent employees who were current and/or due for Infection Control refresher training. • An instruction sheet for "Real Time" Audit for Acute Infections was developed 4/23/2012. The Infection Control Nurse reported they were in the process of implementing "Real Time" audits July 2012. There was no documentation available regarding the status of completing "real time" follow up by the Infection Control Nurses on acute infections. Therefore, the status of implementation and effectiveness of the "real time" follow up on acute infections could not be determined. • The Infection Control Nurse provided training on Handwashing and Standard Precautions at New Employee Orientation and at annual refresher training. • The Handwashing Observations Report indicated observations were conducted on each Unit on each shift for DSPs, CTD staff, QDDPs, administrative staff, and nursing staff. No Handwashing Observation data for medical staff were reported. There were 260 observations completed for incumbent staff and 168 observations made for new employees. There was no trend analysis data available for review for evidence of corrective action taken if deficiencies were found. • The Infection Control Rounds Report for December 2011 through May 2012 was made available for review. The report included two findings of environmental problems located in Building 503 and Fannin A bathroom. The report did not indicate the number of rounds/environmental surveillance observations made or	

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		provide trend analysis data. Therefore, the degree of compliance with the environmental surveillance observations could not be determined. • Quarterly Infection Control Committee Minutes for 1/27/12 were the only minutes made available for review for the past six months. While improvement was found in the content of discussions and dispositions of the minutes, there was no formalized trend analyses of infection control data included that would have alerted the committed if local or systemic infectious/communicable diseases were occurring so that preventative intervention could be put in place to prevent or minimize their spread. For example, the minutes stated that the Infection Control Nurse was notified of a number of individuals on Childress, Driscoll, and Bowie who were being treated for carbuncles, boils, and other skin infections, which are typically caused by Methicillin-resistant Staphylococcus aureus (MRSA) organism. This organism is highly contagious and can lead to serious complications, particularly in a medically fragile population. The discussion did include preventative intervention taken to prevent the spread of infections with in the affected Units. It was of concern that these infections were not immediately identified by the Infection Control Nurse who should have informed the Units of the infections as opposed the Units notifying the Infection Control Nurse. If the Infection Control Nurse had performed "real time" monitoring of infections, the infections should have been identified at the time they were diagnosed and immediately taken preventative measures. It is essential that infectious/contagious diseases are identified promptly and preventative measures put in place to prevent or minimized their spread. According to the minutes the next quarterly Infection Control Committee Meeting was to occur on 7/25/12. The minutes of this committee meeting were not available for review, if the meeting occurred. Therefore, it was not possible to determine improvements or the effectiveness of the Infection Control Committee. • The Section M Self-Assessment reported that the Infection Control Nurse evaluated nursing care plans for individuals with infectious/communicable diseases. This was not consistent with the Monitoring Team's finding after review of Acute Care Plans for individuals with infections. Six Acute Care Plans and associated Integrated Progress Notes were reviewed for Individuals: #446, #94, #366, #151, #89, and #276. Only Individual #89 had an IPN that reported the urine culture results did not show sensitive to Cipro antibiotic but did show sensitivity to Levaquin, and consequently the antibiotic used to treat Individual #89's Urinary Tract Infection was changed to Levaquin. None of the Individuals' IPNs documented notification of the Infection Control Nurse of their various infections, nor was there any documented evidence the Infection Control Nurse had provided the nursing staff with review and consultation on the Acute Care Plans. As was identified and recommended at the last compliance review, the Infection Control	

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		Program should ensure the following improvements are made: • The Infection Control Committee should make better use of information derived from the Infection by Type Reports and other infection control spreadsheets and databases 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. • The Infection Control Nurse should develop and implement formalized procedures/processes to address the reliability of infectious/communicable disease data reported to ensure all incidents of infectious/communicable diseases .are reported and that the reports are timely. • The Infection Control Nurse should ensure that "real time" audits are completed on diagnoses of 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 continue to collaborate with the Nurse Case Managers and other relevant staff to develop and implement plans of care a when acute infectious/communicable diseases are reported to ensure appropriate clinical interventions are put in place to control/prevent their spread. The Infection Control Nurse should document such actions taken in the respective individuals' Integrated Progress Notes. <u>Skin Integrity Activities:</u> Since the last compliance review, minimal progress was found relating to skin integrity activities. During part of the last six months the Skin Integrity Nurse was also working as a RN Case Manager. At the time of this compliance visit she was working fulltime as the Skin Integrity Nurse. Improvements/changes made included: • Development of a monthly Decubitus Tracking Database • Began conducting quarterly Skin Integrity Committee Meetings. • Worked collaboratively with the Nurse Educator and developed a Wound Dressing Protocol to be added to the Nursing Guidelines. • Starting in May 2012 Skin Integrity Monitoring Tool was changed to be audited by the Infection Control Nurse. According to the May 2012 Decubitus Tracking Report the Facility had four unduplicated individuals with pressure ulcers. The duplicated count indicated that the four individuals	

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		had more than one pressure ulcer sites, and there were five pressure ulcers acquired at the Facility with two pressure ulcers acquired in the hospital. There were no Decubitus Tracking Reports for June and July 2012 available for review. The Monitoring Team's review of the incidence of decubitus ulcer data supplied containing raw number of decubitus for September 2011 through May 2012 (ten months) identified there were 38 unduplicated individuals reported to have sustained a decubitus ulcer. Of the 55 total decubitus ulcers diagnosed, 48 (87%) were Facility acquired; six of 55 ulcers were Stage I (11%); 37 were Stage II (67%); five were Stage III; and seven were Stage IV (13%). Based on these finding it is essential that the Skin Integrity Committee analyze and trend decubitus data to identify the contributing factors leading to the development of decubitus ulcers and develop and implement plans of corrections to mitigate their occurrence. Later, the Facility provided clarification that during this 10-month period, there were actually only 18 new occurrences. The Monitoring Team accepts this but was not able to reconcile the data. It will be helpful if the Facility could provide clear and concise data at the next compliance visit. The Skin Integrity Committee Membership was comprised of: • Skin Integrity Nurse, Chairperson • Chief Nurse Executive • Nursing Operations Officer • Infection Control Nurse • Medical Director/Representative • Habilitation Therapy Director/Representative • Quality Assurance Nurse • Nurse Manager Representative • Unit Director Representative • QDDP Representative • Psychology Representative A review of the Skin Integrity Committee Meeting Minutes found no quarterly meetings had been conducted from December 2011 until June 1, 2012. The committee reviewed the monthly compliance monitoring data for March 2012 which was 84%, April 2012 which was 96%, and May 2012 which was 100% with an overall average for the three months of 93.3%. They were pleased that the data showed improvement in compliance with the Nursing Care Skin Integrity Monitoring Tool for the previous months/quarters, which were reported for the quarters ending in January and April 2012 as respectively 37% and 74% compliance. The Sign-in Roster for this meeting did not include the attendance of key disciplines, such as the Habilitation Director/Representative, Quality Assurance Nurse, Unit Director/Representative or QDDP Representative. In order for the Skin Integrity Committee to function effectively all relevant disciplines should attend and	

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		contribute to the meeting to ensure that skin integrity services are integrated across all disciplines and that the Committee analyze and trend longitudinal decubitus data. A review of Individuals #207 and #284 who were at risk for skin integrity issues found: • Individual #207 was assessed at medium risk rating for skin integrity at his annual ISP and had a Health Maintenance Plan for Skin Integrity. Upon return from the hospital on 5/30/12 he was found to have a Stage II Pressure Ulcer on the right buttock. On 6/29/12, he returned from another hospitalization with a persistent Stage II Pressure Ulcer on the right buttock and had acquired what was described as appearing like a Kennedy Ulcer on the coccyx (an unavoidable skin breakdown or skin failure that occurs as part of the dying process). Individual #207 had numerous other complex risks ratings, a do not resuscitate (DNR) order, and was placed on hospice care 6/29/12. A referral was made to the Skin Integrity Nurse, who provides ongoing assessments and consultation to the nursing staff of the pressure ulcers, assisted with the development and implementation of an Acute Care Plan, in collaboration with the PNMT, and provided training to the staff on the plan. The Acute Care Plan for Skin Integrity was reviewed and found individualized and sufficient to meet Individual #207's skin care needs. A review of Integrated Progress Notes and skin assessment tools indicated that the Skin Integrity Acute Care Plan was consistently carried out by the nursing staff and Skin Integrity Nurse. At the time of review the pressure ulcer to the buttocks was graded at Stage III and the wound to the coccyx showed some improvement. • Individual #284: A review of Individual #284's record indicated that the he was diagnosed with a Stage IV decubitus ulcer on the left Ischial Tuberosity on 10/17/11 and the ulcer was being followed with an Acute Care Plan for Skin Integrity related to the Decubitus Ulcer. However, he was hospitalized on 12/19/11 until 1/12/12 for treatment of pneumonia and anemia and intravenous antibiotic wound care, and later sent to a Long Term Acute Care Facility for further care and treatment of the ulcer. Since returning to the Facility the Acute Care Plan for Skin Integrity was followed every shift, with rare exception, and care was provided in collaboration with the PNMT. By 7/18/12 the Stage VI decubitus ulcer was healed. <u>Mock Medical Emergency Drills and Emergency Response System Activities:</u> It was positive to find since the last compliance review, that the Facility had implemented and were carrying out the requirements of the Emergency Response, Policy Number: 044.2 and were continuing to refine and improve their emergency response system. This was demonstrated through staff interviews, observations, document review, and the Monitoring Team's attendance at the CPR/Emergency Response Committee Meeting. Findings included: • Mock Medical Emergency Drills were scheduled and completed according to policy.	

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		The completed drills were analyzed monthly and summarized quarterly. The results of the completed drills were represented in tabular, bar graphs, and narrative forms. According to documents reviewed for the past two quarters the average completed drills were respectively 87% and 100%. The results of the drills were forwarded to the Quality Assurance Department according to policy. • A review of the Incident Management Review Team Meeting (IMRT) Minutes found evidence that the outcomes of the completed Mock Medical Emergency Drills were reviewed and discussed, with additional recommendations made as necessary, at the IMRT meetings. • In an effort to improve the quality, performance, and consistency among the CPR Drill Instructors/conductors, the core group of staff conducting the Mock Medical Emergency Drills was reduced to 10, which included the Nurse Educator, Night Supervisors, and CDT staff. Training was provided on the requirements for conducting the drills. • The nursing staff were trained on the use of emergency equipment at the February 2012 Annual Nursing Competency Fair. • A review of CTD's Due/Delinquent List found there were no delinquent reports for CPR for Healthcare Providers. There were eight residential employees reported delinquent for CPR Basic, of which four were four or more year's delinquent and four were delinquent by one to three months. • Since the last compliance review, the Nursing Department had developed and implemented a process for monitoring the Emergency Checklists in all areas on and off campus where the emergency equipment was located to ensure that the designated nursing staff checked the emergency equipment daily. This was validated through a review of the Emergency Equipment Checklist Summary for the past six months. When Emergency Equipment Checklists were not completed daily, corrective action was taken with the relevant nurses. • The CPR/Emergency Response Committee developed and implemented a process for Medical Emergency Codes and a Code Sheet for use during and after an actual code event. The nursing staff was trained on the use of the process and Code Sheet. A copy of the Medical Emergency Code Sheet and pen were place with the emergency equipment for ready access in the event of a code. After actual codes the attending staff conducted a debriefing to identify what went right and what needed improvement. After the debriefing, if the code was captured on video, the staff reviewed the tape for further information. In addition, the CPR/Emergency Response Committee called a Special CPR Emergency Response Meeting to further review the code event and identify areas that might need improvement and to develop a plan of correction. This was demonstrated through a review of the Special CPR Emergency Response Committee's minutes for a recent code that occurred. • The CPR/Emergency Response Committee membership included:	

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		o Chief Nurse Executive, Chairperson o Facility Director o Medical Director o Assistant Director of Administration o Assistant Director of Programs o Quality Assurance Director o Plant Maintenance Manager o Competency Training, and Development Director o Program Services Director o Risk Manager A review of the CPR/Emergency Response Committee Meeting Minutes and the Monitoring Team's attendance at the Committee meeting on 7/26/12 found that the committee was dedicated to continuously improving the emergency response system. A view of the minutes and attendance at the meeting revealed that all relevant aspects of the Facility's emergency response system were addressed and areas needing continued improvement were identified and plans of improvement/corrections were addressed. This included a review of the status of emergency equipment, review of drill performance, staff CPR training, and other relevant emergency response topics. For example, during the meeting the committee discussed the need to not only review and discuss the outcome of the Mock Medical Drills at the Facility's overall IMRT meeting, but to also include the review and discussion at the Unit IMRT meetings. The Monitoring Team, accompanied by the CNE, NOO, Nurse Shift Manager, and Risk Manager, checked all of the emergency equipment and AEDs, daily Emergency Equipment and AED Checklists, and monthly Emergency Equipment Walkthrough Checklists throughout the entire campus where emergency equipment and AEDs were located. All of the emergency equipment and AEDs, as required by policy, were present and in good working order. The daily Emergency Equipment and AED Checklists were completed for July 2012 to date, except for the checklist in the Recreation Building, which was missing daily checks for two weeks while the designated nurse was on vacation. A backup nurse had not been designated to perform the checks in the designated nurse's absence. As a result of this omission, Nursing Administration immediately designated a backup nurse to check the Recreation Building's emergency equipment and AED in the absence of the designated nurse. A copy of the Recreation Building Emergency Equipment and AED Checklist was provided to the Monitoring Team before the end of the compliance review, validating that the emergency equipment and AED was being checked daily. The Emergency Equipment Walkthrough Checklists for July 2012 to date were completed, indicating that the Risk Manager had checked all of the emergency equipment and AEDs. All of the equipment and AEDs were stored in a secure location. Unit nurses were able to	

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		properly demonstrate the use of emergency equipment. Signs were readily/visually posted throughout the campus indicating the location of the emergency equipment and AEDs. Through the efforts identified since the last review, the Facility demonstrated substantial compliance with the Emergency Response, Policy Number: 044.2, as well as with making additional improvements beyond the requirements of the policy. The Facility needs to maintain the positive practices identified and continue to make improvements when the need arises.	
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 stated they had performed the following activities to conduct the self-assessment: • A RN Case Manager Supervisor was hired to monitor the consistency and accuracy of all RN Case Managers' Nursing Assessments. These assessments were reviewed and followed upon and included corrective action. • The assigned audits were conducted on the Nursing Annual and Quarterly reviews. Theses audits were consistently above 85%. • Nursing summaries were reviewed at the daily Care Plan Committee meeting for any individual with a Health Maintenance Plan. • Nursing Discharge Summaries were completed on all discharged individuals. Summaries were reviewed by the RN Case Manager Supervisor, who evaluated for completion and accuracy. • A tracking tool was developed to track compliance with the admission and discharge process. This tool was monitored by the RN Case Manager Supervisor who followed up with corrective action if needed. The results of the self-assessment: • The Annual Nursing Assessment Monitoring Tool showed 89% agreement in the January 2012 quarter and 91% for the quarter in April 2012. • Comparison of the Nursing/QA Nurses 'Inter-Rater Reliability Tracking, analysis, and trending for Annual Nursing Assessments showed 79% agreement in February 2012, 87% in March 2012, and 89% in April 2012. Self-rating: Based on the findings from this self-assessment, this provision was not in substantial compliance. Inconsistency of documentation of the nursing summaries needed to be monitored with follow up provided to the RN Case Managers. Monitoring Team Findings The Facility's Provision M.2 Self-Assessment stated they were not in compliance with this	Noncompliance

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		provision and the Monitoring Team concurs. A review of the Provision. M.2 Self-Assessment, Section M Presentation Book, staff interviews and review of documents, provided evidence that the Nursing Department had made minimal progress toward achieving compliance in all of the various requirements contained in this Provision. The Nursing Department reported that the Nursing Care Annual and Quarterly Nursing Assessment Monitoring Tool audits were consistently above 85% compliance. The quarterly reports for January 2012 showed 89% compliance and 91% for Aprils 2012. Therefore, no plans of correction were needed. This finding was not consistent with the Monitoring Team's findings in a review of sampled Admission, Quarterly, and Discharge Nursing Assessments, as reported below. A sample of 27 of the Admission, Annual, Quarterly, and Community Living Discharge Plan Comprehensive Nursing Assessments completed over the last six months reviewed on Individuals: #527, #284, #371, #547, #31, #576, #75, #331, #318, # 207, #138, #335, #501, #423, #539, #242, and #181, found: • Twenty seven of 27 (100%) Nursing Assessments were completed on time as required. • Seventeen of 27 (63%) Nursing Assessment Sections I through X were completed thoroughly and accurately with appropriately summarized statements of assessment findings. There was general improvement found in most of the assessments. This may be attributed to the required Nursing Physical Assessment Class recently completed by the RNs Case Managers. • Four of 27 (14%) Nursing Assessment Sections XI found minimal improvement the RN Case Managers' abilities to summarize the raw clinical data succinctly and to describe individuals' health status progress or lack of progress for each nursing diagnosis/nursing problem and/or risk rating identified with a Health Maintenance Plan (HMP) and the effectiveness of the plan. In general, the remaining 23 Nursing Assessment Section XI summaries were found to have improvement in summarizing raw clinical data but failed to succinctly describe individuals' health status progress or lack of progress or to clearly indicate the effectiveness of the HMPs in relation to the identified nursing problem and/or risk ratings. • Twenty-seven of 27 (100%) Nursing Assessments had the BRADEN Scale completed. • Twenty-five of 27 (96%) Nursing Assessments documented the status of individuals' progress toward Self-Administration of Medication. • Twenty five of 27 (96%) Nursing Assessments indicated that the QDDPs were notified when the assessments were completed. • Nine of 17 (53%) individuals had HMPs developed and implemented for all identified high and/or medium risk ratings. Plans most often missing were for individuals' identified medium risk ratings. General trends found related to the HMPs:	

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		o HMPs were not consistently reviewed/revised by the RN Case Managers annually or quarterly or when individuals had a change of status that required modifying the HMPs. o The baseline data frequently consisted of the diagnosis and/or treatment prescribed and did not include clinical indicators/data that lead to the necessity for the HMPs. o Many of the goals set for the desired outcome of HMPs did not adequately describe clinical indicators that were realistic, measurable and observable. o Many of the HMPs failed to specify the frequency of monitoring to be completed for interventions in the plan and where to document the monitoring data. o Many of the HMPs did not incorporate specific orders for treatments, measurements, and monitoring. The HMP interventions should be consistent with other medical/health orders, as well as the integration of relevant aspects included in other disciplines plans of care to ensure integrated services are provided. Examples: • Individual #527 did not have nursing problems/diagnoses and HMPs for high risk ratings for aspiration and medium risk ratings for choking, gastrointestinal problems, falls and fluid imbalance. The risk rating for weight was low. The current weight for the past two quarters was not documented. The last annual weight was documented as 108 pounds with an Ideal Weight Range of 110 – 130 pounds. There was documentation in the summary that indicated she had a problem with weight gain, and was on a modified diet texture and dietary supplements to manage the weight gain. She also had diagnosis of dysphagia and may require g-tube placement at some point. The DSP staff reported she ate slowly, laughed a lot, and looked around during meals, and then starts coughing. There was no follow up mentioned in the overall nursing summary to indicate the Physical and Nutritional Management Team (PNMT) or Personal Behavior Support Team (PBST) were involved addressing these problems. Based on this information it is essential the current weight is accurately assessed and there is collaboration with other relevant disciplines to manage the identified dining problems. • Individual #284 on the last quarterly nursing assessment was marked as having no pressure ulcers or wound, when in fact he had Stage IV decubitus ulcer of the left tuberosity. It is essential that nursing assessments are accurate and up to date to reflect individuals' current health status in relation to identified nursing problems/diagnoses and/or risk ratings. • Individual #39's history of infections was marked "no" for MRSA. By history he was reported to have had MRSA within the past year. A culture of the nares 6/13/12 was	

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		positive for MRSA, antibiotic ointment was ordered to apply to both nares for five days on 6/20/12. There was an IPN that indicated the antibiotic was started but there was no Acute Care Plan (ACP) established or indication that the Antibiotic Protocol was followed. The nursing assessment was not updated to indicate this change of status. • Individual #576's nursing assessment for menstrual status was not completed. Individual #576 is a 41 year old female, it is essential to assess and track menstrual pattern for abnormal changes, particularly because at her age she may begin to express premenopausal symptoms. General trends identified included: • The assessments showed some steady improvement with more substantive clinical data contained in the summaries relative to the body system assessed. The quality of the assessments and summaries varied from Unit to Unit and from RN Case Manager to RN Case Manager. The most notable improvements may be attributable to the RN Case Managers who received the required Physical Assessment and Documentation Class. • The status of immunizations was not consistently completed for all required immunizations. The nursing assessment template left off a block to document polio, consequently individuals' polio status was not addressed. In addition to omission of polio immunization documentation, measles, mumps, and rubella (MMR), varicella, and hepatitis B series immunization documentation was frequently missing. The Nursing Department should add polio vaccination information to the Comprehensive Nursing Assessment template. In addition, the status of Female-Gynecological and Pressure Ulcers were not consistently completed. • The Comprehensive Nursing Assessments were not updated when there was a significant change in health status. The RN Case Managers should consistently review and update nursing assessments when individuals' have a change of status and prior to ISP and ISPA meeting to ensure they accurately reflect their current health status. • Section X, Nursing Problems, often failed to include a nursing problem/diagnosis for one or more high and/or medium risk ratings and an accompanying Health Maintenance Plan (HMP) for the identified high and medium risk ratings that required nursing interventions. Not all identified nursing problems/diagnoses had accompanying HMPs. Conversely, not all HMPs had accompanying nursing problems/diagnoses listed. The Nursing Department should ensure that nursing problems/diagnoses and accompanying HMPs are developed and implemented for all of individuals' high and medium risk ratings that require nursing interventions. • Despite training and monitoring the Nursing Department had put forth in order to improve the quality of the Section XI Nursing Summaries, since the last review, marginal improvement was noted in the analyses and summaries of raw clinical data	

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		to succinctly describe individuals' health status progress or lack of progress and the effectiveness of HMPs related to their identified nursing problems/diagnoses and/or identified risk ratings. • The format and quality of Section XI nursing summaries varied from Unit to Unit and RN Case Manager to RN Case Manager. With the additional categories on the nursing assessment template, the clinical data were more fragmented, making it even more difficult to discern the individuals' health status in relation to each of their problems. The nursing assessments were discussed with the recently hired RN Case Manager Supervisor who reported she had identified discrepancies across campus with the RN Case Managers who have different focuses on completing these tasks. The findings were largely based on their personal training and understanding/interpretation of training in these areas. The RN Case Managers had a varied range of experience from three months to more than 20 years. They also had varied ranges of experience and training. The RN Case Manager Supervisor stated it was necessary for all RN Case Managers to have the same information for continuity of care standards. Having identified these discrepancies, several RN Case Managers had received performance coaching, performance counseling, and disciplinary performance action for level one. In addition, the RN Case Manager Supervisor began retraining on the individual audits and on what was needed in their documentation in the Quarterly and Annual Nursing Assessments and Health care Plans. She was also conducting monthly audits and random spot audits to monitor the effectiveness of training in these areas. More performance coaching will be utilized as appropriate; and additional training will be done to assure improvement is achieved. These efforts put forth by the RN Case Manager Supervisor appeared to be promising.	
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	The Facility stated they performed the following activities to conduct the self-assessment: • A Care Plan Committee was implemented which reviewed all Acute and Health Maintenance Care Plans for appropriateness, accuracy and completeness. The Care Plan Committee reviewed all care plans for completeness of direct support professional training with attached signature sheets. RN Case Managers trained direct support professionals on each care plan. Training rosters with the care plan instructions were located in each home for easy review by staff. • The Care Plan Committee met every Monday through Friday to review all care plans for individualization per individual and per condition. • If care plans were not approved, the RN Case Managers resubmitted plans to the Committee the next day with approved revisions. • A RN Case Manager Supervisor was hired to monitor care plan development by all RN Case Managers to assure consistency was maintained. The RN Case Manager Supervisor used monitoring tools related to nursing care plans. The completed	Noncompliance

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	are developed or revised.	monitoring tools were turned into QA Nurses. The QA Nurses sent back their analyses and trends, which were reviewed by Nursing Administration and Nurse Managers. • The State Office provided training on the new Integrated Risk Rating Form and Integrated Health Care Plan procedure to BSSLC's RN Case Managers. Bowie was picked to pilot the program. Additional training will be provided to the other case managers across campus after Bowie's training is completed. This process started in April 2012. • A care plan folder was developed with several approved care plans available for RN Case Managers to use as needed. These plans of care were approved by the Care Plan Committee prior to placing them in the folder. <u>The results of the self-assessment:</u> • The Annual Nursing Care Plan Monitoring Tool showed 78% for January 2012 and 68% for the quarter in April 2012. Based on these findings the RN Case Managers were retrained on the process and the RN Case Manager Supervisor followed up with corrective action as needed. • Comparison of the Nursing/QA Nurses' Inter-Rater Reliability Tracking, analysis, and trends for Annual Nursing Care Plans showed in 100% agreement in February 2012, 78% in March 2012, and 71% in April 2012. <u>Self-rating:</u> Based on the findings from this self-assessment, this provision was not in substantial compliance because of the inability to obtain 80% or greater agreement with the Annual Nursing Care Plan Monitoring Tool. <u>Monitoring Team Findings</u> The Facility's Provision M.3 Self-Assessment stated they were not in compliance with this provision and the Monitoring Team concurs. A review of the Provision. M.3 Self-Assessment, Section M Presentation Book, staff interviews and review of documents, provided evidence that the Nursing Department had made minimal progress toward achieving compliance in all of the various requirements contained in this Provision. Since the last compliance review, Nursing Administration and the Quality Assurance Nurse had continued the Care Plan Committee that met daily Monday through Friday to review all Health Maintenance Plans (HMPs) and Acute Care Plans (ACPs) developed by the RN Case Managers the previous working day. The Committee reviewed the plans to ensure they were individualized, had realistic baseline data that reflected the rationale for developing the plans, measurable goals based on clinical indicators, that actions/interventions met standards of nursing practice for the identified nursing problems/risk ratings, and there was documentation that the DSP staff were trained on the plans. Plans that were found deficient were sent back to the responsible RN Case	

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		Managers for corrections. If necessary, the plans were sent back to the responsible RN Case Managers for correction until they were found acceptable/sufficient to meet the individuals' health care needs. The data derived from the care plan reviews were tracked, analyzed and trended by Unit/Cottage as well as by RN Case Managers. The data was used for management purposes to identify local and systemic deficiencies and to take corrective action with the respective RN Case Managers and/or Unit/Cottages when indicated. This was an excellent process for improving the quality and appropriateness of the care plans. However, with the hiring of a RN Case Manager Supervisor and the implementation of the pilot project in Bowie on the revised Integrated Risk Rating Review and Integrated Health Care Plan process, the Care Plan Committee was discontinued. It was reported that with this revised process the Nursing HMPs and ACPs were going away. It was expected that the recently hired RN Case Manager would continue to assure consistency and appropriateness of the care plans developed by the RN Case Nurse Managers. It was too soon to determine the implication these changes might have on the quality and compliance of these care plans. Despite the efforts put forth to improve the care plans, the Nursing Care Plan Monitoring Tool quarterly audit results for January 2012 showed 78% compliance and 68% for April 2012. The results of the Quality Assurance Nurse audits for inter-rater reliability on the Nursing Care Plan Monitoring Tools showed the percentage of agreement with the nursing audits for February 2012 was 100%, March 2012 was 78%, and April 2012 was 71%. As mentioned in Provision M.1, the Quality Assurance Nurse and the nursing staff completing the audits should meet and review the Monitoring Tools' Interpretive Guidelines to clarify and/or revise to ensure all auditors have the same interpretation of the items contained on the monitoring tools. This was consistent with the Monitoring Teams findings. A sample of five most recently completed HMPs from across campus was selected for review for Individuals: #264, #493, #473 (two HMPs), and #247. Findings included: • Two of five (40%) HMPs contained adequate baseline data to support the rationale for the plan. • Five of five (100%) HMPs goals were realistic and measurable. • Two of five (40%) HMPs contained preventative measures. • Five of five (100%) HMPs were individualized. • Zero of five (0%) HMPs were integrated with other relevant disciplines. Individual #264's HMP stated there would be collaboration with the behavioral therapist to integrate strategies into the care plan. No such strategies were included in the care plan. The plan also stated there would be collaboration with the physician regarding	

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		psychiatric/behavioral analyst consults and would follow-up on recommendations. No such recommendations were added to the plan. • One of five (20%) HMPs indicated the frequency of routine monitoring of the individual's problem but did not include where the monitoring would be documented. • Five of five (100%) HMPs contained instructions for the DSP staff that were easily understood. • Zero of five (0%) HMPs contained documentation that the DSP staff were trained on the plans. Since copies of functional care plans were kept in notebooks in the homes, with the original care plans filed in individuals' active records, any training or revisions to the care plans might not have been documented on the original care plan in the active record. A sample of the 15 most recently completed ACPs from across campus was selected for review for Individuals: #207, #38, #255, #253, #440, #252, #363 (two ACPs), #446, #411, #94, #366, #151, #89, and #276. Findings included: • Eight of 15 (53%) ACPs contained adequate baseline data to support the rationale for the plans. • Thirteen of 15 (87%) ACPs contained goals which were realistic and measurable to achieve the desired outcome of the care plans actions/interventions. • Nine of 15 (87%) ACPs were individualized and contained actions/interventions sufficient to meeting individuals' health care needs. • Six of 15 (40%) ACPs contained actions/interventions that included integration of services with other disciplines. • Six of 15 (40%) ACPs contained documentation verifying that the DSP staff were trained on the plans. Since copies of functional care plans were kept in notebooks at the homes, with the original care plans filed in individuals' active records, any training or revisions to the care plans might not have been documented in the original care plan in the active record. Other general trends identified in review of the ACPs and accompanying IPNs made available for review included: • Inconsistent prompt notification of the PCP or lack of notification of individuals' acute change of status documented in the IPNs. When there was documentation in the IPNs, the "When to contact the PCP, document that you provided the following:" Nursing Protocol was not followed. • There was inconsistent documentation in the IPNs that other Nursing Protocols were followed, particularly Antibiotic Therapy, Respiratory, Respiratory Distress/Aspiration, and Minimum Documentation Requirements. • The requirements contained on the nursing protocols were not incorporated into the	

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		ACPs. Neither were physicians' orders requiring specific nursing interventions included in the ACPs. • There were inconsistencies in the adequacy of assessments and description of findings for affected body system relating to the acute change of status. • There was inconsistent documentation in the IPNs that the IDTs were notified of individuals' acute change of status. • There was inconsistent documentation in the IPNs that individuals' had ACPs established and implemented and/or the DSP staff were trained on the plans. • There was inconsistent resolution and assessments documentation in the IPNs stating the individuals' response to treatment of the acute problem or documentation on the ACPs that the problem was resolved. • There was a lack of revision to the ACPs when there was a change of treatment interventions. • There was inconsistent documentation in the IPNs that the Infection Control Nurse was notified of infections or when notified there was lack of documentation of their interventions or instructions. • There was inconsistent inclusion of interventions related to integration of other disciplines included in the ACPs. • There were occasional gaps in documentation found when individuals' nursing ACPs or standards of nursing practice indicated that individuals' were to be assessed every shift or daily. This occurred primarily over the weekends/holidays, as was found in past compliance reviews. • There were frequently missing times and dates on the IPNs. • The nursing staff legibility in reading the IPNs and identifying signatures and titles continued to be problematic. Examples: • Individual #446, on 7/4/12, was diagnosed with a Urinary Tract Infection (UTI) and prescribed antibiotic therapy for seven days. There were no nursing assessments regarding the UTI in the Integrated Progress Notes (IPNs) until 7/6/12. The RN who implemented the ACP did not complete a nursing assessment related to the UTI. Individual #446 was assessed each shift for 24 hours. The therapeutic response to the antibiotic therapy was not documented. There were no further nursing assessments for UTI completed until on 7/12/12 that indicated the antibiotic therapy was finished. However, the nurse did not complete an assessment to indicate whether or not the UTI was resolved, nor was there a resolution note. The Antibiotic Protocol was not followed. The ACP for UTI did not include the requirements of the Antibiotic Therapy Protocol, or indicate that the DSP staff were trained on the plan, or include a date of resolution. There was no documentation that the IDT was notified of the UTI. There was no documentation that the Infection Control Nurse	

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		was notified of the infection. It is essential that the Infection Control Nurse be notified of all infections. From review of the IPNs and the ACP, the management of Individual #446's UTI was inadequate. • Individual #411: A review of Individual #411's record found there was a delay in diagnosis and treatment for cellulitis and pitting edema of both lower legs. Although the nursing staff documented nursing assessments daily in the IPN, the pitting pedal edema was not identified until 7/6/12 at 12:07 p.m., when it was discovered by the Physical Therapist. On 7/6/12 at 2:15 p.m., the nurse assessed the lower extremities and found she had 3+ bilaterally with weak pulses. Neither vital signs nor other assessments were completed to rule out the underlying cause of the edema. The nurse placed Individual #411 on sick call to be evaluated by the Primary Care Provider (PCP). There were no further nursing assessments of the lower extremities or other documentation in the IPNs until the physician IPN's on 7/9/12 at 10:26 a.m., when he noted he was called to assess Individual #411's legs. This was over the weekend. Individual #411 was diagnosed with Cellulitis of the right leg and pedal edema. She was prescribed antibiotic therapy for eight days, four inch ace wraps to both legs, and to elevate both legs when possible. Nursing assessments were completed on 7/9/12 at 1900, 7/10/12 at 0200, and 7/20/12 at 2000. There were no further nursing assessments completed until 7/14/12, and then she was assessed daily through 7/16/12. No assessments were completed on 7/17/12 and 7/18/12. The last nursing IPN was on 7/19/12, but there was no nursing assessment that described the status of the cellulitis. None of the nursing assessments adequately assessed or described the status of the pitting edema of the lower extremities or the therapeutic response to antibiotic therapy for cellulitis. The ACP for cellulitis was established on 7/9/12. There were no IPNs indicating that an ACP was initiated, or the DSPs were trained on the plan, or that the IDT was notified of change of status. The ACP did not include the requirement of the Antibiotic Protocol; collaboration with PNMT; include applying ace wraps to the lower extremities and elevation of the legs; documentation that the DSP staff were trained on the ACP; or indication whether the cellulitis was resolved. There was no documentation that the Infection Control Nurse was notified of the infection. From review of the IPNs and ACP, the management of Individual #411's Cellulitis care was inadequate. It is essential that when a change of status in individuals occur that nursing staff promptly notify the PCPs according to the Notification of PCP Protocol, as well as notify the Infection Control Nurse of all infections. • Individual #94: Review of Individual #94's record indicated there was a 24 hour delay in contacting the PCP regarding an infection of the Baclofen pump site. On 7/1/12, at 0800 the nurse documented when the dressing was removed from the Baclofen pump site it was saturated with purulent drainage with an open blister.	

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		There was no IPN indicating the PCP was notified or that Individual #94 was placed on the sick call list. On 7/1/12 at 2200 the nurse documented that wound site continued to be filled with mucopurulent drainage saturating the dressing. The wound was cleaned and dressed but the PCP on call was not notified of the assessment. If fact, there was no documentation that the nursing staff ever notified the PCP of the potentially infected wound. On 7/2/12 at 11:03 a.m., the physician's IPN stated he was called to assess a wound around the Baclofen pump site, for which he diagnosed a carbuncle (boil) and prescribed antibiotics for 14 days. After the diagnosis and antibiotics were ordered the nursing staff adequately assessed and managed the wound every shift for over 72 hours, and then once day or more often through to resolution on 7/23/12. There was documentation in the IPNs that an ACP for Skin Integrity/Infected Carbuncle was initiated on 7/3/12. The RN who established the ACP did not complete a nursing assessment of the wound. There was no documentation in the IPNs that the IDT was notified of change of status, or that the DSP staff were trained. The Antibiotic Therapy Protocol was not included in the ACP, neither was there documentation that the DSP staff were trained on the plan, or the date of resolution documented. There was no documentation that the Infection Control Nurse was notified of the infection. It is essential that when individuals' have acute change of status that nurses promptly notify the PCP according to the Notification of PCP Protocol, as well as notify the Infection Control Nurse of all infections. • Individual #318: There was a delay in completing a reassessment of Individual #318's respiratory system after the initial assessment when she vomited on 6/19/12 at 1200. The respiratory, vital signs, and oxygen saturation showed no abnormal findings. The nurse who completed the initial assessment stated she would continue to monitor for increased vomiting but failed to include how often the individual would be monitored. Individual #318's respiratory status was not reassessed until 2200, six hours after the initial episode of vomiting when another nurse walked by the room and heard her "gurgling" and found she had visible green sputum at the back of her throat. The nurse suctioned her throat and assessed vital signs and the oxygen saturation. The oxygen saturation had fallen to 80 -81%. The lungs were not assessed. Oxygen was applied and the saturation only went to 91%. The physician on call was promptly notified of her condition; the physician ordered her sent to the hospital. She was transfer to the hospital via Emergency Medical Services at 2245 and was admitted with diagnoses of aspiration pneumonia and hypoxia. It was of concern that there was a delay in six hours before Individual #318 was reassessed after the initial episode of vomiting, and what the outcome might have been had the nurse not happened to walk by and hear her "gurgling". This demonstrated the importance for the nurses to document to specifically what will continued to be	

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		monitored, how often, and to report at change of shifts when the monitoring needs to continue, as has been pointed out before. Had Individual #318, been monitored frequently after the vomiting episode, the probability of identifying respiratory distress could have identified earlier and medical attention and treatment sought immediately. The Facility does not appear to take vomiting episodes that lead to aspiration seriously and treat it aggressively enough to prevent or minimize the incidents of aspiration and the associated mortality and morbidly consistently found in this population. It was apparent from review of Section M and other interviews and documentation reviewed the Nursing Department had put forth efforts to improve the quality of the HMPs and ACPs. Many of the self-initiated strategies were recently implemented and had not yet had time to mature to demonstrate significant improvement toward compliance with this Provision. The recent hiring of the RN Case Manager Supervisor to oversee the RN Case Managers, coupled with freeing up the Nurse Manager to devote more time overseeing the staff nursing, were positive steps to move this Provision forward toward compliance. However, only minimal progress was found in this provision since the last compliance review. The most noticeable improvement was in the individualization of ACP and the removal of extraneous information from "canned" care plans. It was reported that the HMPs and ACPs were going away as a result of the revised Integrated Risk Review and Integrated Health Care Plan. It is yet to be determined the impact this change will have on the care planning process. Since the recommendations made at the last compliance review continued to be applicable to this review, no additional recommendations are included. The Monitoring Team did not find compliance with this Provision.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	The Facility stated they had performed the following activities to conduct the self-assessment: • The Annual Nursing Competency Fair was held in January and February 2012. All nursing staff completed competency-based training, except for one LVN who was on extended Family Medical Leave Act (FMLA). Upon her return in May 2012, she received the training. One hundred percent of nursing staff had completed Nursing competencies. Competencies included: Medication Calculations, Enteral feedings, a procedure test, skin management and wound prevention, documentation using SOAP format, Mock Codes/emergency equipment, Hospital report procedure and communication with the hospital, physical assessment, nursing care plans, Hemocult testing, Diastat administration, and neuro checks. • All RN Case Managers were trained on the importance of having a care plan in place if their individual has an Epi-Pen. Training was 100% completed in January 2012. • Death review recommendations were sent out that included: Remembering to take a	Noncompliance

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		complete set of vital signs; document the date and time in the Integrated Progress Notes (IPNs); potential signs/symptoms of sepsis; signs/symptoms to call the physician immediately. Training of 100% of the nursing staff was completed in February 2012. • The nurse practitioners returned February 21, 2012 and completed another round of the physical assessment class, of which 14 RNs took the assessment class, 20 completed unit check-offs, 12 RNs completed nurse to nurse check-offs. The nurse practitioners were planning to return August 2012 to complete the last of BSSLCs RNs. • Nine more of the nursing protocol cards were rolled out. All together there were 18 protocol cards, which include: Head Injury, Constipation, Contacting the PCP, Temperature elevations, Pre-treatment and Post-Sedation, Vomiting, Antibiotic Therapy, Respiratory Distress/Aspiration, Diarrhea, UTI, Hypothermia, Enteral Feedings: Tolerance/Complications, Seizures, Abdominal Distention/Pain, Minimum Documentation Requirements, PICA, Status Epilepticus, and Post Anesthesia Care. All nurses were required to have these protocol cards in their possession when on duty. The nursing staff had attained 100% training completion rate of all protocol cards. The new nurses were trained and provided protocol cards in New Employee Orientation. • Medtronic representatives presented an in-service on the Baclofen pumps. Signs/Symptoms of under dose/overdose and withdrawal were discussed. Pump alarms, concerns, and questions were also discussed. • The Mosby's Physical Examination Books and accompanying lab manuals were distributed. The plan for these books was to continue to provide more information supporting the nursing physical assessment class. The State Office will assign a body system each quarter for review and testing, for which the Nurse Educators will teach the appropriate classes and a statewide test will be administered. • Identified in the last monitoring visit were several issues that needed to be addressed to the nursing staff. A Power-Point Presentation was sent out, as well as a competency test that addressed the following issues: o Charting route temperatures. o When using SOAP charting, "continue to follow" was not enough information, follow up must be measurable. o Importance of notifying and documenting notification to the Infection Control Nurses of infectious/contagious diseases. o Importance of follow-up documentation for all seven days of the week. o Documentation of respiratory issues. o Antibiotic therapy, including their effectiveness and/or side effects. o Documentation of per necessary (PRN) medications. o Calling reports to the hospitals.	

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		• Currently the Nursing Department was at 85% completion with these tests. The plan was to have 100% of the nursing staff trained by June 15th. The results of the self-assessment: • There was 100% completion of annual refresher competency testing/training completed May 31, 2012, after the nurse on FMLA returned. • The Nurses Training Database showed that training compliance was met with any new policy/procedure/protocol. Self-rating: Based on the findings from this self-assessment, this provision was in substantial compliance because protocols have been developed to address the health status of individuals and 100% of the nursing staff had been competency trained on these protocols. Monitoring Team Findings The Facility's Self-Assessment stated they were in compliance with this provision. The Monitoring Team did not concur that this provision was in compliance. Through a review of Section M Self-Assessment, 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 the development and implementation of nursing policies, procedures, processes, protocols and training. However, this was not found in compliance at this review. Compliance with Provision M.4 has been discussed with DADS. For Provision M.4, this team had found compliance in the past based on the presence of policies and practices. However, this was not consistent with the criteria used by the other monitoring teams, both of whom required quantifiable demonstration of implementation of the protocols through actual clinical practice. Although compliance was found in the last review, the Monitoring Team has determined the need to focus on actual clinical implementation rather than just development and training—that is, to ensure implementation of protocols is sufficient to meet the needs of individuals as the provision requires. In order for this Provision to meet compliance, not only must the State and Facility Nursing Policies, Procedures, Processes, and Protocols be established, implemented, and the nursing staff trained; 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 Nursing Policies, Procedures, Processes, and Protocols have not yet been adequately put into clinical practices sufficient to meet individuals' health status needs. Therefore, this Provision was not found in compliance. The Nursing Department reported there had been no new Nursing Policies established since the last compliance review. The Nurse Educator continued to maintain an excellent, comprehensive, and up to date Nursing Training Database that indicated the percentage of the nurses completing the required training; for nurses who had not completed the	

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		training, a date for completion was projected, and included the overall percentages of nurses trained. A review of the Nursing Training Database and the report the Nurse Educator provided on the status of training validated nursing training provided since the last compliance review: Findings included: • Annual refresher training and competency-based testing: Competencies were completed January 30 and 31, 2012. Due to one nurse being out on extended sick leave, 100% of the competencies were not completed until May 31, 2012. The competencies addressed all of the issues listed in the State Supported Living Centers Nursing Competency-based Training: Medication Calculations, Enteral Feeding, a procedures test, Skin Management and Wound Prevention, Documentation using the SOAP format, Mock Medical Emergency Drills and use of emergency equipment, Hospital Report Procedure and communication with the hospital, Physical Assessment, Nursing Care Plans, Hemocult testing, Diastat administration, and Neuro checks. • Epi-Pens: All RN Case Managers were trained on the importance of having a care plan in place for individuals with Epi-Pens ordered. 100% completion, January 2012 • Death Review Recommendations: Death Review recommendations were sent out that included remembering to take a complete set of vital signs, document the date and time in the IPN, potential signs/symptoms of sepsis, and signs/symptoms to call the physician immediately. • Physical Assessment Class: The Nurse Practitioners returned February 21, 2012 and completed another round of the Physical Assessment Class. Fourteen RNs completed the Physical Assessment Class, 20 RNs completed the unit check-offs. Twelve RNs completed nurse to nurse check-offs. The Nurse Practitioners are planning to return August 28, 2012 to complete the last of the RNs' Physical Assessment Class. • Protocol Cards: Nine more of the protocol cards were rolled out. All together there were 18 protocol cards, which included Head Injury, Constipation, Contacting the Primary Care Provider (PCP), Temperature Elevations, Pre-treatment and Post Sedation, Vomiting, Antibiotic Therapy, Respiratory Distress/Aspiration, Diarrhea, Urinary Tract Infections (UTIs), Hypothermia, Enteral Feedings: Tolerance/Complications, Seizures, Abdominal Distention/Pain, Minimum Documentation Requirements, PICA, Status Epilepticus, and Post Anesthesia Care. All nurses were required to have these protocol cards in their possession when on duty. In March 2012, 100% of the nursing staff completed training on the 18 cards and each nurse was provides with a set of the cards to keep with them at all times while on duty. • An Educational Audit Tool: An education audit tool was developed that addressed the following information: o Does the nurse have all 18 protocol cards? o Can the nurse tell the Nurse Educator what a particular card says?	

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		o Does the nurse know the location of the Lippincott Manual on their Unit? o Does the nurse know what Sharepoint is and how to access it? Immediate corrective action was taken if any of the answers were no. This information was tracked by the Nurse Educator in an Excel spreadsheet for trends. This audit was started in May 2012. May 2012, June 2012, and July 2012 data was represented in tabular and bar graph form for the first three questions. However, the actual percentage of compliance for each month and any plans of correction were not included. • Integrated Health Care Plan Training: In April 2012, the Nurse Practitioner Consultant and the State Office Nursing Coordinator rolled out the new Integrated Risk Review Form (IRRF) and Integrated Health Care Plan (IHCP) procedure to the RN Case Managers. Bowie Unit was picked to pilot the program. Additional training will be provided to the other RN Case Managers across campus after Bowie's IDT meetings. • Baclofen Pump In-service: A Medtronic Representative gave an in-service on the Baclofen pumps. Signs/symptoms of underdose/overdose and withdrawal were discussed, as well as pump alarms and other concerns and questions. • Medical Emergency Code Sheet: The CPR/Emergency Response Committee developed A Medical Emergency Code Sheet. This sheet was included in the annual refresher training and competency-based testing. In May 2012, 100% of the nurses had been retrained. • Mosby Physical Examination Books: The Mosby's Physical Examination Books and accompanying Lab Manuals were handed out to the Units. The plan for these books was to continue to provide more information supporting the Nursing Physical Assessment Class. In June 2012, The State Office began assigning a body system each quarter for review and testing. The Nurse Educator will teach the class and administer a statewide test. • Training Provided in Response to Recommendations from the Monitoring Team's Last Compliance Review: A Power-Point presentation was sent out, as well as a competency test that addressed the following issues: o Charting routine temperatures. o When using SOAP Charting, the statement "continue to follow" is not adequate information; follow-up actions must be measurable. o Importance of notifying and documenting notification of the Infection Control Nurse of infectious/contagious diseases. o Importance of follow-up documentation for all seven days of the week. o Documentation of respiratory issues. o Antibiotic Therapy documentation, include the effectiveness and side effects. o Documentation of per necessary (PRN) medications.	

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		o Calling reports to the hospital for individuals going to the emergency room or hospital. In June 2012, 100% of the nursing staff were trained. • Nursing Department Guideline Update: o A new Wound Dressing Protocol, was developed and implemented in June 2012 • Up Coming Training: o A Medication Administration Power Point Presentation had been developed related to Physical and Nutritional Managements Plans (PNMPs), that will be presented by the PNMT and Nurse Educator for safe administration. This training will be provided in the near future to the nursing staff administering medication. . The Monitoring Team attended an overview of the planned presentation training material and found it to be comprehensive and valuable in teaching the nursing staff the physiology of Dysphagia and the rationale for the strategies contained on individuals' PNMP for safe medication administration. • In addition to the training listed above, the Nurse Educator ensured that the Nursing Administration memos sent by email to the nursing staff over the past few months were read and training rosters signed for verification. The memos included: o Medication Refusals. o Residuals for Tube Feedings: o Suicide Attempt: o Sedation: o Dressing Changes: o Sending Chart to the Hospital: . It was of concern that several of the trainings mentioned above were sent to the nursing staff by email to read and sign the training rosters to verify that the training materials were read. The effectiveness of this method of training was questionable. The Nurse Educator should consider a process for evaluating the effectiveness of sending training material to the nursing staff to read and sign. It was positive to find that the Nurse Educator had developed and implemented an Educational Audit Tool, particularly for the protocol cards. The Nursing Department should consider developing and implementing a process for assessing nursing staff's competency related to the protocols, as well as auditing the protocols to ensure that compliance was achieved through actual clinical practice sufficient to address the health status of individuals served. Only when this can be demonstrated through actual clinical practice will compliance with this Provision achieved.	

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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 stated they performed the following activities to conduct the self-assessment: • A Change of Status Form was developed and used for individuals seen during morning sick call. Nurses placed the form on the front of chart and completed the reason for sick call. The physicians who saw individuals in sick call decided if a change of status had occurred and if the individuals' team needed to meet. The physicians' then signed the forms and gave them to the nurses. If individuals had a change of status, the nurse forwarded the forms to the individuals' QDDPs and the Lead QDDPs on their units. The QDDPs conducted ISPA meetings, documented the results of the meetings the change of status in the QDDPs' individual folder. • A Fall Evaluation Form and Policy was approved by the Policy and Procedure Committee. The nursing staff and direct support professional staff were provided training on the Fall Policy and Form. Falls will be assessed and data collection will occur to identify trends if any. • The Hospital Liaison Nurse completed risk monitoring tools on hospitalized individuals and presented findings at the IDT meetings. The Hospital Liaison Nurse also attended IDT meetings on hospital, transition and post hospital individuals and offered input on their physical condition. The Hospital Liaison Nurse shared communication from hospital staff, such as case managers, social workers, and/or physicians. The Hospital Liaison Nurse assisted with the discharge process by communicating with appropriate IDT members to allow individuals a smooth transition back to their home. • The RN Case Managers presented all Health Maintenance Plans to the IDT for approval to ensure that integrated health care plans were in place. • All health care plans incorporated risk indicators and/or potential risk indicators. • A dedicated Nurse Educator assessed Direct Service Professionals (DSPs) educational needs in regard to aspiration triggers, positioning, and preventive care. Training was developed based on these assessments and presented to all shifts. Training was also made available to consult on problems with trigger sheets and reinforce training as needed • Interdisciplinary collaboration on preventive health training was currently in progress. Training material on oral health to prevent aspiration was developed with the dentist, dental staff, nursing staff, Habilitation Therapy, Physical Nutrition Management Team (PNMT) Nurse, and Nurse Educator. Training materials were placed in a binder and distributed to all units. As new topics are developed they will also be placed in this binder to be used as a reference for DSPs. • A dedicated Nurse Educator attended the weekly PMNT Committee meetings and reviewed individuals' charts identified by the Committee. The Nurse Educator also attended the monthly Interdisciplinary Risk Peer Review process and made recommendations regarding the risk ratings and action plans on selected individuals. The dedicated Nurse Educator also covered for the PNMT Nurse during her absents	Noncompliance

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		on post hospital assessments. The results of the self-assessment: • An audit tool needed to be developed to evaluate the use of the Change of Status Form. • Collaborative education on future topics for DSP staff needs to continue to be researched, developed, and presented to DSP staff, with follow up audits conducted to evaluate their effectiveness. The results from audits need to be discussed with teams as appropriate. Self-rating: Based on the findings from this self-assessment, this provision is not in compliance. The Nursing Department was continuing to develop processes to ensure documentation of clinical indicators for risk on each individual. Monitoring Team Findings The Facility's Self-Assessment stated they were not in compliance with Provision and the Monitoring Team concurs. Through a review of Section M Self-Assessment, Section M Presentation Book, staff interviews and review of documents, it was evident that the Nursing Department had continued to put forth concerted efforts to make improvements in this Provision. However, compliance with this Provision is not only contingent upon the nursing's staff competency and compliance with the Individual At Risk, Policy Number: 006.1, it also contingent upon the IDTs competency and compliance with the policy as well as for all relevant disciplines to accurately and comprehensively assess and document clinical indicators of risk for each individual; and to discuss plans and progress at Integrated Risk Rating Review as indicated by the health status of the individual. As was found in the Section M.5 Self-Assessment, the Facility had self-initiated some processes to enhance communication and integration of services. In addition, the State Office had revised the Integrated Risk Rating Review and Integrated Health Care Plan related to the Individual At Risk Policy. The improvement efforts included: • A Change of Status Form was developed and implemented for use when individuals were seen in sick call. The nursing staff were responsible for placing the Change of Status Forms on the front of individuals' record indicating the reason for sick call. After physicians assess the individuals, the physicians decide if a change of status occurred and whether or not the IDT needs to meet. If the physicians determine changes of status had occurred, then IDT meetings are required. The nurses forward the original Change of Status Forms to the Lead QDDPs on the individuals' Unit and copies of the form to the individuals' QDDPs. Then, the individuals' QDDPs set up ISPA meetings. The Change of Status Forms were filed in the QDDPs' individual folder.	

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		The Nursing Department did not report the date the Change of Status Form was implemented; neither did the form include the date. There was no documentation reported indicating the percentage of nurses trained on the Change of Status process and form. The Nursing Department reported that an audit tool would need to be developed to evaluate the Change of Status Form. A review of 23 recently completed Change of Status Forms, of which some individuals had more than one form completed for Individuals: #331, #366, #554, #50, #242, #254,#51, #35, #543, #151, #490, #259, #395, #337, #96, #269, #69, #380, and #527 found: o Seventeen of 23 (74%) individuals were identified with a change of status by the physicians who requested the QDDP to convene an ISPA meeting. o Five of 23 (22%) individuals were identified with a change of status but the physicians did not determine that an ISPA was needed because of the nature of their change of status. o One of 23 (4%) individual was not determined by the physician to have a change of status due to the nature of the sick call visit. Unfortunately, the copies of the Change of Status From provided for review did not include the portion that the QDDPs completed indicating the dates the ISPA meetings were conducted or to validate whether or not the ISPA meetings were conducted. This was probably due to the fact originals and copies of the Change of Status Forms were filed in the QDDPs individual folder and were not made available for review. The creation and implementation of the Change of Status was a positive step forward in promptly identifying individuals with a change of status and arranging for an ISPA to address the reason that lead to the change of status. The Monitoring Team will review this process at the next compliance review for effectiveness in the early identification of individuals' change of status by the physicians for individuals seen in sick call and accompanying ISPAs when indicated. • In May and June 2012, the Cottages began a pilot project to improve integration of services and interdisciplinary participation by having quarterly IDT meetings on every individual. It was reported that a total of 37 individuals were reviewed during these two months. The team reported that the pilot project was generally well attended by the individuals' IDT. Most disciplines were represented. The IDT discussed various aspects of the individuals' care and functioning. In some cases, orders were written, behavior program changes were suggested, and team members' questions were answered. Detailed minutes of the meetings were not kept. It was reported that all individuals' Integrated Risk Rating Reviews were updated. The pilot project will be evaluated in August 2012 and a decision as to whether this process might be recommended campus-wide. The outcome of the pilot project will be reviewed at the next compliance visit.	

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		• The Nursing Department reported since the last compliance visit, they had a Fall Evaluation Policy and Form developed and approved by the Facility Policy and Procedures Committee. The final approved policy and form were not available for review but the draft policy and form was made available for review. According to Section M.5 Action Plans the training on the Fall Policy and form began 6/1/12 with a projected completion by 8/1/12. The percentages of the nurses trained on the policy and form to date was not included for review. A review of the draft policy indicated the policy applied to the nursing staff, DSPs, and QDDPs. While this was a positive step forward in reporting and tracking individuals' falls, the policy steps failed to include the requirement to notify the physicians and PNMT of the falls, although the steps stated once the nurses were notified of falls, nursing assessments would be completed to assess for injury. After the RNs completed the initial assessments, the RNs completed continued to reassess individuals every 24 hour for 72 hours and document findings in the Integrated Progress Notes. The omission of the step to notify the physicians and PNMT of falls and nursing assessment findings was of concern. The Nursing Department should re-evaluate the steps in the Fall Policy to include notification of the physician, PNMT, and other relevant disciplines to ensure that integrated assessments and follow-up care are provided when indicated. • Since the last compliance review, the Hospital Liaison Nurse had been integrated into the IDT meetings for hospitalized individuals, keeping the relevant team members continuously informed of their status while hospitalized. She participated in ISPA meetings on post hospitalized individuals' Integrated Risk Reviews. This activity was validated through review of hospitalized and discharged individuals' records, mentioned in Provision M.1. • A dedicated Nurse Educator was assigned to work with the PNM Nurse to revise the training curriculum on completing the Aspiration Trigger Data Sheet and train DSPs. A review of the revised competency-based Aspiration Trigger Data Sheet found it to contain all the pertinent information to instruct the DSP in accurately and consistently filling out the Aspiration Trigger Data Sheets. According to the Provision M.5 Action plan the training on the revised curriculum on completing the Aspiration Trigger Data Sheet began 6/18/12 and was on going. The best it could be discerned from the related documents supplied for review, the dedicated Nurse Educator has eliminated the test component of the training due to time constraints. The dedicated Nurse Educator goes to the high risk Units and provides training to the DSPs. However, it appeared that the primary responsibility for providing the majority of the training was relegated to the Unit RN Case Managers, who were responsible and accountable for maintaining training rosters and tracking training. Training rosters for the training provided over the past six months on the Aspiration Trigger Data Sheet were not summarized to indicate the	

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		number of DSP staff trained by Unit and by shift. Therefore, the status of training completed for the DSP staff could not be determined. The method used for training the DSP staff on the Aspiration Trigger Data Sheets appeared disorganized and ineffective. Because of the incidence of mortality and mobility related to aspiration pneumonia, plus the number of individuals rated at high or medium risk for aspiration, it is essential that the Aspiration Trigger Data Sheets are accurately and consistently completed by the DSPs, and are reviewed by the nursing staff on each shift with prompt nursing assessments and interventions implemented when aspiration triggers are identified. When the nursing assessments indicate the risk of aspiration, the physician and PNMT must be promptly notified. According to the information reviewed there was no "official" training approved by CTD, to provide training on the Aspiration Trigger Data Sheet in New Employee Orientation (NEO), although training on aspiration is taught by Habilitation Therapist in NEO. The Facility should make every effort to ensure that CTD includes training on the Aspiration Trigger Data Sheet as part of the official training in NEO. The Nursing Department should ensure the implementation of a more organized and effective method for providing and tracking training to the DSP staff on the Aspiration Trigger Data Sheet. • A sample of 10 Aspiration Trigger Data Sheets for June 2012,was selected across campus for Individuals #276, #25, #283, #185, #318, #233, #59, #272, #133, and #149. Findings included: o Seven of 10 (70%) Aspiration Trigger Data Sheets were completed daily on each shift by the DSP staff for the 30 day period. o Seven of 10 (70%) individuals had no aspiration triggers marked for the 30 day period. Two of 10 (20%) individuals had four or more aspiration triggers marked for the 30 day period that required a nursing assessment of lungs and for respiratory compromise. Refer to Section O of the report for information regarding follow up assessments and referrals to the PNMT. o Five of 10 (50%) Aspiration Trigger Data Sheets were reviewed daily on the 6-2 shifts by the shift nurses for the 30 day period. o Seven of 10 (70%) Aspiration Trigger Data Sheets were reviewed daily on the 2-10 shifts by the shift nurses for the 30 day period. o Eight of 10 (80%) Aspiration Trigger Data Sheets were reviewed daily on the 10-6 shifts by shift nurses for the 30 day period. The two sheets not reviewed every day were from the Cottages, who may not have dedicated nurses staffed on the 10-6 shifts. o One of 10 (10%) Aspiration Trigger Data Sheets were reviewed daily, Monday through Friday, by the RN Case Managers. The Nursing Department should develop and implement an audit process to	

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		assess DSPs, shift nurses, and RN Case Managers compliance with completing the Aspiration Trigger Data Sheets as required by policy. • The Monitoring Team discovered at the last compliance review, that the checks for residuals for individuals receiving enteral nourishment were not documented to indicate that the feeding tubes were disconnected at least 30 minutes and residuals checked before bathing. Consequently, the Nursing Administration instructed the nursing staff to add a line on the Treatment Sheets to document disconnecting feeding tubes and checking residuals at least 30 minutes prior to bathing. o A sample of 10 Enteral Feeding Treatment Records for June 2012 and July 2012 to date, was selected across campus for Individuals #411, #209, #392, #453, #567, #190, #93, #53, #437, and #59 for review, and findings included: ▪ The line on treatment records for documenting that individuals who received enteral nourishment had feeding stopped and residuals checked before bathing was not included until July 2012. ▪ Ten of 10 (100%) Enteral Freeing Treatment Records had documentation that residuals were checked daily. This was a positive finding. ▪ The treatment records used for documenting enteral feedings were not standardized, the information varied in the name of the record, format, and organization of content. The statements on the treatment records for checking residuals were inconsistent; for example, statements included: "Residual Prior to Bath √", "Check residual prior to going to bed, bath", "Disconnect g-tube 30m-1hr prior to bath and record residual", "Check residual prior to getting bath (record amt)", "Check residual before bath – if > 60ml notify DSP to delay bath – recheck Q 30 min until < 60ml". Discontinuing feeding at least 30 minutes and checking residuals prior to bathing on the bath table is essential in preventing/reducing the risk of aspirating stomach contents while reclined. In order to ensure continuity and consistency across campus the Nursing Department should develop a standardized procedure for checking and documenting residual checks prior to bathing in collaboration with the PNMT and retrain the nursing staff, as well as review the different treatment records used for documenting enteral feeding information and standardize the enteral feeding record. • It was reported that the Avatar Pneumonia Tracking data had not been analyzed and trended because there was no audit tool. The Pneumonia Tracking Sheet contained a wealth of vital clinical data that could be used in making critical clinical decision with regard to identifying contributing factors that put individuals at risk for aspiration	

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		pneumonia and other pneumonia, as well as identifying systemic trends and assisting in the development of care plans and/or corrective action plans. The tracking of this data is of no value if not used. It is essential that the Nursing Department in collaboration with PNMT and other relevant disciplines develop and implement a system to analyze, trend, and use the data derived from the Avatar Pneumonia Tracking database to make clinical decisions. • It was reported that interdisciplinary collaboration had occurred on developing and implementing Risk Reduction and Preventative Education. Preventative health training material on Oral Health for ICF/MR Individuals was developed by the dentist, dental staff and nursing for the DSP staff. Other training material on Preventing Aspiration was developed by Habilitation Therapists and the PNMT Nurse for the DSP staff. It was further reported that training on these topics were in progress. It was not clear how the DSP staff were trained on this material, how training was tracked, or analyzed for effectiveness in assisting the DSPs in improving their knowledge and skills in providing oral health care and taking measures to prevent aspiration. It was noted that these training materials, along with training material on the Aspiration Trigger Data Sheet, were placed in a binder on all Units for the DSPs to use as a reference. A review of the training materials for Oral Care and Preventing Aspiration found they were sound, written at a level that could be easily understood by the DSP staff, and contained vital information to assist the DSP staff in improving their understanding of the principles of oral health care and aspiration. The Nursing Department in collaboration with dental and habilitation disciplines should consider developing and implementing a more formalized method of training, tracking, and evaluating the effectiveness of the Oral Health and Preventing Aspiration training material, as well as making the material competency-based. Further, consideration should be given to making this material an official training offered by CTD in NEO. The self-initiated processes above were positive steps forward in improving the integration of services and reducing risk factors. However, many of the processes were recently initiated and were still being refined. As these processes are refined and mature they should be able to realize their full potential The following recommendations are offered to assist the Nursing Department and other related disciplines refine the above process: • The Nursing Department should re-evaluate the steps in the Fall Policy to include notification of the physician, PNMT, and other relevant disciplines to ensure that integrated assessments and follow-up care are provided when indicated. • The Facility should make every effort to ensure that CTD includes the Aspiration Trigger Data Sheet as part of the official training in NEO. • The Nursing Department should ensure the implementation of a more organized and effective method for providing and tracking training of the DSP staff on the Aspiration	

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		Trigger Data Sheet. • The Nursing Department should develop and implement an audit process to assess DSPs', shift nurses', and RN Case Managers' compliance with completing the Aspiration Trigger Data Sheets as required by policy. • In order to ensure continuity and consistency across campus the Nursing Department should develop a standardized procedure for checking and documenting residual checks prior to bathing in collaboration with the PNMT and retrain the nursing staff, as well as reviewing the different treatment records used for documenting enteral feeding information and standardizing the enteral feeding record. • It is essential that the Nursing Department in collaboration with PNMT and other relevant disciplines develop and implement a system to analyze, trend, and use the data derived from the Avatar Pneumonia Tracking database to make clinical decisions. • The Nursing Department in collaboration with dental and habilitation disciplines should consider developing and implementing a more formalized method of training, tracking, and evaluating the effectiveness of the Oral Health and Preventing Aspiration training material, as well as making the material competency-based. Further, consideration should be given to making this material an official training offered by CTD in NEO. A sample of six recently Integrated Risk Review Forms and Risk Action Plans was reviewed for Individuals: #284, #576, #371, #547, #31, and #527 found: • Three of six (50%) identified a change of status since the last review. • Six of six (100%) had comprehensive interdisciplinary assessment completed. However, some of the baseline data rationales that supported the risk ratings were more comprehensive than others. The format for reporting baseline data continued to vary from unit to unit and from IDT to IDT. • Six of six (100%) assessments provided data that helped identify risk ratings. • Three of six (50%) ISPs sufficiently addressed all of individuals' identified risk ratings. • Six of six (100%) Risk Action Plans indicated they were approved and implemented by the IDTs within 14 days. However, from reviewing documents in individuals' active record it was difficult to determine the dates the plans for all identified risk ratings were actually implemented. • Four of six (67%) Risk Action Plans adequately met the needs for all of the individuals' identified risk ratings by the IDTs. • Four of six (67%) Risk Action Plans included preventative interventions to minimize all of individuals' identified risk rating conditions. • Six of six (100%) Risk Actions Plans were integrated into individuals' ISPs/ISPAs.	

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		• Three of six (50%) changes were made in individuals' services and supports for all identified risk ratings. • Example: Individual # 576 did not have a Risk Action Plan accompanying the Integrated Risk Rating, on 6/13/12. However, plans resulting from the risk ratings were included in the ISP but the disciplines identified in the ISP to implement and document interventions for the various risk ratings did not include all relevant disciplines. The ISP did contain measurable objectives, but failed to include clinical indicators and interventions for the respective risk ratings. In general, as was found in past reviews, there was wide variation from unit to unit, and within the IDTs in the formats used for the ISPs, Integrated Risk Ratings, and Risk Action Plans, as well as the quality of the clinical data used to support the risk ratings. The Facility needs to ensure consistency across all IDTs, as well as among disciplines, if compliance is to be achieved regarding the integrated risk rating and risk action plan processes. However, with the revised process and format for the Integrated Risk Rating Review Form and Integrated Health Care Plan that was piloted in Bowie, with the expectation after the pilot is reviewed the process will be implemented across campus; it was too soon to determine the effectiveness it will have on determining compliance for this Provision. The Monitoring Team attended the ISP/Risk Rating Review/Integrated Health Care Plan meeting for Individual #86 using the revised process and forms for the meeting. The following observations and concerns were identified: • All relevant IDT members, including Individual #86 were present at the meeting. The facilitator kept the team focused but they were using the piloted revised format for integrated Risk Rating and Risk Action Plans which caused the meeting to take approximately five hours. Since the team was still learning the revised process it was difficult to determine the effectiveness/strengths of process. • The meeting was too long without a break to be productive. Individual #86, an elderly, frail female stayed in the meeting. The staff offered her liquids to drink, took her to bathroom for changes, and occupied her with tearing out pages from magazines. Although she did not indicate she wanted to leave the meeting, it seemed insensitive to have kept her sitting in the wheelchair for so long. After sitting in the meeting for three hours Individual # 86 was observed leaning forward in the wheelchair, apparently dozing. • The RN Case Manager leading the Integrated Risk Rating section dominated the meeting with her opinion as to what the risk ratings should be. There was little discussion or contribution by other team members regarding the risk ratings. A few team members participated more than others. • The Nursing Assessment stated Individual #86 slept 7 to 8 hours per night. The DSP	

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		reported she only sleeps 4 hours per night. The sleep disparity issue was not explored in depth. The Psychiatrist immediately said she would change risperidone to night to help with sleep. There was no further discussion regarding other contributing factors that might affect sleep, such as napping during the day. • The team mentioned Individual #86 frequently threw her food. This was not explored. There was no discussion for taking data for incidents of throwing food or evaluating her food preferences. This behavior was not included in clinical data or in her PBSP. • The team discussed Individual #86's lack of appetite. Contributing factors to cause a lack of appetite were not explored. It was reported that she was offered liquids every hour, including Ensure supplements. No consideration was given to explore if the frequent intake of fluids/Ensure close to mealtime could interfere with appetite at meals. • Several of Individual #86's diagnostic exams should have been completed before her annual meeting to provide an accurate status, e.g., Dexa Scan for osteoporosis, and Ankle-Brachial (ABI) test for circulation. • In discussing Individual #86's circulatory risk the team's physician stated he did not think she had circulatory problems because when he examined her she had hair on her lower legs. The Nursing statement documented that the lower leg's skin was shiny and hairless, which would indicate poor circulation. The Ankle-Brachial (ABI) test for circulation had not been reassessed since 7/11/11. The team agreed to rate circulation at medium risk pending the reassessment of her ABI. The disparity between what the physician reported regarding Individual #86 having hair on her legs verses the RN Case Manager's nursing assessment was discussed by the Monitoring Team with the RN Case Manager Supervisor, who stated that the RN Case Manager told her the Podiatrist documents that on every one. It is essential when there's disparity found between the findings of another provider and the nurse completing the assessment, that the nurse should state her findings and clarify the discrepancy with the other provider. It is essential that the nursing assessments are complete, accurate, and up to date prior to the ISP meetings. • A review of Individual #86's finalized Integrated Health Care Plan found the Action Steps for identified high and medium risks rating to be grossly inadequate to provide actions/interventions to sufficiently meet her needs to prevent/minimize and/or maintain current health status. For example, the action steps contained brief statements to follow PNMP, PBSP, Diet Plan, and other such brief statements for identified risk ratings. The following recommendations are offered for consideration: • The IDT should ensure all required annual and other pertinent diagnostic tests are	

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		completed before the ISP meeting to ensure correct and accurate information is used to develop risk ratings and plans of care sufficient to meet individuals' needs. • Additional data brought up in the IDT meetings should be thoroughly discussed and explored by team members to ensure the issues are adequately assessed and addressed for each risk rating item. • The Nursing Department should ensure that the RN Case Managers review and update Annual Nursing Assessments prior to ISP meetings to assure that all assessment information is complete, accurate, and up to date. The Monitoring Team met with representatives from the State Office and discussed an overview of the revised Integrated Risk Review and Integrated Health Care Plan process. The theoretical concept that the revised process will ensure better integration of services sounds promising. When asked how long it would take to fully implement the revised process across all facilities, it was projected to take approximately a year. After this meeting the Monitoring Team Nurse met with the State Office Nurse Practitioner Consultant and further discussed the revised process. It was positive to find that the Integrated Risk Review Form and Integrated Health Care Plan Format grouped related risk ratings together into six risk groups. The Nursing Health Maintenance Plan will be discontinued and plans for disciplines will be included in risk groups to ensure integration of services. The Integrated Health Care Plans will be placed into individuals' Program Books. Conceptually this approach seemed reasonable to ensure the integration of risk rating assessments and development of plans across relevant disciplines. It was of concern that if the disciplines adequately develop plans sufficient to address each risk rating for individuals, the plans could be exceedingly lengthy, particularly since it is not unusual for individuals who are medically complex to have seven or more high and/or medium risk ratings. The functional usefulness of placing the plans in individuals' program books was of concern if discipline specific plans do not exist, i.e., will the staff actually refer to and use the plans. Another concern was regarding validation of staff training on the plans. For the current Nursing Health Maintenance Plans, special instruction sheets for the DSP staff are developed and attached to Health Maintenance Plans, which included documentation validating DSP staff were trained. The State Office Nursing Practitioner Consultant was receptive to listening to the above concerns. It was positive to find that the State Office was piloting the revised process at the other facilities. No doubt when the pilots are analyzed, refinements to the process will be made, and the concerns expressed above will be resolved. The Monitoring Team will review progress on the revised Integrated Risk Review and Integrated Health Care Plan process at the next compliance review.	
M6	Commencing within six months of the Effective Date hereof and with	The Facility stated they performed activities to conduct the self-assessment: • Monthly Medication Variance Committee Meetings were held consistently.	Noncompliance

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	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.	• Tracking, trending and analysis of medication variance data was reviewed during all of the Medication Variances Committee Meetings; all patterns and trends were discussed and appropriate corrective action plans were completed. Nurse Managers provided unit reports to present trends noted and corrective action taken when trends were identified; if problems were consistent then campus wide correction was taken. Data analyses were used to improve the medication administration processes and documentation. • Medication Administration and Documentation monitoring data for a six months average showed a percentage compliance rate of 97.6%. Trending problems were noted related to missing signatures on the Control Drug Signature Count Sheets. A plan of correction was developed that included revising the signature sheet and requiring the Nurse Managers/designee to check the signature sheets daily before end of shift for missing signatures. The Nurse Managers followed up with any corrective actions. The QA Nurses performed inter-rater reliability checks, for which the results were shared at the Medication Variance Committee Meetings. • Medication Administration Observations showed 76% of nursing staff observed were completed for the first quarter of the six months; for the second quarter of the six months period the completion rate was 91%. The six month average percentage compliance rate was 83%. No corrective action was needed because compliance average was above 80%. However, the Nursing Department developed a new medication administration observation tracking system to make sure every nurse was observed to increase the percentage of nurses completed. The plan consisted of each Nurse Manager creating a schedule of nurses to observe each month in that quarter. The schedules were given to the Nursing Operation Officer to track completion of every nurse having a medication administration observation during a quarter. • Oral and Enteral Medication Administration Observations were conducted on the same observation form. Trending analysis was included together for both oral and enteral medication administration. The six months average percentage compliance rate was 97.6%. A trending problem noted was related to missing signatures on the Control Drug Signature Count Sheets. A plan of correction was developed that included: Revising the Control Drug Signature Count Sheets and requiring the Nurse Managers/designee to check the signature sheets daily before the end of shifts for missing signatures. Nurse Managers will follow up with any corrective actions. The QA Nurses performed inter-rater reliability checks, in which the results were shared at the Medication Variance Committee Meetings. When Nurse Managers followed up with corrective actions, copies of the corrective actions and training rosters were submitted to the Nursing Operations Officer. • Medication Rooms were checked weekly by the Nurse Managers and Inter-rater reliability checks were performed by QA Nurses monthly. The Nursing Department	

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		was in the process of developing corrective action plans as the Nurse Managers will be responsible for auditing the rooms every week and performing corrective actions on their units. They will present the information at the Medication Variance Committee Meetings, where the Committee will discuss and a campus wide plan of corrections will be developed as necessary. • Each unit and workshop areas have dedicated areas for privacy during medication pass. • Nurses referred to the PNMP during medication administration. • MAR audits were completed weekly by the Nurse Managers and monthly by QA Nurses. Audits included reviewing for inclusion of the PNMP as part of that audit. Improvements were made in using the proper assistive equipment to provide safe med passes. • Of the last six months there were no problems noted regarding use of proper assistive equipment. All assistive equipment was cleaned and sanitized according to Facility policy. • Medication errors/variances continued to be reviewed, tracked, analyzed, and trended with follow up as necessary, with Nurse Managers assuring that this process was completed. • Agency nurses' medication variances were reviewed by a dedicated shift manager who completed follow-up. • New nursing employees were cross-trained to different units to become familiar with medication administration routines in areas different from their assigned unit. <u>The results of the self-assessment:</u> • Quarterly medication administration related audit results discussed in January 2012 have showed consistent compliance as indicated below: o Medication Observation 97% • Quarterly audit results discussed in April 2012 have also showed consistent compliance as indicated below: o Medication Observation 97% <u>Self-rating:</u> Based on the findings from this self-assessment, this provision was in substantial compliance. Processes were in place to increase accountability on the unit level, and the monitoring tool has been consistently above 95%. <u>Monitoring Teams Findings</u> The Facility's Self-Assessment stated they were in substantial compliance with Provision M.6; the Monitoring Team recognizes the significant improvement both in medication administration practices and in identification of medication variance and finds that this provision is near to achieving substantial compliance, with a need to demonstrate	

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		effective steps over time to reduce medication variances while maintaining its newly established accuracy of reporting. Through a review of Section M Self-Assessment, Section M Presentation Book, staff interviews and review of documents, it was evident, as found in past compliance reviews, that the Nursing Department had continued to put forth concerted effort to make improvements in this Provision Since the last compliance review, there was evidence demonstrated through documents reviewed, staff interviews, and observations that the Nursing Department was implementing the Medication Variance Policy, 053, and were continuing to make improvements/plans of corrective action based on the monthly and quarterly analyses and trending data derived from Medication Variance Reports, Nursing Care Administration and Documentation Monitoring Tool Audits, Medication Administration Observations Audits, Medication Administration /Record Audits, and Medication Room Audits. In addition, when nursing's Medication Variances were reported or deficiencies were identified while these audits were being conducted there was documentation that immediate local corrective actions were taken with the responsible staff. This is further demonstrated in the report below. There was training documentation that all nursing staff were trained on the Medication Variance Policy, 053. Training on the policy was also included in the New Nurse Orientation, and at the annual nursing competency-based refresher training. The Facility continued to maintain an excellent Medication Variance Database using the root cause method to report data. Reported Medication Variance data included variances by: Severity Index Classifications, type of variance, type of medication, department, Unit/Cottage and by each home responsible for the variance, individual and type of medication for which the variance occurred. The Medication Variance Database reported variance data monthly, quarterly, and longitudinally. Medication variance data was reported and presented in tabular, graphic, and narrative forms. A review of the monthly Medication Variance Committee Meeting minutes for January 2012 through May 2012, and the Monitoring Team's attendance at the Medication Variance Committee while on site, found that the Nursing Department did an excellent job reporting medication variances, and analyzing and trending monthly and quarterly Medication Variance Data Reports and implementing appropriate plans of correction by Unit/Cottage, by home, by shift, and by nurse, by individual for who the medication was committed, as well as campus-wide. This information was attached to the minutes. The June 2012 data and plans of correction implemented were discussed at the Committee meeting attended. The outcome of the discussions and findings of the Medication Variance Committee Meeting were further reviewed and discussed at the quarterly	

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		Pharmacy and Therapeutic Committee Meeting Minutes, and at the Pharmacy and Therapeutic Committee meeting attended by the Monitoring Team while onsite. Although the Nursing Department did an excellent job reporting, analyzing and trending medication variance data, and implementing plans of correction, it was identified again that the Medical Department was not reporting, analyzing and trending medication variance data, and implementation of plans of corrective action. Their medication variances were identified and reported by the Pharmacy staff, as was found at the last compliance review. This fact was pointed out to the Medical Director at the Medication Variance Committee the Monitoring Team attended. The Medical Director acknowledged this area needed improvement and agreed to follow up. The Pharmacy Department was beginning to improve their reporting of medication variances, analyzing and trending data, and implementing plan of correction, although they had not made the degree of improvement in this function as was found by the Nursing Department. The first and second quarters, monthly number of medication variances are reported in the chart below:	

First and Second Quarter 2012 Medication Variances

	January	February	March	April	May	June
Nursing	45	34	34	40	51	246
Pharmacy	63	62	52	53	34	11
Medical	1	24	16	13	19	20
Campus	108	96	86	106	104	277
Ratios	1/1349	1/1124	1/4446	1/1291	1/1369	1/514
Percentages	0.0007412	0.0008896	0.0006915	0.0007745	0.0007304	0.00194553

The Nursing Department reported that there had been an increase in the number of medication variances reported in June 2012. This was due to recognizing that extra doses of medication found in medication carts and/or missing initials found on the Medication Administration Records constituted a medication variance. Since this realization, Medication Variance Reports were completed for these issues, thus an increase in the number of medication variances were reported. The NOO reported as a result of the corrective actions taken the medication variances were beginning to decrease in July 2012. Although the reporting of extra medications found in the medicine carts and missing initials on the Medication Administration Records caused an increase in the number of medication variances reported by the nursing staff it was a positive finding, which demonstrated that the Nursing Department was continuing to use the medication administration audit and medication variance data to identify problems, take remedial action to improve medication administration practices, and reduce the incident of medication variances. To achieve compliance, there must be demonstration over a period of time that the improved accuracy of identification and reporting of variances continues,

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		and that practices to reduce the recently-identified medication variances are continued and are effective. It was positive to find that the Infection Control Nurse had developed an Antibiogram developed that described the sensitivity to the antibiotic prescribed for a variety of infections, which she presented at the Pharmacy and Therapeutic Committee Meeting. This was discussed in the Committee meeting and there seemed to be some reservations regarding it use and decided to further explore the issue since the data used came from an Austin hospital. The Committee plan to work with the local hospital to develop an Antibiogram specific to the Brenham area. This issue will be reviewed at the next compliance visit. The \ Self- assessment reported that 76% of nursing staff administering medication were observed through Medication Administration Observations in the first quarter of the six months. They reported that corrective action was taken to ensure all nursing administering medications were observed quarterly. As a result of the corrective action the second quarter of the six month period the showed 91% of the nurses were observed. There was documented evidence reviewed by the Monitoring Team that validated the corrective action taken. The Nursing Department developed a new tracking system to make sure every nurse was observed to increase the percentage of nurses observed. The plan consisted of each Nurse Manager creating a schedule of nurses to observe each month in that quarter. Oral and Enteral Medication Administration Observations were conducted on the same observation form. Trending analysis was included together for both oral and enteral medication administration. The six months average percentage compliance rate was 97.6%. A trending problem noted was related to missing signatures on the Control Drug Signature Count Sheets. A plan of correction was developed that included: Revising the Control Drug Signature Count Sheets and requiring the Nurse Managers/designee to check the signature sheets daily before the end of shifts for missing signatures. The QA Nurses performed inter-rater reliability checks, in which the results were shared at the Medication Variance Committee Meetings. When Nurse Managers followed up with corrective actions, copies of the corrective actions and training rosters were submitted to the Nursing Operations Officer. These findings were consistent with the Monitoring Teams findings. For example: • A review of the Medication Administration Observation Schedules for each Unit/Cottages verified that observations were scheduled monthly for each nurse administering medication and the schedule was being followed. • The Monitoring Team conducted Medication Administration Observations on the Driscoll Unit, accompanied by the NOO and Nurse, Nurse Shift Manager, and respective Unit Nurse Managers. Medications were administered in a private room to provide individuals with privacy, the DSP staff assisted the nurse by bring one	

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		individual at a time into the room, individuals were treated with respect and courtesy by all staff, the medication room was clean as well as the medication cart that included necessary diagnostic equipment. Waste material was disposed of properly. Proper hand washing techniques were followed before, during, and after medications were administered. Medication Administration Records contained each individual's PNMP and were followed by the nurse. The PNMPs were up date at the annual ISP and/or when there was a change. The nurse complied with generally accepted professional standards of practice for safe medication administration with one exception; after opening the unit medication blister packages of medication and pouring the medications in cups for administration, the nurse immediately disposed of the emptied packages in the waste bend without reserving them on the medication cart to complete the third check of the medication to ensure that the correct medications were administered. The nurse was corrected "on the spot" to ensure that all three medication checks were completed. The nurse acknowledged that she knows to do this but had momentarily forgotten and gave assurance she would not forget in the future. One individual experienced a brief episode of coughing without struggle and appeared to clear after drinking medication mixed with a laxative using a straw and mixed honey consistency according to the PNMP. The nurse immediately followed up by completing auscultation of the throat and lungs and checking oxygen saturations; no abnormal findings were identified. Any additional follow up action completed by the nurse after the medications passes were completed was not determined. • Because of audit compliance scores that fell significantly less than 80% in past compliance reviews on the Medication Room and Medication Administration Records audit, coupled with the corrective actions that were put in place since the last review to improve compliance to achieve at least 95% compliance; the Monitoring Team, accompanied by the NOO, and Nurse Shift Manager inspected all Units/Cottages medication rooms, including medication carts, medication storage, equipment, refrigerators, reference material, and Medication Administration Records using the standardize State Supported Living Center Medication Room Audit Forms. The results of the inspection audits are reported below: o Childress Unit audits met an overall average of 100% compliance. o Fannin Unit audits had an overall average of 100% compliance. o Driscoll audits had an overall average of 99% compliance. o Bowie audits had an overall average of 98% compliance. o Cottages audits had an overall average of 93% compliance. The inspections of all medication rooms demonstrated the effectiveness of the corrective actions taken by Nursing Administration, Unit Nurse Manager, and staff nurses. The areas of audit that resulted in less than 100% in Driscoll, Bowie, and the Cottages were all	

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		related to failure of the nursing staff to cosign the Narcotic Logs with the off-going and on-coming shift nurse. With the revision of the Control Drug Signature Count Sheets even these Unit/Cottages showed significant improvement in cosigning. Immediately after the inspections in the Units/Cottages, the Nurse Managers and nursing staff were commended on the improvements found. They all expressed a sense of pride, which was much deserved considering the audit results found in past compliance reviews. The Units/Cottages Nurse Managers were given copies of the inspection audits, were made aware of the of the missing co-signatures at shift change on Control Drug Signature Count Sheets, and were provided instruction to ensure that this deficiency was corrected. This issue will be reviewed at the next compliance visit. Other improvements were found since past reviews in some of the Cottages medication rooms that had been renovated and the air quality improved. The sizes of the medication rooms in the Cottages are very small, about the size of a closet. The doors of the medication rooms opened into the living rooms. This made privacy and safe medication administration difficult because even with the DSP staff assisting as the nurses administer medications, the individuals could reach in and grab medications as the nurses attempt to pass them at the door. The nursing staff reported such medication errors had happened. Reportedly, there are no other spaces available in the Cottages to use for administering medication. However, this does not negate the problem and the risk of harm that could result from individuals grabbing wrong medications. This was discussed with the Facility Director who acknowledged the lack of adequate and safe space to administer medication was a problem and was working on a solution. This issue will be reviewed at the next compliance review. It was positive to find that four antiquated and malfunctioning medication refrigerators identified at the last compliance had been replaced. An inspection of all the other medication refrigerators found that the temperatures were consistently checked daily but most of the temperature ranges varied greatly from day to day which indicated they were not safe and reliable for storing medications. Some refrigerators' freezers were over frosting and required almost daily defrosting; others constantly leak water into the refrigerator since the freezer was not contained in a separate compartment. When one refrigerator's door was open the seal was hanging loose from the bottom of the door. All of the refrigerators that were not replaced had outlived their functional usefulness by several decades. This issue was brought to the attention of the Facility Director, who immediately instructed the administrative staff to order new refrigerators to replace all of the antiquated malfunctioning refrigerators. The order for replacement refrigerators was completed while the Monitoring Team was onsite. This issue will be reviewed at the next compliance visit. It was positive to find, as was recommended in past compliance reviews, the State Office Nurse Practitioner Consultant and Habilitation Therapist had developed a competency-	

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		based and practicum PowerPoint Presentation on Medication Administration that included the following to ensure safe medication administration practices: • Utilization of the PNMP during medication administration. • Review dysphagia as related to risk of choking and aspiration. • Review effects of dysphagia in relation to medication administration. • Review strategies and interventions to reduce risk of aspiration during medication administration for both oral and enteral methods (positioning, equipment, diet texture and other dining techniques). • Review how Head of Bed Elevation is utilized for safer and more effective medication administration. A review of the training material and attendance of the training presented to the Nursing Administration and the Nurse Educator found it comprehensive and represented all aspects of safe administration related to dysphagia and the reduction in the risk of choking and aspiration during medication administration. The training to the nurses who administer medications will begin in the near future. Further, the Chief Habilitation Therapist provided mealtime data for the past two months that demonstrated that the PNMTs were observing medication administration passes. She explained that nurses were also trained on the PNMP but the training data was aggregated with all of the DSP training data and would be extremely time consuming to extrapolate. These issues will be reviewed at the next compliance review. The Monitoring Team spent a concerted amount of time at this compliance review conducting nursing staff interviews, observing, and reviewing related documents for virtually all relevant aspects of the Nursing Department's medication administration practices and found the Provision to be very near substantial compliance. In order to gain compliance, all of the positive practices identified in the report must be continued. The only aspect of concern related to the systemic analyses and trending of all medication variance data, and development and implementation of systemic plans of corrections. However, this cannot be accomplished until the Medical Department and Pharmacy make more improvements in their report, analysis, and trending of their medication variance data. To achieve compliance with this provision, there must be demonstration over a period of time that the improved accuracy of identification and reporting of variances continues, and that practices to reduce the recently identified medication variances are continued and are effective.	

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

1. The Nursing Department and QA Nurse should consider meeting with the nurse staff responsible for completing the monitoring tools to review, discuss, and clarify the interpretation of the Nursing Care Monitoring Tool Guidelines, and to revise and/or clarify the guidelines to ensure that all

auditors come to an agreement on interpreting items on the monitoring tools. (Provision M.1)

2. The Nursing Department should ensure when any time records/documents are revised or created that they have official numbers and dates of the creation or revision noted to ensure the most current records/documents are used. It is also important to date records/documents created or revised that are used to record health data even though they may not be part of the active record to ensure the most current records/documents are used. (Provision M.1)
3. Retrain the Direct Support Professional to consistently complete their section of the Seizure Record. (Provision M.1)
4. As was identified and recommended at the last compliance review, the Infection Control Program should ensure the following improvements are made: (Provision M.1)
    - The Infection Control Committee should make better use of information derived from the Infection by Type Reports and other infection control spreadsheets and database 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 further analysis and documentation of the effectiveness of the outcomes resulting from the interventions.
    - The Infection Control Nurse should develop and implement formalized procedures/processes to address the reliability of infection/communicable disease data reported.
    - The Infection Control Nurse should ensure that "real time" audits are completed on diagnoses of 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 continue to collaborate with the Nurse Case Managers and other relevant staff to develop and implement plans of care a when acute infectious/communicable diseases are reported to ensure appropriate clinical interventions are put in place to control/prevent their spread. The Infection Control Nurse should document such actions taken in the respective individuals' Integrated Progress Notes.
5. In order for the Skin Integrity Committee to function effectively all relevant disciplines should attend and contribute to the meeting to ensure that skin integrity services are integrated across all disciplines and that the Committee analyze and trend longitudinal decubitus data. (ProvisionM.1)
6. The Nursing Department should add polio vaccination information to the Comprehensive Nursing Assessment template. (Provision M2.)
7. The RN Case Managers should consistent update individuals' change in status in the Integrated Progress Notes, as well as any change in nursing care plans. (Provision M.2)
8. The Nursing Department should ensure that nursing problems/diagnoses and accompanying HMPs are developed and implemented for all of individuals' high and medium risk ratings that require nursing interventions. (M.2)
9. The Nurse Educator should consider a process for evaluating the effectiveness of sending training material to the nursing staff to read via email and sign. (Provision M.4)
10. The Nursing Department should consider developing and implementing a process for assessing nursing staff's competency related to the protocols, as well as auditing the protocols to ensure that compliance was achieved through actual clinical practice sufficient to address the health status of individuals served. (Provision M.4)
11. Nursing Department should develop a standardized procedure for checking and documenting residual checks prior to bathing in collaboration with the PNMT and retrain the nursing staff, as well as review the different treatment records used for documenting enteral feeding information and standardize the enteral feeding record. (ProvisionM.5)
12. The following recommendations are offered to assist the Nursing Department and other related disciplines refine the integrated processes: (Provision M.5)
    - The Nursing Department should re-evaluate the steps in the Fall Policy to include notification of the physician, PNMT, and other

relevant disciplines to ensure that integrated assessments and follow-up care are provided when indicated.

- The Nursing Department should ensure the implementation of a more organized and effective method for providing and tracking training the staff on the Aspiration Trigger Data Sheet, including providing training during new employee orientation and developing and implementing an audit process to assess completion of the Aspiration Trigger Data Sheets as required by policy. Consideration should be given to include the Oral Health and Preventing Aspiration training material.
- In order to ensure continuity and consistency across campus the Nursing Department should develop a standardized procedure for checking and documenting residual checks prior to bathing in collaboration with the PNMT and should retrain the nursing staff, as well as review the different treatment records used for documenting enteral feeding information and standardize the enteral feeding record.
- It is essential that the Nursing Department in collaboration with PNMT and other relevant disciplines develop and implement a system to analyze, trend, and use the data derived from the Avatar Pneumonia Tracking database to make clinical decisions.
- The IDT should ensure all required annual and other pertinent diagnostic tests are completed before the ISP meeting to ensure correct and accurate information is used to develop risk ratings and plans of care sufficient to meet individuals' needs.

The following are offered as additional suggestions to the Facility:

1. The Nursing Department should collaborate with the Quality Assurance Department to evaluate weighting items on the Nursing Care Monitoring Tools by value of significance. (Provision M.1)

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 Self-Assessment (7/12/12) 2. BSSLC Action Plan (7/6/12) 3. BSSLC Presentation Book, July 2012 4. BSSLC pharmacy services and safe medication practices, verification of medication order policy, dated 7/7/2012 (no policy number) 5. DADS State Policy & Procedures: 053, Medication Variances, dated 09/23/2011 6. Psychoactive medication oversight committee meetings minutes (PMOC) for May, June, and July 2012 7. Restraint reduction committee meeting minutes for July 2012 8. First 15 Quarterly Drug Regimen Reviews (QDRRs) that were completed in June 2012 9. First ten new medication orders for June 2012 10. All single patient drug intervention reports for June 2012 11. Incidence, and completed Adverse Drug Reaction (ADR) reports, for all ADRs that occurred during the reporting period 12. Pharmacy and Therapeutics Committee (P&TC) minutes from January through July 2012 13. All data, and trends analysis for ADRs 14. Drug Utilization Evaluations (DUEs) provided during the reporting period, and relevant P&TC minutes **People Interviewed:** 1. Trey Knittel, PharmD, RPh (BSSLC Pharmacy Director) 2. Amy Randall, PharmD, RPh (BSSLC Clinical Pharmacist) **Meeting Attended/Observations:** 1. Medication variance committee meeting, 07/25/2012
	Facility Self-Assessment: The Monitoring Team concurs with the Facility's determination of substantial compliance for Provisions N.1, N.4, N.5, and N.6. The Facility reported non-compliance with provision N.2, because QDRRs were not completed timely; however, at the time of this review, the Monitoring Team assessed that the QDRRs were in fact up to date, and because of the high quality of the QDRR's, determined that the Facility was in substantial compliance. Importantly, the Monitoring Team disagrees with the Facility belief that it will take less time to complete a QDRR in the future. The Monitoring Team has had significant past experience with the QDRR process, and on average a QDRR will take 3 hours to appropriately complete. For Provision N.3, the Facility reported that because the clinical pharmacist did not appropriately address benzodiazepines on the QDDRs, that the Provision would not be in compliance. The Monitoring Team agrees that if benzodiazepines were not assessed for the QDRR process, the Facility would not be in compliance; however, during the review, the Monitoring Team noted that QDRRs appropriately addressed

	benzodiazepines, and determined substantial compliance with Provision N.3. The Facility reported substantial compliance with Provision N.7 because DUEs were timely, comprehensive, and followed up on recommendations. The Monitoring Team agrees that the quality of the DUEs were of high quality, comprehensive, and there was evidence to support that recommendations were followed up on; however, because the Facility did not offer additional DUEs, based on relevant FDA advisories, which has been clearly delineated in prior Monitoring Team Reports, the Monitoring Team determined that the Facility was not in compliance. The Facility reported substantial compliance for Provision N.8 because the pharmacy appropriately identified medication variances, and provided remedial action to help mitigate further variances. The Monitoring Team disagrees with this assessment because the medication variance process requires collaboration by nursing, pharmacy, and medical departments. There remains a need for the Facility to improve the medical providers' participation in assessing and reporting on medical providers' medication variances participation in assessing, and reporting on medical providers medication variances. In addition, the analysis of medication variances must be enhanced.
	Summary of Monitor's Assessment: The Monitoring Team would like to acknowledge Facility's leadership, and staff involved in addressing Provision N. There has been continued and significant improvement with regard to working toward substantial compliance. The Monitoring Team is pleased to be rating substantial compliance for five Provisions that were previously noncompliant. Provision N.7, which was in substantial compliance, was determined to be not in compliance at the time of this review. Provision N.1: The Monitoring Team concurs with the Facility's self-assessment for Provision N.1, and determined substantial compliance, noting excellent review of new medication orders, and documentation of single patient drug interactions. Because there were no prescriptions reviewed by the Monitoring Team that were prescribed for clinical indications that were not FDA indicated for a specific drug during this review period, the Monitoring Team will continue to carefully assess at future compliance visits how the pharmacists document and review medication prescriptions that are not supported by an FDA indication. Provision N.2: The Monitoring Team disagrees with the Facility's self-assessment of noncompliance with Provision N.2. The Monitoring Team noted exceptional quality of the QDRRs reviewed, and based on discussion with the pharmacy director and clinical pharmacist, the QDRR process was current at the time of this review. Because some QDRRs had pharmacy recommendations listed in the comment section of the QDRR, but not the recommendation section, the Monitoring Team recommends that the pharmacist ensure that all necessary recommendations determined from the review be clearly listed in the recommendation section of the QDRR. Most important, the Monitoring Team is aware that a quality QDRR takes at least two and a half, to three hours to complete, even under optimal conditions. Based on the Facility's current census of 299 individuals, it would take, on average, 75 hours per week to appropriately complete QDRRs at the Facility. The Monitoring Team strongly recommends reviewing workload issues related to the QDRR

	process. Provision N.3: The Facility, under the leadership of the pharmacy director, provides excellent review, and assessment of the use of benzodiazepines, anticholinergics, polypharmacy, and metabolic syndrome, and the Monitoring Team is in agreement with the Facility's self-assessment, and determined that the Facility is in substantial compliance with Provision N3. The Monitoring Team recommends that rates be incorporated into the tracking, and analysis of medications. Provision N.4: Because all samples reviewed were noted to have the prescriber's documented review and relevant action plan for all pharmacy recommendations, the Monitoring Team noted substantial compliance with Provision N4. Provision N.5: The provision was determined to be not in substantial compliance. Adequate procedures for screening when there was a change in medication dose had just been started and results could not yet be assessed. Provision N.6: Because of the Facility's assertive follow-up, reporting, and tracking of ADRs, the Monitoring Team determined that the Facility continues to be in compliance with Provision N.6. Provision N.6 requires assertive reporting of ADRs, and the Monitoring Team will closely review for progress in reporting of ADRs, as well as all training venues offered to nurses, direct care staff, pharmacists, medical providers, and other relevant staff who are in contact with individuals on a regular basis. Provision N.7: The Monitoring Team is satisfied with the quality of the DUEs provided, and follow-up on DUE recommendations through the Facility's specific quality assurance process that was developed to track issues related to DUEs. Because the Facility did not provide unscheduled DUEs for advisories issued by the FDA on serious medical concerns, and practices for statin drugs, and Celexa, the Monitoring Team disagrees with the Facility's self-assessment of substantial compliance, and determined that the Facility is not in compliance with Provision N.7. Compliance requires that all relevant FDA advisories result in a DUE at the Facility. The Monitoring Team also recommends that the Facility maintain a more complete tracking process for DUEs, which would enable determination of what DUEs were scheduled, and what DUE had been completed, for both pre-determined DUEs, and DUEs provided because of an FDA advisory, or otherwise clinically indicated. Importantly, the Monitoring Team expects a full complement of relevant health care providers, such as primary care providers, psychiatrists, pharmacists, lead nursing staff to participate at presentations related to DUEs. Provision N.8: The Monitoring Team compliments the nursing and pharmacy departments for their outstanding effort and excellent accomplishments with developing a robust medication variance process at the Facility. There remains a need for the Facility to improve the medical providers' participation in assessing and reporting on medical providers' medication variances. At this time, the Monitoring Team is not in agreement with the Facility's self-assessment of substantial compliance, and determined that Provision N.8 is not in compliance with the SA. Compliance will require that the medical department

	become actively involved in the medication variance process, report on its own variances, develop a process for remediation, ensure documentation of all remediation, and participate at Medication Variance Committee (MVC) meetings on a regular basis. In addition, the medication variance process requires continued enhancement by ensuring that when conducting an analysis of the various types of variances, the cause, and its level of severity are reported on for each variance. Furthermore, the Monitoring Team will assess training records for medical providers, pharmacists, and nursing staff on the medication variance process, and will review records on any remediation provided to staff, relevant to the medication variance process.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	To assess the pharmacy's ability to review, and determine the appropriateness of new medication orders, the Monitoring Team reviewed the Facility's pharmacy services and safe medication practices, verification of medication order policy, dated 7/7/2012 (no policy number), the first ten new medication orders completed in June 2012, and all single patient drug interventions completed in June 2012. Policy The new pharmacy services and safe medication practices, verification of medication order policy was reviewed and determined to be comprehensive, and addresses all compliance issues related to Provision N1. The Monitoring Team believes that appropriate assessment of new medication orders will be assured if staff adhere to the policy. New Medication Orders Of the ten new medication orders, ten out of ten samples (100%) indicated a review by the pharmacist for appropriate indication, drug interactions, allergies, appropriate dose, and assessment of labs, when necessary. Documentation by the pharmacist was indicated on an initialed and dated sticker, which was applied to the medication order, and indicated what issue was reviewed by the pharmacy. Single Patient Drug Interaction Reports Thirty-eight single patient drug interaction reports were reviewed, and 38 out of 38 (100%) indicated that the prescribing provider was contacted, and documented the provider's action plan. Summary: The Monitoring Team concurs the Facility's self-assessment for Provision N1, and determined substantial compliance, noting excellent review of new medication orders,	Substantial Compliance

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		and documentation of single patient drug interactions. Because there were no prescriptions reviewed by the Monitoring Team that were prescribed for clinical indications that were not FDA indicated for a specific drug during this review period, the Monitoring Team will continue to carefully assess at future compliance visits how the pharmacists document and review medication prescriptions that are not supported by an FDA indication.	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	To help ensure that QDRRs are completed quarterly, the Facility maintains a schedule of all pending and completed QDRRs. To assess the Quarterly Drug Regimen Review (QDRR) process, the Monitoring Team requested the first 15 QDRRs that were completed in June 2012, along with copies of labs, annual medical assessment, most recent medication list, and the past two MOSES and DISCUS assessments. In addition, the Monitoring Team discussed the current QDRR schedule with the pharmacy director and clinical pharmacist, and at the time of this review, the QDRR schedule was current. A sample of 15 QDRRs was reviewed. The following summarizes the results of this review: • Laboratory information was submitted as part of 15 QDRRs (100%). • The lab results included exact values or indication of normal range for appropriate measures such as complete blood counts (CBC), electrolytes, glucose, Hgb A1C, lipid panel, hepatic function, ammonia level, thyroid function, as well as blood levels of specific medications. • Other diagnostic information, such as DEXA results and EKGs, was noted. • Fifteen labs (100%) had the date the lab was drawn. • Abnormal values were listed under the notes/comments section line for that particular lab. • Fifteen (100%) indicated polypharmacy, and polypharmacy was appropriately addressed. • Five samples included a benzodiazepine drug, of which five out of five were appropriately addressed by the pharmacist (100%) • There were a total of ten samples that included anticholinergic medications, and ten out of ten were appropriately addressed by the Pharmacist (100%). • Nine samples included neuroleptic medications, which required metabolic screening, and nine out of nine included a comprehensive review of metabolic syndrome (100%) • Ten out of 15 samples included one or more psychotropic medications, and ten out of the ten samples included a review, and documented action plan by the treating psychiatrist (100%) • Fifteen out of 15 samples included a review and documented action plan by the	Substantial Compliance

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		treating primary care provider (100%). • The lab testing that was completed, and the frequency with which laboratory testing was completed indicated the PCPs generally were providing appropriate lab monitoring of medication side effects, adverse effects, and therapeutic drug levels. Summary: Of the 15 QDRRs reviewed, the Monitoring Team noted exceptional quality of work on the part of the clinical pharmacist, and review by the treating medical providers. Each of the QDRRs demonstrated a comprehensive review of the clinical record, and in many cases, discussion with the prescribing clinician, and other team members. Diagnostics, including laboratory levels, DEXA results, and EKGs were reviewed, and commented upon; relevant external consults were reviewed, and commented on; polypharmacy, benzodiazepines, anticholinergics, and metabolic syndrome were well documented, and appropriately addressed. All QDRRs were reviewed by the appropriate medical provider, and the pharmacist's recommendations were accepted, and a follow-up plan was documented for each recommendation by the medical provider. The level of detail, clinical insight, and comprehensiveness was of exceptional caliber. The Monitoring Team did note one issue that requires enhancement. In four of the 15 samples, the comment section of the QDRR listed recommendations that were not listed on part C of the QDRR. For example, for Individual #15, there was a comment stating that periodic monitoring of an EKG should occur as long as the person was on Lithium, and this recommendation was not commented on in section C. Another example is for Individual #259, when the pharmacist commented that the individual's abnormal vitamin D level was not associated with medications, and that other causes should be evaluated. Again, this issue was not addressed in section C. The Monitoring Team will continue to be assertive in evaluating for necessary recommendations, and associated action plan by the medical provider. Most important, the Monitoring Team is acutely aware that a quality QDRR takes at least two and a half, to three hours to complete, even under optimal conditions; when the Monitoring Team questioned the clinical pharmacist about how she completed the QDRRs, it was learned that the clinical pharmacist has had to spend considerable overtime, working late during the evenings, and on weekends. Based on the Facility's current census of 299 individuals, it would take, on average, 75 hours per week to appropriately complete QDRRs at the Facility. The Monitoring Team strongly recommends reviewing workload issues related to the QDRR process. Overall, the Monitoring Team congratulates the pharmacy department, clinical pharmacists, and medical providers for their exceptional work in achieving substantial compliance for section N2, of the SA.	

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N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	To assess the pharmacy department's monitoring of benzodiazepines, anticholinergics, polypharmacy, and metabolic syndrome, the Monitoring Team reviewed the first 15 QDRRs completed in June 2012. To review the pharmacy's assessment of STAT medication use, the Monitoring Team reviewed the Face-to-Face assessment forms for all STAT chemical restraints that occurred during the previous six-month period. In addition, chemical restraint tracking data, and analysis, and committee meeting minutes, from the May, June, and July psychoactive medication oversight committee meetings (PMOC) were reviewed. <u>Review of Benzodiazepines, Polypharmacy, Anticholinergics, and Metabolic Syndrome</u> As delineated in Provision N2, of this report, the Facility provided excellent assessment, benzodiazepine, anticholinergics, and metabolic syndrome. Appropriate review of diagnosis and clinical justification, by the pharmacist documenting approval or disapproval, was noted in 15 out of the 15 QDRR samples reviewed for polypharmacy (100%), five out of five samples for benzodiazepines (100%), ten out of ten samples for anticholinergics (100%) and nine out of the nine samples that required metabolic syndrome screening (100%). <u>Chemical Restraints</u> The Facility reported three chemical restraints during the prior six-month period. A Face-to-Face assessment form was completed for three out of three samples (100%). The pharmacists completed a comprehensive assessment of efficacy in three out of the three samples (100%), comprehensive review of side effects and potential interactions with other medications in three out of three samples (100%), assessment of efficacy in three out of three (100%), and appropriateness of use in three out of three samples (100%). The Facility maintained data, and performed trends analysis, on all chemical restraints, and a marked reduction in chemical restraint had been achieved by the Facility. For example, in September and October 2011, there were five chemical restraints, respectively; however, in March, April, and June 2012 there were zero chemical restraints, and in May 2012 there were two chemical restraints. To review trends for the use of STAT medications, the Facility conducted a restraint reduction committee meeting that meets monthly. The most recent restraint reduction committee meeting was in July 26, 2012. In addition, the Facility discussed the use of chemical restraints during its monthly psychoactive medication oversight committee meetings (PMOC). Minutes from the May, June, and July 2012 PMOC meeting minutes were reviewed. The minutes reflected effective data collection that with time will demonstrate the Facility's positive efforts at reducing inappropriate use of medications,	Substantial Compliance

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		such as anticholinergics, benzodiazepines, neuroleptics, older antiepileptic drugs (AED)s, and STAT chemical restraint. The Monitoring Team recommends incorporation of rates into the tracking and analysis process of medication reviews. Summary: The Facility, under the leadership of the pharmacy director, provided excellent review, and assessment of the use of benzodiazepines, anticholinergics, polypharmacy, and metabolic syndrome, and the Monitoring Team is in agreement with the Facility's self-assessment, and determined that the Facility is in substantial compliance with Provision N3. The Monitoring Team recommends that rates be incorporated into the tracking, and analysis of medications.	
N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	To assess the medical providers' follow-up on pharmacists' recommendations, the Monitoring Team reviewed the first 15 QDRRs completed in June 2012, and all single patient drug intervention reports completed in June 2012. QDRR Review Ten out of 15 QDRR samples included one or more psychotropic medications, and ten out of the ten samples included a review and documented action plan by the treating psychiatrist (100%); 15 out of 15 samples included a review, and documented action plan by the treating primary care provider (100%). Fourteen of 15 samples (93%) were reviewed by the primary care provider within a reasonable and appropriate timeframe. There were no examples of the prescriber not following the pharmacist's recommendation Single Patient Drug Interaction Reports Of the 38 single patient drug interaction reports, 38 (100%) indicated a review, and action plan by the prescriber. There were no examples of a prescriber not following the pharmacist's recommendation. Summary: Because all samples reviewed were noted to have the prescribers' documented review, and relevant action plan for all pharmacy recommendations, the Monitoring Team noted substantial compliance with Provision N4. The Monitoring Team will continue to closely monitor for examples when a prescriber does not follow a pharmacist's recommendation at future Monitoring Team reviews.	Substantial Compliance
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more	MOSES and DISCUS examinations were done by individuals' nurse case managers. The nurse case manager then presented the forms for review and signature to psychiatrist and/or primary care physician, as appropriate. MOSES screens were done every six	Noncompliance

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	often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	months and DISCUS screens were done every three months. The Facility acknowledged that there was not a process in place to ensure that side effect monitoring was done in response to the individual's changing needs. However, during the tour the Facility informed the Monitoring Team that a decision had been made to perform MOSES (and when appropriate, also DISCUS) exams following a change in the dose of psychotropic medication. The 07/06/12 Facility Action Plan also stated that DADS psychiatry policy will be revised to increase the frequency of side effect exams in response to medication changes. Three processes were in place to assure that administration of side effects was taking place and that there was proper clinical follow-up in response to the results. The Monitoring Team reviewed each of these: • The Facility maintained lists of all individuals who were screened with MOSES and DISCUS exams. To make sure that the correct individuals were being screened with MOSES and DISCUS exams, the Monitoring team compared these lists to other lists provided by the Facility that identified who was treated with the various psychotropic medications that required the screenings. The Monitoring Team confirmed that the appropriate individuals were screened, including individuals who took Reglan, a medication given for non-psychiatric purposes that nonetheless can cause dyskinesia and for that reason required screenings. All individuals given Reglan were included in the list of individuals being screened. During previous visits the Monitoring Team had examined the actual screenings of individuals who took Reglan and found that they were being done correctly. • Periodically, PMOC provided clinical oversight regarding follow-up for individuals with current diagnoses of tardive dyskinesia or elevated scores of the DISCUS, which suggested the possibility of that diagnosis. The most recent review was done in June 2012. The Committee identified five such individuals, four of whom were treated with atypical antipsychotics at the time of the review. The comment/recommendation section of the report mentioned changes made in medication treatment over the past year, and in two cases recommended review/clarification of the diagnosis of record (probable dyskinesia for one, masked dyskinesia for the other). The Monitoring Team found that it was very positive that the Committee had selected out this group of individuals for clinical review. That said, the key clinical question at hand was left seemingly unaddressed: In each case one presumes that the IDT and psychiatrist had carefully reviewed the individual's circumstances and had concluded that the benefits of continued antipsychotic treatment outweighed the risks. But that was not mentioned in the Committee minutes and a detailed justification for the	

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		need for continued treatment was not provided. At minimum, the Committee should identify where that review/justification was documented (perhaps in a PTR note), and should mention whether the committee concurred with the psychiatrist's assessment, and why. If annual psychiatric reviews or Psychiatric Treatment Plans are put in place, this is the kind of item that should be discussed. Also, the diagnosis of dyskinesia was not present in the APL for individual #86 (see discussion under provision J2). • As part of QA efforts, the Facility stated that in March and May it had conducted a small (n=5) audit of individuals for the presence of needed MOSES evaluations. In that sample 100% of MOSES exams were signed by both the PCP and psychiatrist. There was no mention of the length of time between test administration by the nurse case manager and the review by the PCP and psychiatrist. During the visit, the Monitoring Team reviewed records of the 15 individuals in Sample J1 for presence of required MOSES and DISCUS forms. The required screenings had been done and they were reviewed by the prescribing physician. but not always in a timely manner. In one case (individual #467) close to a month lapsed before the screen was reviewed. The Monitoring Team attended PTRs on 07/23/12 and 07/25/12, and observed how information about side effects were integrated into the IDT/PTR processes. Information about side effect screening was presented by the nurse during the part of the discussion that was dedicated to objective medical data and review of that data. That section also included information from the pharmacy provided via the QDRRs (please note examples below). Information presented included laboratory data, drug/drug interactions, and pharmacy recommendations for clinical information that were derived from that data. The Monitoring Team observed good clinical discussion between the psychiatrist, nurse and other IDT members on these matters The discussion was integrated, because it tied together the clinical observations about side effects that the nurse had rated, with the various blood tests and information about drug interactions, serum levels and the like, that could explain why the side effects might have occurred. QDRRs were done well and the clinical pharmacist made treatment recommendations. For example, Individual #276 had drug induced elevations of a hormone that had implications about choice of medication; Individual #270 commented on possible management for a medication side effect. Overall, the Monitoring Team observed that the process of timely MOSES and DISCUS reviews by clinicians and the IDT had improved, and noted positively the plans to provide additional screenings when medication doses changed. POMC review and/or documentation could improve, around the issue of Facility wide monitoring for	

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		medication use of individuals with tardive dyskinesia. Implementation of the action planned for further screening following change in dose, along with accurate listing of dyskinesia in the APL and more complete documentation of rationales for decisions about treatment could result in a finding of substantial compliance at the next compliance visit. In addition to the review conducted for Provision for J12, the Monitoring Team reviewed the most recent two MOSES and DISCUS assessments for each review of QDRRs for Provision N2. Of the 27 MOSES assessments reviewed, 20 were appropriately completed by the medical prescriber (75%), and of the 20 DISCUS assessments completed, 13 (65%) were completed appropriately by the medical provider.	
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 assess the Facility's adverse drug reaction (ADR) process, the Monitoring Team requested the incidence of ADRs for the prior six-months, along with copies of completed associated ADR reports. In addition, the Monitoring Team reviewed the past six months Pharmacy & Therapeutic Committee Meeting (P&TC) minutes, and all trends analysis for ADRs. <u>ADR Reports</u> The Facility reported five ADRs occurring in the previous six months. An ADR report form was appropriately completed for each ADR, and reviewed by pharmacy in five out of five samples (100%); the types of ADR was clearly delineated in five out of five samples (100%); a decision to report the ADR to the FDA was considered in four out of five samples (80%); the individual was assessed for the possible need for hospitalization in five out of five samples (100%); the legally assigned representative was informed of the ADR in two of the five samples (40%); a physician was notified of the ADR in five of the five samples (100%); and the pharmacist provided appropriate recommendations in five out of the five samples (100%). Follow up on ADRs was done during P&TC meetings. <u>Trends Analysis of ADRs</u> At each P&TC meeting, a graph, along with a trend analysis, of ADRs is presented for review and comments by the P&TC members. The data is concise, and documents the incidence of ADRs longitudinally, and breaks incidences down by living area. Data reviewed demonstrated a progressive increase in the number of ADRs reported. For example, in 2009 only one ADR was reported for the entire year, while for 2011, 12 ADRs were reported. This increase in number of ADRs reported is encouraging, and was contributed by enhanced education of nursing, and direct care staff. <u>Review of P&TC Minutes</u> Review of P&TC minutes, along with attachments for January, April, and July 2012	Substantial Compliance

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		revealed review of ADRs that occurred during the previous three months, along with a review of a trend analysis. The Monitoring Team noted that documented discussion was appropriate, and meaningful. For example, each ADR was discussed in detail by the pharmacist, corrective actions were issued when necessary, and action steps were follow-up through completion through an internal quality assurance review process. Summary: Because of its assertive follow-up, reporting, and tracking of ADRs, the Monitoring Team determined that the Facility continues to be in compliance with Provision N.6. The Monitoring Team is concerned that only five ADRs were reported; although possible, this number seems low given the number of medications prescribed. Provision N.6 requires assertive reporting of ADRs, and the Monitoring Team will closely review for progress in reporting of ADRs, as well as all training venues offered to nurses, direct care staff, pharmacists, medical providers, and other relevant staff who are in contact with individuals on a regular basis.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Drug utilization evaluation (DUE) was assessed by reviewing all DUEs that occurred during the reporting period, copy of the calendar for scheduled DUEs, and P&TC minutes for follow-up DUEs. <u>DUE Schedule</u> The Facility develops a quarterly schedule for DUEs on an annual basis. Based on clinical need, the P&TC decides which topics will be provided as a DUE during the following year. The Facility maintains a process to offer additional DUEs in the event of FDA advisories, or adverse drug events at the Facility. DUEs have been scheduled to occur quarterly, through October 2013. Facility did not provide a DUE for an important FDA advisory that were issued during the reporting period. The Facility did not provide a DUE for statin drugs, for which a FDA warning was issued on 2/28/2012 indicating label changes to addressed hepatic enzyme monitoring, reversible cognitive changes, and concerns over abnormal glucose metabolism. <u>DUEs Provided During Current Reporting Period</u> The Facility provided three scheduled and no non-scheduled DUEs during the reporting period. The three scheduled DUEs, which included a review of Vimpat, proton pump inhibitors, and valproates, were comprehensive; the included a systems review of use at the Facility, prescribing practices, and drug monitoring. Recommendations made for each DUE were tracked for completion in three out of three of the samples (100%). The Monitoring Team was concerned that of the primary care providers, only the medical	Noncompliance

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		director showed up for the January, and April 2012 P&TC meetings when DUEs were discussed; however, during the July 2012 P&TC meeting, which was scheduled during the Monitoring Team's review, a full complement of medical providers attended the P&TC meeting. The Monitoring Team has serious concerns that the Facility did not provide DUEs for important FDA advisories that were issued during the reporting period. For example the Facility did not provide a DUE for statin drugs, which an FDA warning was issued on 2/28/2012, indicating label changes for monitoring liver enzymes, reversible cognitive changes, and concerns over abnormal glucose metabolism. Summary: The Monitoring Team is satisfied with the quality of the DUEs provided, and follow-up on DUE recommendations through the Facility's specific quality assurance process that was developed to track issues related to DUEs. The Facility did not provide an unscheduled DUE for an advisory issued by the FDA on serious medical concerns and practices for statin drugs, the Monitoring Team disagrees with the Facility's self-assessment of substantial compliance, and determined that the Facility is not in compliance with Provision N.7. Compliance requires that all relevant FDA advisories result in a DUE at the Facility. The Monitoring Team also recommends that the Facility maintain a more complete tracking process for DUEs, which would enable determination of what DUEs were scheduled, and what DUE had been completed, for both pre-determined DUEs, and DUEs provided because of an FDA advisory, or otherwise clinically indicated. Importantly, the Monitoring Team expects that a full complement of relevant health care providers, such as primary care providers, psychiatrists, pharmacists, and lead nursing staff participate at presentations related to DUEs.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	To assess the Facility's medication variance process, the Monitoring Team requested all related policies, and procedures, trends analysis for medication variances, committee minutes for medication variances reviewed during the reporting period, and sign in sheets for all medication variance meetings. In addition the Monitoring Team attended the Facility's medication variance committee meeting. <u>Policy Review</u> The Facility provided a copy of the DADS State Policy & Procedures: 053, Medication Variances, dated 09/23/2011, which was unchanged from previous reviews, and determined appropriate; however, no local policies or procedures were provided for review. <u>Medication Variance Committee (MVC) Meeting Minutes</u>	Noncompliance

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		The MVC meeting minutes for March, April, May, and June 2012 were reviewed. Attendance of the meeting was robust on the part of nursing staff. The pharmacy director attended four out of the four meetings (100%); however, the medical director only attended only one of the four meetings (25%). Review of the MVC meeting minutes indicates that in general, the Facility's medication variance process continue to significantly improve, and offers excellent insight into variance issues of nursing, and by pharmacy staff. There was a noticeable void specific to medical provider input on medication variances. For example, the pharmacy identified, and tracked the 19 prescribing errors reported for May 2012; however, there was no delineation of such variance to determine if it was a medical provider prescribing the wrong dose, incorrectly completing an order form, prescribing a wrong medication, or wrong indication. Importantly, the type of medication variance should be specifically classified into level of severity. For example, in May 2012 there were five reported level C variances; however, by reviewing data and graphs, it was not possible to determine how many of the level C variances were related to transcribing, prescribing, administration, and dispensing. Such data will be important, when conducting longitudinal analysis, and in the event that a root cause analysis is required for some clinical or administrative reason, or to identify what corrective actions might be effective in reducing variances. Both nursing, and pharmacy department provide good insight into the variances caused by department members; however, when conducting an analysis of medication variances, it is important to ensure that the level of severity for the specific types of variance is specifically reported on, and delineate the causative factors for each type of variance. For example, in the June 2012 MVC meeting minutes, nursing staff reported that there were six medication variances for May at Childress living area, and that there were no significant medication variances identified. The analysis should briefly discuss what were the causes of the medication variances, and the specific level of severity for each specific variance. Summary: The Monitoring Team compliments the nursing and pharmacy departments for their outstanding effort, and excellent accomplishments with developing a robust medication variance process at the Facility. There remains a need for the Facility to improve the medical providers' participation in assessing and reporting on medical providers' medication variances participation in assessing, and reporting on medical providers medication variances. At this time, the Monitoring Team is not in agreement with the Facility's self-assessment of substantial compliance, and determined that Provision N.8 is	

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		not in compliance with the SA. Compliance will require that the medical department become actively involved in the medication variance process, report on its own variances, develop a process for remediation, ensure documentation of all remediation, and participate at MVC meetings on a regular basis. In addition, the medication variance process requires continued enhancement by ensuring that when conducting an analysis of the various types of variance, the cause, and its level of severity are reported on, for each variance. The Monitoring Team understands that medication variances are to be expected, and was not concerned with the number of variances reported on; however, the Monitoring Team is most concerned with the medication variance process, remediation of staff, and system improvement efforts to reduce the number of medication variances. The Monitoring Team expects the numbers of medication variances to at times increase during the first few years of implementing a medication variance process at the Facility as improvements occur in definition, identification, and reporting of errors. The Facility should also ensure that it develops a specific local policy and procedure for its medication variance process. At subsequent reviews, the Monitoring Team will assess training records for medical providers, pharmacists, and nursing staff, and will review records on any remediation provided to staff.	

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

1. Ensure that all recommendations provided in the comment section of the QDRR are also listed in section C of the QDRR, or an alternative system developed to ensure that the medical provider reviews, signs off, and develops an action plan for each recommendation noted in the comment section, as well as section C, of the QDRR report. (Provision N.2)
2. Incorporate rates when tracking and analyzing medication use (Provision N.3)
3. Ensure that ADRs are appropriately identified, reported, and followed up upon. (Provision N.6)
4. Ensure that the Facility offers initial training and re-training on ADRs, for nurses, physicians, pharmacists, direct care staff, and other relevant staff who are in regular contact of individuals. (Provision N.6)
5. It is essential that DUEs be offered whenever there is a relevant FDA medication advisory, and in the event of a known medication issue at the Facility that would require a DUE. (Provision N.7)
6. The Medical department must actively participate in the medication variance process, and report on its own variances, develop a process for remediation, ensure documentation of all remediation, and participate at MVC meetings on a regular basis (Provison N.8)
7. The medication variance process must be enhance by providing a more comprehensive analysis of medication variances, as delineated in (Provision N8)
8. Develop a local policy, and procedure for its medication variance process. (Provision N.8)
9. Ensure that there is initial training, and retraining for medical providers, pharmacists, and nursing staff on reporting of medication variances. (Provision N.8)
10. Review the work load of the clinical pharmacist, and ensure that at least 2.5 to three hours can be allocated to completing QDRRs. (Provision N.2)

11. Ensure that the clinical pharmacist documents a. appropriate rational on the QDRR, for all benzodiazepine, anticholinergic, STAT medications, and poly-pharmacy use. (Provision N. 2, and N.3)

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. BSSLC Self Assessment dated 7-12-12 2. BSSLC Action Plan 7-6-12 3. BSSLC Policies for the Physical and Nutritional Management Team (PNMT) 4/14/11, 4. Physical and Nutritional Management Plan (PNMP) 11/14/11 5. Record reviews: • Sample 1: Individuals #30, #41, #59, #132, #159, #303, #318, #413, and #481 • Sample 2: Individuals #39, #94, #165, #186, #195, #283, #305, and #547 • Sample 3: Individuals #35, #88, #93, #226, #395 and #557 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 for the last 12 months 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. Integrated Risk Rating Forms for individuals in samples #1 and #2 11. Tools used to assess PNM status and needs 12. A list of PNM assessments and updates completed in the last two (2) quarters 13. ISPs for the sample individuals 14. Completed Physical Nutritional Management Plans (PNMPs) for all sample individuals 15. Tools used to monitor implementation of PNM procedures and plans 16. A list of individuals for whom PNM monitoring tools were completed in the last quarter 17. Tools utilized for validation of PNM monitoring 18. 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 19. Dining Plan template 20. PNM spreadsheets generated by the Facility 21. Lists of individuals: (a) On modified diets/thickened liquids; (b) Whose diets have been downgraded (changed to a modified texture or consistency) during the past 12 months; (c) With BMI equal to greater than 30; (d) With BMI equal to less than 20; (e) Since 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 22. List of individuals who have received a videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation since the last review 23. Curricula on PNM used to train staff responsible for directly assisting individuals, including training materials 24. Tools and checklists used to provide competency-based training addressing: (a) Foundational skills in PNM; and (b) Individual PNM and Dining Plans **People Interviewed:** 1. Kori Kelm Physical Therapist (PT), Habilitation Therapy Director 2. Tracy Searles Physical Therapy Assistant (PTA), 3. Christina Koehn SLP 4. Direct Care Professionals on (1) Childress, (2) Driscoll, and (2) Bowie **Meetings Attended/Observations:** 1. Daily activities on Driscoll, Fannin, Childress, and Program Services 2. Mealtimes on Driscoll, Fannin, and Program Services**:** 3. PNMT meeting 7/24/12 4. IDT meeting (Individual #61)
	Facility Self-Assessment: BSSLC's Self-Assessment, updated 7/12/12 and Action Plan dated 7/6/12, provided comments/status for Sections O.1 through O.8 of the Settlement Agreement. The Facility indicated it was not in compliance with Provisions O.1 through O.8. This was consistent with the Monitoring Team's findings as all provisions were found to be noncompliant. For the self-assessment, the Facility described, for each provision item, the activities the Facility engaged in to conduct the self-assessment of that provision item, the results and findings from these self-assessment activities, and a self-rating of substantial compliance or noncompliance along with a rationale. This was an excellent improvement in the Facility self-assessment process. The statewide self-monitoring tool may be one of the activities used to self-assess, but will not likely be sufficient for most provision items and the action plans may not always address everything that needs to be addressed.

	Summary of Monitor's Assessment: Overall, there has been improvement regarding the comprehensiveness of the discussions occurring at the PNMT level. There has also been an improvement in BSSLC's ability to accurately identify individuals who are at an increased risk of physical and/or nutritional decline. This represented over a 40% improvement since the previous compliance review. Another positive development noted was that baseline 02 sats, respiratory rates, and lung sounds were being established for multiple positions. Identifying these baselines will assist the team with its ability to identify changes in status and the impact of positioning on respiratory functioning. BSSLC continued to show progress across areas that required direct clinical skill such as PNMT meetings or assessments but systems components such as implementation of PNM related strategies continue to show slow and limited improvement. **Provision O.1:** This provision was determined to be not in compliance. Great strides had been made which included 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. There was also lack of participation by the registered dietitian as a standing member of the PNMT. 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. 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 Head of Bed (HOB) elevation. **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.

	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. Sixty 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. Not all individuals received an annual assessment that addressed the medical necessity of the tube and potential pathways to Per Oral (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.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan 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	Due to the multiple requirements included in this provision of the Settlement Agreement, as well as the requirements of this overarching provision of the Settlement Agreement being further detailed in other components of Section O, the following summarizes the review of the requirements related to the PNMT, including the composition of the team, the qualifications of team members, and the operation of the team. The evaluations and planning processes in which the PNMT is required to engage are discussed below in the sections of the report that address Sections O.2 through O.8 of the Settlement Agreement. 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 • Diane Ashorn RD • Marissa Rudloff OT • Kristi Warner RN PNM Team (PNMT) attendance records and meeting minutes from 02/07/12 to 07/19/12 documented the following attendance numbers.	Noncompliance

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	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.	• SLP attended 18 of 22 meetings (81%) • OT attended 19 of 22 meetings (86%) • PT attended 20/22 meetings (90%) • RN attended 14 of 22 meetings (63%) • RD attended 6 of 22 meetings (27%) The makeup of the PNMT was not in compliance with standards set forth by the Settlement Agreement due to the limited participation by the RN and RD. This represented a decline since the previous compliance visit as the makeup of the team was in compliance in January 2012. 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. Per review of nine individuals hospitalized with aspiration pneumonia, eight of nine (88%) were assessed by the PNMT nurse upon return from the hospital. Seven of nine (77%) were discussed at the PNMT meeting. The concern, as in previous visits, was the lack of detailed discussion regarding the onset of the event as well as details regarding steps to mitigate future risk. For example: • Individual #59 was diagnosed with aspiration pneumonia on 3/1/12. PNMT minutes (4/3/12) stated that the PNMP has sufficient supports but did not provide any information regarding what these supports are and what was reviewed post hospitalization. Additionally, there was no discussion as to what may have caused the event or if plans were reviewed by their authors (e.g., OT, PT, SLP). • Individual #481 was diagnosed with aspiration pneumonia on 12/29/11 and 1/12/12. The individual was assessed by the PNMT RN but no further review or assessment was provided by other team members. No clear investigation regarding potential triggers leading to the event was noted. 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.	

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		The Habilitation Director, Kori Kelm PT, attended the morning medical meetings. Participation n this meeting has resulted in improvement in the ability to identify issues occurring throughout the Facility, but as stated above, there remained a lack of analysis of data acquired from the monitoring process as well as data regarding hospitalizations, and frequency of illness. PNMPs were not in alignment with current best practice standards. For issues related to this component, please refer to provision O.3. PNMPs were not clearly developed with input from all members of the IDTT 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 nine individuals who accounted for 60% 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 consisted of eight individuals. This accounted for a 14% sample of individuals who were at a high risk of aspiration and a 10% sample of individuals who were at a high risk of choking. Sample #3 consisted of six individuals or 16% of the individuals at BSSLC who received enteral nutrition. Based on a review of sample #1 and #2, 17 of 17 (100%) records reviewed accurately identified individuals who are at an increased risk of physical and/or nutritional decline. This represented over a 40% improvement since the previous compliance review. Based on a review of 17 individuals' OT/PT assessments (sample #1 and #2), 17 of 17 (100%) individuals were provided with an annual comprehensive assessment by the PNMT or IDT that focused on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning during the course of the day and during nutritional intake. Improved since the last compliance visit were the comparative analysis and oral motor portions of the assessments. These areas were found to be more comprehensive and provided more clarity regarding status changes over the past year.	Noncompliance

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		A primary role of the PNMT RN was to assess all individuals who returned from the hospital with a PNM related issues (i.e., aspiration, choking). The PNMT RN's responsibility was to alert the PNMT or Habilitation Therapists of individual cases of aspiration pneumonia and changes in health status that were pertinent to the PNMT and/or Habilitation Therapists. BSSLC had also developed a "Change of Status" form that was to be completed each time the individuals were admitted to sick call. The purpose of this form was to improve notification of the QDDP to changes in status and the need to schedule an IDT meeting for additional discussion and review. As stated in Provision O.1, the PNMT nurse assessed eight of nine (88%) individuals upon return from the hospital, and seven of nine (77%) were discussed at the PNMT meeting. Another form of review noted by the Monitoring Team was discussion by the IDT in response to a hospitalization. Nine of nine individuals diagnosed with aspiration pneumonia (100%) were reviewed by the IDT. This represented an improvement since the previous visit but the issue remained the lack of investigation as to what occurred prior to the event and methods to mitigate the risk in the future. For example: • Individual #59 had aspiration pneumonia on 3/1/12 and 4/20/12. While there was assessment by the PNMT RN and discussion by the PNMT, there was no evidence of investigation regarding etiology of the event or need for additional assessment. There also lack of follow up regarding discussions or recommendations made by the PNMT and/or PNMT RN. Examples included: • Individual #413 was assessed by the PNMT RN. The PNMT RN recommended a head of bed (HOB) assessment on 3/14/12 but there was no evidence that this was ever completed. Additionally, the PNMT RN stated that investigation would be provided to identify when the triggers were occurring but there was no evidence that this was implemented. • Individual #481 was recommended a head of bed (HOB) assessment once a wound was healed but there was no evidence that this was ever completed. Lack of follow may be secondary to the PNMT minutes not clearly showing who is responsible for each task and the lack of assigning deadlines to report results of assigned tasks. While review of the event by the IDT has improved as well as discussion by the PNMT, there remains concern regarding how these two teams are interacting and sharing	

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		information. As stated previously, there was evidence of initial review by the IDT but many times the IDT simply stated that the PNMT RN would assess the individual in a few days with no evidence of the IDT following up on the findings of the assessment or the recommendations of the PNMT. 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 remained vague at times and was lacking the detail needed to ensure safe consistent delivery of service. This included lack of staff positioning and specificity regarding HOB elevation. The PNMPs for the 17 individuals in Samples #1 and #2 were reviewed. All of these individuals had a PNMP. However, the plan lacked the comprehensiveness needed to ensure consistent implementation: • Seventeen of the 17 individuals (100%) had a PNMP. • Seventeen of the 17 individuals' PNMPs (100%) were current within the last 12 months • Fourteen of 17 individuals' PNMPs (82%) noted individual-specific risks and related triggers. • In zero of 12 individuals' records (0%), the PNMPs included adequate positioning instructions for wheelchair and alternate positioning, including strategies for safe elevation ranges. Primary issues noted concerned the lack of detailed information regarding Head of Bed elevation. This is discussed further below in Provision O.3. • In 17 of 17 individuals' records (100%), the PNMPs included adequate transfer instructions. • In 17 of 17 individuals' records (100%), the PNMPs included adequate mealtime/dining plans that included written and/or pictorial instructions for positioning, food texture, fluid consistency, and/or staff presentation techniques. • In 17 of 17 individuals' records (100%), the PNMP included the time an individual needed to remain upright after eating and/or receiving enteral nutrition. • In four of seven individuals' records who required adaptive equipment for intake (57%), the PNMPs included adequate strategies for medication administration. Individuals #547 and #165 both required dining strategies but there was no mention of the strategies under the medication administration	Noncompliance

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		portion of the PNMP. • In two of 17 individuals' records (11%), the PNMPs included adequate strategies for oral hygiene. Individuals #30 and #186 were not provided with details regarding staff positioning during oral care. This was noted to be a pervasive issue with the PNMPs. • In 17 of 17 individuals' records (100%), the PNMPs included a listing of individual adaptive equipment. • In 17 of 17 individuals' records (100%), the PNMPs included adequate bathing/showering positioning and related instructions. • In zero of 17 individuals' records (0%), the PNMP included adequate personal care instructions, with elevation strategies during checking and changing. • In 17 of 17 individuals' records (100%), the PNMPs included communication Per interview with the Habilitation Director during the last compliance review, the PNMPs were being revised to include more information regarding oral care and medication administration as well as adding information pertaining to risk and triggers. While there was clear improvement regarding the inclusion of risks and triggers, information remained lacking as it related to oral care, medication administration and personal care. PNMPs were located in the medical record, program record, All about Me Individual Notebooks, MAR, and two copies are held in the therapy department. Per observations, "All About Me" books were readily available to staff but were not being referenced during any of the observations. Per observation by the Monitoring Team of medication administration on Driscoll B, C, and D, pictures of adaptive equipment were not present on the Medication Administration Record and therefore nurses were unable to have access to what the equipment looked like. Head of Bed Assessment is an area that continues to be implemented at BSSLC. Based on review of the eleven that had been completed, BSSLC is on the right path in this area but has many assessments that have yet to be completed. Per review of the data provided by BSSLC, 116 individuals required their beds to be elevated but only eleven of the 116 had received an assessment. Per report, the HT director stated that the assessments were ongoing and they had assigned an OT to focus primarily on these assessments. It is imperative that the assessments are proactively provided at an increased frequency. It was also noted that recommendations identified through the assessments were not clearly integrated into the PNMPs. Examples of this included: • Individual #303's HOB assessment calls for 30-40 degrees of elevation but his	

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		PNMP only stated to have HOB elevated. Lack of specificity in the PNMPs increase the likelihood of inconsistent implementation by staff. Per interview with an OT, the degrees were removed when issues with implementation was noted during survey. To address the issue without including degrees, beds were marked so staff could identify the appropriate angle. The problem is that the person may not always be in his or her own bed (such as in the case of hospitalizations). Another issue was that PNMPs with HOB recommendations often referred to pictures which were not included as part of the medical record with the PNMP. A positive development noted was that baseline 02 sats, respiratory rates, and lung sounds were being established for multiple positions. Identifying these baselines will assist the team with its ability to identify changes in status and the impact of positioning on respiratory functioning. PNMPs were reviewed annually at the ISP meetings, and updated as needed. A review of the 17 individuals' ISPs in Samples #1 and #2 found PNMP content was listed in the ISP. However, there was no evidence that IDT members had discussed the efficacy of the interventions and integrated PNMP strategies into other plans and activities (e.g., action plans, skill acquisition programs, behavior support plans, nursing/health management care plans, and/or daily schedules). In zero of 17 records reviewed (0%), PNMPs were clearly developed with input from the IDT with an emphasis on DSPs, 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. Review of the 17 individuals' ISP attendance sheets in Samples #1 and #2 found: • Medical attendance was 41% (7 of 17 meetings); • Nursing attendance was 94% (16 of 17 meetings); • Dental staff attendance was 11% (2 of 17 meetings) • Occupational Therapist attendance was 41% (7 of 17 meetings); • Physical Therapist attendance was 40% (8 of 17meetings): • Speech Language Pathologist attendance was 58% (10 of 17 meetings); • Registered Dietician attendance was 17% (3 of 17 meetings); and • Direct support professional attendance was 52% (9 of 17 meetings). The absence of these professionals impacted the discussion related to the integration of PNMP and dining plans into the ISP, risk assessment, and multiple support plans. In addition, the absence of dental staff and direct support professionals impacted the ability	

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		of the IDT to adequately review and integrate an individual's PNMP into the ISP. Direct support professionals are responsible for the implementation of PNMPs and dining plans. Their significant contribution to the content of a PNMP and/or dining plan should not be underestimated. Having a direct support professional in attendance with a strong relationship with an individual and who has provided support to the individual would provide invaluable information. These professionals have knowledge regarding how an individual responds to activities in their daily routines. For example, a direct support professional would be able to help the team define how an individual who cannot verbally communicate expresses their discomfort or shows physical signs that might indicate the onset of an illness. This information should be integrated with the triggers on the individual's PNMP and dining plan. In addition, direct support professionals should have the opportunity to discuss PNMP and dining plan strategies that might not be effective and/or request clarification on how to implement a strategy. This should lead to a dynamic discussion resulting in acceptance and/or revision of the proposed PNMP and dining plan strategies. Furthermore, dental staff plays an important role in providing information regarding the current oral hygiene status of the individual. As a result, changes to an individual's oral care services and/or supports might need to be made. An important component of integration of PNM plans into ISPs involves the discharge planning process for individuals on the PNMT caseload. The Facility PNMT Guideline(s) section entitled "After the PNMT meeting" noted: The PNMT was responsible for discussing with the individuals' IDT members the presentation of assessment data, evidence and efficacy data for the PNMT action plan, monitoring results, competency-based training documentation, recommendations and implementation guidelines for ongoing monitoring, proposed review schedule, and criteria for reassessment by the PNMT. Per the Habilitation Director, no individuals had been discharged by the PNMT. Individuals that were provided general oversight by the PNMT were not formally on the PNMT caseload and therefore there was no discharge process. Given that, the expectation was that the information obtained during the oversight process would be shared with the IDT. There was no evidence of information sharing between the two teams or acceptance of PNMT recommendations by the IDT.	
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	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 "All About Me" 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	Noncompliance

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	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.	and instructions, in addition to the photographs. The issue as explained earlier was that the positioning pictures while present in the "All About Me" books were not included as part of the PNMP in the medical active record and were not included as part of the records request. The photos are part of the PNMP; keeping the whole PNMP together in the active record would help to ensure that anyone reviewing the person would have ready access to the entire PNMP. Staff not implementing interventions and recommendations outlined in the PNMP and/or Dining Plan continued to be a concern of the Monitoring Team. Observations on Driscoll, Fannin, Childress, and Bowie 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, increased risk of aspiration, or contractures and skin breakdown in the following areas: • In ten of 31 (32%) observations, staff were following mealtime plans. • In three of 16 (18%) observations staff were following positioning instructions. Examples of where staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan included: o Individual #170 was not provided with cues to alternate liquids and solids and was observed not receiving cues to swallow multiple times post each bite or slow down intake. o Individuals #94, #153, and #191 were observed taking large bites when the plans called for small bites, thus increasing their risk of choking and/or aspiration. o Individual #87was observed with no pillow between her legs. o Individuals #96 and #508 were observed poorly positioned with no pillows under the knees, thus resulting in increased stretching of the hamstrings 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. Based on interviews with five DCPs, percentage of correct responses regarding PNMPs were: • Where is the PNMP/Dining Plan located? (100%) • What kind of transfer do they require? (100%) • What do you look for to ensure the individual is in the correct position? (40%) • Why does the individual need thickened liquids? (60%) • Why does individual eat modified texture foods? (70%) • Why does the individual require a specific utensil? (70%) • Why does the individual require a specific assistance technique? (60%)	

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		• What are the individual's risk indicators? What do you look for before, during and after the meal? (40%) • Does the individual have an Aspiration Trigger Data Sheet, where is it kept and when do you document? (60%) • Have you been trained to implement this plan? (70%) • Who do you contact if you have difficulty with the plan or the equipment? (90%)	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	Per interview with the Director of Habilitation Services, 100% of staff were provided initially with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff. Per interview with Habilitation Director, these trainings will be conducted annually in a condensed version. Staff who are found to be noncompliant multiple times will be required to attend the full version of the class. Review of the Facility's training curricula revealed that training included adequate PNM foundational training (New Employee Orientation NEO) in the following areas: • Dysphagia/Swallowing & Digestion-1 hr • Lifting People-2 hrs • Therapeutic Handling-2 hrs • Optimal Dining-4 hrs In addition to the NEO, staff were required to receive annual refreshers through an I-Learn course called "Preventing Aspiration, " as well as the Lifting People course. 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. Staff were provided person-specific training of the PNMP by the appropriate trained personnel. Habilitation Therapies staff reportedly provided competency-based training for PNMP coordinators. PNMPCs are then responsible to train their assigned homes. Documentation of the training was maintained by the therapy departments as well as sign-in sheets for in-services provided to direct care staff. Although there was evidence of staff training during NEO and annually, it did not translate into implementation of the plans designed to mitigate risk. BSSLC continued to implement 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.	Noncompliance

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		Per report by the Director of Habilitation Therapies, pulled staff were not allowed to work with individuals with specialized training needs or those who were identified as high risk. This process was not clearly understood by the home leaders. Training rosters were to be available on the homes, and the home leader was to ensure that only staff who have received individualized training be allowed to work with individuals who have individualized techniques. Per interview with Home leaders, this process was inconsistently implemented as the Monitoring Team was told that pulled staff were considered trained after they were oriented to the welcome book by the home leader, thus allowing the pulled staff to work with all individuals. This was a concern since review of the welcome book did not ensure competence nor did it consistently contain the PNMP.	
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 included the frequency of the monitors for individuals at risk as well as the areas in which the monitors are expected to be completed (i.e., bath, meal, oral care). The issue was that the results of the monitoring were not utilized in a manner to help drive future services and/or training. 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. A review of Facility monitoring reports from January 2012 to June 2012 documented that staff and individuals were not being monitored in all aspects in which the individual was determined to be at increased risk. Per report provided by BSSLC, 10,920 monitors had been completed in the past 6 months. o 60.4% of the monitoring forms focused on oral intake (meals and snacks) o 13.52 % of the monitoring forms focused on bathing	Noncompliance

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		o 7.12% of the monitoring forms focused on medication administration o 11.47% of the monitoring forms focused on Oral Care. o 2.28% of the monitoring forms focused on positioning 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). Based on review of IDT meeting minutes for individuals with a change in status (sample #1) there was no evidence that these monitors were ever increased and therefore it was not evident that this process was consistently implemented. There were a tremendous amount of monitoring forms completed, though there was no system to review, analyze, and utilize the findings to direct system change, staff training and other supports. Per interview with the PNMP Coordinator, due to changes in the format of the monitoring forms, they were unable to query data for analysis but were in the process of redeveloping their data base to address the concern. This will be reviewed during the next compliance visit. Additionally, while the monitors were frequent, they did not result in improved competence or implementation. As stated, 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. 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 positioning and medication administration to ensure proper technique and consistency of care. That being said, BSSLC has shown improvement in their ability to provide monitoring over a wide range of activities. An Aspiration Trigger Sheet was implemented for all individuals with PNM needs. Issues were noted regarding the frequency in which professionals outside of nursing and the PCP were notified. A guideline was developed that stated the team should consider a	

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		referral to Habitation Therapy to assess for individualized triggers when the following occurs: • More than one pneumonia in a year and the individual is on an altered diet texture of liquid consistency • Any individual with a downgrade in texture or liquid consistency • Any new enteral feed • A choking incident requiring the Heimlich maneuver • Anyone labeled high risk and has a diagnosis of aspiration pneumonia and has no or few triggers recorded for 3 months who hasn't received recommendations from Habilitation Therapy • Recurrent Aspiration or Choking triggers without resolution While the above guidelines were a positive step, the guidelines were not consistently implemented as several individuals experienced triggers without consultation with the Habilitation Therapies to assist with determining the etiology of the trigger. For example: • Individual #318 experienced multiple triggers for consecutive months but was never referred to Habilitation Therapies until the individual was hospitalized. Other issues with the Aspiration Trigger Sheet included: • The trigger sheet contained multiple gaps in data due to lack of completion. • Triggers when occurred were not consistently documented on the trigger sheet. • Nursing review of the trigger sheet was inconsistent and even when present	
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 17 individual records (sample #1 and #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, 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	Noncompliance

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		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 regarding the difference between effectiveness of the plans and staff implementation of the plans.	
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 54 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). Six of these individuals had been included in the sample reviewed by the Monitoring Team. All individuals who were enterally fed were to receive at a minimum annually an Aspiration Pneumonia/Enteral Nutrition Evaluation (APEN). 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. Per review of the APENs for individuals in Sample #3, zero of six (0%) were developed by a full interdisciplinary team. The majority of the APENs were created by the Dietitian, RN Case Manager, a member of the Dental Team and at times the pharmacist. Missing from the process was direct support professionals, and habilitation therapies. 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 six individuals (sample #3), six of six individuals (100%) had received the APEN provided by the State. 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. The need for continued enteral nutrition was not integrated into the ISP and there was no evidence of interdisciplinary discussion or acceptance of findings. Based on a review of six individuals' ISPs, zero of six (0 %) (Sample #3) who received enteral nutrition, the individual's ISP clearly documented the rationale for the continued	Noncompliance

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		need for enteral nutrition.	

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

1. Registered Dietitian must be more of an active participant in the PNMT meetings (Provision O.1)
2. The IDTs continue to require support regarding risk assessment and real time modeling to effectively complete risk assessments and action plans. The refinement of this process will also greatly impact the manner in which the PNMT functions to implement interventions to mitigate identified health risks (Provision O2).
3. Identify issues that require tracking relative to individuals evaluated by the PNMT, establish the baseline, gather new data over a prescribed period of time, then review the findings as a team in order to analyze the relevance to a problem or as evidence of a solution (Provision O2 and Provision O7).
4. The need for continued enteral nutrition should be integrated into the ISP with evidence of interdisciplinary discussion or acceptance of findings (Provision O.8)
5. APENS should be developed by an interdisciplinary team, including direct support professionals, and habilitation therapies. (O.8)
6. Clearer guidelines must be developed to ensure Habilitation Therapies are notified of recurring triggers. (Provision O.6)
7. Increase presence and participation by the RD, DCP, and Dental Staff at the ISPs to assist in the development of the PNMPs. (Provision O.3)
8. Modify PNMPs to include HOB degree requirements. (Provision O.3)
9. Review and revise oral care section on PNMPs to include more detailed information regarding staff positioning and strategies during activity. (Provision O.3)
10. Revise PNMT minutes format so that person responsible, task assigned as well as timeline for completion is more clearly presented. (Provision O.2)

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 Self Assessment, dated 7/12/12 2. BSSLC Action Plan 7/6/12 3. BSSLC Policies for the Physical and Nutritional Management Team (PNMT) 4/14/11, 4. Physical and Nutritional Management Plan (PNMP) 11/14/11 5. Record Reviews: • Sample 1: Individuals #30, #41, #59, #132, #159, #303, #318, #413, and #481 • Sample 2: Individuals #39, #94, #165, #186, #195, #283, #305, and #547 • Sample 3: Individuals #52, #54, #96, #165, #226, #276, #299, #422, and #574 • Sample 4: Individuals #260, #363, #366, and #478 • Sample 5: Individuals #51, #167, #377, and #496 • Sample 6: Individuals #423, #501, and #539 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 (January 2012-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 (DSPs) on (1) Childress, (2) Driscoll, and (2) Bowie **Meeting Attended/Observations:** 1. Daily activities on Driscoll, Fannin, Childress, and Program Services 2. Mealtimes on Driscoll, Fannin, and Program Services**:** 3. PNMT meeting 7/24/12 4. IDT meeting (Individual #61)

	Facility Self-Assessment: BSSLC's Self-Assessment updated 7/12/12 and Action Plan updated 7/6/12, provided comments/status for Sections P.1 through P.4 of the Settlement Agreement. The Facility indicated it was in compliance with Provisions P.1 and P.2 and not in compliance with Provisions P.3 and P.4. Findings of Provision P.1 were consistent with the Monitoring Team's findings but were inconsistent with the Monitoring Team's findings of P.2 as this provision was found to be noncompliant. For Provision P.2, BSSLC stated that data acquired from March 2012 to May 2012 indicated an overall compliance of 93% indicating that the individuals were provided with intervention to mitigate regression. The Monitoring Team found that individuals were not routinely seen by OT/PT in the event of a change in status. For the self-assessment, the Facility described, for each provision item, the activities they were engaged in to conduct the self-assessment of that provision item. The problem noted was that areas that were included as part of the self assessment process were not consistently in line with what the Monitoring Team was observing or did not comprehensively address all the components reviewed by the Monitoring Team. For example, the Facility found 95% compliance for implementation of AAC, which was inconsistent with the findings of the Monitoring Team. The Facility submitted two documents, including: BSSLC Self-Assessment (SA) and the BSSLC Action Plans. The BSSLC SA listed the steps the Facility staff completed or planned to complete to conduct the self-assessment, and the subsequent results for the completion of these tasks. The Action Plans documented the status of action steps that had been completed, were in process, and/or had not been started. The Facility Self-Assessment included minimal data or findings from the self-assessment activities to support the Facility's conclusion of whether it was or was not in substantial compliance with the requirements of the Settlement Agreement for Section P. Overall, the Self Assessment and Action Plans included relevant steps that would assist in the Facility in gaining compliance; however, the activities at times were not consistently in line with what the Monitoring Team assesses as indicated in this report.
	Summary of Monitor's Assessment: Overall, there was noted improvement with the Occupational Therapy (OT) and Physical Therapy (PT) services provided at BSSLC. Assessments were much improved and did a respectable job in providing a comprehensive review of the individual. This was especially noted with the most recent assessments that had begun with a new format and with additional staff assistance. While Provision P.1 was considered to be in substantial compliance on this visit, there was concern by the Monitoring Team that this level of service will be difficult to maintain if BSSLC does not obtain full Habilitation Therapy staffing levels. Other concerns were the lack of notification of Habilitation Therapies by nursing when the individuals were experiencing a potential change in status, lack of implementation of plans, and a monitoring system that did not produce functional data at the time of the review.

	Provision P.1: This provision was determined to be in substantial compliance. Assessments were completed in accordance to the schedule set forth by BSSLC and contained the components necessary to identify issues with functional mobility as well as other therapy needs. Although, BSSLC lacked OT staffing which resulted in less than comprehensive assessments due to no OT presence, the individual was provided at a minimum what would be considered an OT screen and was referred as indicated by its findings. **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 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. The OT/PT assessment format continued to improve and contained more information regarding risk and what interventions are in place to mitigate the risk. Other positives included: • Timely completion of annual assessments • 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	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 nine individuals who accounted for 60% of the individuals who experienced such an event.	Substantial Compliance

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	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.	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 consisted of eight individuals. This accounted for a 14% sample of individuals who were at a high risk of aspiration and a 10% sample of individuals who were at a high risk of choking. Sample 3 consisted of 9 individuals who were chosen by selecting two of the most recent Habilitation Annual Assessments for each therapist from the assessments provided by BSSLC. Sample 4 consisted of four individuals who were chosen from BSSLC's high risk for falls list. Sample 5 consisted of four individuals who experienced the highest number of falls over the past 6 months. Sample 6 consisted of three individuals who were admitted since the last compliance review. All requirements of this provision were identified as being in substantial compliance. All recent assessments (completed since January 2012) were noted to be comprehensive and address all generalized standards of a comprehensive assessment. The individuals who did not have a comprehensive assessment in the new format had received at a minimum an assessment that exceeded the requirements of this provision for a screening although it was not determined to be a comprehensive assessment as per the standards identified below in Provision P.1. While, BSSLC was noted to be in substantial compliance at this time, there is concern by the Monitoring Team regarding BSSLC's ability to maintain compliance with the current staffing issues. These concerns will be noted below. 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 (OT), one Certified Occupational Therapy (COTA), 2.2 Physical Therapists (PT), and one Physical Therapy Assistant (PTA). There were 2.8 Physical Therapy openings and one Occupational Therapy opening. Due to the lack of therapists, there was concern regarding BSSLC's ability to maintain compliance. It should be noted that BSSLC is attempting to fill these positions but had not been successful as of this review. At the time of this review, the census at BSSLC was 299 individuals. The reported	

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		number of individuals with PNM needs was 265 or 88% of the total census. The assistants were not licensed to complete assessments and design interventions supports and, as such, were not included in these ratio calculations. Their roles were critical, however, in that they were to provide training, supervision of technicians and Physical and Nutritional Management Plan Coordinators (PNMPCs), assist with data gathering, provide monitoring, and provide direct/indirect supports. Given that, ratios based on the current census were approximately 1:135 (PT) and 1:74 (OT). The ratios for OT and PT were too high to ensure adequate provision of necessary 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 individuals 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. D**u**e to the lack of OT staffing, PTs were conducting the OT portions of the Habilitation Assessment on Fannin and other staff have had to diminish their services to provide support (ie. SLPs having to decide between providing communication services or swallowing services). Although this occurred, the PTs were able to screen for need OT services and provide referral for additional assessment if indicated. At the time of this onsite review, Kori Kelm PT continued to serve as the Habilitation Therapies Department Director as well as a member of the PNMT. OT/PT staffing was generally consistent with the previous review. Physical therapists included Kori Kelm PT (who also served as director and PNMT lead), Kathy Cloud PT, Stephanie Hintzel PT, , Jana Aguilar PT, and Tracy Searle PTA (who served as the PNMP Coordinator Supervisor). OTs included Jeanne Dannar OTR, Marissa Rudloff OTR (PNM Team Member), Theresa Carmack OTR, Eve Taylor OTR, and Karen Zepeda COTA. All clinicians carried full caseloads in addition to any administrative duties that were	

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		required. The Facility did document appropriate qualifications for licensed OTs and PTs. Ten of 10 staff (100%) were licensed to practice in the state of Texas. Based on a review of continuing education completed in the last 12 months: Ten of 10 OT and PT staff (100%) had completed continuing education related to their areas of practice. Documentation of continuing education courses completed by the OTs and PTs were submitted. The continuing education attended by the clinicians included but was not limited to the following topics: • Wheelchair Seating for Postural Control and Function • Introduction to PNMT • Issues in Evaluation and Treatment of Individuals with DD • Intro to GI/Dysphagia • Ethics • Updates in Wound Management A new comprehensive assessment format was in use at the facility and included assessment by OT and PT. The outline submitted included medical history, medications, behavioral concerns, and other current health issues that would impact the delivery of OT and PT services. The assessment included physical assessment of sensory/motor/neuromuscular systems and functional motor and daily living skills performance. Physical Nutritional Management issues related to positioning supports, mealtime, medication administration, and oral care were also addressed. The outline also included sections to address the clinicians' analysis of findings (summary, strengths and needs), recommendations, measurable outcomes, interval for reassessment, and factors for community placement. Therapists were instructed to analyze the clinical information as each section was completed so that reasoning was not lost. Skill acquisition and functional activities were to be considered throughout the assessment process. Functional and measurable objectives were to be outlined as indicated. Recommendations for supports and activities, other than direct therapy requiring a licensed professional, should be incorporated into the ISP so they may be integrated throughout the individual's daily routine. This was of significant concern to the Monitoring Team because <u>all</u> aspects of supports and services should be included in the ISP. The comprehensive assessment was to be completed within 30 days of admission and	

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		an update was to be completed at least annually to address services provided to the individual during the past year. A comprehensive assessment of specific systems and related areas was to occur upon a change in health status. A schedule for re-assessment was to be included in the written report. The content areas of each of these were extensive and comprehensive in nature. Generally accepted standards of a comprehensive assessment include the following: • Signed and dated by the clinician upon completion of the written report • Dated as completed 10 days prior to the annual ISP • Diagnoses and relevance to functional status • Individual preferences, strengths, interests, likes, and dislikes • Medical history and relevance to functional status • Health status over the last year • Medications and potential side effects relevant to functional status • Documentation of how the individual's risk levels impact their performance of functional skills • Functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day. • Evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work) • Discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings • Discussion of the expansion of the individual's current abilities • Discussion of the individual's potential to develop new functional skills • Comparative analysis of health and impact on functional status over the last year • Comparative analysis of current functional motor and activities of daily living skills with previous assessments • Identify need for direct or indirect OT and/or PT services • Reassessment schedule • Monitoring schedule • Recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs • Factors for community placement and a determination of the most appropriate living environment • Recommendations for services and supports in the community • Manner in which strategies, interventions, and programs should be utilized throughout the day.	

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		The total number of assessments reviewed was 37 (Samples #1, #2, #3, #4, #5, and #6). Comments are below: • 81% (30/37) were identified as comprehensive assessments. The evaluations varied in format and content, though those since January 2012 were generally of the current assessment template. The assessment for Individual #59, dated 10/6/11, did not include a discussion of his risk levels or clear comparative analysis. Individuals #574 and #52 did not have the OT included as part of the assessment. • 100% (37/37) were signed copies of the original, although none had dated signatures. The date of the assessment was consistently identified in the heading, but it was not possible to determine when the report was finalized and signed and, thereby, available to the IDT for review and integration into the ISP. • 100% (37/37) of the assessments were dated as completed prior to the annual ISP meeting. • 86% (32/37) included a section that reported health risk levels that were associated with PNM supports. This information was generally utilized for planning interventions and supports and for recommendations related to changes in the existing risk levels. • 81% (30/37) included an analysis section which provided a sufficient rationale for the interventions and supports recommended. • 81% (30/37) included a monitoring schedule. In some cases the frequency of PNMP monitoring was not identified. The level of health risk was generally used to drive the frequency of monitoring for individual status, effectiveness of supports and interventions, or implementation of the PNMP. • 81% (30/37) included a re-assessment schedule. • 78% (29/37) included supports required for placement in a community setting. • 94% (35/37) included evidence that communication and or collaboration was present in the OT/PT assessments. Per Hab Director, OT collaboration was missing due to staffing issues; however all areas were addressed by the PT. • For the ISPs: o 100% (37/37) of the ISPs submitted were current within the last 12 months. o 52% (18/34) of the current ISPs with signature pages submitted were attended by OT only. No PTs attended these meetings. o 32% (11/34) of the current ISPs with signature pages submitted were attended by PT only. No OTs attended these meetings. Per Habilitation Director, the expectation was that one clinician of Hab Therapy would be present at the IDT or ISP meetings. It is recommended that BSSLC review this policy to ensure all areas of expertise are present at the meetings as needed.	

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		Although some assessments were found not to have all components, it is felt that this did not accurately reflect BSSLC's improvement and competence in this area. The majority of assessments that were not found to be comprehensive were assessments that were completed prior to the format revision of January 2012. With this taken into consideration, compliance percentages exceed 85% for the new assessments. There were three individuals newly admitted to the Facility (Sample #6) since the last onsite review. Three of three individuals (100%) received the required OT/PT assessments within 30 days of admission. Therefore, in spite of the Monitoring Team's concern over vacancies in clinician positions, the current staff were able to perform the screening and assessments required in this provision. Audits were scheduled to be completed by the department director for assessments completed by clinicians to establish competency for each. The assessment reviewed was to be corrected by the therapist prior to submitting to the IDT. This process was informal at this time and inconsistently implemented; the Habilitation Services Director reported plans to formalize the process. As this audit process is fully implemented, the Monitoring Team expects compliance with all requirements of comprehensive assessments to continue to improve.	
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 Provision O.2 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. See above in Provision P.1 for examples. Based on reviews of PNMPs and other positioning plans for 37 individuals (Sample #1, #2, #3, #4, #5, #6) equipment was specified for 40 of 40 (100%) plans reviewed. 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	Noncompliance

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	outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	there was little to no evidence that the majority of plans were reviewed by the IDT related to program changes or changes in status. For example: • Individuals #165 and #547 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, medication administration, and/or personal care. Please refer to Section O for additional information. • Based on reviews of PNMPs and other positioning plans for 37 individuals (Sample #1, #2, #3, #4, #5, #6) the rationale for the plans were clearly stated in the OT/PT assessment or update for 81% (30/37) individuals. • Assessments clearly stated that the PNMPs should be followed as well as stating the function of the device. Staff did not consistently implement interventions and recommendations outlined in the PNMP. See Provision O.4 for information. BSSLC utilized recliners as a primary method of alternate positioning. It is extremely difficult to establish and maintain an appropriate position in a recliner due to the overall lack of support. This continued to be a concern as proper positioning strategies and supports were again inconsistently implemented.	
P3	Commencing within six months of the Effective Date hereof and with full implementation within two	Competency-based training for, and monitoring of, continued competency and compliance of direct support staff related to implementation of PNMPs was addressed in detail in Provision O.4.	Noncompliance

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	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.	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 were also not knowledgeable of the plans that were intended to implement. Examples of this are included in Provision O.4. Staff successfully completed general and person-specific competency-based training related to the implementation of OT/PT recommendations but as stated in Provision O.4, training did not translate over to improved implementation of services; therefore risks were not appropriately mitigated.	
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.	A system of monitoring of the PNMPs, and the condition, availability, and effectiveness of physical supports and adaptive equipment was implemented at BSSLC and addressed in Section O above. Recommended frequency of monitoring was not included in the OT/PT assessments. Frequency or interval of monitoring conducted by the PNMPCs was not identified in the assessments and findings of the monitoring conducted were not reported in the OT/PT assessments in an effort to determine efficacy of the interventions previously recommended and implemented. BSSLC had a wheelchair repair log that identified the date the wheelchair was repaired, the name of the individual, who completed the order, and the part repaired. Missing from the log was information regarding when the repair request was initiated; therefore, it was impossible to determine if repairs were being provided in a timely manner. 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. Monitoring of wheelchairs, assistive devices for ambulation, and other equipment provided by OT/PT were included in the routine monitoring of the PNMPs as described above in Section O. There were no routine maintenance checks documented to assess the working condition of the wheelchairs, gait trainers, and adapted chairs, other than the PNMP monitoring conducted by PNMPCs. A formal system did not exist that ensures staff responsible for positioning and transferring high-risk individuals receive training on	Noncompliance

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		positioning plans prior to working with the individuals. This includes pulled and relief staff (please refer to Provision O.5). BSSLC was aware of this issue and was working towards developing a system for unit supervisors to become more aware of what staff were familiar with the individuals living at the respective homes. A policy/protocol addressing the monitoring process did exist and provided information regarding frequency of monitors and staff responsible. Based on review of the BSSLC PNMP policy rev 11/14/11, 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 noted are formally shared for appropriate follow-up by the relevant supervisor Although the 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. On a regular basis, DSPs 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 Provisions O.4 and P.2, the increased training and monitoring did not translate into increased implementation and knowledge of interviewed staff.	

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

1. Individuals would benefit from having increased consistency of participation by both the OT and the PT. A PT may be knowledgeable of an OT's job and vice versa but that does not replace the need for staff to be present when the individual's needs and preferences require specialized intervention. (Provision P.1)
2. In order to determine timeliness of repairs, the wheelchair log data base should contain the date the wheelchair was broken and the date repaired.

At the time of the review, only the repair date was available. (Provision P.4)

3. Implementation of coaching and skills drills with staff was indicated to ensure that they were consistently able to discuss the rationale behind recommended interventions and to recognize their role in management of health risk issues (Provision P3).
4. Conduct routine validation of monitoring and training completed by the PNMPCs and home supervisors (Provision P4).
5. There was a continued need to develop programs to address increasing or expanding functional skills. OT/PT staff should also model ways to promote skill acquisition and capitalize on opportunities during groups already implemented by direct support staff in the homes and day programs. Therapists should push forward with the development of more collaborative skill acquisition plans and modeling with groups to enhance the day programs and activities occurring in the homes. (Provision P.2)

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. BSSLC Self-Assessment (7/12/12) 2. BSSLC Action Plan (7/6/12) 3. BSSLC Presentation Book, July 2012 4. DADS Policy and Procedure: Client Services/medical Services Dental III.2.1, dated10/24/11 5. Copies of all desensitization and skill acquisition programs 6. Data and trends analysis used to assess dental desensitization and skill acquisition programs 7. Copies of all ISP reports completed with input of the dentist or dental hygienist, and related dental summary 8. Dental emergency log for past six months 9. Copy of blank annual dental report, and annual dental exam form 10. Dental hygiene report, IPN, dental progress note, and IPN for first ten individuals provided dental service in June 2012 11. List of all individuals seen for dental services, and reason for the dental visit, for past six months 12. List of individuals who missed their dental office appointment, and reason for the missed appointments for past six months 13. List of individuals who had a tooth extraction 14. List of all dental emergencies for past six months 15. List of individuals who received preventive and restorative dental services during past six months 16. List of individuals not seen by the dentist during the past 12 months 17. List of individuals who had not received dental x-rays in the past 12 months 18. Appointment schedules for individuals who had TIVA and general anesthesia for dental services 19. List of individuals who received mechanical restraint for dental services **People Interviewed:** 1. Deanna Otts, RDH **Meeting Attended/Observations:** 1. Observation of Individuals # 532, #535, #101, #397, #548, #184, #254, #160, #362, #470, #191, and #450, at their living area
	Facility Self-Assessment: The Facility's self-assessment noted noncompliance for Provision Q1, and had reported that non-compliance was because the self-assessment demonstrated that "rates of compliance are in need of improvement of at least 95% or above, and the need to fully implement use of the database." The Monitoring Team concurred with the Facility's self-assessment of noncompliance; however, it does not agree with its methodology of determining compliance. Compliance will require documentation of not only those who have been seen at the dental office for assessment and treatments, but determination of ability to actually complete the treatment, and assessments. Compliance not only requires implementing the database, but also determining its efficacy.

	The Facility reported that it continues to enhance dental policies and procedures, better determine no show rates, development and implementation of a dental desensitization program, and measures to incorporate dental summaries into the IDT review process; however, because these issues did not yet meet acceptable compliance standard, the Facility reported noncompliance for Provision Q.2, which the Monitoring Team concurs with.
	Summary of Monitor's Assessment: During the period since the prior compliance visit, the newly hired dental director left the Facility for another position. The Facility hired a new dental director, who just recently assumed the role of dental director and full time dentist. The Facility had two dental hygienists, and one dental assistant, but no clerical support. Dental emergency cases were assessed and provided treatment. Dental treatments were not clearly documented in the integrated progress notes (IPN). Importantly, the Facility did not have a mechanism to determine if an individual's treatment for restorative care was complete, unless it reviewed the individual's dental record, and because this information was not documented in the IPNs. The dental department reported that it was in the process of implementing a new dental database system that will address scheduling issues, and help track completed and not completed treatment. In addition, they are developing new dental treatment forms that will be incorporated into the dental database system, and enable more clarity with regards to dental health care needs. Because there was no mechanism in place to track incomplete preventive dental services, the Monitoring Team was unable to accurately assess the efficacy of preventive dental care at the Facility. The Monitoring Team was advised that the new dental database will enable the Facility to carry out efficient review of dental records and the status of dental care of individuals. The Facility enabled only two TIVA days per month, and a total of about 40 individuals were provided dental service by TIVA during the reporting period. The dental office staff reported that many individuals who did not receive TIVA for their dental services were unable to have their assessment and treatments completed because of maladaptive behaviors, which leads to concern over the limited availability of TIVA services at the Facility. The Facility did not have a master list of all Individuals who would benefit by TIVA, and how often TIVA should be provided for each Individual. Although a joint venture between the dental and psychology departments began in January 2012, no significant progress was made with regards to implementing this dental pilot desensitization skill acquisition program. The Facility did not adequately represent the individuals' oral and dental health care issues at the ISP annual planning and other IDT meetings, and must develop a robust mechanism to overcome this barrier.

	Appointment failures, and tracking of appointment failures remains problematic for the Facility. The Facility must develop strategies to help mitigate appointment failures, and better track the reason for appointment failures.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	To Assess Provision Q.1, the Monitoring Team interviewed the dental department's staff, and the dental director, reviewed issues related to dental office administration, assessed the provision of emergency and routine dental care, and assessed the availability of dental services. <u>Dental Administration</u> During the period since the prior compliance visit, the newly hired dental director left the Facility for another position. The Facility hired a new dental director, who just recently assumed the role of dental director and full time dentist. The Facility terminated the contract with the previous contract dentist who was providing approximately 20 hours of dental service per week, and will not be replacing that position with a dentist; hence, the dental director, who works four, ten-hour days, divides her time up between administrative and clinical activities. At the time of the review, the Facility had two dental hygienists, and one dental assistant, but no clerical support. In addition to their primary duty of providing dental services, these three staff divided clerical activities up among themselves. The Monitoring Team is concerned that the Facility has only one dentist, who is providing dental services on a part-time basis, alternating with administrative activities, and because the Facility has only one dental assistant, and no clerical support. Developmental Dentistry usually incorporates two dental assistants per practicing dentist or hygienist. It is essential for safety reasons, to ensure adequate support staff when providing dental services to individuals with special needs and potentially challenging behaviors. Ensuring adequate support staff will also help to mitigate the use of sedation, in some cases. Summary: The Facility must review staffing issues at the dental office, and provide adequate support staff to ensure the safety of individuals served, and to ensure that dental services are provided timely and efficaciously. <u>Dental Emergencies</u>	Noncompliance

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		There were a total of 12 dental emergencies reported on the dental emergency log for the past six-month period. The log delineated the date and time that the dental emergency was reported in one out of the 12 samples (8 %); the log indicated that each case was assessed, and provided treatment at the dental office in 12, out of 12 samples (100%). In three out of 12 samples (25%), there was either an evulsed tooth, or tooth that required extraction. Review of the Facility's policy for dental emergencies indicated that the dental director would be notified to triage any after hour dental emergency. The new dental director corroborated that she was taking call 24/7, for dental emergencies at the Facility. The Monitoring Team disagrees with any clinical staff personally being on call 24/7, and this practice falls outside of acceptable standards of care. <u>Routine Dental Care</u> To assess routine dental care, the Monitoring Team reviewed the provision of dental x-rays, anesthesia, intravenous anesthesia (TIVA), suction tooth brushing, schedule of those who were seen for restorative care, and dental hygiene. X-rays: The Facility reported that a total of 160 individuals had a dental x-ray within the past year. Generally acceptable practice indicates that individuals with low risk for dental decay should receive dental x-rays every two to three years. Many special dentistry clinics obtain dental x-rays annually, for individuals who cannot communicate their dental needs, and at risk for oral pathology. Summary The Monitoring Team is concerned with the number of individuals who did not receive dental x-rays within the past 12-month period. The Facility must maintain a list, and document the clinical rationale why x-rays had not been obtained annually, and develop a schedule for when x-rays should be obtained for each individual. Provision of Restorative Dental Care: During the previous six months, the Facility reported that it provided 49 dental visits for restorative treatments. The Monitoring Team was unable to determine the extent or efficacy of the treatment provided, because treatments were not clearly documented in the integrated progress notes (IPN). Importantly, the Facility did not have a mechanism to determine if an individual's treatment for restorative care was complete, unless it reviewed the individual's dental record, and because this information was not documented in the IPNs. The dental department reported that it was in the process of implementing a new dental database system that will address scheduling issues, and help track completed and not completed treatment. In addition, they are developing new dental treatment forms that will be	

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		incorporated into the dental database system, and enable more clarity with regards to dental health care needs. Summary The Monitoring Team was unable to assess the efficacy of restorative dental services; however, it was made aware that a new dental database will be implemented that will enable an efficient mechanism to determine if dental treatments were completed or not, and a new dental record form will be introduced that will enable greater insight into the oral health care needs of the individual Provision of Annual Dental Assessment & Preventive Dental Care: The Facility reported that 282 individuals were seen at the dental office for their annual scheduled preventive care assessment and treatment, and that 11 individuals were currently pending their assessment, and only six were past due; however, there was no list of individuals who actually completed their annual assessment and preventive care treatment. Dental office staff reported that many times individuals would not fully cooperate with dental hygiene, and the service had to be prematurely terminated, and the individual rescheduled. Early termination of a treatment because of a behavioral issue was not tracked. Summary Because there was no mechanism in place to track incomplete preventive dental services, the Monitoring Team was unable to accurately assess the efficacy of preventive dental care at the Facility. The Monitoring Team was advised that the new dental database will enable the Facility to carry out efficient review of dental records and the status of dental care of individuals; hence, the Monitoring Team will also be able to better assess efficacy of preventive dental services at future Monitoring Team reviews. <u>Oral Hygiene</u> The Monitoring Team was informed by the dental office staff that direct care staff had been provided training on oral hygiene issues, and dental hygienists were working assertively with direct care staff at the living areas to assess for efficacy. The Monitoring Team assessed oral hygiene by casual observation at the living area. Following observation of Individuals # 532, #535, #101, #397, #548, #184, #254, #160, #362, #470, #191, and #450, the Monitoring Team noted that there was no gross debris, glistening plaque, or actively bleeding gums in 12 out of 12 individuals observed (100%), demonstrating excellent work by the hygienists and direct care staff. <u>Conclusion</u> The Monitoring Team determined that the Facility was not in compliance with Provision	

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		Q.1, because it was unable to demonstrate effective and timely provision of dental health care. The Facility must assess its staffing needs and develop an effective method to comprehensively track the provision of dental services.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; 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.	To assess for Provision Q.2, The Monitoring Team reviewed availability of TIVA, general anesthesia, mechanical and physical restraint practices, dental offices participation at the IDT, and the Facility's effort to help mitigate the use of restraint for dental services. <u>TIVA and General Anesthesia, Mechanical Restraint, Physical Restraint, and Pre-Treatment Sedation.</u> The Facility enabled only two TIVA days per month, and a total of about 40 individuals were provided dental service by TIVA during the reporting period. Because it was reported by dental office staff that many individuals who did not receive TIVA for their dental services were unable to have their assessment and treatments completed because of maladaptive behaviors, the Monitoring Team was concerned over the limited availability of TIVA services at the Facility. The Facility did not have a master list of all Individuals who would benefit by TIVA, and how often TIVA should be provided for each Individual; hence, the Monitoring Team could not determine if the Facility provided efficacious TIVA service. Upon subsequent reviews the Monitoring Team will expect a comprehensive list of all individuals who were receiving TIVA, and who should be provided TIVA to complete their dental care, as well as the necessary frequency of TIVA that should be provided for each individual. This is information the Facility needs in order to plan and schedule dental services. The Facility reported that six individuals would benefit by having their dental services completed under general anesthesia (GA); however, only one individual was provided GA during this reporting period. The Facility reported that they did not provide dental services through the aid of mechanical or physical restraint. <u>Pre-Treatment Sedation</u> The Monitoring Team refers to Provision J4 of this report for compliance determination regarding pre-treatment sedation. Following the administration of TIVA, the Facility must ensure that the Individual fully recovers from anesthesia under nursing supervision. Dental staff informed the Monitoring Team that Individuals were under enhanced nursing supervision, until clinically stable. The Monitoring Team assesses monitoring efforts of individuals who receive TIVA at subsequent reviews; please refer to Provision J4 for detailed findings. At the time of this review, there were no quality indicators to assess clinical outcome following TIVA. The Monitoring Team strongly recommends that specific medical quality	Noncompliance

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		indicators be developed to assess short-term, and intermediate-term adverse outcomes, such as the development of pneumonia, sepsis, need for STAT psychotropic medications, falls, and fall related injuries. <u>Mechanisms to Reduce the Need for Sedation</u> The Monitoring Team was informed by the dental staff that no significant progress was made with regards to implementing its dental pilot desensitization skill acquisition program, as a joint venture between the dental and psychology departments that began in January 2012. Since January, a total of seven individuals were introduced to the program. Of the seven, three individuals experienced only one attempt at desensitization; two individuals had a total of four attempts at desensitization; one individual had three attempts at desensitization; and one had two attempts at desensitization; hence, in the past six-month reporting period, there had been only a total of 16 attempts, of seven individuals for dental desensitization, and skill acquisition. There was no longitudinal analysis completed on efficacy of the program. The Monitoring Team determined that the Facility did not have an effective program to assist individuals in helping to mitigate the need for sedation for dental services. <u>Appointment Failures</u> The Facility reported a total of 150 failed appointments during the reporting period: 13 out of 150 were because of staffing issues (9%); 15 out of 150 were because of the individual being ill (10%); 26 out of 150 were no shows, with out any reason (17%); 24 out of 150 were due to behavior issues (16%); and 72 out of 150 were for "other" non-descript reasons (48%). The Monitoring Team was concerned with the over-all appointment failure rate, and the fact that many reasons for appointment failures were for non-identified reasons. Also, the Facility should consider initiating an improvement project to reduce no-show and staffing related failures. <u>Participation at IDT and ISP Meetings</u> The dental hygienists attended a total of seven ISP annual planning meetings during this reporting period. After reviewing the ISPs for Individuals # 532, #535, #101, #397, #548, #184, #254, #160, #362, #470, #191, and #450, the Monitoring Team noted that the dental and oral health care needs of the individuals were not adequately represented. The Monitoring Team was made aware that the hygienists and dentists did not participate at any IDT meetings to discuss health care issues during the reporting period. The Monitoring Team determined that the Facility did not adequately represent the dental and oral health care needs of individuals during their ISP and other IDT meetings. The Provision requires the Facility to adequately reflect the individuals' dental, and oral health care issues at the ISP planning meeting. The Monitoring Team will continue to	

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		assess ISPs to ensure that a comprehensive overview of the individuals' current oral and dental and oral condition, issues regarding any delay with treatment, treatments completed during the past year, necessary pending treatments, the use of pre-treatment sedation, TIVA, or general anesthesia, and the associated risks of providing dental services, versus not providing dental services are reflected in the ISP. <u>Conclusion</u> Since the last compliance visit, the Facility offered TIVA services only two days per month, did not use oral pre-treatment sedation without TIVA, enabled general anesthesia for only one individual, and did not employ mechanical or physical restraint to support individuals with their dental assessments and treatment. Because of reported treatment failures (which were not quantitated or tracked), secondary to challenging behaviors that prevented timely dental assessments and treatment, the Monitoring Team is concerned that the Facility did not providing adequate supportive services such as the appropriate use of TIVA, oral pre-treatment sedation, and general anesthesia. The Facility did not adequately represent the individuals' oral and dental health care issues at the ISP annual planning and other IDT meetings, and must develop a robust mechanism to overcome this barrier. Appointment failures, and tracking of appointment failures remains problematic for the Facility. The Facility must develop strategies to help mitigate appointment failures, and better track the reason for appointment failures. The Facility had only provided seven individuals with an opportunity for dental desensitization, and skill acquisition. Compliance will require full implementation of an efficacious mechanism that helps mitigate the use of sedation for dental, and oral health care. Because of these outstanding issues, the Monitoring Team determined that the Facility remain noncompliant with Provision Q.2.	

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

1. The Facility must review staffing issues at the dental office, and make sure that there is adequate support staff to ensure the safety of individuals served, and to ensure that dental services are provided timely, and efficaciously
2. The dental director cannot provide 24/7 on-call coverage for dental back-up. The Facility must reconsider its policy on dental emergencies, and coverage issues
3. Maintain a list, and document the clinical rational why x-rays had not been obtained annually, and develop a schedule for when x-rays should be obtained for each individual
4. Implement the new dental database, and ensure its efficacy to track and trend the provision of dental and oral health care
5. Ensure that all individuals who appropriately require TIVA, and general anesthesia are provided such service so that their dental and oral health care needs are addressed timely, and efficaciously
6. Develop medical quality indicators to assess short-term, and intermediate-term adverse outcomes, such as the development of pneumonia, sepsis, need for STAT psychotropic medications, falls, and fall related injuries.
7. The Facility must assertively implement its pilot program for dental desensitization, and skill acquisition program, and determine its efficacy for

continued use, or need for enhancement. Trained professionals in behavioral management, must lead this effort

8. The Facility must improve on appointment failures, and better track appointment failures.
9. A mechanism must be developed that ensures each PSP include a comprehensive overview of the individuals current oral condition, issues regarding any delay with treatment, treatments completed during the past year, pending treatments, the use of pre-treatment sedation, TIVA, or general anesthesia, any adverse outcomes secondary to treatment, or not providing treatment, recommendations, and the associated risks of providing dental services, versus not providing dental services.
10. Each dental and oral health care related assessment, treatment, recommendation, and concern, must be described, in laypersons terminology, in the IPNs
11. Ensure that all dental practices are detailed in a policy and/or procedure.

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. Facility Self-assessment 7/12/12, 2. BSSLC Action Plans 7/6/12 3. BSSLC Communication Guidelines: Comprehensive Speech Language Pathologist (SLP) Assessment of individuals 7/2011, Augmentative Communication (AAC) vs. Behavioral Support 6/2012, AAC vs. Environmental Control (EC) 7/2012, Change in Status 6/2012, Indirect Therapy 6/2012, AAC Monitoring 6/2012 4. Record Reviews of Individuals: • Sample 1: Individuals #30, #41, #59, #132, #159, #303, #318, #413, and #481 • Sample 2: Individuals #39, #94, #165, #186, #195, #283, #305, and #547 • Sample 3: Individuals #65, #88, #269, #335, #343, #362, #398, #445, and #462 • Sample 4: Individuals #423, #501, and #539 • Sample 5: Individuals #112, #160, #205, #255, #282, #288, #314, and #511 • Sample 6: Individuals #118, #149 and #508 5. Facility Section R Presentation Book 6. List of current SLPs, caseloads and ratios 7. Copies of each SLP's current license and ASHA certification 8. Continuing education and training completed by the SLPs in the past 12 months 9. Facility list of new admissions since the last review 10. Tracking log of SLP assessments completed since the last review 11. Facility list of individuals with severe language deficits 12. Facility list of individuals with PBSPs and replacement behaviors related to communication 13. PBSP minutes and attendance rosters for the past six months 14. Facility list of individuals with Alternative and Augmentative communication (AAC) devices 15. Facility AAC screening forms 16. Facility AAC-related database reports/spreadsheets 17. Facility list of general common area AAC devices 18. Facility list of individuals receiving direct communication-related intervention plans **People Interviewed:** 1. Direct Support Professionals-Bowie (2), Childress (2) and Driscoll (2) 2. Kori Kelm Physical Therapist (PT), Habilitation Therapy Director 3. Tracy Searles Physical Therapy Assistant (PTA), 4. Christina Koehn SLP **Meeting Attended/Observations:** 1. Daily activities on Driscoll, Fannin, Childress, and Program Services 2. Mealtimes on Driscoll, Fannin, and Program Services
	Facility Self-Assessment: Based on a review of the Facility's Self-Assessment, with regard to Section R of the Settlement Agreement,

	the Facility found it was in noncompliance with provisions R.1, R.3 and R.4 and in compliance with provision R.2. This was inconsistent with the Monitoring Team's findings of noncompliance with all provisions. For Provision R.2, BSSLC stated that data acquired from March 2012 to May 2012 indicated an overall compliance of 77% indicating that the individuals had their AAC integrated into the ISP. The Monitoring Team found that AAC information was not integrated into the ISP and the individuals were not provided with specific recommendations to address decline in communication The Facility submitted two documents, including: BSSLC Plan of Improvement (POI) and the BSSLC Action Plans. The BSSLC POI listed the steps the Facility staff completed or planned to complete to conduct the self-assessment, and the subsequent results for the completion of these tasks. The Action Plans documented the status of action steps that had been completed, were in process, and/or had not been started. The Facility Self-Assessment included minimal data or findings from the self-assessment activities to support the Facility's conclusion of whether it was or was not in substantial compliance with the requirements of the Settlement Agreement for Section R. A review of the Facility Self-Assessment for Section R identified activities engaged in to conduct the self-assessment. Overall, the Self Assessment and Action Plans included relevant steps that would assist in the state in gaining compliance; however, the activities at times were not consistently in line with what the Monitoring Team assesses as indicated in this report.
	Summary of Monitor's Assessment: Outside of the Assessment process, there has been little progress in this section. Due to staffing issues, many communication/speech related duties were given lesser priority and therefore were often not provided in a timely manner or at times not at all. **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 continued to show significant improvement. Assessments were noted to be comprehensive and provided clear details and strategies to improve the individuals' level of communicative functioning. At the time of the review, 49 new assessments had been completed. As of this review, 232 individuals had received the new SLP assessment. 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,

	recommendations provided as a result of the assessments had become more vague and did not clearly identify the pathway (goals and objectives) to expanded communication. **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 ISP. **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 and there was no process in place to capture data acquired through the monitoring process.

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R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	Individuals for sample #1 were chosen from the list of individuals who were diagnosed with an aspiration event since the previous compliance review. The sample consisted of nine individuals who experienced an aspiration or choking event. Sample #2 consisted of eight individuals who were chosen from a list provided by BSSLC of individuals who were identified as being at a high risk of choking or aspiration. Sample# 3 consisted of nine individuals identified by the Facility with severe expressive or receptive language disorders with assessments completed in the last 12 months Sample #4 consisted of three individuals admitted since the last compliance review Sample #5 consisted of eight individuals with a PBSP and communication deficits Sample #6 consisted of three individuals receiving direct speech services This provision of the Settlement Agreement includes a number of requirements that are addressed in subsequent sections within Section R and which have the ability to affect the Facility's compliance with the Settlement Agreement. This provision will address compliance with current staffing, staff qualifications, adequate number of speech language pathologists, and continuing education. The SLP assessment process and the development and implementation of programs are discussed in Provision R.2. Staff training will be addressed in Provision R.3 and the Facility's monitoring system will be presented in Provision R.4. Compliance in Provision R1 related to the adequacy of clinicians must be determined by compliance in Provisions R2 through R4.	Noncompliance

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		Staffing: At the time of the review, BSSLC had five full time Speech Language Pathologists. The Speech Language Pathologists consisted of Christa Koehn SLP, Donna Baron SLP, Erin Pepper SLP, Jamie Goehring SLP, and Kathy Milenki SLP. Jamie Goehring was a new hire since the previous compliance visit. Each Therapist carried a full caseload which are listed below: • Christina Koehn-Childress-66 individuals • Donna Baron-Cottages-93 individuals • Erin Pepper-Driscoll -57 individuals • Jamie Goehring-Bowie-38 individuals • Kathy Milenki-Fannin-45 individuals In addition to their caseloads, Christina Koehn was placed as lead with regards to the Settlement Agreement, Donna Baron was lead with regards to the Positive Behavior Support Committee, and Erin Pepper served as a PNMT member. There were no open SLP positions at the time of this review. Qualifications: The Facility did document appropriate qualifications for licensed SLPs. • Five of five staff (100%) were licensed to practice in the state of Texas. • Five of five staff (100%) had evidence of ASHA certification. Continuing Education: Documentation of continuing education courses completed by the SLPs was submitted. The continuing education attended by the clinicians included the following topics: • Issues in Evaluation and Treatment of Individuals with Developmental Disabilities • Texas Speech and Hearing Association-general session • AAC/Computer Access Methods for the Physically Challenged • Improving Social Interaction and Communication with an Interactive Language Program Based on a review of continuing education completed in the last 12 months: Five of five SLP staff (100%) had completed continuing education related to communication in an area that was relevant to communication and transferrable to the population served. The Facility did not provide an adequate number of speech language pathologists or other professionals (i.e. AT specialists) with specialized training or experience. Evidence	

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		was as follows: • 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. • Individuals did not receive direct services as indicated by need or request by the IDT (see Provision R.3) • Devices were not utilized and systems or devices were not monitored at a frequency that ensured appropriateness and continued use of the device (See Provision R.3) <u>Facility Policy:</u> BSSLC provided a set of guidelines revised in June and July 2012, that provided clear operationalized guidelines for the delivery of communication supports and services. The following components were included in this policy: • Roles and responsibilities of the SLPs (meeting attendance, staff training etc.). • Outlines assessment schedule. • Frequency of assessments/updates. • Timelines for completion of new admission assessments • Timelines for completion of comprehensive assessments • Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication • Addressed a process for effectiveness monitoring by the SLP. • Criteria for providing an update • Methods of tracking progress and documentation standards related to intervention plans. • Monitoring of staff compliance with implementation of communication plans/programs including frequency, data and trend analysis, as well as, problem resolution.	
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	<u>Assessment Plan:</u> BSSLC had a master plan with the goal of ensuring every individual would receive a comprehensive speech-language assessment with AAC screening and/or evaluation by the end of 2013. The process was as follows: 1. Each month SLP will determine which assessments are due and must be	Noncompliance

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	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.	completed based on the Speech-Language Pathology policy, Personal Support Plan Calendar, Master plan, and last assessment recommendations. 2. The SLP will complete a comprehensive assessment to include AAC screening and/or evaluation that focuses on the needs of the individual(s). 3. 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 individuals. 4. This process will continue monthly until all individuals have received a comprehensive assessment. Since the previous compliance visit, 49 comprehensive communication assessments had been completed bringing the total number to 232 reports. Per review of new admissions (sample #4): • Three of three individuals (100%) received a communication screening or assessment within 30 days of admission or readmission. • Three of three individuals identified with therapy needs through a screening (100%) received a comprehensive communication assessment within 30 days of identification. <u>Communication Assessment:</u> Per generally accepted clinical standards, a comprehensive assessment should contain the following elements, at a minimum: • Signed and dated by the clinician upon completion of the written report • Dated as completed 10 days prior to the annual ISP • Diagnoses and relevance of impact on communication • Individual preferences, strengths, interests, likes, and dislikes • Documentation of how the individual's communication abilities impact their risk levels • Description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day. • Evidence of observations by SLPs in the individual's natural environments (day program, home, work) • Evidence of discussion of the use of a Communication Dictionary as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who were non-verbal • Discussion of the expansion of the individual's current abilities • Discussion of the individual's potential to develop new communication skills • Effectiveness of current supports, including monitoring findings	

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		• Comparative analysis of health and functional status from the previous year • Comparative analysis of current communication function with previous assessments • Identify need for direct or indirect speech language services • Reassessment schedule • Monitoring schedule • Recommendations for direct interventions and/or skill acquisition programs including the use of AAC as indicated for individuals with identified communication deficits • Factors for community placement and a determination of the most appropriate living environment • Recommendations for services and supports in the community • Manner in which strategies, interventions, and programs should be utilized throughout the day. Based on review of 26 assessments (Samples #1, #2, and #3), four of 26 (15%) individuals had comprehensive assessments that contained each of these elements. Those assessments that were not considered to be comprehensive did not include the following elements: • Recommendations for direct interventions and/or skill acquisition programs including the use of AAC as indicated for individuals with identified communication deficits • Manner in which strategies, interventions, and programs should be utilized throughout the day Although recommendations were provided, they were often generic and were not specific to the individual. An example of this was the recommendation to utilize the home communication board and to provide choices without offering specifics regarding how staff should utilize the boards and activities in which it would be appropriate. Through interview with the Speech Therapists and based on review of individuals observed to be nonverbal and/or with a limited form of expressive language, it was noted that there were numerous individuals in need of AAC who were not consistently identified as being in need of AAC or were not provided with base communication goals to improve expressive language <u>SLP and Psychology Collaboration:</u> Based on review of eight records for individuals in Sample #5 the following was noted:	

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		• In three of eight, communication assessments and PBSPs reviewed (37%) addressed the connection between the PBSP and the recommendations contained in the communication assessment. • Three of eight communication assessments reviewed (37%) contained evidence of review of the PBSP by the SLP. For example, Individual #160's communication assessments stated an adverse reaction to hand over hand while the PBSP recommends Hand over Hand prompts. Based on review of the PBSC (Positive Behavior Support Committee) meeting minutes from 1/18/12 to 6/18/12, participation by the SLP was noted in 12 of the 17 meetings (70%).	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	<u>Integration of Communication in the ISP:</u> Based on review of the ISPs for 29 individuals in Samples #1, #2, #3, and #4 the following was noted: • In 16 of 29 ISPs reviewed (55%) for individuals with communication needs, an SLP attended the annual meeting. • In 23 of 29 ISPs reviewed (79%), the type of AAC and/or communication supports was identified. • Communication Dictionaries provided to three of 29 individuals (10%) were reviewed at least annually by the IDT as evidenced in the ISP. • In 24 of 29 ISPs reviewed (82%) a description of how the individual communicated, including the AAC system if they had one, was included. • Zero of 29 ISPs reviewed (0%) included how communication interventions were to be integrated into the individual's daily routine. • Six of 29 ISPs reviewed (20%) contained skill acquisition programs to promote functional communication. • Six of 29 ISPs reviewed (20%) included information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports/interventions involving the SLP. <u>Individual-Specific AAC Systems:</u> There are 206 individuals living at BSSLC who were identified as having severe language deficits. Per review of the AAC list provided by BSSLC only 33 individuals had personal AAC devices. Many individuals had recommendations to utilize the common area devices but recommendations were vague and did not provide clear direction as to how and when individuals would utilize such devices. Personal AAC devices ranged from high tech (dynavox) to low tech (communication	Noncompliance

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		books). Observations were conducted in three homes (Bowie A-which was temporarily housed in Bowie D, and Driscoll B and C) for individuals with AAC systems in Samples #1 and #6. (Individuals #508, #59, and #413). Findings included the following: • AAC systems for zero of three individuals (0%) were present. • AAC systems for zero of three individuals (%) were noted to be in use. • AAC systems for three of three individuals (100%) were portable but not utilized. • AAC systems for three of three individuals (100%) were functional but again not utilized. • For zero of three individuals with AAC systems (0%), staff instructions/skill acquisition plans related to the AAC system were available. <u>General Use AAC Devices:</u> BSSCL had 31 communication wall boards, one computer, eight wall calendars, four choice boards, 46 "put em arounds" (which were voice activated button switches), and seven sensory cabinets. Devices were located in common areas, near bathrooms, and the entrance/exits. Sensory cabinets were located within program services as well as many other general devices. Observations were completed in Childress, Bowie, and Driscoll to determine the presence and use of general AAC devices. Findings included the following: • Ten of the 11 homes (90%) had general use AAC devices present in the common areas. Bowie D individuals were temporarily moved from Bowie A due to problems with the air conditioning system and did not have access to their equipment. • Twenty-nine of the 37 general use AAC devices (78%) noted contained clear directives on how staff should use these devices. • Thirty-seven of 37 general use AAC devices (100%) noted had a clear function within that setting/situation. • Zero of 37 general use AAC devices observed (0%) were used by individuals during situations in which use of devices were appropriate (i.e., mealtime, bathing, going outside). Another issue noted was that many communication boards were placed too high on the walls. One board on Childress was placed approximately five feet high on the wall making it virtually impossible to be utilized by individuals who require wheelchairs for mobility.	

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		Direct Communication Interventions: Overall, only four individuals were receiving direct services by the SLPs at the time of the review. Many services had pending start dates due to the department waiting on equipment. Direct communication-related intervention plans for individuals included in Sample #6 were reviewed. Generally accepted practice standards for comprehensive progress notes related to communication interventions include: • Contained information regarding whether the individual showed progress with the stated goal. • Described the benefit of device and/or goal to the individual. • Reported the consistency of implementation. • Identified recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress. Documentation of SLP review for zero of four individuals (0%) was comprehensive as per the indicators outlined above. The progress reviewed that were not comprehensive were missing the following: • Contained information regarding whether the individual showed progress with the stated goal. • Described the benefit of device and/or goal to the individual. • Reported the consistency of implementation. • Identified recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress. The individuals reviewed were not provided the direct services recommended by the IDT due to a decrease in habilitation therapies staffing. Examples of this include: • Individual #149 was recommended in 2/2012 for direct services 2-4 times per month. The SLP did not see the individual during the months of February and March and the individual was only seen once during the months of April and May. • Individual #118 was recommended in 2/2012 for direct services 2-4 times per month. The SLP did not see the individual during the months of February, March and April. Indirect Communication Supports:	

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		Programs for individuals who received indirect communication supports included in Sample #3 were reviewed. • Quarterly documentation for zero of two individuals (0%) contained information regarding whether the individual showed progress with the stated goal(s). • Quarterly documentation for zero of two individuals (0%) identified the benefit of device and/or goal(s). • Quarterly documentation for zero of two individuals (0%) identified consistency of implementation. • Quarterly documentation for zero of two individuals (0%) identified recommendations/revisions to the program as indicated and related to the individual's progress or lack of progress. <u>Staff Interviews:</u> Findings from the six staff interviews conducted on Bowie, Childress and Driscoll included the following: • In three of six interviews conducted (50%), direct support professionals stated whether the individual had an AAC system. • In two of six interviews conducted (33%), direct support professionals located the individual's communication equipment. • In three of six interviews conducted (50%), direct support professionals stated whether there was a communication program. • In zero of six interviews conducted (0%), direct support professionals described the communication program goal. • In zero of six interviews conducted (0%), direct support professionals implemented the communication program as written. • In three of six interviews conducted (50%), direct support professionals showed where, when, and how data was recorded for the program. • In one of six interviews conducted (16%), direct support professionals described the schedule for implementation of the communication program. • In four of six interviews conducted (66%), direct support professionals identified how communication skills in the program were addressed throughout the day. • In one of six interviews conducted (16%), direct support professionals stated that they had received individual-specific training for the program and/or AAC. • In zero of six interviews conducted (0%), direct support professionals described individual-specific communication strategies as identified in the individual's PNMP, ISP, PBSP, and/or Communication Dictionary.	

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		Competency-Based Training and Performance Check-offs: Staff were provided with a class titled "Non-Verbal Communication" during new employee orientation. All staff were required to participate in the class through group exercises (i.e., signing). In-service training was provided by the SLPs upon the introduction of a new communication system and return demonstration of implementation was required. There was no annual refresher provided related to communication. While the interactions of staff with the individuals were generally positive, much of the interaction observed by the Monitoring Team was specific to a task, with little other interactions that were meaningful, such as during a meal. Engagement in more functional activities designed to promote actual participation, making requests, choices, and other communication-based activities (using assistive technology), should be made a priority. This will only be possible when the clinicians are sufficiently available to model, train, and coach direct support staff and to assist in the development of activities for individuals and groups across environments and contexts. Based on review of the NEO training curriculum and observations, direct support professionals, PNMPCs and therapy aides were provided with competency-based training related to communication. New Employee Orientation and individual training included: • Methods to enhance communication • Implementation of programs • Benefits and use of AAC • Identification of non-verbal means of communication. • Opportunities for active participation and practice of the skills necessary for appropriate implementation of communication programs, AAC use, and strategies for effective communication partners. • Adequacy of skill performance check-offs As mentioned above, while the NEO training appeared to meet basic standards, missing from the process was the ability of Speech Staff to have the needed presence at the homes to model and guide staff through real life activities and situations.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and	Monitoring System: The monitoring system consisted of periodic PNMP monitoring that included communication. These were generally conducted by the PNMPCs to check for availability, condition, and working order.	Noncompliance

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	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.	BSSLC AAC Monitoring Policy (rev June 2012) defined the following: • Monitoring for the presence of communication adaptive equipment or other AAC supports/materials. • Monitoring for the working condition of communication adaptive equipment. • Monitoring for the use of communication adaptive equipment in multiple environments (home, day program, work). This policy did not include the following key elements: • The frequency of monitoring. The policy stated that the level of monitoring would be determined by the SLP. This included direct treatment being reviewed for effectiveness at least every 3 months and indirect treatment with AAC to be reviewed at least quarterly and without AAC at least annually. This is not in line with current standards of practice and not sufficient to ensure appropriateness of device or treatment. • The process for identification, training, and validation for monitors. • The process of inter-rater reliability. • A process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic). At the time of the review, BSSLC did not have a process or database in place that tracked the indicators listed below: • Frequency per recommendations • Present • Working order • In use throughout the day • In the case a problem was identified, there was evidence of resolution Working condition and presence was monitored but the data acquired from this monitoring was accumulated for trends analysis. Refer to Provision R.3 for information regarding effectiveness monitoring.	

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

1.
2. Individuals who were identified as having severe language/speech difficulties should be provided with a communication program that is based on the individual's strengths and provides a clear path to improved communication. (Provision R.2)

3. While integration has improved between Psychology and the Speech Department, there remains a need to improve collaboration and consistency between the PBSP and the Communication plan of treatment. (Provision R.2)
4. Due to staff having difficulty grasping the concept of 24-hour communication, it would be beneficial to add "communication" to the list of training classes offered on an annual basis. (Provision R.3)
5. All individuals provided with an order to receive direct Speech services should receive such services (Provision R.3)
6. Staff would benefit from increased hands on modeling of the use and integration of devices with normal daily contexts by the PNMPCs and the SLPs. (Provision R.3)
7. A database should be developed that assist the department in capturing the data from the completed monitors and allow for the analysis of such data by the SLPS in an effort to improve overall services. (Provision R.4)
8. Effectiveness monitoring should be provided at a level that is frequent enough to ensure all communication programs (direct and indirect) remain functional for the individuals (Provision R.4)

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 Self-Assessment (7/12/12) 2. BSSLC Action Plan (7/6/12) 3. BSSLC July 2012 Presentation notes 4. Documents that were reviewed included the annual ISP, ISP updates, Specific Program Objectives/Skill Acquisition Plans (SPOs/SAPs), 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: Individual #21, #30, #65, #86, #167, #231, #255, #288, #367, #381, #423, #467, #501, #539, and #579. **People Interviewed:** 1. Kim Littleton – Assistant Director of Programs (ADOP) 2. Andrea Miller – Program Services 3. Michael Doebler – Vocational Services 4. Pam Boehnemann – QDDP Coordinator 5. Terry Hancock, PhD – Chief Psychologist 6. Shawn Cureton, MS – Psychology Manager **7.** Direct Support Professionals: approximately 35 individuals in Adult Program Services; Bowie Springs; Brenham Production Services; Childress Terrace; Cottages A, B, C and F; Driscoll Gardens; and Fannin Villa. **Meeting Attended/Observations:** 1. Program Implementation Committee (07/26/2012) 2. Human Rights Committee (07/26/2012) 3. Restraint Reduction Committee (07/26/2012) 4. Observations were conducted in the following areas: Adult Program Services; Bowie Springs; Brenham Production Services; Childress Terrace; Cottages A, B, C and F; Driscoll Gardens; and Fannin Villa.
	Facility Self-Assessment: At the time of the site visit, BSSLC reported in the Self-Assessment that no Provision was in substantial compliance with the Settlement Agreement. The Monitoring Team was in agreement with the appraisal in the Self-Assessment. In the documents provided by BSSLC, it was apparent that the Facility was focused upon satisfying discrete elements of the Settlement Agreement rather than achieving more systemic or global improvements. For example, both the Self-Assessment and the Action Plans provided by the Facility emphasized the

	completion of specific tasks such as the development of training curriculum or completing a targeted number of assessments or reports. While the completion of such discrete tasks was likely to be of importance, it was unclear how each task contributed to the development and implementation of a comprehensive system that supported evidence-based practices and services. Furthermore, the Self-Assessment often determined successful completion of tasks in terms of quantitative measures, such as whether a set number of documents was completed by a specific date, rather than in terms of whether tasks or actions provided a meaningful improvement in services. In addition to quantitative versus qualitative limitations, there was also the issue of accuracy. Reports by staff during the site visit reflected considerable discrepancies between the Self-Assessment and the status of compliance at BSSLC. Discrepancies also existed within the self-assessment process. Although the Facility reported in the Self-Assessment that systems were being developed to teach staff how to train, that effort was not included in the activities associated with completed the Self-Assessment, and was not reflected in the Facility Action Plans. For self-assessment to be effective in guiding decisions, BSSLC must focus more upon qualitative rather than quantitative measures. In addition, the Facility must attend to whether necessary systems are being developed, as well as whether those systems ensure that individuals living at the Facility are provided with individualized and evidence-based services that result in greater independence and an improved quality of life. Finally, BSSLC must ensure that the Self-Assessment is accurate, based upon adequate and comprehensive measurement procedures, and reflected in the Facility Action Plans.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at BSSLC from 7/23/2012 through 7/27/2012. Record reviews continued off-site for several days following the site visit. Based upon information obtained during the site visit, it was evident that BSSLC had achieved minimal progress in regard to Section S of the Settlement Agreement. Although information provided by the Facility in the Self-Assessment suggested that improvements had been implemented, staff reports and reviewed documents reflected only minimal changes over conditions observed 18 months ago. Based upon available information, examples of continued lack of progress included the following. • Skill acquisition programs continued to rely primarily upon templates from the Murdoch Center Program Library without modification for individualization. • Formal task analyses were not completed as part of skill acquisition program development. • The ISP, Personal Focus Assessment, and other documents were not routinely used to identify personal needs or guide the development of skill acquisition programs. • Apart from vocational settings, minimal functional engagement for individuals living at the Facility was observed. • Community-based employment had not expanded and community activities had decreased substantially.

	The lack of progress in relation to Section S was striking, especially at this point in the Settlement Agreement compliance process. Based upon conditions noted, it will be necessary for BSSLC to develop and implement a rigorous plan of improvement. Such a plan must consider all facets of assessment, skill acquisition plan development, engagement and active treatment, and staff ability to perform assigned tasks. Without a frank self-assessment, as well as a diligent and concerted effort toward improvement, it will be difficult for the Facility to achieve the requirements stipulated in 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.	<u>Historical Perspective</u> 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 and had replaced the SPOs with Staff Service Objectives (SSOs) that consisted of informal strategies for supporting a skill. 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 initial 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. The review of skill acquisition training at BSSLC In January 2012 revealed a reduction in the quality of SPOs in addition to the reduction in quantity noted above. <u>Current Site Visit</u> In materials received prior to the current site visit, BSSLC had reported in the Facility Self-Assessment that a sample of SPOs/SAPs reflected 79% compliance including, "adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by Interdisciplinary Teams." Upon initiation of the site visit, however, the Facility reported substantially greater limitations regarding skill acquisition training and SPOs/SAPs. Specifically, The Assistant Director of Programs reported that: 1. The majority of SPO activity had focused upon Vocational Services and vocational SPOs/SAPs; 2. The majority of staff were unable to demonstrate adequate skills in relation to the development and implementation of SPOs/SAPs; 3. Efforts to correct the current circumstances had just commenced; and	Noncompliance

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4. Two SPOs/SAPs had been completed that the Facility believed to be in better agreement with the expectations of the Settlement Agreement.

Based upon the information presented by BSSLC, it was decided to modify the review process involving SPOs/SAPs for the current site visit. As part of this modification, a sample of 11 SPOs/SAPs and associated assessments, ISPs, and data, were selected to establish the validity of the Facility's on-site report. In addition, an in-depth review of the two completed SPOs/SAPs was conducted to assesses the quality of the programs and provide feedback to the Facility.

Use of Assessment Information in Planning Skill Acquisition

Adequate assessment is essential for understanding an individual's abilities, identifying specific needs, and determining the strengths upon which new skills can be based. Without thorough and comprehensive assessments, skill acquisition training is unlikely to be successful or meaningful to the individual who is to participate in the training.

Based upon the documentation provided by BSSLC, there was little indication that the Facility had provided adequate assessment in relation to skill acquisition training.

	01/2010	01/2012	7/2012
Skill acquisition plans are implemented to address needs identified in:	0%	0%	0%
ISP	0%	0%	9%
Adaptive skill or habilitative assessment	0%	0%	9%
Psychological assessment	0%	0%	0%
Skill acquisition plans are chosen in an individualized manner.	0%	0%	0%
Skill acquisition plans are related to the individual's preferences.	0%	0%	0%

Although 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 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.

- For Individual #30, the FSA reflected that the individual experienced difficulty writing her name. Although an SPO was provided that required the person to copy individual letters from her name, there was no indication from the FSA that an inability to copy individual letters was relevant. A more comprehensive assessment could have identified the nature of the inability of the individual to write her name and provided guidance toward the development of an

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		effective SPO. • Data for Individual #65 in regard to brushing teeth reflected nearly 100% refusal to participate in training from January through May 2012. Information included in the FSA from April 24 2012 reflected that the individual "does not always comply" with tooth brushing. This statement did not accurately reflect existing conditions. As a result, the assessment did not contribute to an understanding of the individual's tooth brushing skill or facilitate the development of an appropriate skill acquisition program. • For Individuals #167, #231, #423, and #367, no items in the FSA were specific to the needs of the individual in regard to the reviewed SPOs/SAPs. BSSLC had included the FSA as the primary skill assessment instrument for over one year, despite numerous limitations in the design and utility of the rating scale. For example, in regard to skills such as leisure, oral hygiene, and money management, there often were no items that addressed the specific needs of the individual. Individual #423 was provided with an SPO to count the number of one dollar bills necessary to make a purchase of a stated amount. The FSA, however, indicated only that the individual demonstrated limitations in money management, so it was unclear (at least from the FSA) that this was an appropriate goal to work on at this time). The development of SPOs/SAPs requires a comprehensive and precise understanding of numerous facets of an individual's abilities and limitations. The FSA alone lacks the ability to provide such assessment and understanding. The FSA could, however, serve as the initial component to a more comprehensive assessment, helping to focus attention upon general skill areas in which the individual experienced limitations. It would then be necessary to supplement the SFA with assessments specific to the areas where skill deficits were suggested. This approach could lead to a more comprehensive understanding of the individual and lead to specific and individualized training. There was no indication in the records reviewed that such supplemental assessment was provided to individuals living at BSSLC. Observations and record reviews also indicated weaknesses relating to other assessments. • All individuals included in the sample had been provided a Personal Focus Assessment (PFA). The PFA is a subjective measure that relies upon self-report and staff observation regarding what the individual prefers in relation to residence, leisure, employment, diet, and numerous other areas. A large number of individuals living at BSSLC, and several included in the sample for Provision S1, experienced substantial deficits in communication skills. It was not evident from the PFAs that vocal, gestural or other non-language-based communication was considered when identifying personal preferences. Furthermore, it was not evident that BSSLC had made use of other means to identify personal preference with people experiencing communication limitations, such as systematic observations by neutral staff or providing the individual systematic opportunities to select or indicate preferred items. Rather, the PFA for individuals with limited communication routinely consisted of general, anecdotal statements	

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		of undocumented origin that could not be verified or validated. • Of the sample collected for Provision S1, 64% of the individuals (seven of 11) had been provided intellectual and adaptive behavior assessments within the past year. Of those seven, however, only the record for one individual included evidence that the findings of the intellectual and adaptive behavior assessments were considered in the development of a skill acquisition training program. For some individuals, limitations identified in the adaptive behavior assessments could adversely affect the ability to successfully complete and SPO. o For Individual #167, the adaptive behavior assessment identified motor skills as a weakness. This individual had been provided an SPO for manipulating a radio. It was unclear whether the individual possessed the motor skills to perform the training procedures and documentation reflected no effort to address the issue. • At least two individuals included in the sample for Provision S1 experienced receptive communication limitations related to hearing. For neither of these individuals were accommodations made in the SPOs/SAPs for hearing or communication limitations. o For Individual #21, the ISP indicated the individual had hearing difficulties and might not be able to hear spoken speech. The SPOs/SAPs for Individual #21 included verbal instructions as well as reinforcement in the form of verbal praise. These SPOs/SAPs did not include any instructions or guidance addressing the hearing limitations. o For Individual #423, the communication assessment information presented in the ISP recommended that efforts to verbally communicate with the individual be simple, involve choices, and be supported by frequent prompts redirecting the individual back to the topic being communicated. Although the SPOs/SAPs for the individual involved verbal instruction and verbal praise, the instructions did not address the communication recommendations. Based upon the information obtained as a part of the site visit, it was evident that the Facility had failed to provide adequate assessment relating to the development of skill acquisition programs. Furthermore, when adequate assessment had been completed, the Facility failed to use the information from those assessments in the development of SPOs/SAPs. These findings supported the information provided by the Facility that SPOs/SAPs were not being effectively developed and implemented at BSSLC. <u>Teaching New Skills</u> Teaching new skills requires the use of the same learning principles involved in changing undesired behavior. Therefore, effective skill acquisition programs require many of the same basic components as behavior support plans: Comprehensive assessment of skills and individual resources, the use of formal training methods that include adequate opportunities for training and high levels of reinforcement, an evidence-based and empirical approach to teaching, valid and reliable data collection, and a sound strategy for assessing progress. When one or more of these components are lacking, the ability to provide adequate habilitation services is severely compromised.	

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		It was noted during the current site visit that, despite the use of the Murdoch Center Program Library, the SPOs/SAPs 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/SAPs. 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/SAPs were used as written in the Murdoch Center Program Library without any customization.	

	01/2010	01/2012	7/2012
Plan reflects development based upon a task analysis	0%	0%	9%
Behavioral objective(s)	0%	75%	100%*
Operational definitions of target behavior	0%	13%	27%
Description of teaching conditions	0%	0%	27%
Schedule of implementation plans for sufficient trials for learning to occur	0%	0%	0%
Relevant discriminative stimuli	0%	0%	82%**
Specific instructions	0%	0%	27%
Opportunity for the target behavior to occur	0%	88%	100%
Specific consequences for correct response	0%	6%	100%***
Specific consequences for incorrect response	0%	0%	9%
Plan for maintenance and generalization that includes assessment and measurement methodology	0%	0%	0%
Documentation methodology	0%	0%	9%

* All SOPs included a statement labeled as a behavioral objective. Only a 36% of these statements, however, included precisely identified and observable behaviors, objective measures, and precise timeframes for completion.

** The majority of SOPs included a stimulus that could serve as an indicator that reinforcement was available for completion of a specific task. Due to the lack of adequate assessment, however, it was not demonstrated that any of these indicators functioned as a discriminative stimulus.

*** Although present, the consequences were general, were not individualized, and were not based on assessment that would establish a likelihood of being effective.

The following specific issues were noted during the review of skill acquisition programs.

Task analysis. Conducting a meaningful task analysis is essential to the development of a skill acquisition program. For many individuals with intellectual and developmental disabilities, tasks and

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		behaviors must be broken down into small, discrete steps that can be more easily learned. Task analysis is the process of breaking complex tasks or skills down into smaller steps in a way most beneficial to the individual who will be provided training. All of the reviewed SPOs/SAPs were taken from the Murdoch Center Program Library. 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/SAPs were not tailored to the unique learning needs, current skills, or physical condition of each person. <u>Behavioral objectives</u>. It is essential that efforts to strengthen skills include objectives comprised of observable and measurable elements of the behavior. In many cases, the goal for a training program consisted of a general statement that did not clearly indicate what specific skill or behavior was to be increased. As a result, it was not evident how the objective related to the specific needs of the individual or contributed to enhancing the individual's abilities. • For Individual #23, the Behavioral Objective for the SPO stated only that when told to wash her hands the individual would wash her hands. Without a more detailed description, it was possible that different staff could have different interpretations of what was involved in washing hands. • For Individual #367, the Behavioral Objective for the SPO stated only that when told to brush his teeth the individual would brush his teeth. Without a more detailed description, it was possible that different staff could have different interpretations of what was involved in brushing teeth. <u>Operational definitions</u> In order for training programs to be implemented correctly, it is imperative that the program specifically defines the behavior to be increased. This requirement informs the person implementing the program exactly what behavior the individual is expected to display. Without an operational definition, the risk of strengthening unintended behaviors and slowing the individual's acquisition of skills is increased, since different trainers may prompt and reinforce different behaviors rather than have a consistent requirement. In 73% of the skill acquisition programs reviewed, the operational definitions of training targets consisted of general statements such as bathing, turning on water, or complying with a request. • For Individual #231, one operational definition for a step in an SPO for washing hands was, "Have [Individual] rub palm of preferred hand over back of non-preferred hand." Although this statement could have been interpreted as a repetitive motion that produced lather and resulted in the removal of dirt, it could also be interpreted as a single pass of one hand over the other with minimal contact. An additional problem noted in the majority of SPOs/SAPs was the confusion of staff instructions with operational definitions of the behavior that the individual was expected perform. For example, in an SPO for Individual #30, the Operational Definition for one step in the SPO included the statement,	

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		"Present worksheet with sample letter printed on it and give the instruction to copy the letter. Have the individual pick up a pencil and print the letter correctly in the appropriate space." Not only did this statement focus upon what staff would do, it failed to define "print letter correctly in appropriate space". As a result, staff were not fully prepared to implement the SPO or identify when the individual was successful. <u>Description of teaching conditions</u> In order for teaching programs to be implemented consistently as intended, the staff implementing those programs must be given explicit instructions including what materials are to be used, how those materials are to be arranged, where training should be conducted and how the environment should be controlled. Without such instructions, training conditions often drift or change across staff and location. As a result, training is ineffective and can strengthen the wrong behavior. Of the training programs reviewed at BSSLC during the current site visit, 73% lacked details and failed to ensure that training would be implemented consistently. <u>Sufficient trials</u> It has been repeatedly demonstrated in research regarding learning that the development of skills requires repetition. In the majority of cases, while the skill is initially being learned, high rates of repetition are required so that the individual is provided multiple opportunities for reinforcement. Often, lower frequencies of reinforcement result in slower rates of learning. If the rate for reinforcement opportunities falls too low in relation to a specific behavior, that specific reinforcement may not compete effectively and efficiently with other reinforcement in the environment. In the majority of skill acquisition programs reviewed at BSSLC, the teaching trials were provided at a rate of one per day or less. A single trial per day is not usually sufficient to develop a new behavior or skill. <u>Relevant discriminative stimuli</u> In order for training to be effective, there must be a cue or indication for the learner that reinforcement is available for the completion of a specific task. In the majority of reviewed SPOs/SAPs, conditions were described in the SPO that could have served as a discriminative stimulus. For an event to actually serve as a discriminative stimulus, however, an SPO must be based upon careful assessment of the individual and the training methodology must be conducted with consistency. At BSSLC, there was little indication of adequate assessment in relation to SPOs/SAPs. Furthermore, the SPOs/SAPs often lacked instructions of sufficient specificity to ensure that training was conducted consistently. As a result, it was unlikely that the available events or cues served as discriminative stimuli in relation to the SPO. <u>Specific instructions</u> As with the teaching conditions, it is necessary that training be conducted in a consistent and specific manner. Without specific instructions, the trainer may use a different prompt than was intended, offer reinforcement in a different way, or strengthen a behavior other than the behavior to be learned. As	

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		noted in the discussion regarding operational definitions and teaching conditions, the majority of SPOs/SAPs at BSSLC lacked adequate instructions for staff. For example, for Individual #167, a portion of the teaching instructions included the following. 1. Give instruction, "[Individual], play the radio." Have [Individual] obtain and position radio so front of radio faces her and she can easily view the dial. 2. Have [Individual] turn radio on (i.e., turn dial on, turn switch on, push button in, etc.). If volume is controlled by same device, have [Individual] keep volume low, but clearly audible. 3. Have [Individual] adjust tuning dial until clear signal is obtained from designated station. 4. Have [Individual] adjust volume to preferred, socially acceptable, level. The steps in the program for Individual #167 were accurate. The steps were not, however, sufficient to allow the trainer to perform the teaching activity in a consistent and individualized manner. Teaching instructions are more likely to ensure effective teaching if they are presented in less technical language, clearly state the intended activities, provide examples, and describe the teaching activity and people involved in terms that are more person-centered. For Individual #167, it could have been important to describe how the individual was to obtain and position the radio, and describe the specific prompts or supports that would be necessary to assist the individual in turning the radio on, tuning to the desired station, and adjusting the volume. For example, it might be necessary to position the tuning mechanism near to the desired station if the individual had difficulty manipulating the tuning mechanism. In addition, “low”, “audible”, “preferred” and “acceptable” are imprecise and subjective terms. It could be helpful to provide specific guidelines to facilitate consistency and clarity. <u>Plan for maintenance and generalization</u> Skill acquisition programs have the ultimate goal of increasing skills in situations outside of the teaching setting. If an individual learns to differentiate colors in the classroom, but does not exhibit that same skill at home or at work or as part of a new and more complex task being learned, then the training has not been fully successful. In order to determine if skills are being used beyond the training setting, it is important that a specific method for monitoring the skill be in place. In the skill acquisition programs reviewed at BSSLC, none included the necessary elements of such a monitoring system. An additional concern about the SPOs/SAPs reviewed during the current site visit was the failure to ensure that SPOs/SAPs were functional for the individual. A functional skill acquisition program is one that promotes a skill or behavior that is of practical benefit and is likely to lead to greater independence and to gain reinforcement that will maintain the behavior. For some Individuals, the SPO, barring other weaknesses, had a strong probability of providing functional benefit. For example, Individual #21 was provided a SPO for hand-washing and Individual #30 had a SPO for brushing teeth. For other individuals, however, the SPOs/SAPs were of no discernible benefit or were unlikely to be of practical use. • For Individual #231, the skill addressed by the SPO was to identify rings by color. In neither	

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		the ISP nor any assessments was there an indication of how this skill was intended to be of practical value. • Individual #423 had a SPO for money management that involved matching the correct number of pennies to higher denomination coins. The rationale of the SPO was to enhance the individual's ability to use vending machines. Virtually no vending machines will accept pennies, however. Furthermore, the skill was unlikely to be useful in making purchases or developing greater independence in relation to money. 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. As a result, SPOs/SAPs were generic and lacked the essential components for teaching. Documentation also reflected that the Facility rarely attempted to revise or alter teaching strategies when SPO data reflected undesired responses from individuals. As indicated previously in Provision S1, BSSLC provided for review two SPOs/SAPs the Facility believed more closely approximated the expectations of the Settlement Agreement. Outlined below are the general impressions of the Monitor in regard to these two SPOs/SAPs. <u>Individual #288</u> Assessment: • The vocational assessment included answers that were too brief to be useful or meaningful. For example, stating that, "[Individual] currently works at Brenham Production Services" did not constitute an assessment of his vocational and employment visions. A second example involved stating only "Assembly" and "Packaging" as strengths. These terms were far too general. It was recommended that assessment be revised to reflect things such as specific tasks that were routinely completed, fine and gross motor skills, and the ability to attend to a task for more than 60 seconds. It was also recommended that the Vineland Adaptive Behavior Scales (currently being used by the Facility in adaptive behavior assessments) be used to identify personal strengths and abilities. • There were also discrepancies noted between assessments. The Vocational Assessment indicated only that the person "Verbally speaks clearly." The Speech-Language Assessment, however, reflected problems with perseveration and other verbal behavior issues. Training Objective: • The Objective required two consecutive months of success. In most circumstances, two months is excessive. A criterion such as five to 10 trials or three consecutive sessions was more realistic. Beyond that, there is a risk of delaying learning that could occur more quickly.	

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		Operational Definitions: • There was no indication of how target behaviors were to be measured or the criteria for successful completion of the task. Training Location and Schedule: • The overall skills targeted by the SPO were intended for the work environment. However, discrete elements of the SAP could have been practiced in the home or other settings. The SPO did not include the opportunity for training the behavior at multiple locations. In addition, the SPO would have benefited from additional trials in the workplace to strengthen the behavior. Teaching Technique: • Although the SPO was designed as a chaining procedure, the "steps" actually consisted of discrete, complex skills that were useful if displayed apart from the "chain". Therefore, although circumstances could vary, the skills included in the SPO were not appropriate for a chaining procedure. Data Collection: • Data collection emphasized the level of prompting used rather than the mastery of a task or tasks. Although prompt levels should be documented, data collection instruction should reflect the criteria for mastery. <u>Individual #579</u> Assessment: • The Vocational Assessment was too general to provide meaningful information. Other than resistance or opposition when corrected by staff, the assessment suggested that that the individual had no need for training. • The Work Monitor's Report included useful information and was much more helpful than the Vocational Assessment. One weakness in the report, however, involved the included graph. Limitations in the graph were noted to include: o No legend to clarify data targets o Based upon the inclusion of small and large value data points, the use of a single axis on the graph did not appear to be appropriate. To make it easier to read and interpret accurately, the graph should have included one axis for high frequency behaviors and a second axis for the low frequency behaviors. Objective: • The proposed SPO involved skills associated with filling a bag with dining utensils and then sealing the bag. A confounding variable in relation to the objective was the lack of adequate supports for success. Observations revealed that the Individual's success was hampered by	

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		the inability to align the bag and contents for sealing. In addition, the lever on the sealing device was loose, allowing for lateral movement of over an inch. If the environment was modified and equipment repaired, the individual's ability to achieve success would be greatly enhanced. Therefore, the SPO should have included providing and teaching the individual to utilize environmental supports. Operational Definitions: • The SPO reflected appropriate use of a chaining procedure. The included operational definitions addressed the behavior and defined the outcome of the behavior. Training Location and Schedule: • The SPO did not include adequate specificity about where the training would take place and how the training session was to be arranged. For this Individual and SPO, these instructions should include the issues presented in the Objective discussion, such as ensuring that the heat sealer is in proper working condition and that jigs or other adaptive devices are in place. It would also be beneficial to include how to cue the person to use those adaptive devices. Teaching Technique: • The SPO did appropriately use a forward chaining procedure. This was appropriate for the skill targeted. If the suggested adaptive devices were provided, a new task analysis would be required with the findings incorporated into the teaching methodology. Data Collection: • As the steps of the teaching chain included both behaviors and outcomes, the data collection process was sufficient. Based upon a review of the two SPOs/SAPs, it was evident that a greater effort had gone into developing the teaching strategies. Unfortunately, some of the weaknesses noted in the existing SPOs/SAPs were also present in at least one of the two SPOs/SAPs in the sample of "improved" programs. These weaknesses included the following. • Non-specific and conflicting assessment information. • Excessive requirements for successful trials. • A lack of precise target definitions. • Limited details on teaching methodology and data collection. • An inability to identify when shaping and chaining strategies were appropriate. If BSSLC is to make progress toward substantial compliance with the Settlement Agreement, it will be necessary to substantially enhance the quality of the SPOs/SAPs. The effort made by the Facility in the sample SPOs/SAPs reflected an improvement. Nevertheless, moving forward it will be essential that skill assessment and teaching methods more stringently adhere to principles of learning and evidence-	

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		based practices. 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 accurate information or resulted in adequate levels of engagement. <u>Implementation of formal and informal skill acquisition training</u> 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 Functionally Engaged	Percent Functionally Engaged
Bistro	3	9	5	56%
A dining room	2	4	2	50%
A shredding 1	2	6	4	67%
A folding room	1	4	0	0%
TA 3	1	4	2	50%
TA 4	1	5	0	0%
D TA1	1	5	0	0%
D TA2	1	4	1	25%
D TA3	1	6	0	0%
C TA1	1	5	0	0%
C TA3	3	8	4	50%
C TA4	1	4	2	50%
Driscoll D	2	10	3	30%
Driscoll C	2	4	2	50%
Driscoll A	1	4	0	0%
Driscoll D LR	2	8	2	25%
Driscoll C DR	2	2	2	100%
Driscoll B DR	3	4	2	50%
Driscoll B LR	1	5	1	20%
Childress D DR	5	14	3	21%
Childress C DR	3	8	2	25%
Cottage A	1	4	1	25%

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		Cottage F	2	5	2	40%	
		Cottage B	1	4	1	25%	
		Driscoll	2	6	5	83%	
		Driscoll	1	4	0	0%	
		Driscoll	2	8	1	13%	
		Driscoll	1	5	0	0%	
		Driscoll	1	5	3	60%	
		Driscoll	1	4	2	50%	
		Fannin C Porch	1	5	1	20%	
		Fannin A DR	3	4	1	25%	
		Fannin B DR	2	4	2	50%	
		Fannin B LR	2	7	0	0%	
		Fannin B DR 2nd group	2	6	1	17%	
		Fannin A DR	5	10	0	0%	
				204	57		
		Total percentage of individuals functionally engaged				28%	
		Percentage of locations with 50% or greater functional engagement				36%	

Observations revealed that across all settings only 28% of observed individuals were functionally engaged. Furthermore, only slightly more than one third (36%) of all environments observed reflected at least 50% engagement. Specific circumstances noted during observations included the following.

- On 7/25/2012 at 10:36AM in Brenham Independent School District (BISD) Training Area 3, none of six individuals were functionally engaged. The single staff member was observed to ask individuals to identify February holidays. No individuals were attending to staff statements; two individuals were asleep and three were engaged in stereotypic behavior.
- On 7/26/2012 at 10:07AM in a Driscoll activity room, four individuals were observed sleeping. The only activity provided was an audio lecture about the philosophical issues involved in the Israeli and Palestinian conflict.

In general, it is anticipated that meals will involve a high level of engagement as food is a powerful reinforcer and easily focuses attention. Observations conducted at BSSLC, however, reflected that meals were often lacking in engagement and reflected increased challenging behaviors.

- On 7/25/2012 at 5:15PM an observation was conducted in the Childress D dining room. Fourteen individuals were present for the meal with many individuals positioned along the walls watching peers eat. Of the individuals present, only three were engaged. Very little social interaction or choices were offered by staff, with beverages and food served with little conversation. Two individuals were observed to bite their hands without intervention from staff.
- On 7/25/2012 at 5:26PM an observation was conducted in the Childress C dining room. One

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		individual seated on a bench along the wall repeatedly struck her head with her fist. Staff commented but did not intervene. A few minutes later, while the individual continued to strike her head, staff required an individual with vigorous repetitive self-stimulation to sit next to her. Of six individuals seated at the dining tables, only two were engaged in the meal. One individual consumed very large bites and then manipulated her food with her hands. A second individual held a spoon with food near her open mouth for over 30 seconds. Staff observed both situations but did not intervene. • On 7/26/2012 at 4:51PM an observation was conducted in the Fannin B dining room. Of the six individuals present only one was engaged in the meal. One individual jumped about the floor like a frog for over five minutes while he rubbed his hands on the floor and then licked them. Staff did not intervene. A second individual was observed to scream, shake his fists and slam doors for over five minutes. The only response from staff was questions about what the individual wanted to eat. • On 7/26/2012 at 4:58PM an observation was conducted in the Fannin A dining room. Ten individuals were present with none involved in functional activities. Although all were seated at tables, no food was served for several minutes. Staff did not attempt to provide stimulation or distraction during the delay. Three individuals were vocally agitated, while four additional individuals rocked or engaged in other stereotypic behavior. Not all observations conducted at BSSLC reflected low levels of functional engagement. In a few settings, staff attempted to provide the materials and attention necessary to maintain reasonable levels of functional engagement. • Observations in the Bistro consistently reflected staff floating amongst individuals. Staff was observed to call individuals by name, offer choices, and prompt for interaction. Individuals in the Bistro exhibited high levels of smiling and verbal responding. • It was also noted that Brenham Production Services, the off-campus vocational site, consistently achieved near 100% levels of engagement. Individuals working there were frequently observed to be on-task or otherwise engaged in functional activities. 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. Staff seldom was observed to provide individualized attention or use formal prompting. Furthermore, when challenging behavior arose, staff often failed to increase interaction or otherwise act to address the behavior. BSSLC must provide the training, monitoring, and supported needed to ensure that individuals are provided with the necessary functional engagement.	
S2	Within two years of the Effective Date hereof, each Facility	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 ISP process and training program development. Specific issues related to psychological assessments are presented in	Noncompliance

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	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.	Section K of this report. Assessment problems in addition to psychological and behavior assessment were also noted. • The reviewed ISPs did not include specific information regarding adaptive skills. • Very few of the ISPs in the sample included information specific to the SPOs/SAPs, such as assessment findings or documentation that IDT discussions had encompassed skills targeted by the SPOs/SAPs. • All of the individuals in the sample had a completed Functional Skills Assessment (FSA) included in the permanent record. For none of the ISPs or SPOs/SAPs reviewed, however, were there FSA findings discussed in the ISP that corresponded with the specific skills targeted by the SPOs/SAPs. • None of the SPOs/SAPs included in the sample presented formal or informal assessment of preferences or reinforcers. • It was not evident that the training steps in the SPOs/SAPs were individualized or that the task analyses were formulated to reflect individual differences. As a result of the broad weaknesses in assessment practices at BSSLC, it was not evident that the assessments provided adequate measurement of individual abilities or were likely to facilitate the skill acquisition process. Based upon this information, it was not possible to identify any areas of substantial progress in skill or preference assessment at BSSLC.	
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	Due to the limitations noted 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	Noncompliance

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	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	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. Circumstances were noted, however, in which staff demonstrated an inability to conduct informal training. • An observation was conducted on 7/25/2012 at 10:17AM in Program Services Training Area 3. Two individuals were expected to work on skill development tasks. One individual worked only when prompted; prompts were infrequent and were not offered in a systematic manner likely to enhance skills. Two other individuals paced about the room without intervention from staff. • An observation was conducted on 7/25/2012 at 10:17AM in Program Services Training Area 4. Materials were available for four individuals, but none of the individuals were engaged in training tasks. Staff did not reinforce behavior related to learning tasks or attempt to engage individuals in learning activities.	
	(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, no progress was evidenced in any area associated with vocational opportunities. The overall opportunities for vocational services dropped modestly. No opportunities for Supported Employment were provided by BSSLC, and Enterprise employment fell from 2 individuals to none. Only Enclave Work and the Client Worker Program were able to avoid losses in comparison with the previous site visit data.	Noncompliance

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		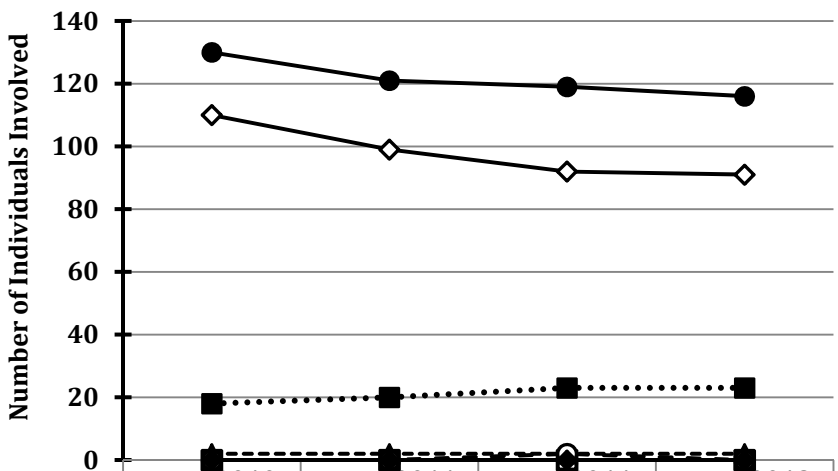	

	Nov - 2010	May - 2011	Nov - 2011	May - 2012
Workshops	110	99	92	91
Supported Employment	0	0	0	0
Client Worker Program	2	2	2	2
Enclave Work	18	20	23	23
Enterprise	0	0	2	0
Competitive Employment	0	0	0	0
Total	130	121	119	116

Data presented by BSSLC did reflect a substantial decrease in the provision of community outings. No information regarding this decrease in community services was provided by the Facility.

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		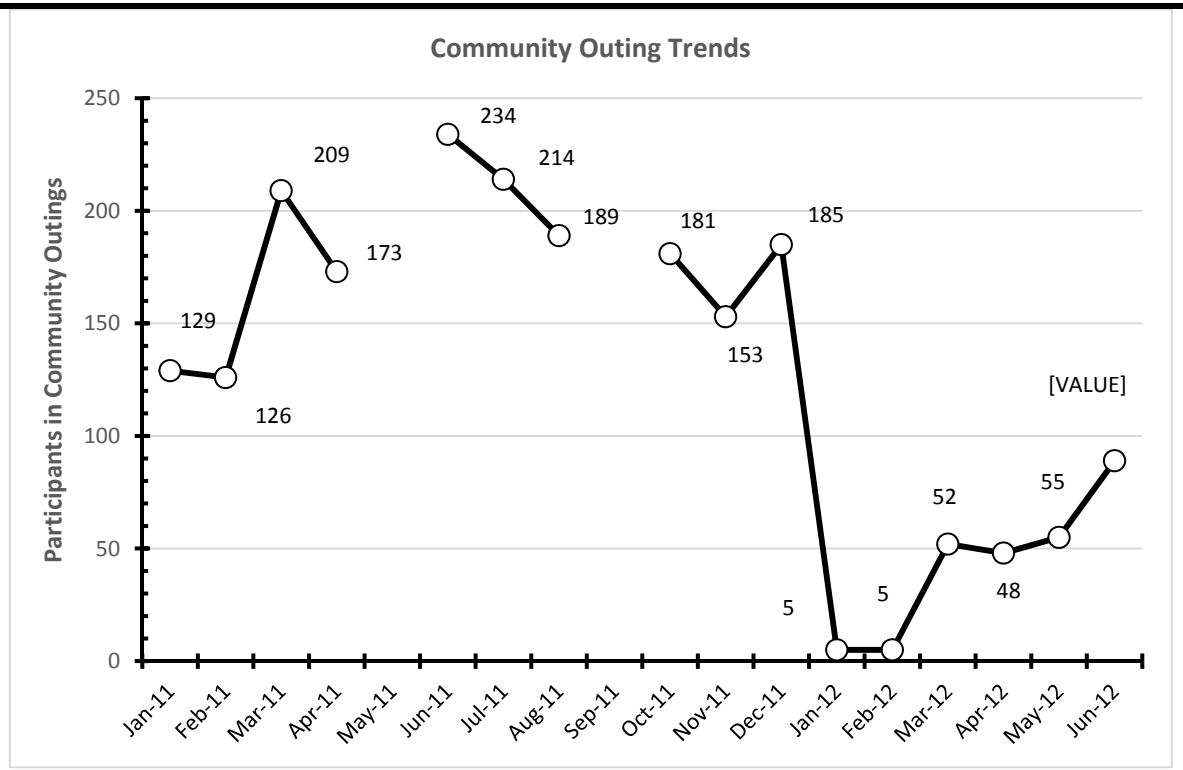	

Recommendations: The following recommendations are offered for consideration by the State and the Facility:

1. The Facility must act to ensure that SPOs/SAPs reflect needs identified in the skill assessment process. SPOs/SAPs should also be developed that build upon each individual's existing skills, do not require 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/SAPs 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 reinforcers, 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/SAPs 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. (Provision S3)

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. BSSLC Self-Assessment (7/12/12) 2. BSSLC Action Plan (7/6/12) 3. Brenham State Supported Living Center Presentation for July 2012 for Settlement Agreement Monitoring Team Visit 4. Section T Presentation Book materials 5. DADS Policy 018: Most Integrated Setting Practices, 3/30/10 6. Draft of updated DADS Policy 018: Most Integrated Setting, undated 7. Draft of DADS Policy 004: Individual Support Plan Process undated 8. Since last on-site review, a list of all individuals who have requested community placement, but have not been referred for placement 9. Since last on-site review, a list of all individuals who have been referred for placement 10. 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" 11. Discharge packets for individuals whose discharge may be classified as an "alternate discharge": Individuals #12 and #513 12. Since last on-site review, a list of all individuals who have died after moving to community living 13. A current list of all alleged offenders committed to the Facility following court-ordered evaluations 14. For the last twelve months, a list of individuals who were reported to have been assessed for placement 15. Community Placement Report, dated June 25, 2012 16. For the last twelve months, lists of all trainings/educational opportunities provided to individuals, families, and LARs to enable them to make informed choices 17. Annual Report: Obstacles to Community Transition, Fiscal Year 2011, Data as of 8/31/2011 18. Quarterly Community Placement Obstacles reports 19. Inclusion of the Designated Local Authority during Living Options Meetings (adopted 5/03/2012) 20. Since last on-site review, a list of all individuals who have had a Community Living Discharge Plan (CLDP) developed 21. Local Authority (LA) Community Living Options Information Process (CLOIP) Worksheets for: Individuals #68, #185, #226, #260, #288, #334, #446, and #548 22. Individual Support Plans (ISPs) and Personal Focus Assessment (PSI) for Individuals #68, #185, #226, #260, #288, #334, #422, #446, #548, and #576 23. Completed CLDPs for Individuals #108, #375, and #590 24. Partial CLDPs for Individuals #173, #181, #273, #442, #490, and #492 25. Pre Move Site Reviews for Individuals #108, #375, and #590

	26. LA Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan for Individuals #108, #375, and #590 27. Completed Post Move Monitoring (PMM) checklists for Individuals ##108, #375,and #590 **People Interviewed:** 1. Debra Green, Admissions and Placements Coordinator (APC) 2. Andrew Williams, Post-Move Monitor (PMM) 3. Juanita Taylor, QDDP Auditor 4. Daniel Dickson, Quality Assurance Director 5. Kim Littleton, Assistant Director of Programs **Meeting Attended/Observations:** 1. ISP annual planning meeting for Individual #86 2. CLDP for Individual #242 3. Post Move Monitoring Visit for Individual #108
	Facility Self-Assessment: The Monitoring Team reviewed the BSSLC Self-Assessment and accompanying Action Plans. For the most part, the Self-Assessment reported on actions taken, and often provided an evaluation of compliance based on the achievement of the desired outcomes or lack thereof. The Self-Assessment 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 continue to expand its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes. It had been reported that there remained considerable discrepancy in inter-rater findings in the Section T Monitoring Tools and that the next step in the process was to attempt to reconcile that disparity. The current process also only displayed the aggregate data without any accompanying analysis. The QA Director reported DADS State Office was going to be providing training for the QA Directors statewide on how to complete a statistical data analysis in October 2012. These issues will need to be successfully resolved in order to allow the data to be effectively used to assess actual progress toward compliance. **For Provision T1**, the Facility indicated it was in compliance with several provisions, including Provisions T1c1, T1c2, and T1c3, each of which address requirements related to the CLDP. The Monitoring Team concurred with that assessment in Provision T12, identification of Facility staff responsible for required CLDP actions, and the timeframes in which such actions are to be completed, and Provision 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 Facility also asserted compliance with Provision T1h, which requires the issuance of a Community Placement Report, and the Monitoring Team did not concur with this assessment, because there remain concerns about the reliability of some of the data as reported by the IDTs, particularly related to how LAR choice impacts referrals. The Action Steps for this Provision were often general in nature and indicated, for example, that the Facility would "ensure" that elements of the SA would occur, or that data collected would be used to develop plans. It would be helpful for the Action Steps to detail how the Facility intends to ensure the elements are achieved, as well as provide details of the plans themselves.

	For Provision T2, BSSLC stated it was in compliance with the PMM process under Provision T2a, but the Monitoring Team did not concur. The Action Plans for Provision T2 included the basic steps required to implement the process, but did not address any data-driven performance improvement actions. **For Provision T3**, no rating is required. **For Provision T4**, the Facility indicated it was in substantial compliance, and the Monitoring Team concurred.
	Summary of Monitor's Assessment: This Section was found to be not in compliance overall. A summary of noted progress included the concerted effort with the families of many children, who had previously expressed opposition to community living, to work toward movement to a more appropriate and integrated setting. The Monitoring Team was very encouraged by this development and commends the Facility for its initiative in this area. In the area of encouraging individuals to move to the most integrated setting, five referrals had been generated as result of Provider Fairs and two resulting transitions had already occurred. In addition, the APC was able to recount the experience of one of the individuals under 18 who went from booth to booth with a set of questions regarding how the providers might address her preferences. This was a very positive development, representing the desired outcome of the Provider Fair. Additional progress was noted in the implementation of the CLDP and PMM processes, although these did not yet rise to the status of substantial compliance. Transition staffing was in the process of being augmented by new Transition Specialist and Placement Coordinator positions which should enhance education and awareness of community living options as well as increase the pace of transitions once a referral is made. Significant deficits in the Facility's assessment processes continued to hamper these efforts to develop and implement adequate transition planning, however. This remained a matter of substantial concern to the Monitoring Team. Other specific findings are detailed below: **For Provision T1**, six individuals had transitioned to community living and there were 15 active referrals. The Monitoring Team did find substantial compliance in two of the provisions, T1c2 and T1c3. Respectively, these addressed the identification of Facility staff responsible for required CLDP actions, and the timeframes in which such actions are to be completed; and review of the CLDP with the individual and LAR to facilitate their decision-making regarding supports and services needed for community living. 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 in compliance with Provision T2a, but the Monitoring Team did not concur. BSSLC did not yet consistently provide an adequate assessment of the presence of supports called for in the CLDP. Significant improvement in the process was noted, however, with the advent of the new Post-Move Monitor who had completed training with the State Office. The Monitoring Team found that the PMM Checklists were completed in a timely manner. A Program Auditor was 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 was encouraged by this progress. **For Provision T3**, no rating is required. **For Provision T4**, the Facility was in substantial compliance. The Facility reported two Alternate Discharges during the past six months and both appeared to have been completed in compliance with CMS discharge planning requirements and DADS policy.

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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	Transition Outcomes During Last Six Months: • Community Transitions: There were six transitions to community living between January 2012 and July 2012. • Referrals for Community Transitions: The Facility reported that IDTs had made a total of eleven referrals for community placement between January 2012 and July 2012. BSSLC had 15 active referrals in process, according to the Community Placement Report. • Adverse Outcomes Related to Transitions: There had been few significant adverse outcomes for individuals who had moved to the community in the past six months. o Returns from Community Placement: There were no returns from a community placement for any individual who transitioned during this six month period or who had lived away from the Facility for less than six months. One individual who transitioned in May 2011 had returned to the Facility in May 2012 due to behavioral concerns. Although the individual had been away from the Facility for a year, it is still important for the Facility to evaluate all returns from community living to ascertain whether any actions might have been taken by the Facility or	Noncompliance

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	account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	the State to further support the individual's transition and/or whether there are any trends toward placement failures that should be addressed. For example, if a number of individuals began to return after around 12 months, it would be important to evaluate what lessons could be learned to improve the success rates. o Deaths Following Community Placement: There were no deaths of any individuals following a community placement who transitioned during this six month period or who had lived away from the Facility for less than six months. As documented in the previous monitoring report, there had been one death following community placement during the last year. As with returns from community placement, the Monitoring Team suggests the Facility evaluate such deaths to ascertain whether information learned could assist in improving transition planning or other State or Facility actions. o Psychiatric hospitalizations: Individual #590 had two psychiatric hospitalizations during the first 45 days after transition. o Unauthorized Departure/Police Contact/Transferred to a Different Setting: Police were contacted on two occasions as result of behavioral incidents for Individual #590, both of which resulted in a psychiatric hospitalization. o Emergency or unexpected medical hospitalizations: There were no emergency or unexpected medical hospitalizations following community transition reported during the past six months. 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 Facility had made a concerted effort with the families of many children, who had previously expressed opposition to community living, to work toward movement to a more appropriate and integrated setting. Individual #590 had already transitioned to the community and several other individuals under the age of 18 were in various stages of transition planning. The Monitoring Team was very encouraged by this development and commends the Facility for its initiative in this area. • The Facility had recently hired a Placement Coordinator as an additional staff position to assist the APC in the completion of transition activities. This staff person was in orientation during the time of the monitoring visit. In addition,	

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		the Facility was expected to soon be assigned a Transition Specialist to assist in community resource development and community awareness and education. 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 and F2ab); 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. An updated DADS Policy 018: Most Integrated setting was pending. It was reported the policy was undergoing public comment and was expected to be issued soon, following some editing. The Monitoring Team completed a review of the draft policy with the following observations: • Requirements for the provision of adequate education about available community placements for individuals and their families to enable them to make informed choices had been significantly expanded, including that the ISP provides for the IDT to follow up to determine the individual's reaction to the educational activities offered, and that the APC must, in conjunction with the Facility's administrative team, establish a plan to promote and encourage exposure to alternate living environments for Facility staff. • The policy indicated the living options discussion should include a number of key elements. Among these were 1) the supports and services needed by an individual for transition to an alternate placement or to remain in the State Center, and 2) the essential and non-essential supports and services for the individual that must be secured if an alternate setting is to be chosen by the individual and/or the LAR. It may be necessary to clarify whether it is the expectation that the second step only be completed if a referral is to be made. In the ISP meeting attended during this compliance visit, the QDDP Educator stated that the identification of supports needed in the most integrated setting would only be made if the team proposed to make a referral for community living. It is the Monitoring Team's expectation that there must be an independent determination of the most integrated setting appropriate to an individual's needs, and that the IDT will also identify the supports, services and protections that would be needed in that setting even if the IDT ultimately chooses not to make a referral. The process of identifying the needed supports and services is	Noncompliance

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		integral to determining whether a setting would be appropriate, and also serves to assist the individual and LAR to visualize how community living could be safely supported. The identification of needed services and supports is also pre-requisite to assisting the team to identify and address potential obstacles. • There was a requirement that the IDT convene every 30 days following the initial 180 day timeframe after a referral was made to discuss an obstacles to transition and identify plans/strategies to overcome those obstacles. A draft of a revised DADS Policy 004: Individual Support Plan Process was also reviewed. This policy outlined the updated ISP format and process which included the living options discussion. <u>Status of Process and Training on ISP Development:</u> Over the past six months, BSSLC had provided some additional training on topics related to ISP development. 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. As reported in Provision F2e, the QDDPs and IDTs had also received training in the updated ISP process, including the Living Options portion. 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.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies	<u>Identification by the IDT of Protections, Services, and Supports That Need to be Provided in the Most Integrated Appropriate Setting:</u> As documented in Provisions F1d, F2a1 and F2a3, the Monitoring Team found the IDT still 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. <u>Identification of and Plans to Overcome Obstacles to Transition:</u> BSSLC reported it gathers obstacle information through the ISP process, and then categorizes these using a list of DADS-approved obstacles. These included: • Individual's reluctance for alternate placement • LAR's reluctance for alternate placement • Lack of supports for people with significant challenging behaviors • Lack of availability of specialized therapy supports • Lack of availability of specialized medical supports • Lack of funding due to an individual's legal and citizenship status • Lack of specialized mental health supports	Noncompliance

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	intended to overcome such obstacles.	• Need for environmental modifications to support the individual • Need for services and supports for persons with forensic needs/backgrounds • Lack of specialized educational supports • Need for transportation modifications to support the individual The Facility also reported that lack of presence of an LA representative at the ISP meeting was no longer to be considered an obstacle to a referral being made. The revised process called for the IDT to proceed with the referral, ensuring that the LA was notified within three business days. If there were any questions or concerns on the part of the LA, a meeting with the IDT was to be held within two weeks of the referral. Overall, the Monitoring Team found that obstacles to transition were not yet appropriately identified or addressed by the IDTs. In a review of ten recent ISPs, zero of ten (0%) recent ISPs reviewed evidenced proficiency in this regard. In none of the ten (0%) were any barriers to referral noted other than LAR or individual choice. Only one of ten (10%) resulted in a referral. In none of the nine (0%) that identified LAR or individual choice as a barrier were there specific action plans developed to address the barriers. In a few instances there were some general statements about tours and Provider Fairs, but no action plans resulted. <u>Conclusion:</u> This provision was found to be not in compliance. Refer to Section F for recommendations.	
	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.	<u>Provision of Adequate Education About Available Community Placements to Individuals and Their Families or Guardians to Enable Them to Make Informed Choices:</u> 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: The Facility did not yet succeed in developing individualized plans for community education and awareness. There was little progress observed in the sample of recent ISPs reviewed. In the ISP process itself, the Monitoring Team found there continued to be little attention 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 only one of ten (10%) recently completed ISPs was there an individualized plan for increasing awareness of community living options that took into account the learning needs of the individual. Even this one plan identified was quite minimalist in its details. An Annual Provider Fair: The Facility had held two semi-annual provider fairs on January 28, 2012 and July 13, 2012. The January Fair was held on a Saturday in hopes of	Noncompliance

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		increasing family/LAR attendance, as weekday scheduling had been identified as a possible barrier for participation. The July Fair was held on a weekday. The Facility reported that five referrals had been generated as result of the Provider Fairs and two resulting transitions had already occurred. In addition, the APC was able to recount the experience of one of the individuals under 18 who went from booth to booth with a set of questions regarding how the providers might address her preferences. This was a very positive development, representing the desired outcome of the Provider Fair. Regular SSLC Meeting With Local LAs: As a practice, the APC had held Interagency Planning Meetings with local LAs and staff at BSSLC to coordinate admissions and discharges. The APC reported this practice had continued during the past six months. Education About Community Options Is Evaluated For Improvement: BSSLC did not have a consistent or formalized plan for collecting data on specific outcomes or measures related to education about community living, nor for using such information to evaluate opportunities to improve outcomes. Examples included: • IDT Action Plans: The Facility reported it was not collecting data regarding the implementation of ISP Action Plans for community awareness and education in order to ensure these receive sufficient priority by IDTs. It should develop a process to do so. Although IDTs are required to document progress and activity in the ISP monthly reviews, the reality is that much of the documentation is limited to statements such as "service provided/not provided," to the extent that it is not useful in developing future community awareness strategies. It was also very concerning that the Facility had been eliminating Staff Service Objectives (SSOs) for community outings as described in Provision F2a1 and merely incorporating community activities as a general item in an individual's daily schedule. The impact of this would likely be that community integration activities would provide even less structured and goal-oriented community education and awareness related to community living options. The Facility recognized this unintended effect, but should take action to review the eliminated SSOs, even expanding upon them to incorporate community education and awareness needs and objectives. In many, if not most, instances, a structured SAP would be more appropriate than an SSO. • CLOIP: As indicated in previous reports, the annual LA CLOIP process continued to comprise a significant portion of the Facility's overall plan for education and awareness for individuals. The Monitoring Team reviewed a sample of eight CLOIP Worksheets for recent ISPs. For one of the seven (14%) in which the LA was permitted to engage the individual, the LA Service Coordinator was able to document the individual had any interest in or meaningful response to the materials or information being offered. In each of the eight reviewed, the LA	

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		Service Coordinator actually documented the individual did not seem to comprehend, even in the case of the individual who offered a response. This would indicate DADS needs to assess how the process, materials and/or information might be modified to more effectively meet the needs of the individuals. • Community Tours: As described further below, the Facility did not yet have a consistent or formal process for documenting and/or evaluating the community tour process. Tours Of Community Providers: In the past six months, there were 14 community tours reported. There did not yet appear to be a consistent, formalized process in place at the Facility to fashion these tours as a part of an individualized community living awareness and education plan. The APC confirmed this to be the case and indicated the Facility still needed to work to make the tour experiences into a meaningful learning event. Specific findings regarding community tours included: • Opportunities to go on a tour available to all (except those individuals and/or their LARs who state that they do not want to participate in tours): There did not yet appear to be a consistent, formalized process in place at the Facility for ensuring opportunities for community tours were available to all. In the past six months, a total count of 33 individuals participated in CLOIP community tours, a number which is slightly more than ten percent (10%) of the population of the Facility. 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 299 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. • Places chosen to visit are based on individual's specific preferences, needs, etc: An individualized education and awareness plan should define the types of settings to which an individual may need exposure to facilitate his or her understanding of community living options. There was no consistent or formalized process described for choosing tour sites based on individual preferences and needs. The Monitoring Team noted, however, that the intensified attention to the community living needs of children under 18 tended to take a more individualized approach. This was a positive development. • Size of tours: The number of individuals attending a single tour may have a significant impact on the learning experience for the participants, as well as the ability of staff to gauge individuals' reactions and respond appropriately to facilitate learning. During the past six months, tour sizes at BSSLC ranged from	

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		one individual up to five. Overall, the size of tours at the Facility appeared to be conducive to both individual learning and assessment of responses. • Individual's response to tours assessed: A careful and thoughtful assessment of an individual's reactions to a community tour is necessary to an understanding of personal preferences, as well as to further guide the IDT in the development of an individualized community awareness plan and of a vision for living in the most integrated setting. There was no consistent or formal process described for making an assessment of an individual's response to the tour experience unless the individual had been referred for transition planning. Opportunities Are Provided To Visit Friends Who Live In The Community: No evidence was provided as to the provision of such opportunities for individuals to visit friends who live in the community. Education Provided In Various Venues: The Facility did hold self-advocacy meetings for adults and youth, but a review of the minutes for the past six months indicated there had been no focus on community living options. A Plan For Staff To Learn More About Community Options: Some educational opportunities about community options had been provided through staff participation in community tours, community exploration activities for individuals, and transition related visits. During the six months since the last monitoring site visit, the Facility documented 82 staff participating in such activities, including tours, and accompanying individuals on pre-placement exploration. It was positively noted that a wide variety of staff participated in these activities, including direct care staff, QDDPs, nursing staff, psychology staff, social workers, habilitation therapy staff, job coaches and even a dental hygienist. Staff also had the opportunity to attend the annual LA inservice and the semi-annual Provider Fair. The most recent LA Annual Inservice was held on June 22, 2012. Its stated objectives were to provide information about community services and supports; to help individuals, staff and family members better understand the living options/referral process; to reinforce the DADS expectations in regards to community placements; and, to prepare individuals, staff and family members for interaction with the LA. Individuals And Families Who Are Reluctant Have Opportunities To Learn About Success Stories: No evidence was provided as to the provision of such opportunities for individuals and families/LARs to learn about success stories. The APC indicated this would be one of the responsibilities of the new Placement Coordinator.	

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		Conclusion: 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.	
	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 ISP format and process had been recently updated. It included specific sections for consideration of living options, specifically requiring 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. IDT members were not yet implementing this in an adequate manner. This is discussed in more detail in Provision F1e above. The updated 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. IDT members were to provide a recommendation regarding the most integrated setting in their individual assessments, but this was not yet consistently occurring. This is discussed in more detail in F1e above. Percentage of Individuals Assessed as Required: The process in use at the Facility to assess individuals for community living remained inadequate to qualify as an assessment for community placement; therefore, the Monitoring Team found that no individuals (0%) had been adequately assessed for placement. Conclusion: This provision was found to be not in compliance. The Monitoring Team found there was not an adequate formal assessment process that included a substantive interdisciplinary evaluation and discussion. This was consistent with the Facility's own	Noncompliance

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		evaluation of their assessment process.	
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	CLDP Policy and Process: There were no changes reported to policies related to the CLDP, although the revised Policy 018 was pending release. The APC was responsible for coordination of the CLDP process, in collaboration with the individual's IDT. Timeliness of Development and Implementation of CLDP: The CLDP was to be initiated at the time of referral and was to be updated on an ongoing basis as circumstances required. Documentation indicated CLDPs were typically initiated upon referral. The Monitoring Team also reviewed the Community Placement Report, dated June 25, 2012. Four of the 15 (26%) current referrals had exceeded the 180 days allowed in the current policy and pending revision. Four of the six (66%) community placements that occurred exceeded 180 days from the time of referral. 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. This review did not always document that the delays were of this nature, however. The Monitoring Team reviewed six CLDPs in process to evaluate whether the Facility was compliant with its policy to document transition activity on an ongoing basis. In five of the six (83%), the documentation reflected a lack of timely action or follow-up on transition activities: • For Individual #273, the IDT indicated the selection of a provider as the appropriate setting on 4/25/2012. No additional activity had been documented since that time. • For Individual #181, the referral was made in July 2010 and a trial visit was documented in January 2011. No additional documentation was available in the CLDP. • For Individual #442, it was stated a provider was selected on April 4, 2012, but no other information had been documented. • For Individual #173, the original referral was made in June 2010 and the CLDP was initiated using the older format which did not require documentation of all steps of the process. The only documentation made available for review was the recent ISP that indicated the individual was on a waiting list for a group home in El Paso, but there was no activity documented since summer of 2011. In addition to considering what actions the IDT needed to take at this time, the Facility should update the CLDP to be consistent with current policy requirements.	Noncompliance

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		• For Individual #492, the last documented activity was attendance at a Provider Fair in January 2008. 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 Provision T1f. 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. This should be accomplished in conjunction with the provision of the revised Policy 018 that requires the IDT to meet every 30 days once the initial 180 days has expired. <u>Development of CLDP in coordination with the LA:</u> A review of completed CLDPs indicated that three of three (100%) evidenced that the plan was developed in coordination with the responsible LA. In addition to participation in the referral meeting, the LA attended the CLDP meetings and completed the Continuity of Care-Move Site Review Instruments for the Community Living Discharge Plan as further described in Provision T1e below. <u>Conclusion:</u> Provision T1c as found to be not in compliance. 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. However, there were a number instances in which placements did not occur within the 180-day requirement, and in several of these the documentation did not reflect timely action and follow-up. The APC should develop and monitor a tracking list and make follow-up with IDTs to ensure timely actions when necessary. Coordination with the LA 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, primarily in the failure by the IDTs to adequately identify the appropriate essential and nonessential supports for each individual. These deficiencies are described in more detail in Provisions 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 (supports that must be in place at the time of the move) and non-essential (supports that may be put into place following the move) 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. This was problematic because IDTs did not yet demonstrate	Noncompliance

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		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. This general lack of proficiency in assessment and integrated planning translate into a CLDP that does not sufficiently identify the essential and nonessential supports each transitioning individual will need. The Monitoring Team also found in a review of three CLDPs that none (0%) included any specific recommendations as to opportunities for new skill development that would be presented in a community living option. Examples of the failure to integrate assessment findings into a comprehensive support plan in the most integrated setting included: • For Individual #375, there were at least several instances in which the IDT did not sufficiently consider needs and preferences and then include adequate strategies in the CLDP. o The individual wore shin guards. The individual's need for this equipment was predicated on a history of skin integrity issues related to venous insufficiency. The assessments indicated in various places that skin breakdown was a result of the individual rubbing the heel of shoe against the shin, and frequent bumping into things. This information was gleaned by reading through the large packet of assessments. It was unclear whether both representations of the cause were correct. In any event, the listing of supports indicated only that shin guards and padded pants were to be worn at work. There was no inservice in the essential or nonessential supports to inform the provider staff of the use of the equipment or the reasons for its use, nor was there a clear explanation in the CLDP Profile or Findings and Observations sections. In fact, the summary of the OT /PT assessment in the Findings and Observations section further confused the issue by stating the shin guards and padded pants might not be needed under certain circumstances. It is not realistic to expect that provider staff will read all of the assessments, particularly since it has been observed the provider homes often do not have copies of these, but it is essential they have an understanding of why a support is needed and how and when it should be implemented. o Section II Community Referral Process indicated the individual enjoyed attending church and would need to have access to a place of worship. This was not referenced in the CLDP nor was it included in the non-	

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		essential supports. o The Person-Directed Planning section indicated the individual would like to learn more about self-advocacy and join a self-advocacy group. This would be a good opportunity for an individual to make new friends in the community and to continue to learn self-advocacy skills. This was not addressed in the non-essential supports. o The Person-Directed Planning section also indicated the individual preferred paid work to have enough money to buy preferred items. The CLDP indicated paid work was not important, but rather a socialization activity, and included only a day habilitation program as a non-essential. The IDT should have documented a much more robust consideration of this issue to at least resolve the discrepancy. • For Individual #590, the Person-Directed Planning section indicated the individual was good at singing, enjoyed going to church and singing in church. These would be excellent opportunities to take something the individual enjoys and feels is a personal strength to assist the individual to become integrated in the community and form new relationships. These preferences and strengths were not addressed in the supports needed or transition. There were some signs of progress in this area. The Monitoring Team attended the single CLDP meeting held during the site visit, for Individual #242, and observed that the IDT process was much improved from the previous visit. There was more interdisciplinary discussion. For example, the team physician played a much more active role and discussed in some detail the PNMP and its essentially dynamic nature, requiring updating on a regular basis to ensure the individual was safe from falls, aspiration, etc. The team also had a good discussion of the uses of the communication dictionary and how it could be used for specific purposes such as how changes in volume of a certain sound could indicate an ear infection. The team also was fairly insistent on a face-to-face inservice by habilitation therapy in addition to the usual video training. On the other hand, in many instances the team could have provided much clearer descriptions of certain supports. One example of this was the need for a "PICA aware environment" which was not yet well-defined to the extent that the provider staff would have a good understanding of what they needed to do. The psychology staff indicated an environmental checklist was being developed, but it was not yet available. It would have been important to have the requirements to be included in this checklist in order to determine whether there were essential and nonessential supports that needed to be noted, particularly keeping in mind that these supports would be checked prior to the individual's movement. As a result, the essential supports listed a PICA aware environment as evidenced by the presence of the checklist and documentation of	

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		inservice. It did not include any specific "PICA aware" needs that could be evaluated for presence prior to the move. There was also some progress noted in the description of the evidence that was required to demonstrate a support was adequately in place. The teams more often identified evidence beyond written documentation than in the past, including observation and staff interview, but it still was seldom specified what the observation or staff interview should reveal. Sometimes this appeared to be self-evident, but in many cases it was not. This was true in both the CLDPs reviewed and the CLDP observed. This is important because the Post-Move Monitor cannot be expected to have expertise in every area; he must rely on the expertise of the team to explicitly define what he should observe and what staff should be able to explain about the supports to be provided. The Monitoring Team provided some technical assistance to the IDT in this area to assist them to provide more ample detail for the Post-Move Monitor to refer to. <u>Coordination of CLDP with provider staff:</u> A review of three 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. The Facility had continued to use this section to document an agreement that would ensure the provider was willing to cover the medications if a lapse were to occur following the depletion of the 30-day supply from BSSLC. <u>Conclusion:</u> 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.	<u>Responsible staff identified for needed actions:</u> For three of three (100%) completed CLDPs reviewed, the Facility consistently identified the Facility staff responsible for each of the essential and non-essential supports. Only rarely were specific responsible parties listed by name. It was clear that Facility staff had been assigned responsibility to monitor and/or follow up with the designated provider staff to ensure implementation and/or timeliness for each and every support. <u>Completion timeframes for needed actions identified</u>: For three of three (100%) completed CLDPs reviewed, the Facility did consistently identify timeframes for completion for each of the essential and non-essential supports. <u>Conclusion:</u> This provision was found to be in substantial compliance.	Substantial Compliance
	3. Be reviewed with the	<u>Review of CLDP with Individual and, as appropriate, the LAR:</u>	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.	A review of both 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 IDT and the community provider would need to develop an appropriate transition plan. 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 Facility was taking some action to improve the quality of ISP assessments by requiring that departmental and discipline heads review completed assessments, but this was not yet being consistently implemented as described in Provision F1c. The Monitoring Team strongly recommends the Facility take all necessary actions, 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 continued a positive practice identified during the previous monitoring site visit, a "pre-CLDP" meeting to review assessments and make assignments for any updates or revisions that needed to be made to the current assessments. 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 continue 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.	LA Continuity of Care Process: The Monitoring Team reviewed three LA Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan and found that these appeared to have been completed in accordance with policy expectations. Pre-Move Site Visit Completed by Facility: BSSLC had also been completing Pre-Move Site Reviews, as required by policy. The APC was designated as the responsible Facility staff for completion of the Pre-Move Site Visit. No such visits were conducted during the monitoring visit, so the Monitoring Team was not able to observe the process but rather relied upon documentation to assess compliance. Reviews for Pre-Move Review Site Reviews for individuals who had moved to a community home since the last monitoring visit indicated 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 called 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 three of three individuals (100%). The Facility did verify that the stated essential supports were present and documented a due date for implementation of non-essential supports that were not yet in place. In some cases, the documentation of a due date could not be said to represent an actual plan, however, and the Monitoring Team also often found that the Facility did not obtain a concrete plan for supports that were to be implemented between the 7-Day and 45-Day visits as described in Provision T2a below. As a result, it was often not possible to verify some non-essential supports were being implemented until well after their due date. The rationale for obtaining a plan from the provider rather than just indicating that a support is not yet due is to avoid such gaps. The Facility should ensure it obtains detailed information from the provider as to the plan for implementation. The Facility's ability to diligently ensure the presence of supports continued to be hampered by the failure of the IDT to provide an adequate assessment of each individual's support needs and to use assessment findings to develop an adequate support plan. For example, as discussed above in Provision T1c1, Individual #590 was reported to consider one of her strengths to be singing and that she particularly enjoyed combining this with attendance at church. The IDT failed to capture this information from the assessment process and identify a support that could have facilitated the individual's integration and adjustment in her new environment. While the supports listed in the Pre-Move Site Review may have been checked off, these did not constitute a sufficiently comprehensive reflection of the individual's actual support needs,	Noncompliance

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		Conclusion: This provision was found to be not in compliance. This provision also relies on supports and evidence having been adequately identified in the CLDP comprehensive assessments and the Monitoring team did not find this to be the case, as described under Provisions T1c1 and T1d, further resulting in a finding of 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 implements the portions of the plans for which the Facility is responsible, consistent with the provisions of this Section T.	Quality Assurance Processes to Ensure Development of CLDPs: QA procedures related to ensuring the development of CLDPs remained essentially unchanged since the last monitoring visit. • A QA Auditor was assigned to monitor Section T. Data was aggregated and displayed, but not yet analyzed and used for quality improvement. • The APC tracked the provision of the 45-Day assessments by the various disciplines. Quality Assurance Processes to Ensure Implementation of CLDPs: There were several quality assurance practices in place related to the implementation of the CLDP. The Facility's QA Department reported it had been completing Section T Monitoring Tools since January 2012. The Pre-Move Site Review conducted by the APC 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 practice, as the existing LA pre-move site visit did not focus heavily on ensuring specific supports were in place. A Program Auditor had been assigned to accompany the Post-Move Monitor on PMM visits to monitor the accuracy of the findings. Trends and Improvement Actions: It was reported that there remained considerable discrepancy in inter-rater findings in the Section T Monitoring Tools and that the next step in the process was to attempt to reconcile that disparity. The current process also only displayed the aggregate data without any accompanying analysis. The QA Director reported DADS State Office was going to be providing training for the QA Directors statewide on how to complete a statistical data analysis in October 2012. 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.	Noncompliance
T1g	Each Facility shall gather and analyze information related to	Obstacle Information Gathered: The APC gathered data on the identified obstacles to individuals' movement to more	Noncompliance

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	identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	integrated settings, consistent with their needs and preferences. These were reported to DADS on a quarterly basis. <u>Annual Obstacle Analysis by Facility:</u> The APC had previously written an assessment report regarding these obstacles, with data through 8/31/11. 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. These included: • 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 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.	

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		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). Conclusion: 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. The Monitoring Team looks forward to reviewing the upcoming Annual Report in order to assess progress in this area.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community	Timeliness: The Facility issued a Community Placement Report on June 25, 2012, covering the period of 2/1/2012-6/25/2012. The report was issued in a timely manner. Required Reporting Categories: The report was in the standardized format as prescribed by DADS State Office. It listed: • Six community placements • Fifteen current referrals • No rescinded referrals • Three individuals who preferred community, not referred-LAR choice • Two individual who preferred community, not referred-other reason • No individuals for whom the LAR prefers community, not referred. Reporting on Individuals not referred due to LAR choice: It was not clear that the data provided in the category of individuals who preferred community, not referred-LAR choice, was accurate, as it did not appear to fairly represent the scope of LAR choice in a team decision not to make a referral. While the Community Placement Report listed three individuals who preferred community but were not referred due to LAR choice, the Facility provided an additional document which indicated 146 individuals were not referred due to LAR Choice. The Monitoring Team again 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 only one of ten (10%) recent ISPs was the Monitoring Team able to find the independent judgment of the IDT clearly documented. Conclusion: This provision was found to be not in compliance. The report was made in a timely fashion but the Monitoring Team notes its concern related to the accuracy of some	Noncompliance

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	Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	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.	<u>Policies and Procedures related to Post-Move Monitoring:</u> The Facility reported there had been no changes or additions to policies related to Post-Move Monitoring. No significant modifications from current practices were indicated in the pending update to DADS Policy 018. <u>Staffing:</u> A new Post-Move Monitor had been hired in November 2011. This new staff person had been a QDDP at the Facility prior to taking on the Post-Move Monitor role. In addition to training reported in the previous monitoring report, the Post-Move Monitor had received training from State Office and mentoring from the DSSLC Post-Move Monitor. The Facility had also assigned a QA Auditor to accompany the Post-Move Monitor on all PMM visits as a reliability check. Overall, there had been considerable improvement in the diligence with which post-move monitoring was being implemented. <u>Timeliness of Visits and Completion of Assessment</u> The Monitoring Team reviewed PMM Checklists for four individuals who had moved to the community since January 2012 and interviewed the APC, the Post-Move Monitor and the QA Auditor. 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. Each of the 7, 45 and 90-day PMM visits were made within the required timeframes. 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. Assessment of Presence of Supports Called for in CLDP: In many cases, the PMM Checklists reviewed during this compliance visit appeared to include a verification that	Noncompliance

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		each support was in place and being implemented. If there were supports that were not in place as required, the Post-Move Monitor had often taken actions and maintained a record of emails and phone logs that documented follow-up and loop closure. While significant improvement in the process was noted, BSSLC did not yet consistently provide an adequate assessment of the presence of supports called for in the CLDP. Deficits identified in the process of assessing the presence of supports included: • There were a number of 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. • For Individual #32, the Post-Move Monitor did not document any testing of staff knowledge of the use of the communication book on the 7-day or 90-day visits, nor did he complete the required meal observation on the 7–day or 45-day visit. • For Individual #598, the Post-Move Monitor did not document the prescribed staff interview as to the use of adaptive equipment on any of the three visits. • As described in Provisions F 1c, F1d, F2, and T1c1, there 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 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. As described in Provision T1c1, the Monitoring Team again provided technical assistance to the IDT to think through the various types of evidence that could ensure the supports were being adequately implemented. The Monitoring Team was pleased to see, as recommended previously, the Post-Move Monitor taking a more active role in ensuring the supports identified in the CLDP were appropriate and measurable, and that the IDT prescribed sufficient and appropriate methodology for obtaining evidence that supports are being implemented as required. <u>Facility's Best Efforts to Ensure Supports are Implemented:</u> The Monitoring Team found there was considerable progress noted in the Facility's processes for taking and documenting actions to ensure supports were being implemented as required. Documentation of the presence of supports was often made in writing and a more comprehensive file that included documentation of follow-up actions taken by the PMM was kept. There were instances in which the Post-Move Monitor failed to document any follow-up	

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		when prescribed supports were not in place. For example, documentation of the plans in place to implement supports that have due dates following the PMM visit were not consistently adequate, and follow-up was only to be at the next visit. In another example, for Individual #375, the diet texture was changed from the recommended ground meat to regular chopped. There was no evidence that the IDT reviewed this decision and whether it was consistent with the health and safety concerns that prompted the original diet texture to be prescribed. Conclusion: This provision was found to be not in compliance. The Monitoring Team commends the Facility for the progress it had made in ensuring the PMM process was implemented in a sufficiently rigorous manner.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	Observation of Post-Move Monitoring Visit: In order to further assess the Facility's assertion that it had achieved compliance in this provision, the Monitoring Team accompanied the Post-Move Monitor and QA Auditor on the 45-day PMM visit for Individual #108. Prior to the visit, the CLDP and accompanying assessments were reviewed. The Monitoring Team noted the improvement in the Facility's implementation of the PMM process described in Provision T1 above was evident in the observed visit as well. The Post-Move Monitor approached the process in a much more methodical manner than the Monitoring Team had observed at BSSLC in the past. He also described his approach as being designed to develop a partnership with the provider staff so that there would be good ongoing communication to report any concerns and/or needs for technical assistance. This was a commendable approach overall, although the Monitoring Team cautioned that the desire to create a comfort level with provider staff not prevent the detailed and sometime repeated questioning that must take place over the course of the 90 day PMM period. There remained some deficits in the PMM process noted during this monitoring visit that require attention. Examples included: • The Post-Move Monitor did not complete a thorough review of the documentation of the individual's home file. He did review the Medication Administration Record (MAR) and the program file at the day program, but did not ask to see the home file even though there were questions about the extent of seizure activity and how to intervene (see next bullet.) The home file also had information about the individual's adjustment on a daily basis, interaction with family, etc. The Post-Move Monitor relied solely on provider staff interview for this information. The QA Auditor did not ask to see the file either; the Monitoring Team prompted this at the conclusion of the visit. • Provider staff in the individual's home did not know the proper procedure for using the Vagus Nerve Stimulator (VNS) device to assist in seizure control. He	Noncompliance

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		understood how it was supposed to be swiped, but did not know if the procedure could be repeated if the seizure activity continued. The Post-Move Monitor did address this issue appropriately to an extent, but did not go far enough. He inquired as to whether the staff person had received inservice training for the proper use of the device and received an affirmative response. The Post-Move Monitor's response was to indicate he would contact the IDT's nurse to obtain this information. The Post-Move Monitor did not display any personal knowledge of the extent of the training, and did not consult any documentation that might have been available at the home, or any in his own file. The Monitoring Team was able to find the specific direction in the CLDP that allowed for the VNS swipe to be repeated. The Monitoring Team's concern in this area was the failure of the Post-Move Monitor to review available documentation. The Monitoring Team was encouraged, however, by the Post-Move Monitor's recognition that this lack of knowledge on the part of the staff indicated a need for re-inservice by BSSLC. • The Post-Move Monitor did not recognize that locked egress at the day program was a safety code violation and a rights concern. He was prompted by the QA Auditor before leaving to address the matter. This may indicate a need for some additional training for the Post-Move Monitor in these areas. The Monitoring Team also appreciated that the QA Auditor waited for the Post-Move Monitor to complete the visit before prompting his attention to this matter and would recommend this approach be followed in all instances in which health and safety would not be otherwise compromised. This will allow for a more accurate assessment of the Post-Move Monitor's own competencies. • The Post-Move Monitor interviewed the individual as to his satisfaction with his new home, but did so in the company of the provider staff and other individuals. This interview should take place in private, as individuals who depend on others to meet their daily needs may not feel comfortable or safe in expressing dissatisfaction or concerns in the presence of those staff. <u>Conclusion:</u> This provision was found to be not yet in compliance, but the Monitoring Team was very encouraged by the evident diligence of the Post-Move Monitor and the improvement in the process overall.	
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		Not Rated

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	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 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	<u>Number and Categories of Alternate Discharges:</u> BSSLC reported two alternate discharges during the past six months. Both individuals transferred to other SSLCs. <u>Compliance with CMS-required Discharge Planning Procedures:</u> The Monitoring Team reviewed the discharge packets for each of the individuals for consistency with CMS-required discharge planning procedures as well as with protocols established in DADS SSLC Draft Policy 019: Most Integrated Setting Practices, undated. The latter policy described a procedure and provided a format for a Discharge Reassignment Summary. Each appeared to be prepared in a manner consistent with all requirements. <u>Conclusion:</u> This provision was found to be in substantial compliance.	Substantial Compliance

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	vacating the commitment order.		

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

1. The Facility should continue to expand its internal quality assurance processes, including the development of additional measures, to assess ongoing progress toward completion and the actual outcomes.
2. The Action Steps in the Self-Assessment should detail how the Facility intends to ensure specific elements of the SA are to be achieved, as well as provide details of plans to be developed rather than simply stating the intent to develop them. (Self-Assessment)
3. (Self-Assessment)
4. Clarify whether it is the expectation that the IDT will also identify the supports, services and protections that would be needed in that setting even if the IDT ultimately chooses not to make a referral. (Provision T1b)
5. 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)
6. The Facility should examine how it might expand on the CLOIP tour process to make more such opportunities available to individuals. (Provision T1b2)
7. 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)
8. 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. BSSLC also needed to continue to focus its attention on whether CLDP assessments were adequately prepared. (Provisions T1b and T1d)
9. 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)
10. For those CLDPs that were initiated under the previous policy requirements, the Facility should update the document to be consistent with current policy requirements. (Provision T1c)
11. The Agreements section of the CLDP may be used creatively to ensure adequate supports, services, and protections are provided and maintained. (Provision T1c1)
12. The Facility should ensure it obtains detailed information from the provider as to the plan for implementation of all non-essential supports. (Provisions T1e and T2a)
13. 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)
14. DADS and the Facility should examine the accuracy of data in the Community Placement Report, particularly related to the number of individuals who prefer community living but are not referred due to LAR choice. (Provision T1h)

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Brenham State Supported Living Center (BSSLC) Self-assessment 07/12/2012 2. BSSLC Action Plans, dated 07/06/2012 3. Brenham State Supported Living Center Presentation for July 2012 for Settlement Agreement Monitoring Team Visit 4. Section U Presentation Book materials 5. DADS Policy 019: Guardianship, effective 3/7/2012 6. DADS Policy 057: Self-Advocacy, effective 5/30/12 7. The most recent prioritized list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and a LAR to render such a decision, dated 04/20/2012 8. Since the last review, a list of individuals for whom an LAR or advocate has been obtained 9. Over the six months preceding the monitoring visit, documentation that reflects the activities of the Facility to obtain LARs or advocates 10. Rights Assessment form, dated 05/07/10 11. Rights Assessment, Form 6614, dated September 2011 12. Completed Rights Assessments for Individuals #68, #185, #226, #260, #288, #334, #422, #446, #548, and #576 13. Self-Advocacy Minutes for the past six months **People Interviewed:** 1. Cheryl Powell, Human Rights Officer (HRO) 2. Daniel Dickson, Quality Assurance Director **Meeting Attended/Observations:** 1. ISP for Individual #86
	Facility Self-Assessment: The Monitoring Team reviewed the BSSLC Self-assessment. BSSLC indicated it was not yet in compliance with any of the provisions for Section U. The Monitoring Team concurred with this assessment. In the previous report of the Monitoring Team, it was recommended the Facility a consider what outcome and/or performance measures it would use to assess progress once policies were in place and being implemented, with the idea that these measures could then be used to support the self-assessment process in the future. This recommendation is continued. The Facility indicated it was not in compliance with Provision U1 due to the lack of a Functional Assessment Tool. While it is true the lack of an appropriate methodology for determining an individual's capacity for decision-making is a significant factor in a finding of noncompliance, there are a number of other findings that affect compliance as well. Similarly, the Facility indicated it was in noncompliance with Provision U2 based on the number of individuals without an LAR or Advocate. The Monitoring Team's assessment of compliance would place more emphasis on the appropriateness and vigor of the efforts to provide individuals with the level of assistance in decision-making that each one needs, rather than basing it on an arbitrary number. The Facility should further assess the performance indicators it plans to use.

	The Facility's Action Plans for Section U included a number of completed actions related to providing training to QDDPs and Social Workers on guardianship and informed consent, developing a monitoring tool for Section U, and continuing to develop an Advocacy program. The Facility should further update its Action Steps to address the requirements of the recently promulgated Guardianship and Self-Advocacy policies. This should include, in addition to the development of a localized policy, identification of measurable performance indicators by which the Facility may assess its progress toward compliance in this area.
	Summary of Monitor's Assessment: This Section was not yet in compliance. A summary of noted progress included the issuance of statewide policies on guardianship and self-advocacy. The Facility had begun to take some beginning steps toward implementing the requirements of the policy, such as recruitment of members for the Guardianship Committee, and the development of materials to be used for staff training. The Facility continued to provide support for self-advocacy and had begun using some formal choice-making materials as a part of its self-advocacy activities. The Facility also continued to develop its capacity to provide advocates for individuals as an alternative to guardianship. Specific findings for each provision are as follows: **Provision U1:** This provision was found to be not yet in compliance. DADS State Office had issued a new policy, DADS Policy 019: Guardianship, effective 3/7/2012, with five Exhibits, that provided some guidance to the Facility in the development and maintenance of a prioritized list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision. The Monitoring Team remained concerned that the new policy, while requiring IDTs to make an assessment of an individual's decisional capacities, provided little to no guidance as to how this assessment should be accomplished. The policy did not address the standardized tools or methodology IDTs should use to assess and prioritize the need for an LAR, an advocate or other assistance an individual might need in decision-making. The Facility had not yet localized DADS Policy 019. BSSLC had begun to take some actions in the past six months to implement the requirements of this provision. The Facility maintained a prioritized list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision, but still did not use any standardized process or tool for purposes of making a judgment about such capacity. **Provision U2:** This Provision was found to be not in compliance. There was little activity toward the solicitation of guardians for individuals during this review period. It was reported no guardians had been obtained. The Facility had completed recruitment of members for its Guardianship Committee, as called for in the DADS Policy, but had not yet held its first meeting. As the Facility operationalizes its Guardianship Committee and other components of the new policies toward the solicitation of guardians, it continues to need to ensure it has an appropriate methodology in place to determine the actual need for guardianship. A new DADS policy on Self-Advocacy had recently been issued, and BSSLC did continue to provide support for self-advocacy, including incorporation of the use of some formal choice-making

	curriculum as had been recommended in the past. The Facility was also continuing to develop its advocacy program.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	<u>Policies and Procedures related to functional capacity to give consent and/nor need for LAR:</u> DADS State Office had issued a new policy DADS Policy 019: Guardianship, effective 3/7/2012, with five Exhibits. The stated purpose of this new policy was "…to ensure that individuals residing in State Supported Living Centers (SSLCs) and their legally authorized representatives (LARs) and correspondents are made aware of guardianship services available in Texas and to identify those individuals without a LAR who would benefit from having an LAR to help them make decisions regarding treatment and programming." The draft policy did not provide substantial guidance to the Facilities and the IDTs in how to assess an individual's decisional capacities and/or need for guardianship. No standardized tool or process was described for IDTs to use in making these determinations. Rather, the policy stated "… (T)he IDT discusses individual decision-making abilities and guardianship need at the annual IDT meeting for each individual residing in the State Center." In Exhibit A: Procedures, the only guidance to the Facility is that the IDT will review the individual's capacity to make decisions regarding his or her health and welfare at the annual meeting Policy 019 did address other requirements pertinent to Provision U1, including the development and maintenance of a prioritized guardianship list. The policy stated that the "IDT" would prioritize the guardianship list, but also assigns responsibility for "developing, prioritizing and maintaining" the list to a Guardianship Committee. Exhibit A: Procedures also indicated it would be the responsibility of the Committee to make the prioritization. DADS should clarify its intent. The prioritization criteria contained in DADS Policy 019 were identical to the requirements in the SA, including those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources. The policy indicated that individuals would be assigned to one of three priority levels, depending on the number of factors that pertained to them. Priority I was to be assigned to individuals who met three of four criteria, Priority II to those who met two of four, and Priority III to those who met one of four. Exhibit A: Procedures calls for the Guardianship Committee to consider the following criteria: whether the individual has an actively involved person to advocate for him or her; a pattern of injury, abuse or neglect; receives or is proposed to receive a	Noncompliance

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		restrictive program; receives psychoactive medication; has serious, ongoing medical needs; and/or has severely impaired communication. It was not clear how these two sets of criteria were meant to be integrated. DADS should clarify its intent in regard as well. The Monitoring Team remained concerned that the new policy, while requiring IDTs to make an assessment of an individual's decisional capacities, provided little to no guidance as to how this assessment should be accomplished. The policy did not address the standardized tools or methodology IDTs should use to assess and prioritize the need for an LAR, an advocate or other assistance an individual might need in decision-making. Facility's IDTs continued to need guidance and training from DADS to prescribe a process for how an assessment should be accomplished to determine a person's specific range of decision-making abilities so that guardianship does not extend beyond the areas needed by the person. Additionally, guidance should be provided as to how, and how often, a need for guardianship should be periodically reviewed. It was reported that a workgroup continued to work toward developing such guidance but there was no known projected date for formal issuance of an approved Rights Assessment methodology from DADS. Since the guardianship policy requires the teams to make this capacity determination, it would seem to be essential that the guidance be provided at the same time the guardianship policy is implemented. Otherwise, the Facility runs the risk of inappropriately identifying need for guardianship that, if acted upon, could result in an individual unnecessarily losing rights to make and/or participate in his or her own decisions. The statewide policy also called for the HRO to maintain data, including a list of individuals without an LAR; names and priority levels of individuals referred to the Guardianship Committee; status of the referrals; and dates guardianships were secured. These data were to be entered into a DADS statewide database. In addition, the Facility was to make monthly progress notes regarding the status of individuals referred to the Guardianship Committee. <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. The Monitoring Team also reviewed the list for timeliness of updates to the list and the prioritization process. • <u>Timeliness of Updating Process:</u> The HRO reported the list was updated each Monday. The Monitoring Team reviewed a list dated July 23, 2012. • <u>Prioritization Criteria</u>: The Facility stated it continued to use the same prioritization criteria as previously reported, although the list provided did not	

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		indicate the priority level each individual was assigned. The Facility should correct this oversight. <u>Assessment of Functional Capacity to Render a Decision:</u> The Facility did not routinely use standardized or valid instruments and/or processes to assess functional capacity, so the decision to place someone on the prioritized list was still without a sound basis for the most part. During the past six months, the IDTs continued to address the ability of an individual to provide informed consent using the annual Rights Assessment dated 05/07/10, but this process was not predicated on any objective criteria. The Monitoring Team requested for review the most recent ISP for each residential unit, including the Rights Assessment. For ten of the ten reviewed (100%), the IDT concluded the individual was unable to give informed consent in any of the six areas listed. There was no specific basis offered for this determination in the way of an individualized assessment of the individual's decision-making capacity. In five of ten (50%) instances the IDT made some attempt to provide a rationale for the determinations, but these were not based on any valid formal assessment process. In none of the ten Rights Assessments (0%) did the IDT document any strategies to improve the individuals' decision-making skills. This finding was borne out in observations made by the Monitoring Team of the ISP meeting held during the site visit. For Individual #86, the IDT did not undertake any significant discussion regarding decision-making capacity or strategies to enhance participation in decision-making as they pertained to the ability to provide informed consent. <u>Conclusion:</u> This Provision was found to be not yet in compliance. The Facility did maintain a list of individuals it deemed to be in need of a guardian that was updated regularly, but the determination of need was not predicated on any formal or standardized process or tool. The Facility reported it was using the prioritization criteria as described in new policy but the list provided for review did not indicate the assigned priority.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs,	<u>Policies and Procedures related to obtaining LARs for individuals in need:</u> DADS Policy 019: Guardianship, effective 3/7/2012, also provided guidance and protocol as to obtaining LARs for individuals who may need one. The Policy designated the Facility HRO to act as the Guardianship Coordinator. Specific duties of the Guardianship Coordinator include the following: • Establishing a Guardianship Committee that meets regularly to discuss guardianship needs at the State Center; • Working with the QDDP Coordinator and QDDPs to develop and maintain a prioritized guardianship list of individuals in need of a guardian;	Noncompliance

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	through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	• Providing information to the State Center's Parent/Family Association members regarding alternatives to guardianship and local guardianship programs and resources; • Sharing appropriate information regarding individuals in need of a guardian with local guardianship programs as permitted by law; • Soliciting information from local guardianship programs regarding community supports available to assist with guardianship fees, court costs, and other expenses; and, • Organizing an annual guardianship in-service for individuals, families, staff and other interested parties to discuss guardianship, alternatives to guardianship, the benefits and disadvantages of guardianship, limitations to guardianship, types of guardianship, who can and cannot be a guardian, and other relevant topics. The Policy also required the Facility to develop a Guardianship Committee. According to the policy, the Guardianship Committee is responsible for developing, prioritizing and maintaining the prioritized list as described in Provision U1. Other responsibilities and requirements found in the policy include meeting regularly to discuss guardianship needs at the center and maintaining meeting minutes that include: requests for guardianship services, the date of the meeting, members in attendance, items reviewed and decisions made. It was unclear whether the Guardianship Committee was expected to somehow act on requests for guardianship services, other than in developing and maintaining the prioritized list. The actual responsibilities of the Guardianship Committee should be clarified. BSSLC was in the process of drafting a localized version of DADS Policy 019, but this had not yet been completed. DADS had also issued Policy 057: Self-Advocacy, effective 05/30/12. The stated purose of the policy was to ensure that individuals living in State Centers are provided the opportunity to participate in self-advocacy opportunities, including education surrounding self-advocacy and participation in self-advocacy meetings and events. The policy designated the HRO to serve as the Self-Advocacy Coordinator for the Facility. The policy focused almost exclusively on providing a variety of support sto formal self-advocacy groups. The only exception was the responsibility to conduct an annual self-advocacy inservice for individuals, families and LARs and State Center staff. The supports for self-advocacy formalized in this policy are commendable, but the Monitoring Team also encouarges DADS and the Facility to consider a broader vision of how self-advocacy may be incorporated into the everday lives of individuals.	

#	Provision	Assessment of Status	Compliance
		Facility Efforts to Obtain LARs: The Facility reported no new LARs had been obtained during past six months for individuals living at BSSLC, nor had there been any significant organized efforts toward appropriately obtaining LARs. New processes prescribed by DADS Policy 019: Guardianship, effective 3/7/2012, were in the very early stages of planning. Findings included: • Guardianship Committee: The Facility had not yet established a Guardianship Committee, as required by the DADS and local policies. The first meeting was reported to be scheduled for August 2012. Two social workers had been added to the membership roster; it was hoped they would be helpful in locating outside guardianship resources. A staff nurse who had been a member had left the Facility and the HRO was hoping to fill that slot with another nurse to assist in providing a health care perspective. The HRO also reported seeking to recruit an additional community member. • Advocacy Program: BSSLC did have an active Advocacy Program as described in the previous report, although the statewide policy had not yet been issued. The QDDPs had been trained as to how to make a referral for an advocate for an individual, and several individuals had been assigned an advocate. Training of advocates continued to be completed by the Volunteer Services Department. • Self-Advocacy Program: As required by Policy 057, the HRO was responsible for providing support for the Self-Advocacy Committee, assisted by the Facility Chaplain. The Monitoring Team reviewed the minutes of Self-Advocacy meetings held since the last monitoring visit. The Monitoring Team noted the Facility had obtained and was beginning to implement a formal choice-making/self-advocacy curriculum to foster the abilities of individuals to participate in meaningful decision-making about their lives on an ongoing and formative basis. The Monitoring Team suggested that self-advocacy not be seen as just a meeting, but should be incorporated into an ongoing program of active treatment for all individuals. • Other Activities of the Guardianship Coordinator: Other activities included: o The HRO provided a training to QDDPs on the Guardianship policy and the procedures for referring an indvidual for guardianship or advocacy. Conclusion: This Provision was found to be not yet in compliance. As part of 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. DADS should provide guidance through the formal promulgation of policy as soon as possible.	

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

1. The Facility should consider further developing specific measurable outcome indicators to be reviewed in addition to the fairly subjective process measures in the current Self-Assessment. (Self-Assessment)
2. The actual responsibilities of the Guardianship Committee under DADS Policy 019: Guardianship, effective 3/7/2012, should be clarified. (Provisions U1 and U2)
3. DADS should clarify how the two sets of criteria for prioritization found in DADS Policy 019: Guardianship, effective 3/7/2012, are meant to be integrated. (Provision U1)
4. The Facility's Restrictions List should be updated to state the priority category assigned to each individual. (Provision U1)
5. DADS should provide guidance as to the standardized tools or methodology IDTs should use to assess and prioritize the need for an LAR, an advocate, or other assistance an individual might need in decision-making. Facility's IDTs continued to need guidance and training from DADS to prescribe a process for how an assessment should be accomplished to determine a person's specific range of decision-making abilities so that guardianship does not extend beyond the areas needed by the person. Additionally, guidance should be provided as to how, and how often, a need for guardianship should be periodically reviewed. Since the guardianship policy requires the IDT to make this capacity determination, it would seem to be essential that the guidance be provided at the same time the guardianship policy is implemented. (Provision U1)

The following are offered as additional suggestions to the Facility:

1. The Facility should ensure that self-advocacy not be seen as just a meeting, but rather incorporated into an ongoing program of active treatment for all individuals.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. BSSLC Self-Assessment 7/12/12 2. BSSLC Action Plan 7/6/12 3. BSSLC Presentation Book for Section V 4. DADS Policy 001.1: Use of Restraint 4/10/12 5. DADS Policy 003.1 Quality Assurance 1/26/12 6. DADS Policy 020.1 Recordkeeping Practices 3/05/10 7. DADS Policy 017 Habilitation, Training, Education, and Skill Acquisition Programs Draft 5/10/12 8. DADS Policy 054 Medical Peer Review 5/30/12 9. DADS Policy 057 Self-Advocacy 5/30/12 10. DADS Draft Policy 004.1 Individual Support Plan Process undated 11. Settlement Agreement policy list undated, provided in email from DADS of 2/6/12 12. List of policies titled Center Policies That Have Been Initiated and or Revised Since 1/25/12 (undated but provided during visit) 13. Brenham State Supported Living Center Master Table of Contents of Policy and Procedure Draft 14. BSSLC Policy IV.3.a Unified Record Keeping Practices 12/17/10; undated draft of revised policy 15. BSSLC Policy A.1 Policy & Procedures Guidelines 2/1/12 16. BSSLC Policy B.1 Dignity and Respect 4/27/12 17. BSSLC Policy D.2 Maintaining & Providing ANE Resource Guide 2/8/12 18. BSSLC Policy DD.2 Injury Reporting-Semi-Annual Under Reporting Audits 2/8/12 19. BSSLC PolicyD.3 Participating In & Completing Incident Management UIR Committee 2/8/12 20. BSSLC Policy E.3 Developing, Implementing & Tracking Corrective Action Plans 5/24/12 21. BSSLC Policy N.1 Pharmacy Personnel Draft 4/25/12 22. BSSLC Policy N.2 Pharmacy and Therapeutics Committee Draft 4/12/12 23. BSSLC Policy N.3 Verification of Medication Orders 7/7/12 24. BSSLC Policy N.4 Standardized Dosage Periods and Abbreviations 7/7/12 25. BSSLC Policy N.5 Dispensing and Transporting Medications 7/7/12 26. BSSLC Policy N.6 [Pharmacy] Hours of Operation and After Hours Services 7/7/12 27. BSSLC Policy N.7 [Pharmacy] Security and Inventory Control 7/7/12 28. BSSLC Policy N.8 [Pharmacy] Records and Retention 7/7/12 29. BSSLC Policy N.9 [Pharmacy] Medication Variances Draft 4/12/12 30. BSSLC Policy N.10 Adverse Drug Reactions 7/6/12 31. BSSLC Policy N.11 Drug Utilization Evaluations 7/6/12 32. BSSLC Policy III.2.f Physician Procedures and Best Practice Guidelines 4/14/11 33. Brenham Policy Training Database listing training on policy by staff name, home, title, and policy 34. Policy-Procedure Review Committee Meeting Minutes of 1/25/12, 2/8/12, 4/11/12, 4/18/12, 5/9/12, 5/23/12, and 6/6/12 35. Active Record Order & Guidelines (AROG) 10/28/10

	36. Master Record Order & Guidelines 12/8/11 37. Individual Notebook Record Order and Guidelines for Filing and Thinning 10/28/10 38. Draft Central Records Filing Procedures undated 39. Draft Inactive Record Thinning Procedures for Iron Mountain undated 40. Description of the S:Drive in response to document request 41. Active Records for Individuals #291, #444, and #539 42. Individual Records for Individuals #444 and #539 43. Master Record for Individual #444 44. Settlement Agreement Cross-Referenced with ICF/MR Standards April 2011 45. Settlement Agreement Cross-Referenced with ICF/MR Standards Guidelines April 2011 46. Inter Rater Reliability Process, January 2012 47. Procedures for corrective actions on records audited 48. Active Record and corrective actions database report for Individual #334 49. Completed audit tools (including Corrections Needed forms) for records audited in May, June, and July 2012 for Individuals #56, #90, #106, #112, #149, #186, #189, #208, #244, #254, #259, #291, #299, #300, #334, #362, #390, #398, #403, #411, #413, #424, and #566 (June and July) 50. Emails tracking corrective actions required following audits for Individuals #56. #106, #149, #186. #189, #299, #300, #334, #403, and #425 51. Email of May 11, 2012, from URC Deborah Borah notifying responsible persons that audit findings needing correction had been entered onto the S: Drive 52. BSSLC Monthly Chart Audit reports for individual records audited (four for April 2012 and 12 for June 2012) 53. Systemic Feedback % Recommendations form for December 2011 through June 2012 54. Problematic Tracking System for Interview Tool for December 2011 through May 2012 55. Problematic Totals for 2012 to date 56. Notification calendar and posted assessments for Individual #264 57. Interview Tool for the Use of the Record **People Interviewed:** 1. Unified Records Coordinators Deborah Borah and Joyce Carnagey, Olivia Najera CARE/CWS, and Daniel Dickson, Director of Quality Assurance (QA) 2. Training for Monitor on records audits by Deborah Borah URC 3. Daniel Dickson and Natalie Montalvo, Facility Director 4. Mary Ann Brett, M.D., Medical Director 5. QDDP Coordinator Pam Boehnemann and QDDPs Shanitra Dennis, Kathryn Seifert, Grace Preston, and Dartania Shelton 6. Kori Kelm, SLP, Director of Habilitation Services **Meetings Attended/Observations:** 1. ISP Annual Planning Meeting for Individual #86 2. QA/QI Council 3. Cottage G, Childress D, and Driscoll B homes

	Facility Self-Assessment: BSSLC determined that no provision of this Section was in compliance, and the Monitoring Team concurs. The Self-Assessment included data on compliance with requirements of Provisions V1 and V3—a positive finding, as these data were taken from the ongoing quality assurance audit processes and therefore would be expected to be usable for identifying need for improvement initiatives and corrective actions. The same was found for Provision V4, but the Facility needs to identify a broader set of elements to review. For Provision V2, data were provided for the percent of policies that were current; self-assessment should also include review of implementation of policies once they are current. The Facility also provided an Action Plan. Most steps involved actions that are ongoing but did not provide further steps for achieving compliance. For example, Provision V1 actions included conducting audits, but did not provide actions for how to improve records and meet the requirements of provisions as these audit procedures continue to provide information. The action steps for Provision V4 did identify the steps of developing corrective action plans and a tracking system for those, but all this was based only on the use of the interview monitoring tool; there should also be development of other measures of use of the records to make decisions.
	Summary of Monitor's Assessment: Although no provisions were found in compliance, the Monitoring Team found improvements in the records. Records continue not to meet all requirements of Appendix A of the Settlement Agreement, but they are not as widespread as in the past. This indicates the audit and corrective action processes are leading to improvement. The Recordkeeping Policy revision should be completed as quickly as possible to improve consistency with requirements. The Facility should also identify areas for systemic improvement actions rather than only corrective actions for individual records. The Facility should develop means to monitor whether staff are actually referring to and using records in making decisions and providing services on a daily basis. As policies are updated, the Facility should ensure training is consistently provided as it determines necessary, and should identify ways to monitor to ensure policies are followed.

#	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 sometimes 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 (the overflow 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		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. The draft policy addressed the requirement about authorized persons, but the definition of the Master Record continued to identify only documents thinned from the Active Record; nevertheless, the Master Record reviewed by the Monitoring Team did include the documentation regarding legal status. As stated above, the recordkeeping staff and Director of Quality Assurance reported that an Inactive Record is being developed to contain overflow records (records thinned from the Active Record, which would be held for two years before being sent to long-term storage); the Master Record would then contain only the documentation (including legal documents) to be maintained at the Facility. Active Records were filed in two or three binders (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 binder. The AROG was in process of revision at the time of the compliance visit; the Policy and Procedure Review Committee had approved the new table of contents (AROG) on 1/25/12. However, the new table of contents had not been fully implemented, as the Facility reportedly was awaiting a new table of contents being developed by DADS; as a result, some records were filed in the order of the new table of contents and some followed the current table of contents. There were not substantial differences, but the AROG did not include some documents that had been implemented more recently.	

#	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 #291, #444, and #539, the Individual Record for Individuals #444 and #539, and the Master Record for Individual #444. Individual #539 was selected by computer randomization out of the admissions since the last compliance visit. Individual #444 was selected by computer randomization from the individuals who had been included in a pilot quarterly review process at the Facility. Individual #291 was selected for an inter-rater reliability audit; this was the only individual for whom a Program Compliance Auditor had not yet completed a planned audit for the month. 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 that had a place to check whether a document was present, not present, or not applicable to the individual, and a place to check if it was in order; there was a form for the Individual Notebook and for Chart 1 and Chart 2. Per training provided to the Monitor by Deborah Borah, this tool used a revised table of contents, but a document would be marked as in order if it followed either the revised or current order. For the Active Records and Individual Record checked, the Monitoring Team completed the Active Record Audit. 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. Based on information found during this review, the Monitoring Team also completed the Section V Monitoring Tool (the Settlement Agreement Cross-Referenced with ICF/MR Standards) that included the requirements of Appendix D. Although the Active Records and Individual Notebooks were generally neat, legible, and accessible to staff, none of the Active Records reviewed met all the requirements of Appendix B and Facility policy. Some documents were not current, others were filed out of order or in wrong tabs, and many documents remained in Active Records after the guidelines stated they were to be purged. The table below reports the percent of required documents that were identified in the Monitoring Team review as found in the Individual Notebook and Active Record. Individual | Individual | Active Record	

#	Provision	Assessment of Status	Compliance

	Notebook	
#291	Not checked	84%
#444	38%	86%
#539	60%	66%

Following are examples found in the three records:

- For Individual #291, neither a Reiss Screen nor a psychiatric assessment was present. Two Quarterly Drug Regimen Reviews were present of the four that should have been in the record. The Nutritional Annual Assessment in the record was more than one year old.
- For Individual #444, there were two Social Summaries in the Active Record; neither was dated, and one was unsigned. The invitational letter to correspondents was from 2008. The Rights Assessment was from 2009, and vocational assessment was from 2007. There were significant gaps in observation notes in the Active Record, but many of those (including some dating back to 2010) were in the Individual Notebook (although they should have been moved to the Active Record, and older ones should have been moved to the overflow record).
- For Individual #539, who had been admitted since the last compliance visit, there were already numerous errors in filing, such as filing the clothing inventory in the PBSP tab and PNMP data sheets in the SPO (specific program objectives) tab. There were gaps at the bottom of physician orders. Errors were corrected by writing over in bold, heavy pen rather than having a line through, initials and date of person making the change, and the revision.
- In all three records, purging of materials did not match the maintenance guidelines, as older documents remained in the Active Record.

The Master Record was reviewed for Individual #444. All required documents appeared to be present, and the documents were filed neatly and were easily accessible. The URCs also showed the Monitoring Team one of the new Master Record folders that separated the Master Record documents into subfolders in an envelope file; this appeared to make documents even easier to find. This new record process is being rolled out as time permits.

The Facility has been in the process of establishing an Inactive Record; contents will be somewhat different from the current Overflow Record and are being determined. Documents that remain permanently, such as legal documents, will remain in the Master Record. Documents that are to be sent for DADS central storage will be placed into the Inactive Record for two years. Because this process is being determined, the Monitoring Team did not establish whether the Facility has a way to ensure that documents that

#	Provision	Assessment of Status	Compliance
		should be purged are actually sent to Central Records for overflow filing; however, as noted above, many documents that should have been purged remained in Active Records and Individual Notebooks. In general, the Monitoring Team did not report difficulties in use of the record. Some issues with meeting the requirements of Appendix A remained, but records had improved. As an example of a remaining issue: • As reported in Provision M1, there was no difficulty accessing records. One problem was the illegibility of the individuals' names and demographic information printed on the records by the use of an addressograph card/machine. Either the addressograph cards were too worn to print the information clearly or the machines were out of ink. Times of entry were frequently missing from Integrated Progress Notes, and military time was not used consistently. Furthermore, there were some issues of legibility in the IPNs. <u>Accessibility and Security of Records</u> When asked, staff in Cottage G, Childress D, and Driscoll B 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 but were not out in the open for view by people who did not have a need to view them. Active Records in all three sites were in a secure area but were easily accessible for staff. <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 IDT. Policy requires IDT members to file their assessments and recommendations on the Share drive 10 days prior to the ISP meeting, and requires IDT members to review all assessments and "be prepared for a comprehensive, integrated discussion during the PSP meeting." During a meeting with QDDPs, they showed the notification calendar that lists the assessments needed prior to an ISP annual planning meeting and how they can use the share drive to review whether all required assessments have been posted to the Share Drive. According to the QDDPs interviewed, all IDT clinicians have access to the Share Drive to post and read assessments. During an interview with QDDPs, the Monitoring Team asked to see the assessments in the Share Drive for Individual #264, whose annual ISP planning session was to be held within 10 days. Of 13 assessments or updates due, 10 (77%) had been posted; the Water Safety Assessment could not be done as the individual's mother wished to be present and had asked to do that on the day of the ISP annual meeting. Therefore, 10 of 12 assessments that could be done (83%) had been posted.	

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		Conclusion Although, as reported below in Provision V3, the Facility had a robust audit system, this had not resulted in significant improvement in compliance of the unified 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 develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	As discussed throughout this report, policies and procedures necessary to implement the Settlement Agreement were in various stages of development. This included policies that DADS State Office was developing, as well as those being developed or revised at the Facility level. Statewide policies DADS continued to develop and revise policies. 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. New statewide policies implemented since the last compliance visit include: • DADS Policy 001.1: Use of Restraint 4/10/12 • DADS Policy 003.1 Quality Assurance 1/26/12 • DADS Policy 019 Guardianship 3/7/12 • DADS Policy 054 Medical Peer Review 5/30/12 • DADS Policy 057 Self-Advocacy 5/30/12 Local Policies and Policy Development Process BSSLC had continued to develop new policies and revise policies into its new format; however, much more remains to be done. New BSSLC policies implemented since the last compliance visit include: • BSSLC Policy A.1 Policy & Procedures Guidelines 2/1/12 • BSSLC Policy B.1 Dignity and Respect 4/27/12 • BSSLC Policy D.2 Maintaining & Providing ANE Resource Guide 2/8/12 • BSSLC Policy DD.2 Injury Reporting-Semi-Annual Under Reporting Audits 2/8/12 • BSSLC Policy D.3 Participating In & Completing Incident Management UIR Committee 2/8/12 • BSSLC Policy E.3 Developing, Implementing & Tracking Corrective Action Plans 5/24/12	Noncompliance

#	Provision	Assessment of Status	Compliance
		• BSSLC Policy N.1 Pharmacy Personnel Draft 4/25/12 • BSSLC Policy N.2 Pharmacy and Therapeutics Committee Draft 4/12/12 • BSSLC Policy N.3 Verification of Medication Orders 7/7/12 • BSSLC Policy N.4 Standardized Dosage Periods and Abbreviations 7/7/12 • BSSLC Policy N.5 Dispensing and Transporting Medications 7/7/12 • BSSLC Policy N.6 [Pharmacy] Hours of Operation and After Hours Services 7/7/12 • BSSLC Policy N.7 [Pharmacy] Security and Inventory Control 7/7/12 • BSSLC Policy N.8 [Pharmacy] Records and Retention 7/7/12 • BSSLC Policy N.9 [Pharmacy] Medication Variances Draft 4/12/12 • BSSLC Policy N.10 Adverse Drug Reactions 7/6/12 • BSSLC Policy N.11 Drug Utilization Evaluations 7/6/12 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 • 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. • 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). • As noted in Provision D2a, the Facility had not addressed a concern reported at	

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		the prior compliance visit that there was no policy or instructions for reporting serious incidents. In its last review the Monitoring Team noted that with regard to serious incidents, the BSSLC policy Protection from Harm – Abuse, Neglect, and Incident Management (4/14/11) did 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. During this review the Monitoring Team specifically asked to see the Facility's policy directed at injury reporting and none was provided. • DADS had not yet implemented policy on integrated clinical care or minimum elements of clinical care, and the Facility had not revised its policy to address all requirements of those provisions. <u>Procedures for Development, Approval, and Implementation of Policies</u> BSSLC Policy A.1 Policies & Procedures Guidelines governed the process of policy development. This policy 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 according to the sections of the manual (for example, the policy that governs Incident Management UIR Committee is labeled D.3). The 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. Only a few of the current policies had migrated to the new manual at the time of the compliance visit. Most remained in the older format and manual. This was available on the Share Drive, so it was easy to access. The Director of Quality Assurance stated that many of the current policies require changes in content, and each will be reviewed before changing the format and moving the policy into the new manual. For example, he reported the Competency Training and Development policy was being reviewed and will be revised significantly. Although that has slowed the process of migration to the new format, it makes sense to make the necessary content changes at the time of change in format.	

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		Training and Implementation of Policies 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 evaluates 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. Conclusion 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 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	Audit Process and Corrective Actions The Facility had a process in place in which the URCs were each assigned to audit five records per moth selected through computer randomization. The URCs audited the Individual Notebook and each chart of the Active Record; there was no audit of the overflow records or the Master Record to ensure documents would be available if needed. For each of the audited records, the URCs used the Active Record Audit tool that identifies presence and correct order of filing. 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	Noncompliance

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	the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	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" (also referred to as the Section V Monitoring Tool) 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. Each URC selects two records each month for completion of the Section V Monitoring Tool; rather than selecting these randomly from the five audited records, the URCs try to rotate these across living units so no unit is left out for long. DADS 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 two URCs carried out the audits. The URCs are staff of the Department of Quality Assurance and therefore provide independent audits. The Facility provided audits of 10 records using the Active Record Audit tool for May, five for June, and 10 for July 2012. During June, one URC retired, so only one URC completed audits; the number of audits met the requirements of this provision. The Facility provided Section V monitoring tools for four records for May, two for June, and four for July. The Facility had placed a database on the S: Drive on which the URCs entered the corrections needed. This database included information such as the name of the individual, the auditor, which binder and tab held the item needing correction, a narrative of the finding, a place for responsible staff to report what corrections were made, the date corrected, who made the corrections, when the URC checked the correction, and whether the URC found that the correction was complete. This provided an excellent tool to spot easily whether corrections had been made or more follow-up was needed. It also appropriately put the responsibility of documenting corrections on the people responsible for making those corrections. When items needing corrections from all the audits for the month were entered onto the database, the URC sent an email to Residence Directors, unit clerks, QDDPs, and RN Case Managers notifying them that they were ready for review and correction, and providing two weeks to complete corrections. When the due date was reached, the URCs checked each correction in the records to ensure it was completed. If there was no documentation of completion, or if a documented correction was not complete or	

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		adequate, the URCs followed up by sending contacting the responsible person and requesting correction within a few days, and then would contact the QDDO and Unit Director. Also, Unit Directors and Department heads had access to review the database at any time so they could identify any uncorrected items. For items that could not be corrected (such as missing data or lack of signatures, as opposed to thinning a record or putting documents in the correct order), there was not a clear set of rules for how to document correction. For example, there was no process by which re-training of staff would be documented and provided to the URCs, or how the URCs would spot-check for the effectiveness of re-training. The Facility should develop a process to confirm that corrections, such as re-training, that do not result in a change in the record itself, are made. The Monitoring Team selected the record of Individual #334 from the May audits through computer randomization. One URC and Monitoring Team member checked to determine if all documented corrections to the Active Record and Individual Notebook had actually been made. All (100%) of the corrections to the Individual Notebook were observed to have been made. For the Active Record, all documented corrections had been made except for the Considerations for Implementation of restraint, which was filed in the wrong tab. One correction that had not yet been documented had actually been made. One correction had not yet been made or documented. Three items identified no corrective action; some corrective action should have been identified and taken. The record for Individual #566 was selected randomly for the months of June and July 2012. Audits were done by two different URCs. As expected, a few items that had been reported as not present in June were present in July, perhaps due to the corrective action process. However, even more documents reported as present in June were reported in July as either not present or as not applicable, and many items marked not applicable in June were present in July. The Monitoring Team could not determine from the comments why these differences occurred, but they indicate that review of the process and a close examination of inter-rater reliability information (see below) should be done. A second audit process was also in place. The Facility had long had a process in which Program Compliance Auditors (PCAs) do monthly chart audits of active records per month. PCMs 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 PCAs 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 plan steps	

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		match Skill Acquisition Programs and whether Monthly Reviews address all Action Steps). The audits by URCs and by PCAs provide differing levels of detail on different requirements for a current and accurate active record; combined, they would provide both very detailed audit and information that could guide decisions on systemic actions to be implemented to improve accuracy and usefulness of records. The Monitoring Team reviewed the Monthly Chart Audit forms for 16 audits. The range of scores was from 18%-78% with most forms being in the range of 40%-55%. Although several questions related to issues other than documentation required by Appendix D (such as, "Is there evidence of aggressive activities on part of the facility to promote active involvement of the individual's LAR/Guardian/family/correspondent(s)?"), review of the specific questions indicated a great deal of work was needed to ensure all required documentation was present. Although the records monitored by the PCAs and recorded on the Monthly Chart Audit forms are not the same as the randomly selected audits, the Facility might find it useful to compare findings regarding specific items that are found in both the Active Record Audit and the audits by PCAs. For example, both include a check on presence of the following items: • Water Safety Assessment • FSA (Functional and Structural Assessment) • Data sheets for skill acquisition plans and specific service objectives • Quarterly reviews These two processes have the potential to serve as an audit process that would comply with the requirements of this provision. At least five randomly selected records were reviewed (although the audit reviewed only the Active Record and Individual Notebook without review of overflow records or the Master Record), a second audit process is in place that complements the random audit, and a corrective action process is in place for individual corrections (but, to be in compliance, would need also to include systemic corrective actions to minimize reoccurrence of errors). <u>Interrater Reliability</u> The Facility had developed an Inter Rater Reliability Process that included a set of steps for identifying monitoring tools, training monitors, and conducting refresher training. The Monitoring Team asked to be trained in use of the Active Record Audit tool to enhance the likelihood of finding interobserver agreement and to determine how this training would be done when staff began to do audits. One URC provided training. There was no specific curriculum, no set of examples, and no determination of competence, but the URC did go through the items in a record and describe how she scores them.	

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		In addition to the audits by PCAs identified above, a new process had begun in which a PCA audited two records per month using the same tools used by the URCs. This provided a check for inter-rater reliability. Per interview with the URCs, these checks could occur as much as two weeks apart, with the PCA audit following notice of the need for corrective actions. Therefore, the validity of these checks is questionable. In fact, the QA/QI Council Inter-Rater Reliability report for the audits from March 2012 through May 2012 showed agreement of 21% for March, 42% for April, and 47% for May. These scores indicate that there is little agreement, which means either the definitions of items were inadequate or changes were made to records in between the two audits. The Facility did not report having addressed either of these possibilities. However, data on compliance percentage for two records reported for May 2012 showed the finding by the PCA to be lower than the finding for the URC in both cases, thus indicating that the issue was more likely to be a problem with clear definitions of the items. <u>Agreement in Ratings Between Facility Audit and Monitoring Team Audit</u> The Monitoring Team audited one Active Record on the same day it was audited by a PCA. On the Active Record Audit, agreement between the PCA and the Monitoring Team on presence of documents was 67%; although this was higher than the reported agreement levels between the PCA and the URCs, it was not adequate. Agreement on the Section V Monitoring Tool was 63%. The Monitoring Team findings were also compared with the audit done by a URC one week earlier. Agreement on the Active Record Audit on presence of documents between the URC and Monitoring Team was 79%, approaching an acceptable level. Agreement on the Section V Monitoring Tool was 80%, an overall acceptable level. The URCs and PCAs need to identify sources of disagreement and prepare and document definitions of items, including procedures to determine whether documents are required or are not applicable to the individual. <u>Review of Trends and 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 on the Section V Monitoring Tool as rated by the URCs, the compliance percentages found by each auditor, the overall compliance for the month, and inter-rater reliability. Except for data on reliability, all data provided in the report for May 2012 were for that month only. No trend data were reported. The Monitoring Team recommends that each report to the QA/QI Council provide trend data for a several-month period (preferably 12 months), at least on overall compliance. It may be useful to provide trend data also on presence of required documents. These data could then be used to determine whether systemic actions are needed. Observation of the QA/QI Council meeting and interview	

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		with the Director of QA and the URCs established that the Facility had not yet begun to identify or address systemic corrective or improvement actions that would limit reoccurrences of errors in records.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	The monitoring teams, DADS, and DOJ agreed to a list of actions for the SSLCs to engage in to demonstrate substantial compliance with this provision. These actions are categorized below, with report of their status at BSSLC. The Facility process to evaluate whether records are used in making decisions involved two activities. One was an interview of disciplines that participated on the IDT for one individual whose record was audited for each URC (documentation provided by the Facility showed this was done for one individual in some months and two individuals in other months). The second was a review of the IPNs (the guidelines "suggest to review at least prior 3 months") to see if there are (as instructed in the guidelines) "comments and follow–up from all clinical disciplines regarding clinical/medical issues (as appropriate). " The guidelines do not provide clear enough guidance to ensure auditors are looking for the same content over the same period of time. <u>Records are accessible to staff, clinicians, and others</u> The Facility was not yet assessing this. The Monitoring Team observed that records were available and easily accessible to staff providing services and supports. Individual Notebooks were found in the area in which individuals were, including living areas and day program sites. Active Records were kept in a secure area to which staff had access. The S: Drive made assessments readily available to clinical staff, residential directors, QDDPs, and others who might need to refer to them. However, the Monitoring Team observed that although records were accessible, they were not always used in delivering services and supports. • As reported in Provision O3, PNMPs were located in the medical record, program record, All about Me Individual Notebooks, MAR, and two copies are held in the therapy department. Per observations, "All About Me" books were readily available to staff but were not being referenced during any of the observations <u>Documents are filed in the record timely and accurately</u> This was assessed as part of the monthly record audit and also as part of the monthly audit by PCAs. As reported in Provision V1, although most documents were present, there were	Noncompliance

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		numerous missing documents and gaps in documentation (such as the observation notes). The results of the monthly audits confirmed that some records do not have all required documents; however, the lack of adequate inter-rater reliability made it impossible to come to a firm conclusion on the extent of missing documents. The Facility reported it had begun using an Assessment Tracking Database to help ensure timely completion of assessments. In May 2012, QDDPs were trained as to the placement and organization of the assessments in the shared drive. The Monitoring Team found this training had not yet produced the desired outcomes. A review of the assessments available on the shared drive for ISPs upcoming over the next ten days revealed that zero of three (0%) had all required assessments available. The Monitoring Team found that the process for posting the assessments to the shared drive remained erratic. It remained necessary to search through multiple folders in order to locate all the available assessments. During an interview with QDDPs, the Monitoring Team asked them to open the S: Drive and find the assessments for an individual who was scheduled to have an annual ISP planning meeting within the following 10 days, as policy requires they be posted within 10 days (presumably, at least 10 days in advance). The folder for Individual #264 was opened. Of 13 assessments required, 10 (77%) were present. The individual's LAR had requested that the Water Safety Assessment be delayed so she could be present when it was done. Therefore, 10 of 12 assessments that could be done (83%) had been posted. <u>Data are documented/recorded timely on data and tracking sheets</u> This was assessed for some tracking sheets as part of the monthly record audit and also as part of the monthly audit by PCAs. The monthly PCA audits reviewed by the Monitoring Team revealed that the item "Data sheets current" was marked "Yes" for one of 16 audits (6%). <u>IPNs indicate the use of the record</u> Based on their reviews of IPNs, the URCs reported on the Section V Monitoring Tool whether they found evidence of use of the records; for all tools for which this item was checked, the auditor reported there was such evidence. However, the guidelines provide little information on how to determine this, and the Facility did not provide information that would permit review of reliability for this item. <u>Staff surveyed/interviewed indicate how the unified record is used</u> The URCs pick one individual from their two audits using the Settlement Agreement Monitoring Tool each month; they try to pick a different unit and home than the prior	

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		month. The URC sends an email with a copy of the interview form to each discipline listed on the S: Drive Population Report, which lists all disciplines that serve each individual. IDT members are asked to fill out responses to the questions on the interview form and return by email; URCs send reminders to IDT members who have not responded in two weeks. Each response is summarized and documented on a Systemic Feedback and Recommendations table. The URC then enters information on the Problematic Tracking System for Interview Tool, including name of individual, month and year of audit, number of disciplines polled, number of disciplines reporting, number of positive and negative reports for each question, and narrative for negative reports of the feedback and recommendations provided. The Facility provided both the table and the tool, along with a table titled "2012 Problematic Totals" that gave the percent of participation (% of disciplines that responded to the interview) and percent Positive Score (the % of respondents for whom the URC determined from their responses that they used the records). In comparing the table with the Problematic Tracking System for Interview Tool, the Monitoring Team noted discrepancies in months for which two interview forms were received; only the first of those on the Problematic Tracking System tool was included in the participation and the positive score percentages; this should be corrected for the table to be a useful summary. Nevertheless, the responses provided on the Problematic Tracking System tool indicated that IDT members reported use of the record routinely. To confirm this finding, the Monitoring Team interviewed QDDPs, the Director of Habilitation Services, and the Medical Director. In all interviews, the respondents provided examples of their use of the records, including examples of preparing for decisions through use of records from other disciplines. <u>Observation at meetings, including ISP meetings, indicates the unified record is used and data are reported rather than only clinical impressions</u> The Monitoring Team observed the ISP annual planning meeting for Individual #86. Both the physician and the person providing information about physical and nutritional management brought information from the record to the meeting and used that information in discussion. Health Maintenance Plans were brought to the meetings, and specific weights were reported. All this indicated at least some use of the records in planning for the meeting . Although observations of meetings indicated use of the record, there were examples in which data in the record did not lead to timely changes in services and supports. For example: • As reported in Provision C7g, According to the record, the PBSP for Individual	

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		#173 had been revised in July 2011. Although self-injury and physical aggression had substantially increased beginning in January 2012, no additional revisions to the PBSP were documented. • As reported in Provision K4: o For Individual #481, the treatment expectations included in the PBSP had been met. The PBSP continued despite the successful reduction in the target behaviors. o For Individual #51, replacement behaviors were documented as increasing but later fell to zero. The PBSP continued for four months without revision despite the lack of replacement skill development	

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

1. When finalizing the policy for the Master Record and Inactive Record, ensure all requirements of DADS policy are covered. (Provision V1)
2. Develop a process to update the Active Record Order & Guidelines so all current documents are included with accurate names. (Provision V1)
3. Complete development of policies needed to implement all requirements of the Settlement Agreement. (Provision V2)
4. The policy development and implementation process should address how the need for training is determined as part of approval of policies. A centralized process should be developed at least for specific critical policies to ensure all relevant staff receive consistent training. (Provision V2)
5. Develop a process to confirm that corrections, such as re-training, that do not result in a change in the record itself, are made. (Provision V3)
6. Identify and address systemic actions to minimize future reoccurrence of errors in the unified record. (Provision V3)
7. Consider developing a process to compare findings on specific items checked in both the random record audits and the monthly chart audits and determine how these can complement each other. (Provision V3)
8. Identify audit items with low agreement and revise the definitions in the recordkeeping guidelines and criteria or provide written examples for specific items of documentation. Then, any understandings or changes in definitions arising from discussions among URCs and PCAs must be kept in writing so they can be included in the training to anyone auditing the records. (Provision V3)
9. Each report to the QA/QI Council should provide trend data for a several-month period (preferably 12 months), at least on overall compliance. It may be useful to provide trend data also on presence of required documents. These data could then be used to determine whether systemic actions are needed.
10. Develop guideline to assess whether the records show records are being used in making decisions that is more definitive than the current guideline about review of the IPN. (Provision V4)

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, Action Plan
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
BMC	Behavior Management Committee
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
EC	Environmental Control
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
HIM	Health Information Management Department at Rio Grande State Center

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
IRR	Integrated Risk Rating
ISP	Individual Support Plan
IT	Information Technology
i.v./IV	Intravenous
LA	Local Authority (formerly MRA)
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
MVC	Medication Variance Committee
NA	Not Applicable
NANDA	North American Nursing Diagnosis Association
NCP	Nursing Care Plan

NDC	Non Direct Care/No Direct Contact
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
PDD	Pervasive Developmental Disorder
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
PSI	Preferences and Strengths Invetory
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
QMR	Quarterly Medication Review
QMRP/QDDP	Qualified Mental Retardation Professional/Qualified Developmental Disabilities Professional
QPR	Quarterly Psychiatric Review
RAD	Reactive Attachment Disorder
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
SAP	Skill Acquisition Plan
SFA/SFBA	Structural and Functional Assessment/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