United States v. State of Texas

Monitoring Team Report

Brenham State Supported Living Center
April 8-12, 2013

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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.
g) **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 from 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

As always, 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, Natalie Montalvo, was extremely supportive of the Monitoring Team's activities throughout the week of the compliance visit. 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, and the staff who assisted her to keep up with all our requests. They ensured the documents requested were available before, during, and after the visit. They coordinated arrangements for all the meetings and observations. Many other staff assisted in numerous ways.

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 293 individuals.

Facility Self-Assessment. BSSLC continued to improve its process of assessing status of compliance. The self-assessment described the activities engaged in to assess status, results (in some cases including data on status of processes or on outcomes), and the self-rating and rationale for the rating. The Monitoring Team provides, in this report, many specific reviews of the self-assessments 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, BSSLC 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.

Specific Findings

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

Restraints

Use of crisis intervention restraint continued to decline. Review of restraint use was comprehensive. The Facility had not yet implemented policy requirements associated with protective mechanical restraint for self-injurious behavior.

- Positive Practices and Improvements Made
    - Use of crisis intervention restraint decreased from an average of 7.3 per month to 5.8 a month. This 20% decrease is a continuation of the Facility's decrease in restraint use noted in the last review and report.
    - 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. Psychology Department staff reviews 100% of restraints. The Facility use of available video surveillance tape to review restraint episodes is commendable.
    - Crisis intervention Restraint was only used if the individual posed an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures had been exhausted, and restraints were terminated as soon as the individual was no longer a danger to him/herself or others.
- Improvements Needed

- The Facility's restraint review process did not always accurately identify 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, while still good, had regressed some from that observed at the last review.
- The Facility revised its restraint policy effective 12/31/12. The requirements associated with protective mechanical restraint for self-injurious behavior (PMR-SIB) had not as yet been implemented.
- Periodic competency checks on restraint policy and procedures had been discontinued and should be reinstated. Staff did not consistently retrain knowledge from training.

Abuse, Neglect and Incident Management

The Facility had made substantial improvements in the processes associated with the conduct of Facility investigations of serious incidents and the Facility review of non-serious discovered injuries (to rule out abuse/neglect). The Facility also made substantial improvements in the processes associated with the conduct of its review of DFPS investigations.

- Positive Practices and Improvements Made
  - The Facility appeared committed to ensure that abuse and neglect of individuals was not tolerated, and encouraged staff to report abuse and/or neglect.
  - The scope of the tracking and trending of incidents and injuries, and the analysis of these data, was in need of improvement.
  - The staff training requirements associated with this section of the Settlement Agreement were up-to-date.
- Improvements Needed
  - The Facility reported it did not have Facility-specific policies in place to parallel DADS policies on abuse and neglect, and incident management. The Facility initiated a draft of a facility-specific version of the State policy during the review week.
  - The Facility had not demonstrated consistent reporting of allegations and serious incidents within the timeframes required by policy.

Quality Assurance

Quality Assurance activity necessary to achieve compliance with Section E of the Settlement Agreement was still in a formative stage. Policies and procedures had been revised recently or were in process of revision and development.

- Positive Practices and Improvements Made

- The Facility had revised its Quality Assurance Process policy (1/1/13) and its Quality Assurance/Quality Improvement Council policy (scheduled for implementation 4/21/13) to reflect current expectations and requirements of both the Settlement Agreement and the new State QA policy which was issued in January.
- 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.

- Improvements Needed.
  - The QA Plan contained many of the written procedures and administrative requirements necessary to implement the QA policies. One key exception was the lack of reference in any of these documents addressing the requirement of the development of outcome measures and process indicators/measures (key indicators for evaluation).
  - Listing of key indicators and gathering of data on them had not as yet started and is a much needed next step in the development of the QA program.

<u>Integrated Protections, Services, Treatments and Supports</u>

It was noted that BSSLC was serving as a model site for implementation of a newly revised ISP and had the option to pilot innovations. The Facility had chosen to focus training and skill development related to the revised ISP process on four IDTs, and therefore requested the Monitoring Team to similarly focus its review on the work of these teams to provide feedback and some level of technical assistance. It was agreed this focused effort could not result in any finding of substantial compliance at this point due to its limited scope. A sample was selected from the work of these four teams over the past six months and included the ISP and ISP Preparation meetings held during this monitoring visit. Overall, the Monitoring Team was impressed with the effort and resources devoted to this initiative and believed it held promise for future development.

- Positive Practices and Improvements Made
  - A revised ISP format and process had been introduced to the focus IDTs and considerable training and coaching had been provided. The new process included an ISP Preparation meeting held approximately three months prior to the ISP annual meeting as a means of ensuring adequate IDT preparation for the latter. The Monitoring Team found this to be a particularly promising practice that had already resulted in improved preparation and participation by IDT members as observed in the annual ISP meetings held during this site visit.
  - There was still no meaningful preparation provided to ensure the PSI and/or ISP processes were conducted in a manner that facilitated real participation by the individuals.
  - The focus IDTs often failed to conduct timely or comprehensive assessments of sufficient quality to reliably identify the individual's strengths, preferences and needs.
- Improvements Needed

- 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, the ISPs reviewed 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 yet sufficiently constructed or assessed for progress.
- ISP strategies still did not reflect encouragement of community participation in any meaningful or purposeful manner.
- There were a number of instances in which issues were not addressed in an appropriate and/or timely manner.

<u>Integrated Clinical Services</u>
BSSLC continued to expand integrated planning in a many ways, including the active participation of numerous disciplines in committees and workgroups, integrated planning opportunities such as psychiatric treatment reviews, and the Morning Medical Debriefing process. There are still examples in which integrated planning of services and supports needs to improve.

- Positive Practices and Improvements Made
  - Committees such as the Skin Integrity Committee, the Infection Control Committee, and the Physical and Nutritional Management Committee have active and consistent participation by several disciplines.
  - The Morning Medical Debriefing process has continued to evolve by adding disciplines and developing processes to follow up on actions and on referrals to the interdisciplinary teams.
  - Psychiatric Treatment Reviews were attended by psychiatry, psychology, nursing, QDDPs, DSPs and other disciplines, and sometimes by family members/guardians (via telephone) and Primary Care Physicians (PCPs). There was active discussion that contributed to diagnostic understanding of individuals, and the early stages of combined case formulation were evident.
  - Documentation of review by facility clinicians of recommendations from non-facility consultations showed that all were reviewed, indicated whether the recommendations were accepted, and usually included documentation in the active record through a progress note.
- Improvements Needed
  - Policies for integrated clinical services and for the consultation review process need to be developed or revised both to reflect the current improved practices and to provide guidance.
  - There was limited documentation of referral of recommendations from consultations to the interdisciplinary teams for discussion and action as needed.

- Examples in which integrated planning needed to improve, including programs and services that conflicted with information from assessments, were still present.

Minimum Common Elements of Clinical Care

The Facility continued to make progress in addressing several provisions of this Section. The development of processes to meet several requirements was moving forward. The lack of timeliness of assessments was a significant barrier to meeting the requirements of several provisions.

- Positive Practices and Improvements Made
  - In general, medical diagnoses were supported by the assessments and evaluations.
  - Diagnoses generally were consistent with ICD-9 and DSM IV nomenclature.
  - Timely assessments and revisions in treatment were found in response to hospitalizations.
  - Development and use of clinical indicators to assess individual health care had continued. Clinical indicators were in place for six chronic conditions, including diabetes mellitus, osteoporosis, hypertension, seizure disorder, lipid disorders, and constipation. One area of progress was the inclusion of review of co-morbidity, such as tracking the lipid panel for individuals with diabetes.
- Improvements Needed
  - Timeliness of assessments continued to be variable. Assessment practices did not provide assessments 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.
  - Comprehensiveness of assessments had improved but still required additional improvement. Improvements were found particularly in nursing and PT/OT assessments.
  - Improvement is needed in ensuring the diagnoses are listed on the Active Problem List and in the annual medical summary.
  - Although follow up was clear in regard to malignancy, status epilepticus, and acute conditions, it was less clear for aspiration pneumonia and falls.
  - Although clinical indicators were being developed, continued work will be needed to ensure the clinical indicators are consistently reviewed and used to make treatment decisions.
  - The use of aggregated information on clinical indicators to identify systemic health care issues and areas to target for improvement is in early stages and needs continued development.

At-Risk Individuals

The BSSLC processes to demonstrate compliance with this section of the SA had improved in some areas and regressed in others. The most notable improvements were in the areas under supervision of the Habilitation Therapies Department.

- Positive Practices and Improvements Made
    - The Facility initiated an At-Risk Individuals policy to guide the risk assessment process. Having written policy and procedural direction should facilitate more consistent performance across the Facility, which would be expected to address the types of issues enumerated in this report.
- Improvements Needed
    - 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.

Psychiatric Care and Services

During the current review period Provision J12 came newly into a status of substantial compliance with the requirements of the SA, and Provisions J1 and J15 continued to be in substantial compliance. Considerable progress was made for many provisions even though the relevant provisions had not yet come into substantial compliance with all provision requirements.

- Positive Practices and Improvements Made
    - All psychiatrists actively and appropriately participated in interdisciplinary processes, including IDT and ISP meetings.
    - The Facility implemented a new process that provided needed medication treatment plans.
    - Facility psychiatrists gave increased attention to diagnostic justification. DSM criteria for the proposed diagnoses were cited often and the diagnoses were discussed with those criteria in mind. Discussions were substantive and reflected the excellent diagnostic skill of the psychiatrists.
    - The Facility added a polypharmacy justification section to the PTR format. The new section provided psychiatrists with a place to clarify whether polypharmacy regimes were being eliminated and, if not, why they were clinically necessary.
    - Individuals who needed side effect screens had received them, and these were generally reviewed and signed by prescribers. Good clinical judgment was evident for review of findings during interdisciplinary meetings and for determinations of need for additional screenings.
- Improvements Needed
    - Progress on completing comprehensive psychiatric evaluations (CPEs) had stalled, but the Facility developed a plan to focus more of the available psychiatric time on the important task of CPE completion.
    - A process for consistent development and implementation of plans to reduce pre-treatment sedation had been started but was still in early stages, with 11 plans approved. There needs to be development of steps to assess the efficacy of the plans, to be taken at both the individual and Facility levels.
    - There remains a need to ensure good case formulations are present in evaluations.

- Reiss Screens or CPEs need to be completed for individuals who need them.
- The consent process needs to ensure that the ISPA addressed the needed risk vs. risk assessment.

Psychological services

Much progress had been made in a number of areas, but there were other areas in which little progress had occurred. It was clear that BSSLC was making multiple, serious efforts to improve the quality of services at the Facility. In several areas these efforts were effective.

- Positive Practices and Improvements Made
  - Structural and Functional Assessments reflected improvement across most measured elements. The areas of lowest rating involved the adequate identification of functions and functionally equivalent replacement behaviors.
  - Positive Behavior Support Plans (PBSPs) reflected improvement in several areas, including the provision of background information, and the provision of intervention strategies addressing establishing operations, setting events, and antecedents.
  - The Facility had hired several Board Certified Behavior Analysts, bringing the total employed by the Facility to five.
- Improvements Needed
  - Documentation provided by the Facility reflected that fewer individuals had current assessments of intellectual ability and adaptive skills.
  - Although ratings improved modestly, two-thirds of interventions developed at the Facility continued to lack effective integration of psychiatric and behavioral services.
  - The Facility continued to lack a system for determining if staff were trained to implement the behavior interventions for which they were responsible.

Medical Care

Medical care at BSSLC had continued to progress. The entire medical staff, under the leadership of the medical director, has worked diligently on many areas.

- Positive Practices and Improvements Made
  - The Facility maintained a functional, and useful morning medical rounds, that integrates all clinical, and habilitation services, and enables much better follow-up on acute and serious health care conditions. During the observation period, the Monitoring Team noted robust collaboration among primary care providers and other clinical disciplines.
  - The medical staff provided outstanding following-up on hospitalizations, and ensures efficacious continuity of care for those individuals hospitalized.
  - The Monitoring Team noted significant improvement with assessing acute medical conditions.

- Improvements Needed
    - The Facility must enhance its practice in areas such as recurrent pneumonia, degenerative spine disease, and other common and serious issues that affect individuals with developmental disabilities.
    - Further development is needed of Facility's internal and external medical audit process, to include medical management elements for the most common and serious conditions that occur in people with developmental disabilities.
    - The mortality review process must be further developed, to ensure that all mortalities undergo a comprehensive review, as to the "root cause" of the death, and ensure that meaningful recommendations are developed to improve system issues.
    - The Facility must develop and implement a medical quality assurance process, and further develop policies, procedures, and clinical guidelines, deemed necessary for operational needs.

<u>Nursing Care</u>
Progress continued to be found. Provisions M.2, M.4, and M.6 came into substantial compliance, and the remainder of the provisions showed further improvement.

- Positive Practices and Improvements Made
    - The Nursing Department continued to maintain a stable and motivated staff, established staffing ratios continued to be met on all shifts.
    - Significant progress was also made in the Quality Assurance Efforts, Documentation and Assessment of Acute Changes in Health Status, Hospital Liaison Activities, Infection Control Activities, and Skin Integrity Activities.
    - The Facility continued to maintain a robust Emergency Response System that went beyond the basic requirements of Emergency Response Policy.
    - The Nursing Department had made significant improvement in the comprehensives and accuracy of the Annual/Quarterly Comprehensive Nursing Assessment.
    - The Nursing Department continued to maintain a comprehensive system for conducting and tracking competency-based nursing education for New Nurse Orientation, annual refresher training, as well as other required ongoing training.
    - All (100%) of the RN Case Managers had completed the state mandated Physical Assessment Class and were continuing to review assigned chapters from the Mosby Physical Assessment.
    - All nurses had been trained on the 25 nursing protocols. Protocols were fully implemented and were incorporated into relevant health care plans.
    - The Facility had operationalized the State's Medication Variance Policy, and there was documented evidence that 98% of nursing staff responsible for medication administration practices were trained on the policy.

- All Unit/Cottages were inspected using the standardized Supported Living Center Medication Room and Medication Administration Record Audit Tool. The outcome of the audit found that the Units substantially complied with requirements.
- Medication Administration Observations were found in compliance with following the individuals' PNMPs and standards of safe administration practices.
- Medication Administration for Individuals with Developmental Disabilities with dysphagia and/or swallowing difficulties was taught jointly by the Nurse Educator and Habilitation staff. At the time of the compliance visit, 94% of the nursing staff responsible for administering medication had been trained with a projected completion date of June 2013.
- A comprehensive Medication Database was in place, using the root cause method, to track, analyze, and trend all medication variances reports. 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 critical decisions regarding medication variances and developed local and systemic plans of correction, as indicated.

- Improvements Needed
  - The Facility continued to refine and implement the Integrated Risk Rating Form and Integrated Health Care Plan Process but these processes had not fully matured.
  - Individuals' health care plans, in relation to identified risk ratings and problems, varied in the format used for the plan. Therefore, it was not possible to accurately determine which health care plan was actually followed or the status of compliance with any given health care plan.
  - The Acute Care Plans were still used and were continuing to individualize and incorporate the relevant nursing protocols and primary care providers' orders that required ongoing nursing intervention into the plans. However, there was a continued need for improvement.
  - The Nursing Discharge Summaries and plans of care need continued improvement.
  - There needs to be guidelines developed to define the RN Case Managers' role and responsibilities for developing individuals' plans of care for transition into community living.

<u>Pharmacy Services and Safe Medication Practices</u>

The Monitoring Team would like to acknowledge the Facility's leadership, and staff involved in addressing Section N, and congratulates them for achieving substantial compliance. The Facility has developed and implemented many policies and procedures that have substantially improved the prescribing, dispensing, monitoring, and assessing of efficacy of medication usage at the Facility. The Facility's effort has contributed to the reduction of unnecessary medications, the monitoring, and management of side effects, and to addressing adverse effects of medications. The Monitoring Team would like to compliment the staff for their hard work, and diligence.

- Positive Practices and Improvements Made

- Single Patient Drug Interventions (SDIs) included a clinically appropriate recommendation by the pharmacist and documented evidence that the medical practitioner addressed the pharmacist's concern.
- The pharmacist appropriately documented reviews of new medication orders for allergies, drug interactions, clinically appropriateness, and appropriate dose.
- The Monitoring Team was impressed by the continued high quality of the QDRR process, and will continue substantial compliance.
- There was documentation to indicate that the pharmacist comprehensively reviewed the one sole use of stat psychotropic chemical restraint for appropriate dose, provided justification, assessed risk and efficacy, and provided clinically appropriate recommendations.
- Review for each individual using polypharmacy documented justification for use. The Facility did provide an annual systems review for polypharmacy, as part of the PMOC meeting.
- Individuals who needed side effect screens had received them, and these were generally reviewed and signed by prescribers. Good clinical judgment was evident for review of findings during interdisciplinary meetings and for determinations of need for additional screenings.
- The Facility provides a clinically relevant, and effective Adverse Drug Reaction process.
- The Facility has a drug utilization and evaluation process that enables a high quality review of medication usage at the Facility, and provides prescribers with clinically relevant and important recommendations on the use of medications.
- The Facility had developed an impressive medication variance process that was supported by a comprehensive and effective policy, by a committee structure that tracked and trended medication variances by type and category, department, staff, living area and individual, and by remediation and system improvement efforts.

- Improvements Needed
  - There was a discrepancy with how the Facility determined risk factors for metabolic syndrome; however, the Facility plans to correct that continuing forward.
  - The Facility needs to develop and implement a trends analysis for the use of benzodiazepines and polypharmacy.

<u>Physical and Nutritional Management</u>

Overall, there has been noted improvement with all provisions in Section O. 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 outlining the roles and responsibilities of the PNMT had been implemented.
  - Although improvement is still needed, BSSLC has shown great improvement in identifying those individuals who are at risk and assigning the appropriate risk classification as it relates to issues related to PNM.

- 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.
- Individuals with PNMPs were reviewed on an annual basis with changes in the interim, generally indicated based on referral or the identification of a problem.

- Improvements Needed
  - PNMT assessments/reviews lacked evidence that all potential areas impacted by the change in PNM status were at a minimum reviewed/discussed as part of the PNMT meeting.
  - PNMPs were not comprehensive due to the plans lacking detailed information regarding oral care and communication.
  - Although PNMPs were 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. The reliability of monitoring data is in question due to the large disparity in findings from BSSLC and that of the Monitoring Team.
  - There needs to be a process in place to ensure PNM supports for individuals who are determined to be at an increased level of risk are only provided by staff who have received the competency based training specific to the individual. Staff on third shift were not provided with the same level of training as those on first and second shifts.
  - BSSLC had ample frequency of monitoring but there was no evidence that staff or the individual was monitored across all three shifts. Additionally, the reliability of the acquired data is in question due to the large disparity in findings from BSSLC and that of the Monitoring Team.
  - There was limited evidence of indicators integrated as part of the IHCPs to assess the individual's PNM status as well as limited to no monthly review by the QDDP.
  - 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 as has the pathway to oral intake but the information was not contained within the IRRF as an established plan of care.

<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. An area that saw decline was in the timeliness in which assessments were provided.

- Positive Practices and Improvements Made

- The Habilitation Assessment addressed the majority of components needed to fully assess an individual with the exception of consistently providing comparative analysis, listing potential side effects related to medications and investigating more ways to improve functional skills. Both of these areas were improving with the newer assessments.

- Improvements Needed
  - Habilitation Therapy assessments were not consistently provided in a timely manner. Additionally, there appeared to be a delay in responding to individuals who had experienced changes in status (e.g., falls).
  - Therapy services were not consistently integrated into the ISP. There was little evidence that individual's progress was reviewed and documented based on the action plan in the ISP/ISPA at least monthly.
  - Therapy plans were not implemented as written. Individuals were observed without supportive devices.
  - BSSLC had ample frequency of monitoring but there was no evidence that staff or the individual was monitored across all three shifts. Additionally, the reliability of the acquired data is in question due to the large disparity in findings from BSSLC and that of the Monitoring Team.

<u>Dental Services</u>

Because of the resignation of the dental director, the dental department had sustained significant delay with moving forward towards substantial compliance with Section Q. The Facility had recently hired a new dental director, who shared with the Monitoring Team her ambition of assisting the Facility towards compliance. At the time of this review, the Facility had made little progress from the previous reporting period, and it is anticipated, that with the support of the new dental director, the Facility will develop many processes to improve dental services.

- Improvements Needed
  - The Facility did not have an effective method of maintaining its dental schedule in real-time. As a result, the Facility cannot effectively monitor individuals who were current and not current with dental evaluations, treatments, and hygiene.
  - The Facility is significantly behind with providing annual dental evaluations, and must develop a process to ensure timely annual dental treatments.
  - The Facility had yet to develop and implement necessary policies, procedures, guidelines, and practices to gain substantial compliance for Provision Q.2.

<u>Communication</u>

BSSLC has shown some improvement with Section R but continues to face roadblocks as communication is given lesser priority than swallowing. Assessments remained one of the stronger aspects of the Communication Section but still lacked the comparative analysis piece that demonstrates improvement or decline of their health as well as communicative status.

- Positive Practices and Improvements Made
    - BSSLC was at full capacity with regards to Speech Pathologist and had recently opened another position for a Speech Therapy Assistant. All Therapists were board certified and licensed to practice in the state of Texas. All Therapists had evidence of participating in continuing education that was relevant to the field of practice.
    - Individuals identified as having decreased communication were being provided with the needed assessments.
- Improvements Needed
    - Training had improved as part of the first and second shift but staff on third shift was not provided with consistent training.
    - Assessments remained one of the stronger aspects of the Communication Section but still lacked the comparative analysis piece that demonstrates improvement or decline of their health as well as communicative status. Recommendations were at times vague and did not provide clear ideas as to how strategies and supported equipment could be utilized through all programming.
    - DCPs were not observed utilizing strategies to engage Individuals in using general area augmentative communication devices. Individuals receiving indirect communication supports did not have their plans reviewed at least quarterly by the QDDP, and individuals were not provided direct speech treatment as per physician's order.
    - 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.

<u>Habilitation, Training, Education, and Skill Acquisition Programs</u>

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 during previous site visits..

- Improvements Needed
    - Formal task analyses were not completed as part of skill acquisition program development.
    - The ISP, Personal Focus Assessment, and other assessments 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.

<u>Most Integrated Setting</u>

This Section was found to be not in compliance overall. A summary of noted progress included the continued impressive effort with the families of children, many of whom had previously expressed opposition to community living, to work toward

movement to a more appropriate and integrated setting. Additional progress was noted in the thoroughness of the implementation of the CLDP and PMM processes, although these did not yet rise to the status of substantial compliance.

As noted in Section F, the Facility had chosen to focus training and skill development related to the revised ISP process on four IDTs. It was requested the Monitoring Team similarly focus its review on the work of these teams and provide feedback and some level of technical assistance. It was agreed this focused effort could not result in any finding of substantial compliance at this point due to its limited scope.

- Positive Practices and Improvements Made
  - Several children had successfully transitioned in the past six months and the Facility had hired a Children's Specialist to support their transition planning. The Monitoring Team again commends the Facility for its initiative in this area.
  - The Facility identified Facility staff responsible for required CLDP actions, and the timeframes in which such actions are to be completed.
  - The Facility ensured review of the Community Living Discharge Plan (CLDP) with the individual and Legally Authorized Representative (LAR) to facilitate their decision-making regarding supports and services needed for community living.
  - The significant improvement in the process of Post Move Monitoring (PMM) noted during the last visit had been sustained and the PMM Checklists continued to be completed in a timely manner. A Program Auditor continued to be 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 Facility reported four Alternate Discharges during the past six months and each appeared to have been completed in substantial compliance with CMS discharge planning requirements and DADS policy.
- Improvements Needed
  - Improvement is needed in assessing, planning for, and implementing 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.
  - The IDT also often 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.
  - Improvement is needed in adequate assessment and timely action to prevent the failure of community transitions.

Consent

This Section was not yet in compliance. A summary of noted progress included the implementation of a Guardianship Committee, as required by DADS policy. The Facility continued to provide support for self-advocacy for both children and adults and made use of formal choice-making materials as a part of these activities.

- Positive Practices and Improvements Made
  - The Facility did maintain a prioritized list of individuals lacking an LAR, which was updated on an ongoing basis based on referrals from the IDTs.
  - A Guardianship Committee had been implemented.
  - The Facility continued to develop its commendable capacity to provide advocates for individuals as an alternative to guardianship, with some 34 individuals currently having an advocate assigned.
- Improvements Needed
  - There was no statewide or local policy that addressed either a 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, nor was there any evidence that IDTs were yet making any concerted effort to address capacity for decision-making or strategies to enhance these capacities.
  - Although a prioritized list was maintained of individuals lacking a Legally Authorized Representative (LAR), not all individuals without guardians had yet been assigned a priority level.

Recordkeeping and General Plan Implementation

Progress continued in all provisions of the Section. Records were generally in order, a robust audit system was in place, and there was evidence that records were being used in making decisions. However, records still were not consistently accurate, timely, and complete, and the corrective action process for addressing issues identified in the audit had not yet limited reoccurrence of similar errors.

- Positive Practices and Improvements Made
  - The Facility maintained a Unified Record consisting of an Active Record, Individual Notebook, and Master Record.
  - A table of contents for an Inactive Record had been developed and was in process of implementation facility-wide.
  - Active Records and Individual Notebooks were accessible and in good condition.
  - There was improvement in records being substantially consistent with the requirements of Appendix D to the Settlement Agreement.
  - The Facility process to audit records included audit of six randomly selected records per month. The audit was a comprehensive review of documents that should be in the Active Record and Individual Notebook. Checks of interobserver agreement are done routinely and demonstrate acceptable levels of agreement.
- Improvements Needed

- Presence of current documents in records reviewed was variable.
- Although a number of new policies and procedures had been implemented, at both the DADS and Facility level, there remains a need for policies and procedures to guide aspects of several sections of the Settlement Agreement.
- Although a thorough system was in place to monitor corrections of deficiencies or errors found in records during audits, the system does not ensure corrections are made and that the system has the effect of reducing reoccurrences of similar errors.
- Although audit data were reported to the Facility's Quality Assurance/Quality Improvement Committee, audit data had not led to identification of and action on systemic issues.

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 (3/21/13) 2. BSSLC Action Plan (3/11/13) 3. DADS Policy 001.1 Use of Restraint (4/10/12) and related training materials 4. DADS SSLC Nursing Protocol: Pretreatment and Post-Sedation Monitoring (February 2011) 5. BSSLC Policy C.1 Restraint (12/31/12) 6. List of crisis intervention restraints since the last review (2/28/13) 7. List of medical restraint since the last review (3/21/13) 8. List of Individuals with more than three restraints in a rolling 30 day period since the last review (3/6/13) 9. List of Individuals with a Crisis Intervention Plan (undated) 10. Sample C.1: 20% of the crisis intervention restraint records listed by the Facility in response to the document request. Records included at a minimum the restraint checklist form, face-to-face / debriefing form, the individual's Crisis Intervention Plan, if applicable, the documentation of any and all reviews of each use of restraint, and any addenda or changes to the ISP or Crisis Intervention Plan that resulted. This sample included the one instance of use of chemical restraint and the one instance of off-campus restraint and involved Individuals #467 - 1/28 at 8:55am, #173 - 2/6 at 9:23am, #381 - 2/15 at 12:11pm, #460 - 10/18 at 12:48pm and 8/16/12 at 9:46am (chemical), #130 - 11/1 at 8:11am, #4 - 2/8 at 1:50pm, #11 - 1/31 at 11:30am, #118 – 12/14 at 4:36pm (off campus), and #52 11/30 at 8:30am 11. Sample C.2: For twenty-four Direct Care Professionals, their training transcripts showing date of most recent PMAB training; training on use of restraints, and training on abuse and neglect; and the signed forms to show that each identified staff member had acknowledged his/her responsibility to report abuse/neglect 12. Sample C.3: Medical restraint records for 20% of the individuals subject to medical restraint as listed by the Facility in response to the document request. Records included at a minimum the physicians' orders for the restraint including the monitoring schedule, the medical restraint plan, the restraint checklist, the documentation of the monitoring that occurred pursuant to restraint policy and physician instructions, any reviews of this use of restraint, and any applicable desensitization plan or strategies implemented to reduce the need for medical restraint. Individuals #419 - 2/6 at 8:00am, #195 - 11/7 at 12:20pm, #339 - 12/14 at 10:00am, #473 - 1/25 at 9:30am, #255 – 2/6 at 10:30am, #75 – 12/28 at 7:26am, #293 – 11/8 at 7:30am, #193 – 9/14 (no time noted on log), #133 – 12/5 (no time noted on log), and #170 – 2/22 (no time noted on log) 13. Sample C.4 (individuals who were restrained more than three times in a rolling 30 day period): for Individuals #467, #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 14. Sample C.5 (protective mechanical restraint for self-injurious behavior) for the four Individuals subject to this form of restraint (Individuals #29, #428, #14, and #331) 15. BSSLC "Do Not Restrain" list (undated) 16. Staff training records for sample of staff designated as restraint monitors 17. DADS report "Percent of All Employees Completing Courses of Training Programs" 3/6/13 18. DADS report "Course Due/Delinquent for BSSLC" for various required courses 3/6/13 19. Restraint related staff training material 20. Minutes of Restraint Reduction Committee 10/29/12 and 2/14/13 21. Minutes of Pre-treatment Sedation Workgroup 1/24/13 22. Log of restraint related injuries since the last review. 23. BSSLC Restraint Trend Report 3/31/13 **People Interviewed:** 1. Terry Hancock, PhD, BCBA, Chief Psychologist 2. Dr. Victoria Morgan, Lead Psychiatrist **Meeting Attended/Observations:** 1. QA/QI Council meeting 4/10/13 2. Restraint Reduction Committee meeting 4/11/13 3. Behavior Support Committee 4/8/13 1.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section C. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section C, in conducting its self-assessment, the Facility did not use monitoring/auditing tools. The Facility reported that it had not modified the Section C Monitoring tool to reflect changes in the DADS restraint policy (which was effective 4/12/12). In preparing for this review the Facility reported that a psychology assistant in the psychology department had reviewed records associated with 100% of restraints used since the last review to determine compliance with Settlement Agreement (SA) requirements. This review was not formally recorded or otherwise documented by the Facility. Consequently, the Monitoring Team was unable to comment on the efficacy of the Facility's self-assessment process, including whether or not those staff conducting the reviews had been deemed competent to conduct such review activity and whether or not the review activity included any inter-rater reliability.

	Finally, there was no indication that any of the self-assessment document review activity was conducted by the Quality Assurance (QA) Department. Despite the shortcomings described above the self-assessment findings presented data in a meaningful/useful way. Specifically, the Facility's Self- Assessment: 1. Presented findings based on specific, measurable indicators. Most indicators reported a high degree of compliance so the self-assessment included limited discussion of areas of strength, weakness, or the status of progress. 2. Did not appear to consistently measure the quality, in addition to the presence, of items. 3. Did not distinguish data collected by the QA Department versus the program/discipline. The Facility rated itself as being in compliance with the following provisions of Section C: Provisions C.1, C.2, C.3, and C.6. This was consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with the following provisions: C.1, C.2, C.3. , and C.6. Sampled data, both analyzed by the Facility and the Monitoring Team, for Provision C.4 showed a low level of compliance with medical restraint requirements. The Monitoring Team also identified issues with medical restraint requirements reported under Provision C.6. In other Provisions the level of analysis and conclusions reflected in the Facility self-assessment was generally consistent with analysis and conclusions reached by the Monitoring Team. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. ▪ Most Actions did not include a start date but did include a projected completion date. ▪ The Facility data identified areas of needed improvement, primarily in the area of additional staff training. ▪ Most actions did provide a set of steps likely to lead to compliance with the requirements of this Section, for example, in Provision C.4 action steps included developing a medical mechanical restraint process and training necessary staff.
	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, Overall, the Facility's use of crisis intervention restraint decreased from an average of 7.3 per month to 5.8 a month. This 20% decrease is a continuation of the Facility's decrease in restraint use noted in the last review and report. Only one instance of use of chemical restraint was reported. The Facility should further analyze restraint data to determine the effect of new admissions, and discharges, on the downward trend. 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. Psychology Department staff review 100% of restraints. The Facility use of available video surveillance tape to review restraint episodes is commendable. The Facility's restraint review process did not always accurately identify 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, while still good, had regressed some from that observed at the last review. The Facility revised its restraint policy effective 12/31/12. The requirements associated with protective mechanical restraint for self-injurious behavior (PMR-SIB) had not as yet been implemented. Crisis intervention Restraint was only used if the individual posed an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures had been exhausted, and restraints were terminated as soon as the individual was no longer a danger to him/herself or others. The Facility needs to engage in additional strategies to reinforce key provisions of restraint policy such as periodic competency checks (the Facility reported competency checks were previously done but had been discontinued). Lack of staff knowledge retained from training, at least as demonstrated by a small sample of employees, could have a negative effect on future compliance with this provision.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>C1</td><td>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.</td><td>A review of the Trend Analysis Report for March, 2013 showed:

<table>
<tr><th>Type of Restraint</th><th>4/2012 through 9/2012</th><th>10/2012 through 3/2013</th></tr>
<tr><td>Personal restraints (physical holds) during a behavioral crisis</td><td>42</td><td>34</td></tr>
<tr><td>Chemical restraints during a behavioral crisis</td><td>2</td><td>1</td></tr>
<tr><td>Mechanical restraints during a behavioral crisis</td><td>0</td><td>0</td></tr>
<tr><td>TOTAL restraints used in behavioral crisis</td><td>44
7.3/month</td><td>35
5.8/month</td></tr>
<tr><td>TOTAL individuals restrained in behavioral crisis</td><td>13</td><td>9</td></tr>
<tr><td>Of the above individuals, those restrained pursuant to a Safety/Crisis Intervention Plan</td><td>8</td><td>2</td></tr>
<tr><td>Medical/dental restraints</td><td></td><td>46</td></tr>
<tr><td>TOTAL individuals restrained for medical/dental reasons</td><td></td><td>22</td></tr>
</table>

This represents a 20% decrease in the use of crisis intervention restraint and appears to</td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		validate the continued downward trend in restraint use previously reported by the Monitoring Team. The Facility should further analyze these data to determine the effect of new admissions, and discharges, on these data. <u>Prone Restraint</u> Based on Facility policy review, prone restraint was prohibited. Based on review of other documentation (trend reports and lists of restraints), prone restraint was not identified. A sample, referred to as Sample C.1, was selected. (See Documents Reviewed Section above). Based on a review of the restraint records for individuals in Sample C.1 involving 10 individuals, zero (0%) showed use of prone restraint. Based on interviews with 10 direct support professionals, 10 (100%) were aware of the prohibition on prone restraint. <u>Other Restraint Requirements</u> Based on document review, the Facility and State policies do state that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. Restraint records were reviewed for Sample C.1 that included the restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: • In10 of the 10 records (100%), there was documentation showing that the individual posed an immediate and serious threat to self or others. • For the 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 10 of the records (100%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. • Facility policies do identify a list of approved restraints.	

#	Provision	Assessment of Status	Compliance
		• Based on the review of 10 restraints, involving nine individuals, 10 (100%) were approved restraints. These restraints involved nine individuals whose PBSPs also were reviewed. In nine of these records (100%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. Four Individuals were subjected to the regular use of restraints that were determined by the Monitoring Team to be protective mechanical restraint for self-injurious behavior (PMR-SIB). Records for these four were reviewed by the Monitoring Team (Sample C.5). Of these, none (0%) followed state policy regarding the use, management, and review of PMR-SIB. The Facility erroneously classified restraint of these four Individuals as medical restraint. Consequently, in documenting these restraints they applied incorrect provisions of the State policy on restraint and used incorrect State required forms in doing so. The Facility self-assessment rated this Provision as in compliance. Based on this review the Facility was not in substantial compliance because of its failure to properly apply the policy required administrative and review requirements associated with the use of PMR-SIB. This provision had been rated as in compliance the last review. The restraint category PNR-SIB was introduced with the DADS revised restraint policy (4/10/12). The Facility revised its restraint policy effective 12/31/12. The requirements associated with PMR-SIB had not as yet been implemented.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The restraint records involving the 10 Individuals in Sample C.1 were reviewed. Of these, two of the individuals had Crisis Intervention Plans that defined the use of restraint. For two Individuals who had Crisis Intervention Plans, two (100%) included sufficient documentation to show that the individual was released from restraint according to the criteria set forth in the Crisis Intervention Plan. For eight Individuals who did not have Crisis Intervention Plans, seven (88%) included sufficient documentation to show that the individual was released as soon as the individual was no longer a danger to him/herself. Individual #130 was the exception. The Restraint Checklist for Individual #130 reports in the Action/Release codes that at the time of release (8:26am) the Individual was attempting self-injurious behavior, was yelling/screaming, and was quiet. The Face-to-Face Assessment and Debriefing Form (FFAD) under item 1.6 reported the restraint stopped when the person no longer posed a danger to self or others. None of the restraint review documentation reconciled these	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		inconsistent data. For nine of 10 (90%) restraints in Sample C.1, documentation validated that the Individual was released from restraint as soon as the Individual was no longer a danger to him/herself or others. The Facility self-assessment rated this Provision as in compliance. Based on this review the Monitoring Team determined this Provision was in compliance.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	The Facility's policies related to restraint are discussed above with regard to Section C.1 of the Settlement Agreement. As reported in Provision C.1 the Facility had not implemented policies associated with PMR-SIB. Review of the Facility's training curricula revealed that it did include 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. Sample C.2 was selected from a current list of staff. See description of Sample C.2 in Documents Reviewed above. A sample of 24 current employees was selected from a current list of staff. A review of training transcripts and the dates on which they were determined to be competent with regard to the required restraint-related topics, showed that: • 24 of the 24 (100%) had current (as part of new employee orientation or as refresher training within the last 12 months) training in RES0105 Restraint Prevention and Rules. • 24 of the 24 (100%) had completed (as part of new employee orientation or as refresher training within the last 12 months) PMAB training within the past 12 months. In order to evaluate staff knowledge in the area of restraint 10 Direct Care Professionals were asked a series of questions. DCP staff selected for this review activity worked in residential areas where restraint occurs and most had been involved in the restraints in Sample C.1. The Monitoring Team selected names from the Restraint Checklist and this was supplemented by names selected by the Facility if staff selected by the Monitoring Team were not available. Each response was evaluated by one member of the Monitoring Team, the BSSLC Director of Residential Services, and a BSSLC QA Auditor. Consequently,	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		each question was evaluated 30 times (10 staff times 3 raters). Based on responses to questions, 10 direct support professionals provided satisfactory answers to the following questions as follows: • What policies govern the use of restraint? Sixteen of 30 were evaluated as satisfactory (53%). Staff did not have to name the policy but needed to explain content. • Describe two verbal or redirection techniques. Seventeen of 30 were evaluated as satisfactory (57%). • Describe two approved restraint techniques. Twenty four of 30 were evaluated as satisfactory (80%). • How would you supervise an individual in restraint? Twenty five of 30 were evaluated as satisfactory (83%). The above data suggests staff is not retaining information learned in formal training classes. The Facility needs to engage in additional strategies to reinforce key provisions of restraint policy such as periodic competency checks (the Facility reported competency checks were previously done but had been discontinued). Lack of staff knowledge retained from training, at least as demonstrated by this small sample of employees, could have a negative effect on future compliance with this provision. The Monitoring Team expects staff to be able to articulate that restraint is only to be used if the individual poses an immediate and serious risk of harm to him/herself or others and after a graduated range of less restrictive measures has been exhausted, state at least one example of a verbal redirection technique, two examples of approved restraint techniques, and that 1:1 supervision is ordinarily required when a person is in restraint. As noted above with regard to Section C.1 of the Settlement Agreement, 100% of the restraint records reviewed showed that restraint was only used after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. The Facility self-assessment rated this Provision as in compliance. Based on this review the Monitoring Team determined this Provision is in compliance. Competency-based training had been completed for all staff reviewed, and all restraint records reviewed showed restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. However, retention of information did not meet standards. This could become an issue for continued compliance with this Provision. To retain compliance, the Facility should implement procedures to assess and improve retention prior to the next compliance visit.	

#	Provision	Assessment of Status	Compliance
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	Based on a review of 10 restraint records (Sample C.1), in 10 (100%) there was evidence that documented that restraint was used as a crisis intervention. In review of eight Positive Behavior Support Plans, in eight (100%), there was no evidence that restraint was being used for anything other than crisis intervention (i.e., there was no evidence in these records of the use of programmatic restraint). In addition, Facility policy did not allow for the use of non-medical restraint for reasons other than crisis intervention. In nine of 10 restraint records reviewed (90%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to the "Do Not Restrain" list maintained by the Facility. Individual #460 was on the Do Not Restrain list as of 7/9/12 noting no horizontal restraint because of a fractured wrist. Individual #460 was horizontally restrained four times on 8/16/12 and once on 10/18/12. In two of 10 restraint records reviewed (20%), there was evidence that the restraint used was not in contradiction to the individuals' medical orders according to a comparison of the Annual Medical Summary Active Problems list and the form used by the Facility to document restraint considerations/restrictions (Considerations for Implementing Restraint). Examples where this was not the case included Individuals #173 and #381 (Facility reported the Considerations form was missing from the chart and was unable to locate the form to present to the Monitoring Team), Individual #460 2x (Facility reported it could not locate the chart and provided no information by the end of the review), Individuals #11 and #118 (the Considerations form did not indicate whether or not there were any medical conditions to consider), and Individuals #4 and #130 who had possibly relevant medical conditions reported on the Active Problem List (e.g. seizure disorder and post-traumatic stress disorder) but the Considerations form reported "no medical conditions to consider." In two of ten restraint records reviewed (20 %), there was evidence that the restraint used was not in contradiction to the individual's ISP, PBSP, or crisis intervention plan according to a comparison of the form used by the Facility to document restraint considerations/restrictions and subsequent action/inaction by the IDT. Examples where this was not the case are noted above. In reviewing 10 ISPs for individuals for whom restraint had been used for the completion of medical or dental work: • g. Zero (0%) showed that there had been appropriate authorization (i.e., Human Rights Committee (HRC) approval and adequate consent). Although HRC and	Noncompliance

#	Provision	Assessment of Status	Compliance
		others often referenced consents, the actual consent forms were not provided; and • h. Seven (70%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint. Examples where this was not the case included Individuals #193 and #133. Please also see discussion under Provision J4. Based on this review the Monitoring Team determined this Provision is not in compliance. This was consistent with the Facility's self-assessment.	
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	Review of Facility training documentation showed that there was an adequate training curriculum on the application and assessment of restraint. This included: PMAB 320 (PMAB Basic), PMAB 400 (PMAB Restraint), PMAB 700 (PMAB Prevent), RES0105 (Restraint: Prevention and Rules for Use at MR Facilities), CPR0100 (CPR Basic), RIG0100 (Rights of Consumers), ABU0100 (Abuse, Neglect, and Exploitation), and RMT2011 (Restraint Monitoring Training). This training was competency-based and all staff who served as restraint monitors were required to complete this training. Based on review of training records, the seven staff at the Facility who performed the duties of a restraint monitor for those restraints in Sample C.1 successfully completed the training to allow them to conduct face-to-face assessment of individuals in restraint. Based on a review of 10 restraint records (Sample C.1), a face-to-face assessment was conducted: • In 10 out of 10 instances of restraint (100%) by an adequately trained staff member. • In nine out of 10 instances (90%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. Records that did not contain documentation of this included: Individual #52. Data recorded on the Restraint Checklist and the FFAD shows that the restraint was initiated at 8:30am and the restraint monitor was notified at 9:57am and arrived at the site of the restraint at 10:00am. • In 10 instances (100%), the documentation showed that an assessment was completed of the application of the restraint. • In 10 instances (100%), the documentation showed that an assessment was completed of the circumstances of the restraint. None of the restraints used at the Facility included a physician ordered alternative monitoring schedule. Based on a review of eight restraint records for crisis intervention physical restraints in	Noncompliance

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	medical restraint, the physician shall specify the schedule and type of monitoring required.	Sample C.1 that occurred at the Facility, there was documentation that a licensed health care professional: • Conducted monitoring at least every 30 minutes from the initiation of the restraint in eight (100%) of the instances of restraint. • Monitored and documented vital signs in four (50%). The following restraint records documented that the accompanying nursing Integrated Progress Notes described Individual's maladaptive behavior and refusal to allow vital signs taken: Individual #460 on 10/18/12 at 12:48 p.m.; Individual #467 on 1/28/13 at 8:55 a.m., and Individual #173 on 2/6/13 at 7:40 a.m. and 9:23 a.m. Although the individuals above refused to have vital signs taken, the nursing staff did assess their mental status. Because documentation showed that the nurse made reasonable attempts to take vital signs for the above individuals, but they refused, and the reasons for refusal were well documented, the Monitoring Team assesses the above requirement as being 100%. When individuals refuse to have vital signs taken, the nursing staff should make every effort to assess vital signs that could be assessed through visual observations, such as respirations. When these instances of refusal occur, the IDT and/or Behavioral staff should evaluate the circumstances and determine whether to put an individualized plan in place to allow vital signs to be taken. • Checked eight (100%) for injuries related to physical restraint use. Individual #467's Restraint Checklist on 1/28/13 at 8:55 a.m., indicated there were no injuries; however, the staff nurse and RN Case Managers' Integrated Progress Notes on 1/28/13 stated Individual #467 was noted to have superficial injuries of a bite mark to left arm, 1 cm red mark on right arm near the elbow, and redness to the upper lip. The note stated that the medical director's office and mother were notified. Based on a review of one restraint record for crisis intervention chemical restraint in Sample C.1 that occurred at the Facility, there was documentation that a licensed health care professional: o Conducted monitoring at least every 15 minutes from the initiation of chemical restraint at least for two hours in one (100%) instance of restraint o Monitored and documented vital signs in one (100%). o Monitored and documented mental status in one (100%). In addition, as reported in Provision J3, documentation on a chemical restraint for Individual #402 on 2/13/13 reported appropriate monitoring by the nurse on duty. The nurse did not obtain vital signs during the two hours following the restraint; the nurse did document that the individual was agitated and did not allow the vital signs but was	

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		monitored closely and did not show any evidence of physical distress. Vital signs were done five hours after the medication, when the individual had deescalated and allowed the vital signs to be taken. Based on a review of one restraint record for crisis intervention physical restraint in Sample C.1 that occurred away from the Facility, there was documentation that a licensed health care professional: o Conducted monitoring within 30 minutes of in one (100%) upon return to the Facility. o Monitored and documented vital signs in one (100%). o Monitored and documented mental status in one (100%). Sample C.3 was selected from the list of individuals who had medical restraint in the last six months. It represents 20% of the individuals for whom medical restraint was used. (See Sample C.3 above) For these individuals, the physicians' orders were reviewed, as well as documentation of monitoring. • In five out of 10 (50%), the physician specified the schedule of monitoring required; and • In five out of 10 (50%), the physician specified the type of monitoring required. Based on this review the Monitoring Team determined this Provision is not in compliance. This was consistent with the Facility's self-assessment.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in	A sample (Sample C.1) of 10 Restraint Checklists for individuals in crisis intervention restraint was selected for review. The following compliance rates were identified for each of the required elements: • In 10 (100%), continuous one-to-one supervision was provided; • In 10 (100%), the date and time restraint was begun; • In 10 (100%), the location of the restraint; • In 10 (100%), information about what happened before, including the change in the behavior that led to the use of restraint • In 10 (100%), the actions taken by staff prior to the use of restraint to permit adequate review per C.8 • In 10 (100%), the specific reasons for the use of the restraint • In 10 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint; • In 10 (100%), the names of staff involved in the restraint episode; • Observations of the individual and actions taken by staff while the individual was in restraint, including:	Substantial Compliance

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	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.	o In 10 (100%), the observations documented every 15 minutes (no restraint lasted longer than 15 minutes) and at release (at release for physical or mechanical restraints of any duration); o In 10 (100%), the care provided by staff during the restraint, including (when appropriate) opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan • In 10 (100%), the level of supervision provided during the restraint episode; • In 10 (100%), the date and time the individual was released from restraint; and • In 10 (100%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects. In a sample of 10 records (Sample C.1), restraint debriefing forms had been completed for 10 (100%). A sample of 10 individuals subject to medical restraint was reviewed (Sample C.3), and in six (60%), there was evidence that the monitoring had been completed as required by the physician's order. Medical restraint monitoring, as specified by the physician, had not been assessed in prior reports but is an important component of ensuring monitoring is done appropriately in order to maintain safety. Sample C.1 included the one instance of use of chemical restraint (#460). In this instance 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. Based on this review the Monitoring Team determined this Provision was in compliance. Documentation of medical restraint monitoring, as specified by the physician, will need to be presented at the next review for this Provision to remain in compliance. The Facility self-assessment rated this Provision as in 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:		
	(a) review the individual's	According to Facility documentation, during the six-month period prior to the onsite	Noncompliance

#	Provision	Assessment of Status	Compliance
	adaptive skills and biological, medical, psychosocial factors;	review, a total of four individuals were placed in restraint more than three times in any rolling 30-day period. A sample (Sample #C.7) of four of these individuals (100%) was selected for review to determine if the requirements of the Settlement Agreement were met. The Individuals included in the sample were Individuals #173, #381, #460, and #467. The results of this review are discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement. Records for three of the four individuals (75%) included documentation of an ISPA following each episode of an individual having more than three restraints in a rolling 30 days. Of the four individuals reviewed, none (0%) of individual's teams (as reflected in ISPAs) discussed each individual's adaptive skills and biological, medical, and psychosocial factors and raised questions about all of these variables, thereby acknowledging the possibility of these variables influencing the individual's behavior. In none of the cases (0%), one or more of these factors were hypothesized to affect the behaviors that provoke restraints. In none of the cases (0%), there was evidence of an action plan or discussion/recommendations, identified in the ISPA, for modifying them to prevent the future probability of restraint The Facility self-assessment rated this Provision as not in compliance. Based on this review the Monitoring Team determined this Provision is not in compliance.	
	(b) review possibly contributing environmental conditions;	Records for three of the four individuals (75%) included documentation of an ISPA following each occurrence of an individual having more than three restraints in a rolling 30 days. Of the four individuals reviewed, none (0%) of individual's teams (as reflected in ISPAs) had discussed the possibly contributing environmental conditions. None of these cases (0%) included documentation of review of possibly contributing environmental conditions. For none of four (0%) individuals in the sample, IDT review documentation reflected a review of the most recent behavior assessments addressing the antecedents and consequences related to the behavior resulting in restraint. The Facility self-assessment rated this Provision as not in compliance. Based on this review the Monitoring Team determined this Provision is not in compliance.	Noncompliance
	(c) review or perform structural assessments of the behavior	Records for three of the four individuals (75%) included documentation of an ISPA following each occurrence of an individual having more than three restraints in a rolling	Noncompliance

#	Provision	Assessment of Status	Compliance
	provoking restraints;	30 days. None (0%) of these ISPAs reflected a discussion of potential environmental antecedents to the behaviors that preceded restraint, For none of four (0%) individuals in the sample, documentation, IDT review documentation reflected a review of the most recent behavior assessments addressing characteristics of the external environment (for example. availability of choice, population density, noise) and internal environment (for example. mental illness, neurological disorders, pain) related to displays of behavior resulting in restraint The Facility self-assessment rated this Provision as not in compliance. Based on this review the Monitoring Team determined this Provision is not in compliance.	
	(d) review or perform functional assessments of the behavior provoking restraints;	Records for three of the four individuals (75%) included documentation of an ISPA following each occurrence of an individual having more than three restraints in a rolling 30 days. None (0%) of these ISPAs reflected a discussion of the variable or variables that potentially are maintaining the behavior provoking restraints. For none of four (0%) individuals in the sample, IDT review documentation reflected a review of the most recent behavior assessments addressing the function of the behavior (for example. escape from demand, attention, obtaining tangibles)resulting in restraint. The Facility self-assessment rated this Provision as not in compliance. Based on this review the Monitoring Team determined this Provision is not in compliance.	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or	Records for three of the four individuals (75%) reflected a PBSP current at the time of each restraint application. Three reviewed PBSPs (100%) had operationally defined target behaviors. Three reviewed PBSPs (100%) contained functional replacement behaviors. None of the reviewed PBSPs (0%) specified, as appropriate, the use of other programs to reduce or eliminate the use of restraint. Although it might be appropriate for these other programs to be described in the ISP or ISPA rather than in the PBSP, the ISPAs for these individuals did not address these issues in a substantive manner. Three reviewed PBSPs (100%) contained interventions to weaken or reduce the	Noncompliance

#	Provision	Assessment of Status	Compliance
	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;	behaviors that provoked restraint and that were clear, precise and based on a functional assessment. No Crisis Intervention Plans were provided. Therefore: • No plans (0%) delineated the type of restraint authorized. • No plans (0%) specified the maximum duration of restraint authorized. • No plans (0%) specified the designated approved restraint situation • No plans (0%) specified the criteria for terminating the use of the restraint. The Facility self-assessment rated this Provision as not in compliance. Based on this review the Monitoring Team determined this Provision is not in compliance.	
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	Records for none of the three individuals with a PBSP (0%) reflected the presence of treatment integrity data from the time period surrounding the applications of restraint for the individual having more than three restraints in a rolling 30 days. Records for none of the three individuals with a PBSP (0%) reflected the treatment plans were implemented with at least 80% treatment integrity. The Facility self-assessment rated this Provision as not in compliance. Based on this review the Monitoring Team determined this Provision is not in compliance.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	Records for none of the four individuals (0%) included documentation of a review of the PBSP in the ISPA for individuals having more than three restraints in a rolling 30 days. For none of the four individuals (0%) did the ISPA indicate that a revision to the PBSP was necessary. Furthermore, there was evidence of a revision to the PBSP in none of the cases (0%). The Facility self-assessment rated this Provision as not in compliance. Based on this review the Monitoring Team determined this Provision is not in compliance.	Noncompliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as	The BSSLC process for reviewing each episode of restraint starts with a FFAD with the first three sections completed by the restraint monitor immediately after the restraint episode and a fourth section completed by a psychologist after interviewing staff involved in the restraint as well as the Individual restrained. The restraint episode is reviewed in the unit morning meeting the next business day after the restraint episode 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, behavioral services staff, or both. The restraint use is also	Noncompliance

#	Provision	Assessment of Status	Compliance
	appropriate.	reviewed by the Individual's IDT within three days of occurrence. If a restraint was recorded by the Facilities video surveillance system the video is reviewed and observations of the restraint episode are recorded on a Video Restraint Review Form. This provided additional opportunities for staff training and to ensure data recorded on the RC and FFAD was accurate, and if not, corrected. The Facility reported that relevant restraint related topics are discussed at regularly scheduled Restraint Reduction Committee meetings, and, occasionally at Behavior Support Committee meetings. The circumstances associated with frequently restrained Individuals are sometimes presented as "case studies" at these meetings. The files produced pursuant to Sample C.1 included this Facility-specific restraint review process in all 10 (100%) restraint episodes. A sample of documentation related to the 10 incidents of crisis intervention restraint was reviewed (Sample C.1), including the Unit Team meeting and IMRT meeting minutes, Restraint Reduction Committee minutes, ISP addenda, and debriefing meeting minutes. This documentation showed that: • In10 (100%), the review by the Unit IDT occurred within three business days of the restraint episode and this review is documented by signature on the Restraint Checklist and FFAD. • In 10 (100%), the review by the IMRT occurred within three business days of the restraint episode and this review is documented in IMRT minutes. • In 10 (100%), the circumstances under which the restraint was used was determined and is documented on the Face-to-Face Assessment Debriefing form, including the signature of the staff responsible for the review. • In none (0%), the review conducted (and documented) by the Unit IDT and the IMRT was sufficient in scope and depth to determine if the application of restraint was justified and if the restraint was applied correctly. Furthermore, it is essential for this review 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. This was not evident in the reviews; the Facility must immediately begin to address this. • In none (0%), referrals were made to the team, as appropriate. This determination was made by the Monitoring Team because there is no clear place in restraint documentation to indicate whether or not the IMRT referred a restraint to the IDT for additional consideration beyond the initial IDT meeting	

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		that usually is held within one day of the restraint episode. Restraint review did not always detect obvious discrepancies in information that should have been reconciled. For example, the video review form for restraint of Individual #4 reported both that there were not any issues during restraint with staff who were involved, and, staff were crowding the Individual causing the situation to escalate. Documentation associated with the unit review, the IMRT review, and the IDT review either did not address this by attempting to reconcile obvious conflicting information, or the video review form was not available to them when they did there reviews. Restraint review was not always complete. For example, the video review form for restraint of Individual #460 reported issues and concerns with respect to the application of this restraint. Documentation associated with the unit review, the IMRT review, and the IDT review either did not address this by attempting to reconcile obvious conflicting information, or the video review form was not available to them when they did there reviews. Sample C.1 included one chemical restraint. For this one chemical restraint, the clinical review conducted by the pharmacist and psychiatrist was sufficiently detailed to determine whether the chemical restraint was used in a clinically justified manner; that medication related risks were considered prior to the use of the chemical restraint; of the apparent effectiveness of the chemical restraint in reducing the dangerous behavior in the hours after administration; and that relevant recommendations were made by the pharmacist and the psychologist. This information was correctly documented on the Post- Chemical Restraint Clinical Review form and was signed by the pharmacist and the psychiatrist. Restraint procedures used in the sample were also reviewed at the monthly Restraint Reduction committee, typically focusing on restraint procedures associated with policy implementation issues, for example, the use of PMR-SIB, and the use of medical restraint, including TIVA. Restraint procedures were not discussed at the Behavior Support Committee observed by the Monitoring Team. 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. Based on this review the Monitoring Team determined this Provision is not in compliance. This was consistent with the Facility self-assessment.	

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

1. Train staff and implement the DADS restraint policy with respect to PMRs-SIB (Provision C.1).
2. Revise and implement a Section C Monitoring Tool (all Provisions).
3. Develop and maintain accurate information regarding the use of medical restraint (Provision C.4 and C.6).
4. Develop standardized work processes, including protocols and documentation requirements, which comply with State and Facility policy, and the requirements of the SA, with respect to medical restraint. (Provision C.4).
5. Initiate training reinforcement strategies with respect to key provisions of restraint policy such as periodic competency checks (Provision C.3).
6. Ensure that reviews conducted by the Unit IDT and IMRT address whether 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. (Provision C.8)

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 (3/21/13) 2. BSSLC Action Plan (3/11/13) 3. DADS Policy 021.2 – Protection From Harm – Abuse, Neglect, and Exploitation (12/4/12) 4. DADS Policy 02.4 Incident Management (11/20/12) 5. DADS State Supported Living Center Procedure: Injury Audits (undated) 6. Draft BSSLC Policy D.1 Protection from Harm-Abuse, Neglect, and Exploitation (12/4/12) 7. Draft BSSLC Policy DD.1 Incident Management (11/20/12) 8. BSSLC Policy D.2: Maintaining and Providing ANE Resource Guide (1/25/12) 9. BSSLC Policy D.3: Participating in and Completing Incident Management UIR Committee (1/25/12) 10. BSSLC Client Injury Report: Notification Flow Chart (undated) 11. BSSLC Instructions for Completing Non-Serious Injury Investigation (undated) 12. BSSLC Non-Serious Injury Investigation (NSI) Report (undated) 13. Form 1020 for sample of 24 employees 14. Your Rights and Zero Tolerance posters 15. Training materials used by BSSLC Abuse/Neglect classes April, 2012 16. Abuse/Neglect/Exploitation Competency Exam updated 8/1/12 17. Log of Department of Family and Protective Services (DFPS) cases 7/1/12 to 3/5/13 18. Data report prepared by the BSSLC reporting abuse & neglect allegations, and investigation disposition, from 3/1/11 to 2/28/13 19. Data report prepared by the BSSLC reporting serious incidents, by type, from 3/1/11 to 2/28/13 20. Log of Office of Inspector General (OIG) cases 7/1/12 to 3/5/13 21. Log of serious injuries 7/1/12 to 4/8/13 22. Log of other serious incidents 7/1/12 to 4/8/13 23. Log of witnessed injuries 7/1/12 to 4/8/13

	24. Log of discovered injuries 7/1/12 to 4/8/13 25. DFPS investigation reports and related materials for Sample D.1: included a sample of nine DFPS investigations of abuse, neglect, and/or exploitation with the Facility investigation reports that were selected from the log provided by the Facility noting investigations from 7/1/12 to 3/5/13. The sample was 20% of reported investigations and represented investigations that resulted in confirmed, unconfirmed, inconclusive, and administrative referral findings. Investigation records included: 42649673, 42636616, 42635981, 42633024, 42631246, 42574620, 42478149, 42470635, and 42444829 26. Facility investigation reports and related material for Sample D.2: included a sample of eight investigation reports completed by the Facility only that were selected from the log of serious injuries since the last review dated 2/28/13. The sample was 20% of reported investigations and represented investigations of serious injuries. Investigation records included: UIR's 13-019, 13-066, 13-059, 12-210, 12-213, 13-049, 13-040, and 13-056. 27. Facility investigation reports and related material for Sample D.3 included a sample of four investigation reports completed by the Facility only that was selected from the log of serious incidents since the last review dated 2/28/13. The sample was 20% of reported investigations and represented investigations of serious incidents other than serious injuries. Investigation records included: UIRs 13-038, 13-048, 13-062, and 13-067. 28. Sample D.4: ISPs for Individuals #398, #449, #115, #486, and #217 29. Other DFPS case reports: 42396346 30. BSSLC Investigator Recommendation Log 4/3/13 31. Injury review documents for a sample of discovered non-serious injuries for Individual #52 (2/5 at 7:00am), Individual #282 (10/26 at 5:35pm) , Individual #309 (8/2 at 6:10am), Individual #61 (8/23 at 7:00am), and Individual #19 (11/19 at 2:00am) 32. Injury review documents for nine reviews done by the Facility for its self-assessment. Individuals #195, #15, #41, #173, #159, #65, #19, #462, and #362 33. Incident Management Team meeting minutes 12/10, 17, and 31/12, 1/7, 14, 23, and 28/13, 2/4, 11, 19, and 25/13, and 3/4/13 34. Independent Ombudsman annual survey August, 2012 35. List of the ten most injured individuals since the last review 36. List of peers who caused the most injuries since the last review 37. BSSLC Unusual Incident Reports Trend Report 3/31/13 38. BSSLC Abuse, Neglect, Exploitation Trend Report 3/31/13 39. BSSLC Injury Trend Report 3/31/13 40. Training transcripts for Facility Investigators 41. Training transcripts for DFPS Investigators 42. Minutes of DFPS/OIG/BSSLC meeting 9/5/12 43. Minutes of Self-Advocacy group 8/20/12, 9/24/12, 10/22/12, 11/26/12, 1/28/13, and 2/25/13 44. List of BSSLC employees 3/6/13 45. DADS spreadsheet documenting background checks 9/6/12 46. DADS report MHMR0102 Percent of All Employees Completing Course of Training 3/6/13 47. Course/Due Delinquent reports for ABU0100 and UNU010 3/6/13

	48. Quality Assurance/Quality Improvement (QA/QI) Council meeting minutes for all meetings since the last review **People Interviewed:** 1. Natalie Montalvo, Facility Director 2. Kim Littleton, Assistant Director of Programs 3. Susie Johnson, Director of Residential Services 4. Melissa Moehlmann, Unit Director 5. Daniel Dickson, Quality Assurance (QA) Director 6. Michael Appling, Incident Management Coordinator 7. D'eandra Polk, Facility Investigator 8. Sandy Crenshaw, Campus Coordinator Supervisor **Meetings Attended/Observations**: 1. Childress Unit Incident Management Team meeting 4/9/13 2. IMRT Meeting 4/9/13 and 4/10/13 3. QA/QI Council meeting 4/10/13 4. Restraint Reduction Committee meeting 4/11/13 5. UIR Committee 4/9/13
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section D. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section D, in conducting its self-assessment, the Facility: ▪ Did not use monitoring/auditing tools. The Facility has not been using any monitoring tool for Section D. The Incident Management Coordinator (IMC) reported he reviews policies to ensure they cover the requirements of the SA. The IMC reported he conducts a 100% review of all investigation documentation. There was not any external validation of these reviews by the QA department. ▪ In some cases, used sampling to validate compliance, for example completion of required training classes. ▪ Used other relevant data sources such as computer generated tracking logs and staff training transcripts. ▪ The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Where appropriate, presented findings consistently based on specific, measurable indicators. For example, it compared the number of investigations completed within the required timeframe with the total number of investigations. Nearly all calculated compliance scores were 100% or near 100%; therefore, there was little discussion of the areas of strength, weakness, or the status of progress. o Consistently did not measure, when appropriate, the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the incident management

	office. ▪ The Facility rated itself as being in compliance with the following provisions of Section D: Provisions D.1; D.2.a, b, c, d, f, g, h, and i; D.3.a, b, c, d, e, f, g, h, I, and j; D.4; and D.5. This was not consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with the following provisions: D1; D.2.b, c, d, e, f, g, and h; D.3.a, b, c, d, h, i, and j; and D.5. Some of the inconsistencies resulted from sampled data showing different levels of compliance than self-assessment data. In other instances the level of analysis reflected in the self-assessment was insufficient or inconsistent with analysis conducted by the Monitoring Team. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. Actions were reported, for the most part, as maintenance of current activity to maintain compliance in Provisions that had been reported as being in compliance. The Facility data identified areas of needed improvement (for example, D.2.e) and provided a detailed set of action steps directed at compliance. The actions did provide a set of steps likely to lead to compliance with the requirements of this Section, for example additional training of IDTs and self-advocates. For those Provisions determined to be in noncompliance by the Monitoring Team the Facility will need to examine its Action Plan and make appropriate modifications.
	Summary of Monitor's Assessment: The Facility had made substantial improvements in the processes associated with the conduct of Facility investigations of serious incidents and the Facility review of non-serious discovered injuries (to rule out abuse/neglect). The Facility also made substantial improvements in the processes associated with the conduct of its review of DFPS investigations. The Facility reported it did not have Facility-specific policies in place to parallel DADS policies on abuse and neglect, and incident management. Draft Facility specific policies were developed during review week. DADS policy (which the Facility uses) expresses 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. Based on responses to questions about reporting, 10 direct support professionals provided satisfactory answers only 37% of the time when asked to describe the reporting procedures for abuse, neglect, and/or exploitation. This is of concern to the Monitoring Team. Recommendations coming from the review process were tracked and recorded 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 and injuries, and the analysis of these data, was in need

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

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	At the time of the review the Facility was unable to provide the Monitoring Team with a Facility-specific policy on Abuse/Neglect or Incident Management. The Facility reported it had adopted, and was following, the State policies on these topics. The State 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 State 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 section D of this report. The criterion for substantial compliance for this provision is the presence and dissemination of appropriate state and facility policies. The Facility initiated a draft of a facility-specific version of the State policy during the review week. Because of the Facility's high level of compliance with Section D Provisions, their implementation of the DADS statewide policy, and their initiation of a facility-specific policy during review week, the Monitoring Team is satisfied the Facility had been operating within acceptable policy parameters. Implementation of these policies on a day to day basis is monitored throughout the remaining items of section D of this report. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	Substantial Compliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>D2</td><td>Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:</td><td></td><td></td></tr>
<tr><td></td><td>(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.</td><td>According to DADS policy 21.2 (which the Facility used to guide its administrative activity with respect to abuse/neglect) staff was required to report abuse, neglect, and exploitation within one hour by calling the Department of Family Protective Services (DFPS) 800 number and notifying the Facility Director/designee. This was consistent with the requirements of the Settlement Agreement.

With regard to serious incidents, the DADS policy 2.4 (which the Facility used to guide its administrative activity with respect to incident management) required staff to report serious incidents within one hour. The process for staff to report such incidents required staff to immediately report the incident to the Facility Director/designee. This policy was consistent with the requirements of the Settlement Agreement.

According to data the Facility provided in response to the Document Request the numbers of abuse/neglect/exploitation allegations for the past two years were:

<table>
<tr><th></th><th>3/1/12 to 2/28/13 (12 months)</th><th>3/1/11 to 2/28/12 (12 months)</th></tr>
<tr><td>Total physical abuse allegations</td><td>78</td><td>167</td></tr>
<tr><td>Number confirmed</td><td>5</td><td>4</td></tr>
<tr><td>Number inconclusive</td><td>1</td><td>5</td></tr>
<tr><td>Total verbal abuse allegations</td><td>18</td><td>41</td></tr>
<tr><td>Number confirmed</td><td>0</td><td>0</td></tr>
<tr><td>Number inconclusive</td><td>0</td><td>0</td></tr>
<tr><td>Total neglect allegations</td><td>47</td><td>95</td></tr>
<tr><td>Number confirmed</td><td>1</td><td>12</td></tr>
<tr><td>Number inconclusive</td><td>1</td><td>2</td></tr>
<tr><td>Total exploitation allegations</td><td>5</td><td>1</td></tr>
<tr><td>Number confirmed</td><td>0</td><td>0</td></tr>
<tr><td>Number inconclusive</td><td>0</td><td>0</td></tr>
</table>
</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		According to Facility data provided in response to the Document Request the numbers of Unusual Incidents investigated over the past two years included: **3/1/12 to 2/28/13 (12 months)** / **3/1/11 to 2/28/12 (12 months)** Deaths: 9 / 9 Serious Injuries: 53 / 42 Sexual Incidents: 4 / 14 Suicide Threat (credible): 5 / 4 Unauthorized Departure: 1 / 3 Choking: 8 / 5 Other: 3 / 4 In order to evaluate staff knowledge in the area of abuse and neglect, 10 Direct Care Professionals were asked a series of questions. Each response was evaluated by one member of the Monitoring Team, the BSSLC Director of Residential Services, and a BSSLC QA Auditor. Consequently, for each question 30 responses were evaluated. Based on responses to questions about reporting, 10 direct support professionals provided satisfactory answers in only 11 instances (37%) when asked to describe the reporting procedures for abuse, neglect, and/or exploitation. Staff knowledge related to the results from this small sample is of concern to the Monitoring Team. Based on responses to questions about reporting, 10 staff responsible for the provision of supports to individuals provided satisfactory answers in only eight instances (27%) when asked to describe the reporting procedures for other serious incidents. The above data suggests staff is not retaining information learned in formal training classes. The Facility needs to engage in additional strategies to reinforce key provisions of abuse and serious incident reporting policy. Lack of staff knowledge retained from training, at least as demonstrated by this small sample of employees, could have a negative effect on future compliance with this provision. Based on a review of the nine investigation reports included in Sample D.1: ▪ Nine (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by Facility policy. ▪ Nine (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by Facility policy.	

#	Provision	Assessment of Status	Compliance
		Separate from Sample D.1 the Facility reported that it had identified, through the normal course of investigation reviews, two instances of untimely reporting. In both cases appropriate administrative follow-up occurred. Based on a review of 12 incident reports included in Samples D.2 and D.3: ▪ Eight (67 %) showed evidence that serious incidents, including serious injuries, were reported within the timeframes required by Facility policy. Those that did not were: UIR13-38 (incident occurred at 10:40 am and was reported at 11:58am), UIR 13-049 (incident occurred on 12/31 and was reported on 1/24), UIR 12-210 (physician exam with referral to ER occurred at 11:50am and was reported at 4:03pm, with x-rays confirming fracture not confirmed until after report to Facility administration), and UIR 12-213 (incident occurred at 8:19 pm, individual was sent to ER for treatment and, upon return at 12:35 am was reported to have had sutures; the incident was reported at 12:56am). UIR13-049 was of particular concern to the Monitoring Team. This Individual was assessed at the hospital emergency room for a possible fracture on 12/31/12. An x-ray was taken at the hospital (but not read) and sent to the Facility to be read. The Facility did not read the x-ray until 1/7/13 noting a likely fracture to the little toe. No treatment was provided pending an orthopedic consult to confirm the fracture. This was scheduled for the following week but was rescheduled. The orthopedic consult occurred on 1/23/13 confirming the fracture. Treatment consisted of placement of a stabilizing boot on the affected foot. This incident/injury was not discovered by facility staff and reported to Facility administration until 1/24/13. This Individual endured an untreated fracture for 24 days; furthermore, Facility medical staff were aware of the likely fracture for more than two weeks prior to the report. ▪ 12 (100%) showed evidence that serious incidents were reported to the appropriate party as required by Facility policy. The Facility had a standardized reporting format which meets generally accepted standards in that it contains information necessary for adequate follow-up as well as tracking and trending of incidents. Based on a review of 21 investigation reports included in Samples D.1, D.2 and D.3, 21 (100%) contained a copy of the report utilizing the required standardized format. Based on a review of 12 incident reports included in Samples D.2 and D.3: ▪ 12 (100%) utilized the standardized reporting format; and ▪ 12 (100%) were completed fully.. The Facility self-assessment rated this Provision as in compliance. Based on this review	

#	Provision	Assessment of Status	Compliance
		the Monitoring Team determined this Provision was not in compliance. The frequency of late reporting of serious injuries and incidents is problematic.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	According to DADS policy 21.2 (which the Facility used to guide its administrative activity with respect to abuse/neglect***)*** the Facility is required to immediately remove any alleged perpetrator of abuse or neglect from contact with Individuals, placing the effected staff in NDC (no direct contact) status. Additionally, the Facility is to take immediate steps with the affected Individuals such as a nursing assessment and an emotional assessment. Based on a review of nine investigation reports included in Sample D.1 100% of alleged perpetrators were removed from direct contact with individuals immediately following the Facility being informed of the allegation. Based on a review of nine investigation files included in Sample D.1 nine (100%) showed that staff that had been removed from direct contact were reinstated only after a well-supported preliminary assessment showed that the employee posed no risk to individuals or the integrity of the investigation, or the conclusion of the investigation allowed their return to direct contact duties.. Based on a review of nine of the above documents, it was documented that adequate additional action was taken to protect individuals in nine cases (100%). Actions included, for example, medical care, reassignment of roommates, and immediate training for staff. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	Substantial Compliance
	(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.	DADS policy 21.2 (which the Facility used to guide its administrative activity with respect to abuse/neglect***)*** required that all staff complete the Abuse/Neglect training class ABU0100 annually. This was consistent with the requirements of the Settlement Agreement. Training curricula related to abuse and neglect were reviewed 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 be competency-based, testing provided at the completion of training classes validated staff competency in understanding the definitions of abuse, neglect, and exploitation; and, reporting requirements. ▪ The training did provide adequate training regarding recognizing and reporting signs and symptoms of abuse, neglect, and exploitation.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Review of 24 staff records (Sample C.2), showed that 24 (100%) of these staff had completed competency-based training on abuse and neglect as part of New Employee Orientation and therefore prior to working directly with individuals. Review of DADS computer reports displaying the percentage of completion for training classes showed that 99% were current in completing abuse and neglect training. In order to evaluate staff knowledge in the area of abuse and neglect 10 Direct Care Professionals were asked a series of questions. Each response was evaluated by one member of the Monitoring Team, the BSSLC Director of Residential Services, and a BSSLC QA Auditor. Consequently, for each question 30 responses were evaluated. Based on responses to a question asking staff to describe two signs/symptoms of abuse, 10 direct support professionals provided satisfactory answers in only 15 instances (50%). Based on responses to a question asking staff to describe two signs/symptoms of neglect, 10 direct support professionals provided satisfactory answers in only 12 instances (40%). Based on responses to a question asking staff to describe the reporting procedure/timeline for abuse/neglect, 10 direct support professionals provided satisfactory answers in only 11 instances (37%). The Monitoring Team is concerned that staff knowledge retained from training, at least as demonstrated by this small sample of employees, could have a negative effect on future compliance with this provision. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment. The Facility needs to develop and implement strategies to ensure staff retains knowledge learned in training on abuse and neglect.	
	(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	According to DADS policy 21.2 (which the Facility used to guide its administrative activity with respect to abuse/neglect) staff is notified of abuse/neglect reporting responsibilities and must sign an acknowledgment form. This is Form 1020. 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 acknowledgement form. A sample of 24 staff (Sample C.2) was randomly selected to determine if annual	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	acknowledgements had been signed. Of these, 24 (100%) had signed annual acknowledgments. The Facility was asked for a list of staff who had been identified as having failed to report abuse and/or neglect. This generated a list of five instances of delayed reporting. Staff training and appropriate personnel actions related to these failures were taken. No instances of failure to report were identified by the Facility or detected by the Monitoring Team in its review of documents. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	
	(e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation.	According to DADS policy 21.2 (which the Facility used to guide its administrative activity with respect to abuse/neglect) IDTs were to provide LARs with written communication on abuse/neglect identification and the reporting process. Additionally, this topic is to be a regular point of discussion at each Individual's ISP meeting. A review was conducted of the materials to be used educate individuals. Materials included necessary information and were easy to understand and available in English and Spanish language versions. A review was conducted of the materials to be used to educate legally authorized representatives (LARs) or others significantly involved in the individual's life. Materials were easy to understand and available in English and Spanish language versions. The Monitoring Team review of ISPs associated with other Sections of the SA confirmed that there is now a consistent method of documenting in the annual ISP the education of the LAR and individual on identifying and reporting ANE. The ISP template includes this topic to ensure it is covered in each ISP meeting. Based on a review of five individuals' ISPs (Sample D.4), five individuals, or their LAR and/or other significantly involved individual had been informed of the process of identifying and reporting unusual incidents, including abuse, neglect, and exploitation. The ISP template includes a section addressing this topic. Additional validation of compliance with this Provision was provided in a survey completed by the Independent Ombudsman which included a four day site review. This survey occurs annually and the survey report was presented to the Facility QA/QI Council. This survey included an interview with 30 Individuals. From this survey it was reported: • 60% of respondents reported they had been informed of their rights and could	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		name some of their rights. • 80% reported they know what to do if they have a rights concern. • 100% reported they are comfortable speaking up for themselves. The survey included a family member component. Family member respondents reported: • 90% had been notified of the Individuals rights. • 80% know how to file a complaint. In interviewing a sample of four individuals, all were able to describe what they would do if someone hurt them, or they had a problem with which they needed help. The Facility reported no serious incidents were reported by individuals or LARs. The Facility self-assessment rated this Provision as not in compliance. Based on this review the Monitoring Team determined this Provision was in 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.	According to DADS policy 21.2 (which the Facility used to guide its administrative activity with respect to abuse/neglect***)*** postings directed at compliance with this requirement are to be maintained at all times. A review was completed of the posting the Facility used. It did include a brief and easily understood statement of: 1) individuals' rights; 2) information about how to exercise such rights; and 3) information about how to report violations of such rights. Observations by the Monitoring Team of 24 of 24 living units and day programs on campus showed that 24 (100%) of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. The Facility reported it has on ongoing surveillance process that ensures the presence of posters is maintained. At the time of the review this process was informal and the Facility was unable to provide any documentation to validate its existence. The Facility will need to formalize this process and include it (and reports) in its regular QA program. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	Substantial Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	According to DADS policy 21.2 (which the Facility used to guide its administrative activity with respect to abuse/neglect***)*** allegations of abuse/neglect are to be reported, as appropriate, to law enforcement.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Based on a review of nine allegation investigations completed by DFPS (Sample D.1), in seven for which a referral to law enforcement was necessary/appropriate, DFPS had made referrals in seven (100%). The following provide examples of allegations that were referred appropriately: ▪ Investigation 42470635, an allegation of physical abuse ▪ Investigation 42478149, an allegation of physical abuse Based on a review of 12 investigations completed by the Facility (Samples D.2 and D.3), in none was a referral to law enforcement necessary/appropriate. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	
	(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.	According to DADS policy 21.2 (which the Facility used to guide its administrative activity with respect to abuse/neglect***)*** retaliation against reporters of abuse/neglect is prohibited and not tolerated. Based on interviews with the Facility Director, Assistant Director of Programs, and the Director of Residential Services, these requirements are included in training curriculum and re-enforced using postings throughout the facility. Each stated emphatically that retaliation is not tolerated and when alleged or detected was formally investigated. One such allegation is presently under investigation and the alleged victim has been provided with a work environment which assures no opportunity for contact with the alleged perpetrator of retaliation. Based on interviews with 10 staff, 10 (100%) reported they were confident that retaliation would not be tolerated. As noted in Provision D.2.e in response to a survey conducted by the Independent Ombudsman 30 of 30 (100%) Individuals interviewed reported they were comfortable in speaking up for themselves. In addition to data reported under Provision D.2.e, these 30 respondents also reported they felt their teams listened to them. This suggests that they could tell staff or call to report that someone had hurt them or not taken care of them, and they would not get into trouble. Based on a review of investigation records (Samples D.1, D.2, and D.3), there were not concerns noted related to potential retaliation. Outside investigators (DFPS/OIG) were not onsite during the week of this review and were not interviewed to further validate compliance with this Provision. In previous reviews outside investigators reported no issues with retaliation.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		The Facility was asked for a list of staff against whom disciplinary action had been taken due to their involvement in retaliatory action against another employee who had in good faith had reported an allegation of abuse/neglect/exploitation. The Facility reported no allegations of retaliation had been reported or detected since the last review by the Monitoring Team except for the recent case noted above which was still under investigation at the time of the review. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	DADS policy 21.2 (which the Facility used to guide its administrative activity with respect to abuse/neglect***)*** establishes a general framework for the review and investigation of injuries. The Monitoring Team was provided with an additional document by DADS at the entrance conference titled "State Supported Living Center Procedure: Injury Audits." This procedure reports the following as its purpose: 1. A process to conduct audits of the resident's records to detect incidents which may have resulted in an injury and generate a Client Injury Report (CIR). 2. The proper coding of injuries to residents 3. Decreasing injuries of known or unknown source or origin 4. Ensuring residents remain free from abuse, neglect, or exploitation 5. Compliance with significant injury audit requirements D2i of the Settlement Agreement. The procedure calls for a six month review of a 20% sample of Individuals living at the Center. The review will look at, at a minimum, Integrated Progress Notes, Home/Shift Logs, Observation Notes, and Campus Coordinator Logs to review and identify incidents that may have resulted in completing a UIR. The audit will also determine if the injury was coded and investigated (serious injuries and injuries of unknown source) per SSLC Incident Management Policy and Injury Reporting Procedure. This procedure does not specifically require that the Facility review Individuals who had multiple minor injury issues that may represent a pattern or trend that might merit further investigation, either because of the type or body location of injury, location or shift that injuries occur on, a preponderance of discovered injuries, and any other variables that might merit examination and could be potentially useful in reducing the number of injuries incurred by that Individual. Because this procedure was new and had only recently been provided to the Facility it had not as yet been implemented. Irrespective of this new DADS requirement the Facility had engaged in some impressive	Noncompliance

#	Provision	Assessment of Status	Compliance
		review activity of non-serious discovered injuries to ensure they were not significant and therefore merited official investigation via the UIR process, or reported to DFPS because of a suspicion of abuse or neglect. The Monitoring Team was provided with a document titled "Client Injury Report: Notification Flow Chart" and a companion document titled "BSSLC Instructions for Completing Non-Serious Injury Investigation (NSI)." Injury reviews (investigations) conducted pursuant to these instructions were documented using a standard template, titled "Non-Serious Injury Investigation (NSI) Report" that clearly shows what documents were reviewed, summarizes relevant information from these documents, who was interviewed and a summary of relevant information obtained from the interview, a clear statement of conclusion whether or not abuse/neglect is suspected, and validation that the injury had been properly reported. This process had been put in place in September, 2012. Additionally, as part of its self-assessment process the Facility reported it had reviewed nine discovered injuries which because of their type or location were considered suspicious. The purpose of this review was to determine if any should be reported to DFPS for formal investigation. These reviews were conducted by Facility Investigators The Monitoring Team reviewed these reviews and found them to be very thorough looking at much of the same information described in the previous paragraph, including interviews with relevant staff. Still lacking at the Facility was a process which reviewed data associated with frequently injured individuals to assess whether or not the nature of the injuries, the time and/or place of the injuries, or any other factors suggested a need to examine trend data further to assess system causes and trends of injuries to prevent future injuries from occurring. Based on this review the Monitoring Team determined this Provision was not in compliance. DADS had recently established procedures for injury audits which had not yet been implemented. The Facility is to be commended for the initiative it had taken since the last review in implementing reviews/investigations of non-serious suspicious discovered injuries.	
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		

#	Provision	Assessment of Status	Compliance
	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.	DADS policy 2.4 (which the Facility used to guide its administrative activity with respect to incident management***)*** did describe in a comprehensive fashion of the conduct of all such investigations; did require that investigators be qualified requiring that Investigators complete training in Comprehensive Investigator Training (CIT0100), People with MR (MEN0300), Conducting Serious Incident Investigations or Fundamentals of Investigation (INV0100, and, a class in Root Cause Analysis; and required that investigators be outside of the direct line of supervision of the alleged perpetrator. Training curricula were reviewed for Department of Family and Protective Services (DFPS) and Facility investigators. This review of material used by DFPS in training its investigators revealed the following: The required class "MH&MR Investigations ILSD" consisted of the following modules: 1. Introduction and History of DFPS, APS, DADS, and DSHS 2. Laws, Rules, & Policies Governing APS MH&MR Investigations 3. Dynamics of Abuse, Neglect, and Exploitation 4. Psychiatric Terms 5. Client Rights 6. Prevention and Management of Aggressive Behavior 7. Evidence Collection 8. Basic Interviewing 9. Interviewing Persons with Developmental Disabilities 10. MH&MR IMPACT Technical Guide 11. Analysis of Evidence 12. Effective Writing 13. Disposition of Cases The required class MH&MR Investigations ILASD included the following modules: 1. Cross-Cultural Interviewing 2. Strengthening the Written Report 3. Deception and Confrontation of Deception 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 and meets the requirements of the SA. DADS policy reported that Facility Investigator training is to consist of the following classes:	Substantial Compliance

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		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, was competency based, and meets the requirements of the SA. The training records for DFPS investigators were reviewed with the following results: ▪ Two out of two DFPS investigators (100%) had completed the requirements for investigations training. ▪ Two out of two DFPS investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. The training records for Facility investigators were reviewed with the following results: ▪ Four out of five Facility investigators (80%) had completed the requirements for investigations training. The fifth investigator was new and had not as yet taken the Conducting Serious Investigations class but was scheduled to do so the following week. This investigator had not been assigned cases. ▪ Five out of five Facility investigators (100%) had completed the requirements for training regarding working with individuals with developmental disabilities. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	According to DADS policy 2.4 (which the Facility used to guide its administrative activity with respect to incident management), Facility staff were required to cooperate with outside entities conducting investigations of abuse and neglect. This included the following language: 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. 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. Employees who fail to cooperate with an investigation are subject to disciplinary	Substantial Compliance

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		action. As described above with regard to Section D.2.a of the Settlement Agreement, three samples of investigation files were selected for review. These included Samples D.1, D.2, and D.3, which consisted of DFPS investigations, and Facility investigations, respectively. Review of the investigation files in Sample D.1 showed that in nine out of nine investigations (100%), Facility staff cooperated with DFPS investigators. Outside investigators (DFPS/OIG) were not onsite during the week of this review and were not interviewed to further validate compliance with this Provision. In previous reviews outside investigators reported no issues with Facility cooperation. As an added measure to ensure inter-agency communication, the Facility convenes a quarterly meeting with DFPS and OIG to discuss, among other things, any issues which may affect compliance with this Provision The Facility self-assessment rated this Provision as in compliance. Based on this review the Monitoring Team determined this Provision was in compliance.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The Memorandum of Understanding, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Based on a review of the investigations completed by DFPS and the Facility, the following was found: ▪ Of the nine investigation records from DFPS (Sample D.1), seven had been referred to law enforcement (Office of Inspector General). For these seven (100%) there was adequate coordination to ensure that there was no interference with law enforcement's investigations. ▪ Of the 12 investigation records from the Facility (Samples D.2 and D.3), none had been referred to law enforcement agencies because none were appropriate for referral. Outside investigators (DFPS/OIG) were not onsite during the week of this review and	Substantial Compliance

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		were not interviewed to further validate compliance with this Provision. In previous reviews outside investigators reported no issues with coordination of investigatory effort. As an added measure to ensure inter-agency communication, the Facility convenes a quarterly meeting with DFPS and OIG to discuss, among other things, any issues which may affect compliance with this Provision. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	
	(d) Provide for the safeguarding of evidence.	According to DADS policy 2.4 (which the Facility used to guide its administrative activity with respect to incident management***)*** the Facility is required to preserve and secure physical evidence. The policy also states "the facility investigator should prioritize the collection of evidence that is most at risk of contamination. In most cases, the highest priority will be to identify interviewees and physically separate them until they have interviewed." Evidence gathered through interview is considered testimonial evidence. While on site, the Monitoring Team observed the area the Facility uses for safeguarding physical evidence. This included a locked cabinet in the office of the Incident Management Coordinator. Physical evidence was placed in a paper bag and was identified as to content, collector, and date. The IMC office is also locked and only accessible to the IMC and his supervisor, the QA Director. Based on a review of the investigations completed by DFPS (Sample D.1) and the Facility (Samples D.2 and D.3): ▪ Physical evidence that needed to be safeguarded was safeguarded in all DFPS investigations; and ▪ Physical evidence that needed to be safeguarded was safeguarded in all Facility investigations. With regard to testimonial evidence, the Monitoring Team found no evidence that would suggest that component of the DADS policy (separation of witnesses until they are interviewed) was being followed. In reviewing Sample D.1 (DFPS investigations) there was no indication that interviewees had been physically separated pending interview. As a practical matter this would be difficult since DFPS rarely began interviews of collateral witnesses or alleged perpetrators (AP) until at least three days after the allegation was reported, and in several cases seven days or longer (including 11 days in one case) after the allegation was reported. When an AP is placed on No Direct Care (NDC) status they sign an acknowledgment statement that includes, among other things, the following statement: "You are not to discuss the allegations or details of the investigation with	Substantial Compliance

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		anyone other than the investigators." In abuse/neglect training, and unusual incident training, staff is instructed to not discuss with each other any information regarding incidents under investigation. Outside investigators (DFPS/OIG) were not onsite during the week of this review and were not interviewed to further validate compliance with this Provision. In previous reviews outside investigators reported no issues with protection of physical evidence. As an added measure to ensure inter-agency communication, the Facility convenes a quarterly meeting with DFPS and OIG to discuss, among other things, any issues which may affect compliance with this Provision. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment. DADS should review its policy with respect to testimonial evidence and provide guidance to Facility's as to how it should be implemented.	
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	According to DADS policy 2.4 (which the Facility used to guide its administrative activity with respect to incident management***)*** investigations of serious incidents: ▪ Were to commence within 24 hours or sooner, if necessary; ▪ Were to be completed within 10 calendar days of the incident; ▪ Did require a written extension request from the Facility Superintendent or Adult Protective Services Supervisor to be completed and approved outside of the 10-day period, and only under extraordinary circumstances; and ▪ Were to result in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample D.1) and the Facility (Samples D.2 and D.3) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: Nine out of nine (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation. Typical activity reported in investigation reports included:	Noncompliance

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		• 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). • Checking to assure that any known APs were placed in NDC status, • The identification of any collateral witnesses, • Validation that the Facility has (or is) gathering all relevant documentation, • Validation that any physical evidence is secure, • A determination that there is or is not likely video surveillance evidence to review, • The development and review of a preliminary investigation plan. Commencement of interviews with collateral witnesses and AP's is not required to occur within 24 hours except for Class I allegations. In some cases the time delay in beginning staff interviews was extraordinary and could have affected the accuracy of testimonial evidence. For example, with case 42470635 (confirmed physical abuse) staff interviews did not begin until seven days after the allegation. With case 42478149 (inconclusive physical abuse) staff interviews did not begin until 11 days after the allegation. With case 42574620 (unconfirmed neglect) staff interviews did not begin until seven days after the allegation. With case 42631246 (unconfirmed physical abuse) staff interviews did not begin until seven days after the allegation. Six out of nine (67%) were completed within 10 calendar days of the incident, including sign-off by the supervisor; for the three that were not completed within 10 days, one (33%) had documentation of a written extension request that had been approved by the Adult Protective Services Supervisor, and there was documentation of the extraordinary circumstances that necessitated the extension. Those that did not have such documentation included investigation 42478149 (inconclusive physical abuse) and investigation 42631246 (unconfirmed physical abuse). Following the compliance visit, the Facility stated that it recognized investigation 42478149 had no supervisor signature but stated a DFPS Extension Request Form cannot be generated without supervisor approval. Investigation 42478149 took six weeks to complete. Documentation provided to the Monitoring Team included extension requests that did not include supervisor approval. The primary reason for each extension request was related to the investigator's workload. This is not acceptable as an extraordinary circumstance. DFPS should ensure cases are assigned to investigators in such a manner that they can be reasonably assured of meeting the 10 day requirement of the SA. Investigation 42631246 took 20 days to complete. Documentation provided to the	

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		Monitoring Team did not include any evidence of extensions being requested or being approved. Nine (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. None of the investigations reviewed (0%) included recommendations for corrective action. In four of the investigations (44%), concerns were noted regarding Facility practices that should be addressed. Because these were not stated in the form of recommendations the Monitoring Team cannot determine if addressing the concerns would be adequate to address issues related to the findings of the investigation. It would be helpful if DFPS reports were to contain specific recommendations, where appropriate, rather than merely reporting concerns. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: Twelve out of 12 (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the Unusual Incident Report (UIR) that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of the Facility being notified or becoming aware of the serious incident. The Facility had modified the UIR template to clearly describe commencement timeframes and work activity. Twelve out of 12 (100%) were completed within 10 calendar days of the incident, including sign-off by the supervisor. Twelve (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. In twelve of the investigations reviewed, recommendations for corrective action were included. In 12 of the investigations (100%), the recommendations were adequate to address the findings of the investigation. Based on this review the Monitoring Team determined this Provision was not in compliance because of insufficient documentation associated with DFPS investigations taking longer than 10 days to complete.	
	(f) Require that the contents of the	Based on a review of According to DADS policy 2.4 (which the Facility used to guide its	Noncompliance

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	report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	administrative activity with respect to incident management***)*** the policy did require that: ▪ The contents of the investigation report be sufficient to provide a clear basis for its conclusion; ▪ The report utilize a standardized format that sets forth explicitly and separately: o Each serious incident or allegations of wrongdoing; o The name(s) of all witnesses; o The name(s) of all alleged victims and perpetrators; o The names of all persons interviewed during the investigation; o For each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o All documents reviewed during the investigation; o All sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o The investigator's findings; and o The investigator's reasons for his/her conclusions. Investigation files maintained by the Facility were well organized. Each file contained 23 tabs which identified content of each tab and organized relevant material. Each file included a "BSSLC Filing System for Unusual Incident Investigations" cover sheet which served as a table of contents for the file, and a checklist recording the presence of required documents in the file. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample D.1) and the Facility (Samples D.2 and D.3) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ In seven out of nine investigations reviewed (78%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. The following provides information regarding the concerns identified: o Investigation 42478149 (inconclusive physical abuse): the alleged victim was on 1:1 supervision and received injuries to the upper back and shoulder that, according to the allegation, could have possibly been caused by being hit with a coat hanger or belt. Interview statements could have been used to establish the last time the Individual was observed without the injury and the first time the Individual was	

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		observed with the injury (the next morning). The investigation report did not clearly identify which staff had 1:1 assignment responsibility during this period or a timeline associated with these assignments. Interviews reported in the investigation report were not always complete; for example, the interview of a staff who walked in to the Individual's room in the middle of the night does not appear to include questions such as "what did you see?", what did you hear?", "was anyone else in the room?", "what were they doing?". The video review associated with this investigation was incomplete. The injury likely occurred in the time period between being observed without the injury and first being seen with the injury. Video was not reviewed for this entire time period (9:32pm to 2:35am). Review of this video could have determined who may have entered and exited the Individual's room and possibly been the perpetrator of the injuries. Finally, staff interviews did not begin until 11 days after the incident was reported. This could have affected the accuracy of the testimonial evidence. All staff interviewed denied having any knowledge of how the Individual received the injuries despite several of them having been assigned 1:1 supervision responsibility. o Investigation 42444829 (administrative referral). This was reported as an injury involving multiple red marks 6-8 inches long on the lower back including eight "down the center" of the back. The preliminary investigation by DFPS concluded the injuries occurred because of an unpadded gait belt. As a result it did not meet the definition of abuse or neglect and was sent back to the Facility as an Administrative Referral. None of the documentation provided to the Monitoring Team confirmed with certainty that the scratches were vertical or horizontal. If horizontal, the gait belt hypothesis was plausible; however, documentation reported eight "down the center" suggesting the scratches were vertical, and making the gait belt hypothesis much less plausible. It was not clear if pictures of the injury were available to DFPS. DFPS should have reviewed this reported injury further and accepted this allegation for formal investigation. ▪ The report utilized a standardized format that set forth explicitly and separately o In nine (100%), each serious incident or allegations of wrongdoing; o In nine (100%), the name(s) of all witnesses; o In nine (100%), the name(s) of all alleged victims and perpetrators; o In nine (100%), the names of all persons interviewed during the investigation; o In nine (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of	

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		questions posed, and a summary of material statements made; o In nine (100%), all documents reviewed during the investigation; o In nine (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 nine (100%), the investigator's findings; and o In nine (100%), the investigator's reasons for his/her conclusions. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ In 11 out of 12 investigations reviewed (92%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. The investigation of the serious injury documented in UIR 13-066 did not. The Individual was discovered with a fractured thigh. The investigation did not consider that staff handling of the Individual could have caused or contributed to movement that resulted in the fracture (although clearly documented in the UIR were statements related to the staff turning the Individual over in bed several times). This should have been examined closer. ▪ The report utilized a standardized format that set forth explicitly and separately o In 12 (100%), each serious incident or allegations of wrongdoing; o In 12 (100%), the name(s) of all witnesses; o In 12 (100%), the name(s) of all alleged victims and perpetrators; o In 12 (100%), the names of all persons interviewed during the investigation; o In 12 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In 12 (100%), all documents reviewed during the investigation; o In 12 (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 12 (100%), the investigator's findings; and o In 12 (100%), the investigator's reasons for his/her conclusions. The Facility is to be commended for changes it initiated in formatting data presented in the UIR to be more consistent with SA requirements. This should facilitate consistent and accurate self-assessments. Based on this review the Monitoring Team determined this Provision was not in compliance because of issues associated with DFPS investigations. The Facility, in its review of DFPS investigations, must ensure the investigations are thorough, complete,	

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		timely, and reach appropriate conclusions.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	According to DADS policy 2.4 (which the Facility used to guide its administrative activity with respect to incident management***)*** it did require that staff supervising the investigations reviewed each report and other relevant documentation to ensure that: 1) the investigation is complete; and 2) the report is accurate, complete and coherent. The policy did require that any further inquiries or deficiencies be addressed promptly. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample D.1) and the Facility (Samples D.2 and D.3) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ In nine out of nine investigation files reviewed (100%), there was evidence that the supervisor had conducted a review of the investigation report. ▪ In seven (78%), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. For the two investigations noted above (in Provision D.2.f) for which the Monitoring Team identified deficiencies, the supervisory review did not appear to identify and address these deficiencies. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ In 12 out of 12 investigation files reviewed (100%), there was evidence that the supervisor had conducted a review of the investigation report. ▪ In 11 (92%), there was evidence that the review had resulted in changes being made to correct deficiencies or complete further inquiry. ▪ For the one investigation noted above (Provision D.3.f) for which the Monitoring Team identified deficiencies, the supervisory review did not appear to address these deficiencies. The Facility's process for review of investigation reports was much improved from that noted in previous reviews. The IMC was much more thorough in his reviews. Fewer, and less substantive, issues are being identified by the Monitoring Team. The work of the Facility's UIR Review Committee was also impressive. Twice a week this group (consisting of the Facility Director, Assistant Director of Programs, Director of Residential Services, the Independent Ombudsman, and a Unit Director) meets to review, in detail, UIRs and DFPS investigation reports. This has, in the view of the Monitoring	Noncompliance

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		Team, had a positive impact on the overall improvements observed by the Monitoring Team in the conduct of Facility investigations and the review and follow-up associated with DFPS investigations. Based on this review the Monitoring Team determined this Provision was not in compliance. Three of 21 (14%) investigations reviewed were not thorough and complete. Two of the DFPS investigations (22%) and one Facility investigation (8%) were deficient in meeting the requirements of this Provision.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	The Facility prepared a written report addressing each investigation deficiency or area needing further inquiry that the Facility discovered pursuant to the provisions of subparagraph g. This was done consistently for each Facility investigation and DFPS investigation. This was a separately prepared brief report prepared by the IMC summarizing relevant information pertinent to subparagraph g. Additionally, the UIR Review Committee report associated with each incident further documents actions taken pertinent to subparagraph g. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	According to DADS policy 2.4 (which the Facility used to guide its administrative activity with respect to incident management, disciplinary or programmatic action necessary to correct the situation and/or prevent recurrence was to be taken promptly and thoroughly. In addition, the Facility was to have a system for tracking and documenting such actions and the corresponding outcomes. The Facility maintained a UIR Tracking Log which described each recommendation made by the IMRT and UIR Review Committee, the person responsible for implementing, and the projected and actual completion dates. The Monitoring Team examined documentation associated with each investigation in Samples D.1, D.2, and D.3 to determine if recommended actions had been taken and could be verified with source documentation. In each case it did. The following summarizes the results of this review: For 21 out of 21 of the investigations reviewed (100%), prompt and adequate disciplinary action, when appropriate, had been taken and documented. For example, the following disciplinary actions had been taken: 1) UIR-005: appropriate Personnel Performance Measure (PPM) for failure to properly supervise when assigned 1:1 responsibility, and 2) UIR13-003: termination related to confirmed abuse.	Substantial Compliance

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		For 21 out of 21 of the investigations reviewed (100%), prompt and thorough programmatic action had been taken and documented. For example, the following programmatic actions had been taken: 1) IDT review of Positive Behavior Support Plans, 2) retraining of specific staff person, and 3) retraining of all home staff. For 21 out of 21 investigations (100%), there was documentation to show that the expected outcome had been achieved as a result of the implementation of the programmatic and/or disciplinary action. Documentation of planned and completed actions described in each UIR and the UIR Review Committee Report Recommendations was complete in all 21 investigations. Outcome related data was not well organized and often was anecdotal information, for example, "since John Doe was retrained in abuse/neglect reporting we've had no further reports of late reporting by John Doe." The Facility needs to improve its processes, including the use of QA data, in determining that actions taken relative to this Provision achieved the intended outcomes. Most actions developed pursuant to this Provision focused on an individual employee, or small group of employees, changing work practices, usually as an outcome from retraining. Evaluative measures should be undertaken to see if whatever deficient practice was identified seems to be occurring more, or less, frequently at the Facility. The Facility had an effective mechanism for tracking and documenting recommended actions and in part 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 tracked 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. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	
	(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	According to DADS policy 2.4 (which the Facility used to guide its administrative activity with respect to incident management***)*** records of every investigation are to be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual. At the Facility, electronic data systems are maintained which allow the IMC to sort investigation records by name of the alleged perpetrator or by name of the alleged	Substantial Compliance

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	particular staff member or individual.	victim. The IMC reported that DFPS also has a data management system that allows a search of prior case history of alleged perpetrators and alleged victims. Additionally, DFPS, if necessary, can obtain these data from the Facility. For Facility investigations, these data are included in the UIR template which enables the Facility investigator to determine its relevance to each investigation. Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	
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.	The Facility did not have a written defined process for the collection, compilation, and analysis of data relevant to this provision. While not having a defined process, at least some elements of what would be included in a defined process were present. These are discussed below. BSSLC produced a monthly Trend Report. The Abuse/Neglect Exploitation section of this report displayed the number and type of abuse, neglect, and exploitation allegations for each month going back to the start of the prior fiscal year. This included the number of cases referred to DFPS. Total allegations and the outcome of investigations were trended for a rolling 12 months. The rolling 12 month data was also delineated by unit, by living area within each unit, and by individuals involved in allegations. Current month data also identified alleged perpetrators. The BSSLC produced a similar report tracking and trending injuries to individuals and Unusual Incident Reports. In its last report the Monitoring Team reported that the trend report for UIRs needed improvement in the tracking and trending of serious injuries. The report tracked "undetermined cause" and "determined cause" for the report month only. The determined category included discovered injuries for which a probable cause (as opposed to an injury that was witnessed) was established as part of the investigation process. It would 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." It is important that the Facility closely examine discovered serious injuries for which a probable cause is established to ensure the identified probable cause is based on objective evidence and sound logic. Additionally, these data should be trended over time using a line graph to quickly identify trends. It is important that compilation of data is useful for analysis. Although some information required in this provision was collected and made available in a monthly report, and should have been regularly reviewed at the Quality Assurance	Noncompliance

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		Quality Improvement Council (QA/QA Council), there was not evidence provided to the Monitoring Team that this review occurred according to the established quarterly schedule or that it comprehensively identified and addressed issues, systemic or otherwise. In reviewing minutes of the QA/QI Council from November, 2012 through April, 2013 (six months), Section D was included in the agenda once, at the March meeting. The report included data but did not include any narrative interpreting the data or highlighting key data that could have been noted by either the QA Director of the IMC. The minutes contained limited review information, briefly commenting on serious injuries. The minutes did not reflect any discussion of abuse or neglect, or other serious incidents (other than injuries). Information collected by the Facility should be used to address problems that are barriers to protecting individuals from harm. In its last report the Monitoring Team noted that as the Facility continued to develop its system of quality improvement, these reports would be critical in evaluating progress. This was not occurring. 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 Facility did not use its analysis of data collected pursuant to this provision to identify trends and identify apparent problems and issues that needed attention. One obvious area ripe for analysis is the data presented in Provision D.1. According to these data the number of allegations, year to year, decreased dramatically. Any time key data, when reviewed longitudinally, change dramatically they should be examined closely. In this example the significant decrease in allegations could be attributable to any of a number of causes--some Individual or Individuals who had been the subject of frequent allegations having been discharged; some staff who had been the subject of frequent allegations no longer working at the Facility; or under-reporting might exist. Conversely, the Facility may have increased presence of supervisors in residential areas or may have improved active treatment and behavioral programming, The point in all this is that data that appears to be "good news" (decreased allegations) may not be when probed in greater depth. In this case, number of allegations decreased, but number of confirmed allegations did not; the Facility should evaluate the possible reasons for the decrease in light of that. Based on this review the Monitoring Team determined this Provision was not in compliance. This Provision was rated as in compliance at the last review based on progress to date. The lack of continued progress in the areas of data analysis, and use of data to identify needed improvements demonstrates regression in compliance with this Provision.	

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D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: criminal background check through the Texas Department of Public Safety (for Texas offenses) and an FBI fingerprint check (for offenses outside of Texas); Employee Misconduct Registry check; Nurse Aide Registry Check; Client Abuse and Neglect Reporting System; and Drug Testing. Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position also had to undergo these background checks. In concert with the State Office, the Director had implemented a procedure to track the investigation of the backgrounds of Facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. A random sample of 24 employees confirmed that their background checks were completed. The information obtained about volunteers was discussed and confirmed through the review of documents provided to the Monitoring Team. Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. All employees were subject to fingerprint checks during the month of October, 2010. Since then, new hires have had fingerprint checks as part of their pre-employment screening. Once the fingerprints were entered into the system, the Facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry. In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. Examination of the self-reporting information documented that the Facility Director maintained o a log of instances where an employee did not self-report and initiated appropriate administrative/disciplinary action when this occurred. In an interview with the Facility Director, her decisions regarding the employment of a sample of applicants with any criminal history were discussed on a case-by-case basis. In each instance, her decisions were based on the facts and were mindful of her responsibility to safeguard the individuals and staff of the Facility Based on this review the Monitoring Team determined this Provision was in compliance. This was consistent with the Facility's self-assessment.	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. The Facility needs to implement the recently issued DADS procedures for injury audits (Provision D.2.i).
3. Investigations of serious incidents need to begin within 24 hours of being reported (Provision D.3.e).
4. 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).
5. The thoroughness of Facility review of investigation needs to continue to improve (Provision D.3.g).
6. Data maintained and trended needs to be more comprehensive and needs to be used to make improvements at the Facility (D.4)

The following additional recommendations are offered to the Facility:

1. The Facility-specific policies governing abuse and neglect, and incident management, need to be finalized.
2. DADS should review its policy with respect to testimonial evidence and provide guidance to Facility's as to how it should be implemented.
3. Work on qualitative enhancements to the trend reports so that facility leadership can better understand issues that may require focused attention.
4. The Facility should identify and implement strategies that reinforce knowledge gained in staff training classes with respect to abuse policies.

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 3/21/13 2. BSSLC Action Plan 3/11/13 3. DADS Policy 003.1 Quality Assurance 1/26/12 4. DADS SSLC Nursing Quality Assurance Audit Process 3/21/13 5. BSSLC Policy E.1 Quality Assurance Process 1/1/13 6. BSSLC Policy E.2 Quality Assurance/Quality Improvement Council – scheduled for implementation 4/21/13 7. BSSLC Policy E.3 – Developing, Implementing, & Tracking Corrective Action Plans 5/24/12 8. BSSLC Quality Assurance Plan (including QA matrix) 8/25/12 9. Quality Assurance/Quality Improvement (QA/QI) Council meeting minutes for all meetings since the last review 10. QA/QI meeting agenda and meeting handouts 4/10/13 11. Facility Trend Reports 3/31/13 12. Sample of monitoring tools for Sections C, D, F, I, J, and K **People Interviewed:** 1. Daniel Dickson, QA Director 2. Juanita Taylor, QA Auditor **Meetings Attended/Observations**: 1. QA/QI Council meeting 4/10/13
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section E. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section E, in conducting its self-assessment, the Facility reviewed minutes of the QA/QI Council, reviewed longitudinal data, reviewed the QA and CAP tracking policy, and reviewed the CAP tracking system. The Facility QA Department did not use any specific monitoring tools in assessing compliance with Section E. The Facility did not present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment did not provide sufficient detail to determine the status of QA implementation by departments and disciplines resulting in overly broad and generic statements that "disciplines are currently in the developmental stage of internal QA monitoring processes, analysis, and corrective action planning." It was evident to the Monitoring Team that the Facility was still in the developmental stage of a comprehensive QA program and different departments/disciplines were at different stages of QA implementation. The QA self-assessment should be more detailed describing implementation status by department/discipline. The Facility did not rate itself as being in compliance with any provisions of Section E. This was consistent

	with the Monitoring Team's findings. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. Action steps were overly general and were not targeted at specific actions for specific departments and disciplines at the Facility. Most stated "training staff" on QA policy or similar general statements rather than the specific administrative steps necessary to move towards compliance with Section E. These actions steps did not provide a set of steps likely to lead to compliance with the requirements of this Section. The Action Plan should include, where appropriate, Action Steps for each department/discipline as well as Facility-wide actions and benchmarks for completion of all required department/discipline steps needed to complete Facility-wide actions.
	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 revised its Quality Assurance Process policy (1/1/13) and its Quality Assurance/Quality Improvement Council policy (scheduled for implementation 4/21/13) to reflect current expectations and requirements of both the Settlement Agreement and the new State QA policy which was issued in January. The Facility also updated its QA Plan (8/25/12). The QA Plan contained many of the written procedures and administrative requirements necessary to implement the QA policies. One key exception was the lack of reference in any of these documents addressing the requirement of the development of outcome measures and process indicators/measures (key indicators for evaluation). The Facility needs review its QA policies to ensure each and every State requirement is included. 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 (restraint, abuse/neglect, UIRs, and injuries) had been in place for a considerable period of time which enabled longitudinal trending and tracking of many data points. Trend reports associated with other monitoring tools had been in place for some sections of the SA for a considerable period of time and longitudinal tracking and trending was beginning to emerge. Most sections of the Settlement Agreement were subjected to this monitoring. These data were regularly presented to the QA/QI Council and they are beginning to be used for longitudinal trending. This will improve as more months of monitoring data are compiled and as the inter-rater reliability monitoring continues to validate the efficacy of the data. At the last review the Facility reported it had started the process of developing key indicators for evaluation 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. Listing of key indicators and gathering of data on them had not as yet started and is a much needed next step in the development of the QA program. The Facility had begun implementing a corrective action planning (CAP) process. Three CAPs had been initiated, all addressing significant Facility-wide (systemic) issues. Because of the small number of CAPs a data base to support it had not as yet been developed. Limited progress had been made towards achieving

	compliance with Provisions E.2, E.3, E.4, and E.5. The entire QA process needs to mature and become administratively reliable in all areas (e.g. data collection, inter-rater reliability, data compilation, data review, use of data for problem identification, developing and implementing CAPs, and evaluating the effectiveness of CAPs). The QA Director was able to describe his plans to move the QA process forward. These plans were sound; however, they were not articulated in the Action Plan provided to the Monitoring Team.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	There was a state policy that adequately addressed all five of the provision items in section E of the Settlement Agreement. There were no changes to the state policy, titled #003.1: Quality Assurance, dated 1/26/12. Positive aspects included: • It seems to have reserved policies for statewide development, and procedures for facility development. This will keep the terminology consistent and the facility should not have to re-label the state policy to adopt it. • It included language for CAPs to both remedy and prevent (reduce recurrence), acknowledging both important roles. • The policy language was simple and straightforward and the bullet style will make it easy for staff to read. • It required disciplines to keep account of their databases and the QA department to keep track of all databases. Other comments: • The policy hinted at addressing both systemic issues and serious individual ones, but stopped short of encouraging the facilities to have procedures to deal with both. • There did not appear to be a list of key indicators or a directive to develop a list. • The tie between QA and the self-assessment was not well described. This could, however, be covered in procedure or in a guideline for the self-assessment. The state policy called for a statewide QA/QI Council, and for statewide discipline QA/QI committees. Neither was in place at this time. Also, given that the statewide policy was disseminated more than a year ago, edits may already be needed. State office should consider this. There were facility policies that adequately supported most of the requirements of State policy for quality assurance. The Facility had revised its Quality Assurance Process policy	Noncompliance

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		(1/1/13) and its Quality Assurance/Quality Improvement Council policy (scheduled for implementation 4/21/13) to reflect current expectations and requirements of both the Settlement Agreement and the new State QA policy which was issued in January. The Facility also updated its QA Plan (8/25/12). The QA Plan contained many of the written procedures and administrative requirements necessary to implement the QA policies. One key exception was the lack of reference in any of these documents addressing the requirement of the development of outcome measures and process indicators/measures (key indicators for evaluation). The Facility needs to review its QA policies to ensure each and every State requirement is included. The Facility QA Director reported that the QA Department data list/inventory of data was not current or complete. It also did not accurately depict all data available from all departments/disciplines at the Facility. Work was occurring with several departments (e.g. Behavioral Services and Dental) in this regard. The QA Director acknowledged that there is likely data being kept at some Departments that he has not as yet discovered, or has discovered and is in the process of determining if it should be incorporated into the QA plan and if so, how best to accomplish this. In addition to what was reported by the QA Director, the Facility needs to review its existing data list/inventory to be sure data associated with specific subject matter is sufficiently detailed to meet the SA requirement that data is identified for all "program areas; living units; work shifts; protections, supports and services; [and] areas of care." The QA plan narrative at the facility was not current, complete, and adequate. The plan did not include a presentation of the organizational structure of the QA process (including individual roles and responsibilities), a complete data list/inventory, or a description of key indicators. The QA Director acknowledged these deficiencies with the QA Plan and intended to correct them for the next review. The QA plan matrix contained the data to be submitted to the QA department; these data are then included in QA reports and presented to the QA/QI Council. As noted above, because the data list/inventory is incomplete the QA Plan Matrix is similarly deficient. The QA Director reported that the Facility had not as yet developed key indicators to measure both process and outcome indicators as required by State policy and that this would be a priority for the next review period. The QA plan matrix did not include all self-monitoring tools/self-monitoring procedures. For example, there were not monitoring/audit tools for abuse/neglect and incident management, dental services, and restraint use, including medical restraint. All data that QA staff members collect were listed on the matrix. All of the items in the QA	

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		plan matrix did not also appear in the QA data list/inventory. The QA Director was in the process of reconciling data items noted in the plan matrix with the QA data list/inventory. The Facility QA Director reported that not all data in the QA plan matrix was submitted, collected, received, reviewed, and analyzed by the QA department for the last two reporting periods for each item (e.g., monthly, quarterly). He characterized implementation of the QA plan matrix as "not yet fully operational". Documentation and interview did indicate that QA staff assisted each discipline in analysis of data. The QA Director, Settlement Agreement Coordinator, and SA Section lead for each Provision met monthly for this purpose. These were referred to by the Facility as benchmark meetings. There was no documentation (e.g. minutes) to validate these meetings occurred, any record of topics covered, or any description of meeting outcomes. The QA Director reported he would start doing this. The QA Plan reported QA department monitoring tools were used for 12 sections of the SA. Six were chosen for review. Of the six self-monitoring tools for the SA included in the sample, (a) the content of all appeared to be appropriate and (b) all were reviewed within the past six months, and revised as appropriate. Other types of review/monitoring documents were reported to be used for some sections of the SA. Some sections had no apparent review/monitoring documents, for example Section Q (dental services) and the portion of Section C dealing with medical restraints. Of the six self-monitoring tools for the SA included in the sample, none had specific instructions for the user. Since the last onsite review, all of the self-monitoring tools for the six sections reviewed were implemented as per the QA plan (e.g., number, schedule, person responsible, inter-observer agreement). Since the last onsite review, of the six sections where monitoring tools were reviewed, there was documentation that the implementation (including inter observer agreement) and results (including outcomes) of self-monitoring were reviewed with the department staff at least once each quarter for all six (the benchmark meetings). Quality Assurance activity necessary to achieve compliance with Section E of the Settlement Agreement was still in a formative stage. This had been expressed by the Monitoring Team in past reports. The Facility needs to pursue implementation of its QA plan and process with a greater sense of urgency. The Facility self-assessment rated this Provision as not in compliance. Based on this review the Monitoring Team determined this Provision was not in compliance.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of	Continued progress was seen at the Facility regarding the analysis of data. Data from the QA plan matrix for the self-monitoring tools for 17 of the 19 (89%)	Noncompliance

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	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.	sections of the Settlement Agreement (not section E) were summarized and graphed showing trends over time. Twelve of the 17 tools were monitoring tools used by the QA department and the discipline. Five were used only by the particular department. This was an important step forward in the QA process; however, , there was a need to review the content of some of these tools. Further, there was a need to identify important data/indicators for each section of the Settlement Agreement and, when appropriate to do so, also provide an analysis across (a) program areas, (b) living units, (c) work shifts, (d) protections, supports, and services, (e) areas of care, (f) individual staff, and/or (g) individuals, as required by this provision. The Facility reported that the QA Director, Settlement Agreement Coordinator, and SA Section lead for each Provision met monthly. These were referred to by the Facility as benchmark meetings. There was no documentation (e.g. minutes) to validate these meetings occurred, any record of topics covered, or any description of meeting outcomes. The QA Director reported he would start doing this. At some prescribed interval, perhaps quarterly, these meetings should include discussion directed at: o Reviewing the data listing inventory and matrix, o Discussing data and outcomes, o Reviewing the conduct of the self-monitoring tools, o Creating corrective action plans, o Reviewing previous corrective action plans. These benchmark meetings will continue to be an important part of the Facility's further implementation of its QA plan. For most sections of the SA data were now available for analysis. Notable exceptions were Section Q Dental, and data related to medical restraints in Section C. Data were reviewed and analyzed quarterly by the QA department in preparation for the QA/QI Council meeting that includes review of that particular section of the SA. As noted above, data elements were often not delineating in sufficient detail across (a) program areas, (b) living units, (c) work shifts, (d) protections, supports, and services, (e) areas of care, (f) individual staff, and/or (g) individuals, as required by this provision. Since the last onsite review, during six of the six (100%) meetings, data were available to facilitate department/discipline analysis of data. Since the last onsite review, data review and analysis, and QA/QI Council decision-making, resulted in three Corrective Action Plans (CAPs) created for systemic problems. Since the last onsite review, a facility QA report (for dissemination at the facility and for presentation to the QAQI Council) was created for six of the six months (100%). Of the 20 sections of the SA, 20 (100%) appeared in a QA report at least once in each quarter since the last onsite review. Of the sections of the SA that were presented at the QA/QI Council, none contained all of	

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		the following components: a. Self-monitoring data i. reported for a rolling 12 months or more ii. broken down by program areas, living units, work shifts, etc., as appropriate b. Key indicators i. reported for a rolling 12 months or more ii. broken down by program areas, living units, work shifts, etc., as appropriate c. Narrative analysis There was an adequate description of the QA/QI Council in the QA plan narrative and in a separate QAQI Council policy and procedure document. Since the last onsite review, the QA/QI Council did meet at least once each month. Minutes from six of the six (100%) QA/QI Council meetings indicated that the meeting occurred according to schedule. Minutes from six of the six (100%) QAQI Council meetings indicated that the agenda included relevant and appropriate topics. Minutes from six of the six (100%) QA/QI Council meetings indicated that there was appropriate attendance/representation from all departments. Observation of the meeting held during the week of the review showed active participation by those in attendance other than the presenter. Minutes from none of the six (0%) QA/QI Council meetings since the last review documented that (a) data from QA plan matrix (key indicators, self-monitoring) were presented, (b) the data presented were trended over time, (c) comment/interpretation/analysis of data was presented but was in many instances too brief to lend itself to substantive discussion. The Facility did not present key indicator data to the QA/QI Council. Minutes showed that other relevant QA data was presented and discussed. In none of the six meetings (0%), were recommendations and action plans selected when appropriate to do so based on the data presented. While the Facility had initiated three CAPs, these were developed outside the QA/QI Council and presented to the Council. The QA/QI Council should be reviewing and analyzing data and making recommendations and suggestions for action plans and CAPs. It should also be the decision-making body in this regard. An adequate written description did not exist that indicated how CAPs are generated, including the criteria for the development of a CAP. The Facility reported it needed to improve its practices with respect to establishing criteria for CAP development, for example, compliance thresholds related to monitoring audits. Of the three CAPs reviewed by the monitoring team, all (100%) appeared to appropriately address the specific problem for which they were created, except that they did not include the anticipated outcomes of action steps. • Three (100%) included the actions to be taken to remedy and/or prevent the	

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		reoccurrence. • None (0%) included the anticipated outcome of each action step. • Three (100%) included the person(s) responsible. • Three (100%) included the time frame in which each action step must occur. Presumably review and analysis of monitoring data would lead to identification of a need for one or more corrective action plans. While the Facility had only initiated three CAPs since the last review they all targeted systemic issues and represented a good start in understanding the need for and purpose of a Corrective Action Plan. While the Monitoring Team confirmed the Facility's limited use of Corrective Action Plans managed through the QA Department, it was evident that some discipline departments had informal corrective action planning occurring. For example, both the Nursing Department and the Habilitation Therapies Department had initiated activity that was, in essence, a CAP when internal monitoring data suggested a need for improvement. . In moving forward the Facility should keep in mind that action plans and CAPs should be targeted at two distinct sets of activities and strategies for outcomes: 1. Development of specific actions necessary to correct specific problems discovered through monitoring and auditing conducted by disciplines and 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 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 Facility self-assessment rated this Provision as not in compliance. Based on this review the Monitoring Team determined this Provision was not in compliance.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	Based on a review of the Facility's three CAPs there was not documentation about how the CAP was disseminated, when each CAP was disseminated, and to whom it was disseminated, including specific person(s) responsible. The Facility self-assessment rated this Provision as not in compliance. Based on this review the Monitoring Team determined this Provision was not in compliance.	Noncompliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely	The Facility reported that the three CAPs that had been put in place had not been implemented fully and timely and they were still developing more effective mechanisms to track implementation status. For now the primary method used to track	Noncompliance

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	manner, to meet the desired outcome of remedying or reducing the problems originally identified.	implementation was the provision of a verbal report at QA/QI Council meetings. The Facility also reported it needed to establish requirements for evidence needed to document completion of action steps, and to identify and document desired outcomes, including steps necessary to measure effectiveness and modify CAPs as necessary. The Facility demonstrated correct understanding of what is required in this Provision and had begun administrative steps necessary to effectively manage the CAP process. The Monitoring Team looks forward to observing significant improvements at its next review. The Facility self-assessment rated this Provision as not in compliance. Based on this review the Monitoring Team determined this Provision was not in compliance.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	The Facility reported that the three CAPs that had been put in place had not been implemented fully and timely and they were still developing more effective mechanisms to track implementation status. For now the primary method used to track implementation was the provision of a verbal report at QA/QI Council meetings. The Facility also reported it needed to establish requirements for evidence needed to document completion of action steps, and to identify and document desired outcomes, including steps necessary to measure effectiveness and modify CAPs as necessary. The Monitoring Team did not find evidence of CAPs being modified in response to reporting that certain aspects of action plans were not working as intended. The Facility did not appear to have a formal method for evaluating the effectiveness of CAPs and for determining which CAPs needed modification. The Facility demonstrated correct understanding of what is required in this Provision and had begun administrative steps necessary to effectively manage the CAP process. The Monitoring Team looks forward to observing significant improvements at its next review. The Facility self-assessment rated this Provision as not in compliance. Based on this review the Monitoring Team determined this Provision was not in compliance.	Noncompliance

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

1. Given that the statewide policy was disseminated more than a year ago, edits may already be needed (Provision E1).
2. The data list inventory needs improvement as described in E1 (Provision E1).
3. The QA matrix needs improvement as described in E1 (Provision E1).
4. A report on implementation of the items in the QA matrix is needed (Provision E1).
5. For each section of the Settlement Agreement and, when appropriate to do so, conduct a review that provides analysis across (a) program areas, (b) living units, (c) work shifts, (d) protections, supports, and services, (e) areas of care, (f) individual staff, and/or (g) individuals, as is required by this provision (Provision E2).
6. The QA report should include other relevant data for each Settlement Agreement section and, when appropriate, provide information regarding

program areas, living units, work shifts, etc., as per the wording of this provision (Provision E2).
7. Document discussion relative to the need for CAPs/ action plans during QAQI Council meetings (Provision E2).
8. Improve the system of CAPs as described in E2, E3, E4, and E5 (Provisions E2, E3, E4, and E5).
9. Pursue implementation of the QA plan and process with a greater sense of urgency (Provisions E1, E2, E3, E4, and E5).

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, dated 03/21/2013 2. BSSLC Action Plans, dated 03/11/2013 3. Initiatives/Activities Update since Last Compliance Round Presentation for April 2013 for Settlement Agreement Monitoring Team Visit 4. Section F Presentation Book materials 5. Draft of updated DADS Policy 018: Most Integrated Setting, undated 6. DADS Policy 004.1: Individual Support Plan Process, dated 11/20/12 7. BSSLC Policy F.1: Individual Support Plan (ISP) Process, implementation date 10/26/12 8. Available assessments on shared drive for Individuals #65, #190, #195, #392 and #462 9. ISP Attendance-ISPs only for 7/1/2012-11/30/2012 and 12/1/2012-1/31/2013 10. Individual Support Plans (ISPs), including ISP Preparation documents and related assessments, for Individuals #30, #115, #118, #217, #283, #286, #353, #379, #449, #486, #492 and #599 11. ISP Preparation documents for Individuals #191 and #545 12. Thirty-Day ISPs for Individuals #114, #239, #243, and #546 13. Sample of Monthly/Quarterly Reviews for Individuals #30, #115, #118, #217, #283, #286, #353, #379, #449, #486, #492 and #599 14. Brenham State Supported Living Center QA/QI Council Meeting, Quarterly Quality Assurance Report, dated February 27, 2013 15. Section F Monitoring Tool **People Interviewed:** 1. Pam Boehnemann, QDDP (Qualified Developmental Disability Professional) Coordinator 2. Kim Littleton, Assistant Director of Programs 3. Crystal Chavez, QDDP Educator 4. Daniel Dickson, Quality Assurance Director 5. QDDPs for four focus Interdisciplinary Teams (IDTs) 6. Iva Benson, DADS staff **Meeting Attended/Observations:** 1. ISP annual planning meetings for Individuals #286 and #599 2. ISP Preparation Meetings for Individuals #191 and #545
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section F. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. The current Self-Assessment reported on the activities engaged in to conduct the self-assessment, provided its assessment of the results of the self-assessment and finally provided a self-rating stating why or why not it believed compliance had been achieved.

	The Facility had in some instances coupled the self-assessment with its internal quality assurance processes to assess ongoing progress toward actual outcomes, in that it referenced the results of internal Section F Monitoring Tools. The Facility noted there remained concerns with inter-rater reliability, although this the trend was improving. Most of the activities engaged in to complete the Self-Assessment remained subjective, so it continued to be recommended the Facility identify some more discrete and objective indicators within the broader SA requirements that could be made more readily measurable. In order to complete a meaningful self-assessment, the Facility should further develop a set of outcome indicators that it believes would be likely to lead to substantial compliance based on its own experience and on the findings and recommendations in the Monitoring Team's report. This should include the identification of the data needed to measure these indicators. The QA Director indicated a revised monitoring tool for this section was currently being circulated that may address the ability of the Facility to accurately measure and substantiate its outcomes. The Facility also provided as part of its self-assessment an Action Plan that reported on actions being taken or planned to achieve compliance. Once it develops its outcome indicators, the Facility should review these actions to ensure they are focusing on those most likely to support the identified outcomes. For example, for Provisions F1a through F2a3, as well as F2a5, the Facility's primary Action Step was to fully implement the state approved ISP process. The evidence that will be used to measure this was not defined, nor the process for measuring it. The Facility should define the provision-specific outcomes it hopes to achieve as a result of this Action Step and others as well as how they will be measured.
	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. It was noted that BSSLC was serving as a model site for implementation of a newly revised ISP and had the option to pilot innovations. The Facility had chosen to focus training and skill development related to the revised ISP process on four IDTs, and therefore requested the Monitoring Team to similarly focus its review on the work of these teams to provide feedback and some level of technical assistance. It was agreed this focused effort could not result in any finding of substantial compliance at this point due to its limited scope. A sample was selected from the work of these four teams over the past six months and included the ISP and ISP Preparation meetings held during this monitoring visit. The findings and recommendations found below and throughout this section should be read within this context. Overall, the Monitoring Team was impressed with the effort and resources devoted to this initiative and believed it held promise for future development. **Provision F1:** A revised ISP format and process had been introduced to the focus IDTs and considerable training and coaching had been provided. The new process included an ISP Preparation meeting held approximately three months prior to the ISP annual meeting as a means of ensuring adequate IDT preparation for the latter. The Monitoring Team found this to be a particularly promising practice that had

	already resulted in improved preparation and participation by IDT members as observed in the annual ISP meetings held during this site visit. Some improvements in integrated planning were also observed. Overall, however, the revised 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 PSI and/or ISP processes were conducted in a manner that facilitated real participation by the individuals. The focus IDTs often failed to conduct timely or comprehensive assessments of sufficient quality to reliably identify the individual's strengths, preferences and needs. **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, the ISPs reviewed 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 yet sufficiently constructed or assessed for progress. The Monitoring Team found ISP strategies still did not reflect encouragement of community participation in any meaningful or purposeful manner. BSSLC IDTs also needed to be attentive to emerging needs and take assertive action sooner rather than later; the Monitoring Team found a number of instances in which issues were not addressed in an appropriate and/or timely manner.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:		
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	The Qualified Developmental Disabilities Professional (QDDP) was the one person assigned to each individual to facilitate the work of each IDT. <u>Staffing of QDDP Department</u> The Facility reported that it had 23 QDDP positions, including four Lead QDDPs, a QDDP Coordinator and a QDDP Educator. All individuals had an assigned QDDP. The QDDP/individual ratio appeared to be sufficient based on the workloads of staff as affected their abilities to manage and complete their tasks in an adequate and timely manner. The Facility was also re-organizing certain aspects of its workflows and responsibilities to ensure QDDPs had sufficient time and opportunity to facilitate the team process and monitor implementation and progress. This was to	Noncompliance

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		include delegating the FSA and PSI assessment processes to a group of staff that would also write SAPs and implement activities. Additional clerical staffing was being made available to support the work of the QDDPs, and days free from other tasks before and after each annual meeting ISP were also provided to each QDDP to allow them to complete related documentation. <u>Process of determining competency of QDDPs in the facilitation process</u> Based on the list provided, none of the QDDPs (0%) had been deemed fully competent in facilitation. The Facility was using the Q Construction Facilitation curriculum for training in this area and evaluating competence. Per the QDDP Coordinator, the use of this process for evaluating competence had been re-started in December, 2012, but there had not yet been any monitorings of the facilitation process completed. In response to the document request, the Facility stated, "Q Construction was reinstated in December 2012. I have been unable to complete any of these tools. The lead QDDPs also complete Section F tools: Q Construction, & ISP monitoring tools. If any of these are needed, please request them during the onsite visit." The Monitoring Team has made clear that the purpose of these tools is to provide information the Facility can use in assessing its status and identifying areas of improvement needed. To demonstrate compliance, the Facility should present its processes for assessing the quality of its services and for identifying and addressing improvements needed. The Monitoring Team focused its attention for this monitoring period on the work product and observed facilitation skills of the QDDPs for the four focus teams, who had been provided with additional coaching and mentoring in facilitating the implementation of the revised ISP process. The results of this additional training and support were most evident in the more organized manner in which the ISP annual and ISP Preparation meetings were completed and, in most instances, in the facilitation of the participation of the IDT members at the meetings. This represented progress over the previous site visit; however, outcomes in terms of improvements in ISPs were not yet substantial. For example: • For none of the 12 plans reviewed or meetings observed (0%) did the facilitation process result in the adequate assessment of individuals, and the development, monitoring, and revision of adequate treatments, supports, and services. • For none of the twelve ISPs reviewed or meetings observed (0%) did the facilitation process resulted in an adequate discussion of the most integrated setting. See Provision F1e. • For none of the two ISPs annual meetings observed (0%) did the facilitation process resulted in the adequate participation of the individual. See Provision F1b. • The assigned QDDP also remained responsible for monitoring and revising treatments, services, and supports. The Monitoring Team found in its review of the focus sample that there was progress noted over previous visits, but the QDDPs did not yet consistently ensure the team completed assessments or monitored and revised treatments, services, and supports as needed as described below under Provisions F2a6 and F2d.	

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		Extent of Individual participation in ISP: In addition to actual meeting participation by individuals, meaningful participation remained very limited, as reported in previous assessments by the Monitoring Team. A newly revised Preferences and Strengths Inventory (PSI) process, as described in DADS Policy 004.1: Individual Support Plan Process, was not robust enough to facilitate an individual's real understanding and participation. As observed in previous reports, 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 QDDP Coordinator indicated the Facility was not yet concentrating on how it might better support individual understanding of and participation in the ISP process. The State and Facility were urged to consider how to revamp this process to truly support individuals to be active participants in their own planning. The Monitoring Team recommended that the Facility implement a curriculum for "planning my future" that would be incorporated into the overall active treatment program on an ongoing and regular basis. During this site visit, the Monitoring Team observed two ISP annual planning meetings in the newly revised format and process. One was attended by the individual (Individual #599); for the second meeting, the individual was not in attendance due to hospitalization. For purposes of highlighting opportunities to enhance individual participation, the comments that follow are predicated on the single meeting in which the individual was in attendance: • Participation of the individual was not facilitated to the extent the Monitoring Team would expect to see. The individual attended the meeting, but was prompted by staff to leave on at least two occasions, although there was no apparent anxiety or discomfort that would have necessitated the individual's departure. In fact, the individual seemed to be engaged in the process and declined to leave on at least two occasions. • The annual meeting began with a brief review of the individual's preferences from the PSI. The QDDP described to the individual a written list of "preferences and strengths", rather than saying, for example, "Let's talk about the things that you really like and the things you are really good at." For the most part, individuals were not participating in the ISP Preparation meeting, so there had been little structured opportunity with individuals to review the PSI in advance of the ISP annual meeting. It would be advisable, for the purposes of enhancing the participation of individuals, to review the PSI with them prior to the ISP annual meeting, but also summarize it at the beginning of the meeting using language that facilitates their understanding. • This was immediately followed by the IRRF discussion. Neither the PSI nor the IRRF discussion was held in such a way as to be meaningful or comprehensible to the individual in attendance. There was no introductory explanation made to the individual as to the purpose of these activities. Staff also continued to use technical terminology, referencing such diagnoses as GERD and osteoporosis without framing this in terms more likely to be	

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		understood by the individual. In order to facilitate individual understanding and participation, it is not sufficient to simply preface a statement with the individual's name. The discussion and explanations must also take into account the knowledge as well as communication and cognitive skills of the individual. For example, rather than saying to an individual that "you have GERD so you receive omeprazole and remain upright for two hours after meals," staff might say "you know how you sometimes get that burning feeling in your throat? The purple pill you take in the morning should be helping with that. That's also why we want you to not lay down for a while after meals. Are you still having a lot of that burning feeling or does it seem to be getting better?" The Monitoring Team appreciated the improvement in the discussion of the IRRF, such that it was shortened without curtailing sufficient discussion of risk. Nevertheless, it remained a lengthy discussion focused solely on risks and problems that did not set a stage for developing a plan based on an individual's personal goals, preferences and strengths. • The Monitoring Team recommends the State and Facility reconsider how the current process could be modified in part to focus more planning time on preferences, strengths and personal goals, while retaining the overall structure and improvements found in this new format. In addition, QDDPs should receive additional training in how to facilitate individuals' understanding of and participation in the ISP process. Conclusion: This provision was found to be not in compliance. The Monitoring Team was impressed with the effort and resources devoted to this initiative and believed it held promise for future development.	
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> BSSLC Policy F.1: Individual Support Plan (ISP) Process and DADS Policy 004.1: Individual Support Plan Process, clearly identified requirements for team composition, attendance and participation and the processes for ensuring them. During the ISP Preparation meeting, the IDT was to identify the requisite composition of the team for the purposes of the annual planning meeting and record this in the Attendance-Assessment checklist. The QDDP Coordinator noted in the Quarterly Quality Assurance Report that the overall use of these checklists was improving. BSSLC's Self-Assessment indicated the Facility had analyzed data from an Attendance Tracking database and found it showed overall attendance rates over 99 meetings stood at 85%. This included Individual participation at 60%, LAR participation at 65% and Direct Support Professional (DSP) participation at 84%. Additional documents were provided in response to the Monitoring Team's pre-visit document request in this area. One set of documents entitled ISP Attendance-ISPs only, for 7/1/2012-11/30/2012 and 12/1/2012-1/31/2013, indicated overall compliance for the Facility was 81% and 84% respectively. In these documents, individual participation ranged from 58% to 74%, LAR	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>participation at 65% to 70% and Direct Support Professional (DSP) participation at 85% to 100% across the two periods. On the other hand, the Brenham State Supported Living Center QA/QI Council Meeting, Quarterly Quality Assurance Report, Data Reporting Period November 1, 2012-January 31, 2013, indicated Facility data showed a compliance rate of 30% for meeting participation that include the LAR, QDDP, DSP, and other professional staff that is dictated by the individual's preferences, strengths, and needs. It was not clear why there was such variation among these several documents.

The Monitoring Team also reviewed a sample of signature sheets for all ISPs held during March 2013 as an alternative measure. This review revealed the following rates of attendance for a sample of IDT members:

<table>
<tr><th>Individual</th><th>LAR/ Family</th><th>QDDP</th><th>Nursing</th><th>Medical</th><th>Psychology/Behavior Analyst</th><th>Speech/ Language</th><th>DSP</th><th>Vocational</th></tr>
<tr><td>63%</td><td>83%</td><td>92%</td><td>100%</td><td>67%</td><td>46%</td><td>75%</td><td>79%</td><td>71%</td></tr>
</table>

These appeared to be relatively consistent with the data referenced in the Self-Assessment, but not always consistent with the data provided in the other documents. For example, the ISP Attendance-ISPs only, for 7/1/2012-11/30/2012 and 12/1/2012-1/31/2013, indicated Psychology/Behavior Analyst staff attended between 88%-99% of the meeting for those two periods respectively. This was significantly higher than the documented participation in March 2013 of 46%. While it was possible that these staff were not identified as being required to attend the March meetings, the difference between earlier participation and recent participation seemed to be inordinate.

<u>Conclusion:</u> This provision was found to be not in compliance.</td><td></td></tr>
<tr><td>F1c</td><td>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.</td><td><u>Extent to which assessments are conducted routinely:</u>
Assessments for the ISP were still not routinely 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. In the revised ISP procedure, the IDT was to identify the assessments that were required for the annual ISP meeting at the ISP Preparation meeting. The assessments were then to be used by the QDDP to develop an ISP Guide no later than five days prior to the ISP annual meeting. This latter process was yet to be fully implemented.

The Facility was 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 reviewed the timeliness of assessments for</td><td>Noncompliance</td></tr>
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		the sample of focus teams as well as for as sample of upcoming ISPs. Findings included: • In the sample of 12 ISPs reviewed and/or observed, only 1 (8.3%) had all assessments included and completed on a timely basis, at least ten working days prior to the ISP annual meeting. • The Monitoring Team also requested the assessments available on the shared drive for a sample of individuals with ISP annual meeting scheduled within ten working days of the date of our request. The number of available assessments ranged from four to ten. Only one of four (25%) had a current Medical Assessment, and none of four (0%) had a Psychological Assessment or Update. The most consistently available assessments included Habilitation Therapies, Communication, Nursing and Dental, although even each of these was present for only three of the four (75%) individuals. • The Monitoring Team also viewed the assessments available on the shared drive for Individual #195, who had an annual ISP meeting scheduled within the next ten working days. For eleven of the assessments that were required per the ISP Preparation meeting, five (45%) were available. <u>Extent to which to which assessments are conducted in response to significant changes:</u> The Monitoring Team found that there were some instances in which assessments were being updated in response to significant changes. For example, in five of the five individual records reviewed from Sample O1 (100%), when an individual experienced a change in status that would initiate a referral to the Physical and Nutritional Management Team (PNMT), there was evidence of an IDT referral to the PNMT within five working days of the ISPA meeting. In addition, BSSLC's PNMT RN conducted assessments in response to all changes in status and discussed the results during the PNMT meeting. Despite this progress, there were still many instances in which in which assessments were not being conducted or updated in response to significant changes. • None of the 14 individuals in a sample (0%) in Provision S1had been provided an intellectual assessment within the past five years. The most recent intellectual assessment had been completed in 2005, and several of the intellectual assessments were at least 20 years old. • Two of the 14 individuals in the S1 sample (14%) had been provided with a Psychological Evaluation in the previous 12 months. For both of those individuals the most recent intellectual and adaptive assessments were over 20 years old. • As reported in Provision P3, zero of three individuals who experienced falls were appropriately reviewed by the IDT. Individuals who experienced multiple falls did not have evidence of team discussion regarding the situation in which the falls occurred and factors potentially impacting the occurrence. <u>Extent to which to which assessments are of sufficient quality to reliably identify the individual's</u>	

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		strengths, preferences and needs: The most significant improvement noted in this area was found in Provision M2. Forty-three Annual and/or Quarterly Comprehensive Nursing Assessments were reviewed using the Nursing Care Annual/Quarterly Nursing Assessment Monitoring Tool and found an overall percentage of compliance of 94%. Noncompliance was found in the following provisions related to the quality of assessments, however: J6, K5, L1, O2, O8, R2, S2, T1b1, T1b3 and T1d. These findings, taken together, demonstrated assessments were still not routinely of sufficient quality overall to reliably identify the individual's strengths, preferences and needs. In addition, as it relates to this provision, the Monitoring Team found that the PSI was not effectively providing a basis for describing an optimistic living vision as originally intended, nor even being implemented in a careful and thoughtful manner. The Analysis Section of the PSI was intended to synthesize the findings of the PSI such that they could be used to provide the team with guidance and insight in the development of the ISP. This section was typically a summary of preferences, but without any synthesis as to how the team might use them to support the individual's future, even though the template prompted such an analysis. In addition, very few PSIs devoted any attention to work exploration or opportunities. The Monitoring Team did observe the PSIs for the two ISPs observed on site were considerably more extensive; this was an encouraging sign, but wider implementation is needed. Likewise, the Functional Skills Assessments (FSA), which was often referenced as the basis for the development of SAPs, was not implemented in such a manner as to effectively address the learning needs of individuals. It was noted that the Facility had recognized the deficiencies in the PSI and FSA processes. It reported that a consultant team was going to be developed to provide training in these areas. In addition, the Facility reported that an assessment team that would be responsible for the development of SAPs, rather than the QDDPs, would also be tasked with completing the FSA tool in the future. 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. The Facility's Self-Assessment confirmed this remained a significant area of deficiency.	
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	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 QDDPs to complete the ISP Guide five days before the ISP annual meeting that would have enabled IDT members to review before the meeting, nor were assessments completed with sufficient thoroughness. Even when the results of this flawed	Noncompliance

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	individual.	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, none of the most recent ISPs for the 12 individuals in the sample (0%) reflected that the Psychological Evaluation, intellectual assessment, or adaptive skill assessment had been considered in the development of SAPs in the ISPs. • As reported in Section P, skill acquisition programs continued to be rarely identified as part of the Habilitation Assessment. The Habilitation assessments continued to focus primarily on supports to mitigate risk or provide support and did not identify potential areas in which skills such as Activities of Daily Living (ADLs) could be addressed. For only 11 of 18 individuals in Samples P1 and P2 (61%) did the ISP/ISPAs address each of the recommendations outlined in the current OT/PT assessment. For the two focus ISPs observed, the Monitoring Team found there was some improvement in the overall awareness of IDT members as to the content of the assessments and how these may contribute to the development of the ISP. This was not yet consistently applied, but was a positive sign for the system the Facility was piloting. <u>Conclusion:</u> This provision was found to be not in compliance.	
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	<u>Adequacy of process to develop each ISP in accordance with ADA and Olmstead decision</u> This provision is discussed in detail later in this report with respect to the Facility's progress in implementing the provisions included in Section T of the Settlement Agreement. In order for the State Office requirement to be met, each discipline's assessment needed to include an opinion/recommendation. In addition, at the ISP meeting, the IDT needed to make a recommendation to the individual/guardian. For the focus ISPs, the Monitoring Team found the required determination was still not being consistently provided. • Of the 12 ISPs reviewed and/or observed, for none (0%) did all of the assessments include the applicable statement/recommendation. Of the 114 total assessments that were reviewed, 53 (46.5%) included a determination of whether the individual could be served in a more integrated setting. • Of the 114 total assessments reviewed, only 26 (22.8%) included recommendations for how the individual's needs could be met in a more integrated setting. • Of the 12 ISPs reviewed, three of the individuals (25%) had been referred for transition to the community. For the remaining individuals, nine of nine ISPs (100%) included an independent recommendation from the professionals on the team to the individual and LAR. Of the 12 ISPs reviewed, however, none (0%) adequately identified the protections, services and supports that would be needed by the individual in the most integrated setting; therefore, it was not possible to comprehensively identify those that were obstacles to living in the most integrated environment because they were not available. For the most part, a template statement indicated that the professional opinion was based on the current	Noncompliance

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		services and support being provided at the Facility and did not take into account that any different services might be needed in the community. • The Facility typically did not have an adequate basis for determining the preferences of individuals for living arrangements. As described in Provision T1b2, a relatively small proportion of individuals living at BSSLC had opportunities to tour community living options, and IDTs did not develop individualized plans for education and awareness that would be sufficient to meet the learning needs of the individuals residing at the Facility. In the section below that addresses Section T1b1, there is extensive discussion regarding the Facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such obstacles. In summary, the Facility was not yet effectively identifying or addressing obstacles. For example: • As noted above, the lack of identification of protections, services, and supports made it difficult to identify comprehensively the obstacles that might prevent movement. • None of nine (0%) of the recently completed ISPs reviewed in which a referral was not made evidenced proficiency in identification and addressing of obstacles. • In none of the nine (0%) that identified LAR or individual choice as the barrier were there specific action plans developed to address these specific barriers other than providing annual CLOIP information and/or Provider Fair invitations. The Monitoring Team also continued to observe in the on-site ISP annual meetings that IDTs were not effectively addressing either the concerns of the LARs or offering information to LARs about the potential benefits of community living. There remained a clear discomfort on the part of the IDT members in this regard. It is difficult to have such a conversation with a reluctant LAR or family member on an annual basis. This review of the recently completed ISPs indicated IDT members continued to need additional training in how to facilitate an appropriate discussion of the most integrated setting with family members and LARs over the course of the year. The ISP Preparation meeting also would provide an opportunity to discuss the barriers and plans to address them, particularly in relation to ongoing interactions and discussions with reluctant LARs. <u>Conclusion</u>: This provision was found to be not in compliance. DADS should require, as a part of the ISP process, the IDT to not only make a determination regarding the most integrated setting appropriate to an individual's needs, but also describe what would be needed in that setting. This process should help to facilitate a discussion and inform the individual and LAR of the potential advantages of community living, such as having more privacy, living in closer proximity to family, etc. Having accomplished that, the determination of whether or not a referral will be made can be completed in which individual and/or LAR preference would take final precedence.	
F2	**Integrated ISPs -** Each Facility shall review,		

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	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 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;	<u>Identification and Use of Individuals' Preferences and Strengths:</u> In the review of twelve ISPs by the focus IDTs, the Monitoring Team found that none (0%) had effectively incorporated individuals' preferences into related action plans. Preferences and strengths identified in the PSI were acknowledged at the beginning of the ISP Preparation meetings and ISPs, but were less seldom reflected in assessments developed for the annual ISP and/or integrated throughout the narrative and/or discussion of the ISP. The Monitoring Team did observe some Action Plans related to preferences. Action Plans to address strengths were not observed, nor did Action Plans developed for various needs also incorporate approaches to integrate strengths in the methodologies. As an example of how this might have happened, but did not, it was found in the ISP narrative for Individual #353. It was noted the individual liked to write. There was a discussion that a notebook and pen would be provided and that instruction could also be provided to enable the individual to trace his name as a possible self-administration of medication strategy, as this could enable the individual to recognize the appropriate medication box. This was a good example of integrating preference and strength to meet a need for promoting independence. Unfortunately, this discussion did not result in an Action Plan. Overall, as reported in Provision S1, the integration of individual preferences into the SAP development process had improved, but the percentage of SAPs reflecting such integration (29%) remained low. <u>Prioritization of Needs and Explanation for Any Need or Barrier Not Addressed:</u> The ADOP indicated in interview that the prioritization process in place at the Facility needed to be evaluated. The Monitoring Team also found that none of the nine completed plans reviewed (0%) included a list or discussion of prioritized needs in which the IDT clearly indicated whether any	Noncompliance

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		needs were to be prioritized for implementation. For the two ISPs observed during the monitoring visit, there was discussion related to prioritizing needs based on the current health status of both individuals. For example, for Individual #599, there were several Action Plans deferred. One included a tooth brushing program that was to be deferred pending the results of a Modified Barium Swallow Study (MBSS), which was an appropriate step. Other deferments discussed were less clearly rationalized, as it was not defined how these needs were more likely to be impacted by pain the individual was reported to be experiencing than many of the others that were not deferred. For example, the QDDP encouraged the IDT to defer assessments and/or program implementation related to using toilet paper and employment, but Action Plans were to be implemented for a number of other skills related to activities of daily living. The rationales for these deferments were not clearly stated. The ISP did reference these deferments in the Action Plans for future action, however; the QDDP was to be commended for ensuring this information was captured in the Action Plan documentation. In none of the 12 focus ISPs (0%), including the two for which annual planning meetings were held during this monitoring visit, were barriers adequately identified and addressed. Barriers to living in the most integrated setting did not always lead to goals, objectives, or service strategies. The ISP did not consistently specify individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain outcomes related to identified barriers to living in the most integrated setting appropriate to his/her needs. As reported in Provision T1b1, the Monitoring Team found that obstacles to transition to the most integrated setting were not consistently appropriately identified or addressed. None of nine (0%) recent ISPs reviewed for which a referral had not been made evidenced proficiency in this regard. For example, for Individual #599, the obstacle to community living was reluctance of the LAR. The Action Plans did not adequately address this obstacle, as they simply indicated that the individual and LAR would be provided information through an invitation to the Provider Fairs and the annual CLOIP process. An additional SAP under the goal area of living in the most integrated setting did not address the identified barrier in any way, nor did a note to be added to the daily schedule for the individual to have opportunities for community outings twice a month. Both of these activities might well be constructed to fit as a part of an overall plan to enhance awareness of community living and address LAR reluctance, but they were without clearly stated purpose, methodology and indicators of effectiveness to address this need. Also see Provision F1e above. <u>Identification of Supports Needed to Encourage Community Integration</u>: None of the twelve ISPs (0%) reviewed or observed included specific skill acquisition action plans for implementation in the community, in which the objective provided a specific purpose and methodology, was couched in measurable terms, and defined a data collection and analysis process. When Action Plans were included that addressed community participation, they were general in nature and referred to the individual having opportunities for community outings. In a number of instances, it was noted that IDTs had converted Action Plans for such outings from previous ISPs to	

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		simply calendared activities on an individual's schedule. The ISP Preparation Meeting offered an opportunity to focus the attention of the IDTs on ensuring that each of these requirements is adequately represented in each individual's ISP. The Monitoring Team attended two ISP Preparation meetings and found there were indications the meeting was being appropriately used in this manner to a certain extent. There were tentative Action Plans discussed regarding preferences in both instances, although strengths were less well addressed. There were also discussions about supports for community integration, but additional emphasis is needed on how preferences, strengths, and needs are relevant to community participation, and on what assessments are needed to provide information for the ISP annual planning meeting discussion related to community participation and integration. <u>Conclusion</u>: 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 to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	<u>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:</u> As described in Provision F2a4 and further in Section S, ISP programs were still 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. BSSLC failed to conduct individual task analyses. As a result, SAPs were not tailored to the unique learning needs, current skills, or physical condition of each person. The ADOP indicated in interview that the Facility was reducing the number of SAPs because it believed IDTs were trying to do too much. While the Monitoring Team appreciated the intent of focusing on prioritized needs, it appeared the ISPs being developed did not included a full complement of individualized goals or objectives and/or strategies to address the array of supports and services the individual required. The IDTs did not consistently develop such a comprehensive complement of individualized goals and objectives that were relevant to and likely to lead toward attainment of outcomes related to each preference, meet identified needs and overcome barriers to living in the most integrated setting. Examples included: • For Individual #217, the Action Plans included 1) referral to the Harmony Center; 2) visits to another Facility residence to see if it would be appropriate; 3) implementation of the Health Care Plan; and, 4) a Staff Service Objective (SSO) for water exercise. This array was unlikely to produce much in the way of skill acquisition or increased independence. It was also unresponsive to identified needs, including needing more exposure to the outside community in order to determine her preferences, and increasing communication strategies for choice making. • For Individual #486, the ISP Action Plans were limited to the following: 1) String Beads; 2)	Noncompliance

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		Toss Bean Bag; 3) Rinse Hands; 4) Brush Teeth and 5) Implement Health Care Plan. These did not address her interests in music, sightseeing or community outings, nor the team's lack of information upon which to determine her preference for living option. Adequacy of processes for identification of and plans to overcome barriers: In the section below that addresses Provision T1b1, there is extensive discussion regarding the Facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such barriers. This also requires the development of action plans in ISPs. In summary, barriers to living in the most integrated setting did not always lead to goals, objectives, or service strategies. The ISP did not consistently specify individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain outcomes related to identified barriers to living in the most integrated setting appropriate to his/her needs. As reported in Provision T1b1, the Monitoring Team found that obstacles to transition to the most integrated setting were not consistently appropriately identified or addressed. None of nine (0%) recent ISPs reviewed evidenced proficiency in this regard. Also see Provision F1e above. The Monitoring Team again noted the ISP Preparation Meeting offered an opportunity to focus the attention of the IDTs on ensuring these requirements would be adequately represented in each individual's ISP. See Provision F2a1. Conclusion: This provision was found to be not in compliance.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	Extent to which ISP integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions: This provision requires that all protections, services and supports, treatment plans, clinical care plans, and other interventions are delivered in a manner that forms a unified approach to meeting an individual's needs and supporting his/her aspirations and preferences. In such an approach, one would expect to see, for example, training in independent living skills to also have components that might include communication skills development, strategies for use of the skills in community settings, incorporation of positive behavior support techniques, risk action plans, etc. A program to improve dining skills might include techniques to encourage eating at a reasonable pace for both social and risk prevention purposes; use of a graphic menu to assist the individual to identify preferences, learn the names of foods and make choices; incorporation of reinforcement for safe dining behaviors and/or replacement behaviors; and might describe both formal and informal opportunities for community dining. Overall, adequate integration should be demonstrated through: • Integration of various plans (e.g., PNMP, PBSP, counseling plans, psychiatric treatment plans, crisis intervention plans, integrated health care plans, etc.,) in a measurable way into the ISPs, through, for example, measurable objectives;	Noncompliance

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		• Individuals' personal goals, preferences and/or needs are integrated across and throughout Action Plans; • Delineation of various staff's responsibilities through measurable action steps (e.g., development of plans, ongoing monitoring, staff training, implementation, etc.) • Inclusion, as appropriate, of skill acquisition plans, services objectives, and other interventions, as necessary The Monitoring Team found that, although teams were making progress in their efforts to identify and incorporate individuals' preferences and work in a more integrated manner, none of the twelve plans reviewed for this section (0%) integrated all of the protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. The Monitoring Team observed two ISPs and two ISP preparation meetings during the on-site visit. There was some progress noted in this area. The best example of potential integration among these was the ISP Preparation meeting for Individual #545: • There was a good integrated discussion regarding the individual's weight as it related to various causes, as well as interventions such as dietary management, reduction of psychotropic medication, increased exercise and active leisure pursuits in the community such as walking in the park and dancing. Staff across all disciplines participated in the discussion, including the DSP. • One tentative goal integrated preferences and strengths to address sustaining relationships with friends from the Facility while engaging in preferred community activities. This was well done but could, in fact, have been taken a step further to address building new relationships with people in the community through participation in clubs or groups related to the individual's many interests, which would have also addressed enhancing the individual's awareness of community living. It would have also built upon one of the individual's primary strengths of good social skills and ability to form friendships. Other examples that demonstrated that ISPs still failed overall to consistently integrate all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for an individual included: • For Individual #286, whose ISP annual meeting was held during the monitoring visit, there were missed opportunities for effective integration. The Behavior Assessment and Intervention Plan (BAIP) discussed during the meeting included replacement behaviors focused on communication, but the Speech/Language Therapist at the meeting had not been consulted in its development and was not familiar with its content. Similarly, the BAIP did not address the behaviors reported to be at least partially causative for the frequent falls. • As reported in Provision O2, for zero of nine individuals (0%) in Sample O2, all recommendations by the PNMT were addressed and/or integrated in the ISPA, Action Plans, IRRFs and IHCPs.	

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		• As reported in Provision P2, eleven of 18 ISPs or ISPAs (61%) integrated the OT/PT interventions. The ISP or ISPA did not consistently describe the supports based on the rationale provided in the therapy assessment. Many ISPs simply stated that the individual had a PNMP and the IDT approved it. Conclusion: This provision was found to be not in compliance. Overall, additional training was still 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 in a way that involves collaborative planning and recognition of the possible contributions of several disciplines to an area of need and/or preference.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Adequacy of methods for implementation: Findings in Provision S1 indicated that during the current site visit, despite some improvement, the 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 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. Adequacy of identification of time frames in action plans: For none of the twelve ISPs reviewed (0%) did action plans include adequate timeframes for completion. This assessment was based on a review that indicated timeframes were not individualized according to need and activity, but rather consisted for the most part of a standard (i.e. one year) completion date across the board. There were exceptions, but these were very limited. Adequacy of identification of persons responsible in action plans: The ISPs typically indicated by position who would be responsible for program implementation, documentation and data review. This did not appear to be sufficient to achieve the outcomes of ensuring program implementation was accomplished as required, however, as evidenced by the finding described above that methods of implementation were not adequately constructed by those identified as responsible for designing the specifics of the action plans. This was further evidenced by findings in Provision S1, which indicated that training data was not being adequately documented by those identified as responsible for implementation, and in Provision F2f which indicated that ISPs, including the completed Action Plans, were not being put into place by those identified as responsible for ensuring plan development. Conclusion: This provision was found to be not in compliance.	Noncompliance
	5. Provides interventions,	Adequacy of interventions, strategies and supports that are practical and functional at the Facility and in community settings:	Noncompliance

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	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	To establish compliance in this provision, IDTs must develop individualized action plans that effectively address the individual's assessed needs for services and supports and to promote increased independent functioning both at the Facility and in the community, as well as design interventions, strategies and supports that can be practically implemented both at the Facility and in community settings. None of the twelve plans (0%) reviewed and/or observed effectively addressed the individual's full array of needs for services and supports in a manner that was practical and functional across settings. Examples included: • For many individuals, the Facility was discontinuing formal money management training as not appropriate to individuals' needs. Instead, individuals were to be offered some undefined form of informal money management on community outings. While it was true that individuals might not be benefiting from the current programs such as identifying coins or using a vending machine, the Facility should consider other aspects of money management that might better suit individuals' assessed skills and needs. For instance, many individuals could benefit from perceiving the immediate connections among work, remuneration, and obtaining personal desires, and could progress from receiving coins and making immediate purchases to receiving a pay voucher to take immediately to the trust office to obtain the coins to make the purchase, and so on. Following the compliance visit, the Facility clarified that it is in the process of moving the formal money management training programing into the community and offering opportunities for "informational training"; the Monitoring Team encourages the Facility to work toward formal money management training in the community and looks forward to reviewing what formal training is provided as an outcome of this transition. • As noted in Provision F2a1 above Individual #353 liked to write. The ISP narrative included a good example of the possibilities for integrating preference and strength to meet a need for promoting independence. The IDT considered teaching the individual to trace his name as a possible self-administration of medication strategy, as this could enable the individual to recognize the appropriate medication box. Unfortunately, this discussion did not result in an Action Plan. On the other hand, there was an Action Plan for the individual to have a "personal, handheld pinwheel," based on an interest in gazing at these objects. Without full knowledge of the individual's interest in pinwheels, it remained fairly certain that the former plan for tracing the name would be far more functional. Additional examples found throughout this report included: • Overall, as reported in Provision S3a, 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. Due to the numerous limitations in the skill acquisition programs described in	

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		Provision S1, it was not possible to determine that SAPs were practical or functional. • In addition, as described in Provision F2a4 and further in Section S, ISP programs did not contain the requisite essential components of skill acquisition programs such as operational definitions of teaching targets, discriminative stimuli, consequences, and teaching instructions that would effectively facilitate learning. • As reported in Provision R3, one of 25 ISPs reviewed (4%) contained skill acquisition programs to promote functional communication. Strategies were not integrated into existing SAPs and SAPS were not developed to address identified concerns with communication. • As reported in Provision P2, for zero of five individuals' records (0%) reviewed were measurable objectives related to functional individual outcomes included in the ISP or ISPA. <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> There is an extensive discussion in Provision S1 related to issues negatively impacting the identification of data and/or documentation and the frequency of data collection in order to permit the objective analysis of the individual's progress. These issues included: • 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. • The Facility achieved substantial progress in ensuring a valid and reliable method of measuring and documenting the performance of the person being taught. The percentage of SAPs that described adequate documentation procedures increased from nine percent to 57 percent since the previous monitoring visit. Despite the progress, however, this reflected that almost half of all SAPs lacked adequate documentation procedures. • Despite the improvement in the documentation procedures, the actual recording of training data remained poor. Due to the factors relating to SAP documentation, it was not evident that the Facility was able to identify and implement an effective strategy to document skill acquisition. As a result, it was generally not possible for the IDT to determine when an individual was benefiting from teaching and developing functional skills. There were similar findings in Provision K9. In nine of nine BAIPs (100%), data collection instructions consisted only of the single phrase, "Document on the Behavior Data Sheet." <u>Extent to which ISP identifies the person(s) responsible for the data collection, and the person(s) responsible for the data review:</u> For twelve of the twelve ISPs reviewed (100 %), the Action Plans defined the person(s) responsible	Noncompliance

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		for data collection. Similarly, for twelve of the twelve ISPs reviewed (100%), the Action Plans also clearly defined the person(s) responsible for data review. Conclusion: This provision was found to be not in compliance.	
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	Adequacy of coordination of goals, objectives, anticipated outcomes, services, supports, and treatments in the ISP: This provision requires that disciplines work together and coordinate activity to achieve ISP goals, objectives, anticipated outcomes, services, supports, and treatments. The Facility continued to implement initiatives toward coordination among staff, including the development and monitoring of the IRRF, the Integrated Health Care Plans (IHCPs) and a variety of routinely scheduled cross-discipline meetings. The Monitoring Team commends the Facility for these initiatives to promote staff coordination in the development and monitoring of supports and services. Overall, however, coordination of goals, objectives, anticipated outcomes, services, supports, and treatments in the ISP continued to be lacking, as described throughout this Section F. Conclusion: This provision was found to be not in compliance.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	Extent to which ISP is accessible and comprehensible to staff: For the twelve ISPs reviewed, none (%) appeared to be written in a manner that would facilitate the ability of staff to comprehend and implement it appropriately. The ISP did not provide a picture of the services and supports the individual requires over the 24-hour day, nor was it written in a manner that facilitates understanding of who is supposed to do what, particularly direct support professionals, or how these activities would support an overall vision for the individual's life. The Monitoring Team would recommend DADS and the Facility consider providing more of a succinct narrative summary at the beginning of the ISP, so that staff, particularly DSPs, can envision the big picture and have a better understanding of what all the sections of information that follow are about and why they need to refer to them. In addition, there was some progress noted, in terms of outcomes, that staff comprehended how to implement the ISP. For example: • As reported in Provision O4, three of three individuals' transfer plans (100%) were implemented as written, and during three of three observations of medication administration (100%), the nurse followed procedures in the PNMP. • As reported in Section O, 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. • As reported in Provision S1, in Program Services D, Training Room One, a staff member	Noncompliance

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		demonstrated comprehensive knowledge of the SAPs for all individuals. In addition, the staff member was observed to float amongst the individuals, focusing attention and prompting for participation. In the Bowie B dining room, staff demonstrated extensive knowledge of dining plans and individual needs. In addition, staff were consistently observed to enquire about preference, additional portions, and the use of condiments. Overall, however, observations and review of program data indicated that 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. Examples included: • As reported in Provision O4, three of 13 individuals' positioning plans (27%) were implemented as written. • Also reported in Provision O4, per observations conducted by the Monitoring Team, staff were not knowledgeable of the Individuals' PNMPs. Eleven of 22 individuals' (50%) dining plans were implemented as written. • As reported in Provision R3, zero of the 13 general use AAC devices (0%) noted contained clear directives on how staff should use these devices. Directions were vague and did not provide detailed instructions/directions to ensure consistent staff implementation. • As reported in Provision S1, three individuals were observed lying on the floor in Driscoll C Classroom 4 without supervision; all three were engaged in stereotypic behavior. When staff arrived, they were asked about training programs and data collection. The staff replied, "They get snacks about 6:00." In Program Services C, leisure materials were present but not in use. When asked about training materials, the staff replied, "They just work with the stuff in front of them." <u>Conclusion</u>: 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	<u>Monthly review of progress</u>: The Facility had returned to requiring the QDDP to make an overall monthly review and evaluation of progress rather than a quarterly review. The Pre-ISP meeting also provided an additional important vehicle to ensure the IDT was alerted to a lack of progress and/or significant changes, either of which would call for needed modifications to be assessed and implemented. This preparatory activity should serve as a complement to the monthly review process and ongoing IDT discussions that should be occurring. The Monitoring Team observed there was progress in the actual timely completion of the monthly reviews. In nine of ten ISPs (90%) completed prior to the monitoring visit, there was evidence the QDDP had made a timely monthly review over the past several months. There was also some progress noted in the substance of the recent monthly notes; however, 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. For example:	Noncompliance

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	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.	• As documented in Provision P3, for 0 of 14 individuals (0%) with PNMPs or SAPs, there was evidence that their progress was reviewed and documented based on the action plan in the ISP/ISPA at least monthly. The monthly QDDP note simply stated that service was provided. No more detail regarding the implementation of the services, the effectiveness, or the need to revisit identified concerns was contained within the monthly review. • As reported in Provision S1, training data remained poor. It was not evident that the Facility was able to identify and implement an effective strategy to document skill acquisition. As a result, it was generally not possible for the IDT to determine when an individual was benefiting from teaching and developing functional skills. • As reported in Provision R2, zero of 25 ISPs reviewed (0%) included information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports/interventions involving the SLP. • As reported in Provision R3, zero of 20 individuals (0%) receiving indirect Speech Services were provided with comprehensive progress notes that contained each of the expected indicators. • As reported in Provision K4, BCBAs had begun a monthly review of PBSP data. The addition of monthly review by BCBAs and a formalized approached to tracking appeared to be a positive step forward. This review process was just initiated in March 2013, however, and insufficient data were as yet provided to assess efficacy and compliance with the Settlement Agreement. This provision of the SA also requires the IDT to meet if a significant change in the individual's status has occurred to determine if the ISP needs to be modified, and make the modification as appropriate. The Monitoring Team found there were a number of examples in which the IDT should have taken assertive action to address the needs for services, supports and protections but did not. BSSLC IDTs needed to be attentive to emerging needs and take assertive action sooner rather than later. One of the most significant of these findings concerned Individual #286. At the ISP Preparation meeting on 3/13/13, it was identified there was discrepancy regarding the number of falls the individual had experienced in the past year. The QDDP had documented four falls, while the Habilitation Therapist had completed an extensive review of the record in addition to the falls log and found the number to be significantly higher. No changes were made or suggested at that time to modify the IRRF falls rating which was set at medium, nor were any immediate protection strategies discussed according to the minutes. There was an Action Plan documented in the ISP Preparation minutes as a result was to further analyze the causes of the falls in order to minimize risks of a serious injury. This was to be completed by 3/27/13. The Comments for this section included a compilation of these twelve falls, which led to an assumption by the Monitoring Team that this had been completed with the	

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		suggested timeframe. Given this assumption, the Monitoring Team reviewed the record to verify the IDT had taken appropriate action in meeting to review the falls and make needed changes to ensure the individual's protection. No documentation of such a meeting was found. At the ISP annual meeting on 4/10/13, it was learned the individual had recently experienced another fall and sustained significant injuries requiring hospitalization. It was also noted the falls data included in the ISP Preparation meeting had not actually been compiled until after this most recent fall had occurred, well after the 3/27/13 noted completion date. At the ISP annual meeting, as a part of the IRRF proceedings, data reviewed indicated the individual had in fact experienced 16 falls in the past year, including two that occurred after the ISP Preparation meeting. The IDT did at the time of the annual meeting appropriately raise the risk rating to High, but had tentatively agreed to set the goal for the upcoming year as having the individual experience less than 16 falls. This would not be an acceptable standard. This series of events was of great concern to the Monitoring Team. It indicated the IDT had not recognized nor engaged each other in discussing falls that were occurring on an ongoing basis; had not acted in a timely manner to assess the falls assertively brought to its attention by the Habilitation Therapist; and did not set an appropriate expectation regarding the individual's protection going forward. In addition to this significant failure to take action as needed, the Monitoring Team found in review of ISP documents and the individual records for both Individual #286 and #599, there were unreasonable delays in responding to an MBS recommendation by the Habilitation Therapists. <u>Conclusion</u>: This provision was found to be not in compliance.	
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-	<u>Extent and adequacy of competency-based training for staff responsible for development of ISPs:</u> As noted in the Summary of Monitor's Assessment, the Facility was implementing a revised ISP process, with a focus on training and mentoring for four IDTs. The Facility reported it had begun again in December 2012 to implement a structured approach to assessing competencies in the Q Construction skills, although no monitorings had been completed thus far. Training sessions for the focus QDDPs and other IDT members responsible for development of ISPs included ongoing training provided by State Office staff and consultants on the implementation of the revised ISP process, including the Pre-ISP meeting. The Facility provided a list of trainings that were conducted since January 1, 2013: • Training was conducted in reference to the ISP Preparation meeting. Two mentors, the QDDP Coordinator and QDDP Educator provided hands-on training on what needed to be discussed during the Prep ISP meeting and how to complete the documentation. • Two trainings were conducted with Supervisors, Unit directors, QDDP and Home Leaders. One of the state office consultants discussed the importance of and how to complete the PSI.	Noncompliance

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	based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	• Training was conducted with the Unit Directors, Mentors, Clerical staff, and QDDP's. One of the State Office consultants discussed the entire ISP process. This course served as a refresher course for many and the initial course for others. • Training was conducted with the four focus IDTs in which a State Office Consultant broke down the ISP process and discussed the assessments, the draft ISP guide, action plans, IRFF, and IHCP, and the IDT responsibilities before and during the ISP. • Training was conducted with the four focus IDT's regarding the ISP preparation meeting and how to prepare for the ISP meeting. • The focus IDTs were provided with hands-on training by state office consultants and the BSSLC mentors on ISP meeting and ISP preparation meetings, documentation, and preparation for ISP. The Facility had also identified QDDP staff to serve as ISP mentors. These included the QDDP Coordinator, the QDDP Educator and the four Lead QDDPs. There were also four additional mentors from various other disciplines. It was reported the mentors would be receiving additional training on the ISP process in the coming months, with the timeline to be finalized following this monitoring visit. 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. It is recommended the mentors review and address these issues as they move forward. <u>Extent and adequacy of competency-based training for staff responsible for implementation of ISPs:</u> The Facility continued to work towards other competency-based training for staff responsible for implementation of ISPs. Examples included: • As reported in Provision O5, 731 of 747 current staff that require training (98%) successfully completed the current PNM core competencies (i.e., foundational skills) performance check-offs. • As reported in Provision M4, the Nursing Department continued to maintain a comprehensive system for conducting and tracking competency-based nursing education for New Nurse Orientation, annual refresher training, as well as other required ongoing training. All nurses had been trained on the 25 nursing protocols and their use was fully implemented and incorporated into relevant health care plans. The Nursing Department was in the process of implement Nursing Protocol Audits, which had not yet produced data to evaluate their effectiveness. Overall, however, the Monitoring Team found staff were not yet adequately provided with	

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		competency-based training. Examples included: • As reported in Provision O5, the Habilitation Director stated that staff on third shift had not received the same level of training as those on other shifts. Individuals require staff to be well trained on all areas of the PNMP even if they are on third shift as many supports individuals require may be provided on third shift, and third shift staff may come in and provide support on other shifts. • Also as reported in Section O, 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. • The Facility noted it did not have a system in place to monitor competency-based implementation of the ISP. A Corrective Action Plan (CAP) had been devised that addressed the QDDP monitoring of the implementation of ISP programs, but it was still in the planning stages. The Monitoring Team commends the Facility for its recognition of this need and looks forward to observing the results at the time of the next monitoring visit. This finding was also influenced by the lack of active treatment and engagement observed and by the lack of fluency with which staff were able to discuss the strategies, supports and interventions included in an individual's ISP without referring to the record. The Monitoring Team conducted observations in a variety of settings across the BSSLC campus with the following findings: • As documented in Provision S1 of this report, there were isolated instances during observations in which employees were noted to be conducting formal training. In a few settings, staff attempted to provide the materials and attention necessary to maintain reasonable levels of functional engagement. In the majority of settings, however, staff had not provided or demonstrated an inability to conduct informal training. Staff were infrequently observed to provide individualized attention or use formal prompting. • As reported in Provision O4, staff were not knowledgeable of the Individuals' PNMPs. 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. • As reported in Provision R3, two of six staff interviewed (33%) were knowledgeable of the individual and their communication related programs <u>Conclusion</u>: 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	<u>Extent to which ISPs are developed within 30 days of admission:</u> The Monitoring Team requested all ISP information for admissions between 10/1/12 and 3/8/12. The documentation provided by the Facility for this request included four individuals. For each of these four, the 30-day ISP meeting was completed within 30 days. According to the list of individuals served, however, there were four additional individuals (Individuals #234, #347, #388 and #402) admitted to the Facility during that timeframe for which no ISP documentation was	Noncompliance

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	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.	provided. These admissions occurred in February and March 2013. The assumption is made that the ISPs were not completed and available for review. <u>Extent to which ISPs are revised annually and as needed:</u> 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. This list was dated 3/1/2013. From this list the Monitoring Team was able to determine that only one of 278 (.03%) was listed as having been held more than 365 days past the date of the previous ISP. The Facility was to be commended for this improvement. The same list was reviewed to evaluate whether the Facility had put the ISPs into effect within 30 days of preparation. The Monitoring Team evaluated this annual list with particular emphasis on the more recent period of 10/1/12 through 3/1/13, the date of the report, as a means of assessing progress. While progress was noted as described below, there were still significant deficiencies in the Facility's current practices: • Fifty-five of 278 (20%) ISPs were not implemented within 30 days of the ISP meeting during the past year. (Twelve additional individuals had recent ISP meetings and had not reached the 30 day threshold. As a result they were not subject to this assessment.) Several were extremely delinquent. For example, the list provided by the Facility showed that Individual #190's ISP meeting was on 4/6/12 and was not put into effect until 11/14/12. Individual #159's ISP meeting was on 6/12/12 and was not put into effect until 12/14/12. • There were seven ISPs that had been held as far back as 7/18/12 that were listed as having not been completed. Three of these were for ISPs that occurred since 10/1/12; two of these dated back to October and had not been completed as of March. • In a positive sign, the rate of delinquent ISPs seemed to be decreasing. There were 11 ISPs out of 105 (10%) that were not implemented within 30 days for individuals with ISPs held between 10/1/12 and 3/1/12. While this would not represent substantial compliance with this provision, it did reflect overall progress in the Facility's implementation. • The Monitoring Team also noted progress in the increasing number of ISPs that were being implemented within two weeks of the ISP annual meeting date. <u>Conclusion:</u> This provision was found to be not in compliance due to the failure to complete ISPs within 30 days of admission or to implement annual ISPs within the required timeframes.	
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the	The Monitoring Team reviewed the Brenham State Supported Living Center QA/QI Council Meeting, Quarterly Quality Assurance Report, dated February 27, 2013 and interviewed the Quality Assurance Director regarding the status of quality assurance processes for identification and remediation of problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section. Findings included:	Noncompliance

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	Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	• The Facility had been implementing the Section F Monitoring Tool since January 2012. Each month the three lead QDDPs, the QDDP Educator and the QDDP Coordinator completed a tool for an ISP completed 60 days prior. A QA Auditor then completed an inter-rater audit for two of these, per the interview with the QA Director. It was reported that there remained discrepancy in inter-rater reliability as reported during the last monitoring visit, but the trend was improving. Current data from this process indicated the Facility was approximately 55% compliant with the provisions of this section. • A draft of a revised monitoring tool for this section was currently being circulated for comment that was reported to be more in line with the revised ISP process. It would include review of documents related to both the ISP and the ISP Preparation meeting. • The QA Director was also working with the QDDP Coordinator to revise the current chart audit process to reflect the changes in the ISP process. • There was a Corrective Action Plan (CAP) in place to address the lack of a competency-based system for program monitoring for the implementation of the ISP, dated 11/14/2012. The QA Director reported the Facility was currently tracking progress of the implementation of the CAP, but was not yet measuring the effectiveness of the actions. This was reported to be a next step to be undertaken. The CAP provided for Monitor review did not include any status update as to the progress in its implementation, nor was it addressed in the Analysis and Summary section of the Quarterly Quality Assurance Report. The Monitoring Team would recommend that any current CAPs for this section be adequately updated for the QA/QI Council meeting and addressed in the narrative of that report. <u>Conclusion:</u> This provision was found to be not in compliance. The Facility was continuing to develop its quality assurance processes.	

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

1. Define provision-specific outcomes the Facility hopes to achieve as a result of each Action Step in the Action Plans as well as how they will be measured. (Self-Assessment)
2. To facilitate individuals' participation as IDT members, a curriculum for "planning my future" should be incorporated into the overall active treatment program on an ongoing and regular basis. (Provision F1b)
3. For the purposes of enhancing the participation of individuals, review the PSI with them prior to the ISP annual meeting, and also summarize it at the beginning of the meeting using language that facilitates their understanding. (Provision F1b)
4. The State and Facility should reconsider how the current process could be modified in part to focus more planning time on preferences, strengths and personal goals, while retaining the overall structure and improvements found in this new format. In addition, QDDPs should receive additional training in how to facilitate individuals' understanding of and participation in the ISP process. (Provision F1b)
5. Barriers and plans to address them, particularly in relation to ongoing interactions and discussions with reluctant LARs, should be included in the ISP Preparation Meeting agenda. (Provision F1e)
6. Require, as a part of the ISP process, the IDT to not only make a determination regarding the most integrated setting appropriate to an individual's needs, but also describe what would be needed in that setting. This process should help to facilitate a discussion and inform the individual and LAR

of the potential advantages of community living and the supports that would be needed for success. (Provision F1e)

7. Consider other aspects of money management that might better suit individuals' assessed skills and needs rather than discontinuing formal money management training as not appropriate to the individuals' needs. (Provision F2a5)
8. DADS and the Facility should consider providing more of a succinct narrative summary at the beginning of the ISP, so that staff, particularly DSPs, can envision the big picture and have a better understanding of what all the sections of information that follow are about and why they need to refer to them. (Provision F2c)
9. The Facility's ISP mentors should focus efforts on the following priority needs: 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)
10. Any current CAPs should be adequately updated for the QA/QI Council meeting and addressed in the narrative of the report. (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 (3/21/13) 2. BSSLC Action Plan (3/11/13) 3. Presentation Book for Section G 4. BSSLC Policy H.1 Minimum Common elements of Clinical Care 10/29/12 5. Minutes of Morning Medical Debriefing of 4/9/13, 4/10/13, and 4/11/13 6. Sick call Change of Status form 7. Statement from BSSLC in response to document request for forms used to document review and response to recommendations from non-Facility clinicians: "No Evidence" 8. Sample of medical consultation reports for Individuals #24, #170, #220, #239, #305, #323, #444, #461, and #597 **People Interviewed:** 1. Interview of Mary Ann Brett, MD, Director of Medical Services, Arthur Austin, MD, Adolfo Carvajal, MD, Malcolm Lochiel, MD, Martha Hare, DP/RN/FNP, and Penny Foerster, RN 4/10/13 **Meeting Attended/Observations:** 1. Morning Medical Debriefing 4/9/13 2. ISP Annual Planning Meeting for Individual #599 3. ISP Preparation Meeting for Individual #191
	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. The activities identified for the assessment of Provision G1 involved the Morning Medical debriefing meeting and IDT referrals from that meeting, and the Interdisciplinary Quarterly Review. No monitoring tools were used, and no data or indicators were provided from which an assessment of the occurrence or effects of these processes could be evaluated. For Provision G2, the self-assessment reported implementation of a tracking system for monitoring non-SSLC clinician recommendations follow up and the development of a monitoring tool to address this. However, no data from the monitoring tool were presented. The Facility reported that neither of these provisions was in compliance. The Monitoring Team concurs but recognizes significant progress. However, the activities engaged in to conduct the self-assessment may not be adequate to assess progress and compliance. The Facility also provided an Action Plan that reported actions being taken to achieve compliance. For Provision G2, the only actions listed were completed actions related to the Morning Medical Debriefing

	meetings. These meetings, while valuable in the approach being used, do not address the broader set of actions that will be needed to achieve substantial compliance. For Provision G2, the actions listed are clear and should lead toward progress, but they are not a complete set of actions that would achieve and maintain compliance.
	Summary of Monitor's Assessment: BSSLC continued to expand integrated planning in a many ways, including the active participation of numerous disciplines in committees and workgroups, integrated planning opportunities such as psychiatric treatment reviews, and the Morning Medical Debriefing process. There are still examples in which integrated planning of services and supports needs to improve. Policies for integrated clinical services and for the consultation review process need to be developed or revised both to reflect the current improved practices and to provide guidance. Documentation of review by facility clinicians of recommendations from non-facility consultations showed that all were reviewed, indicated whether the recommendations were accepted, and usually included documentation in the active record through a progress note. However, there was limited documentation of referral to the interdisciplinary teams for discussion and action as needed. Overall, the Facility is nearing substantial compliance with both these provisions.

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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 integrate planning for both individuals and for systemic improvement continued to evolve. <u>Policy</u> BSSLC Policy H.1 Minimum Common elements of Clinical Care: Ensuring Integration of Clinical Care was revised and implemented 11/30/12. Included in this policy are requirements for assessments or evaluations to be performed on a regular basis and in response to changes in status, and frequency and timelines for those assessments. The policy provides no further guidance about integration of planning or carrying out services and supports. <u>Integrated Care at Morning Medical Debriefing Meetings</u> BSSLC continued the Medical Morning Meeting, now referred to a s the Medical Morning Debriefing. The Monitoring Team reviewed minutes of the meetings of 4/9/13, 4/10/13, and 4/11/13 and attended the meeting on 4/9/13. Observations were consistent with	Noncompliance

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		the positive observations made during the last compliance visit. The discussion was balanced between, and integrated across, the clinical disciplines and helped contribute to a continuity of interdisciplinary care for individuals who were experiencing stress or behavior crisis (as evidenced by reports from on-call clinicians from the various disciplines) and medical disciplines (again via on-call clinician reports and reports on individuals who received care form area hospitals). Simply put, this is an extraordinarily useful and well-run meeting that involves collaborative and active participation from a variety of disciplines, including primary medical providers, psychiatry, nursing, habilitation therapy, pharmacy, PNMT, residential services management, and, most recently, psychology. In addition, nutrition services regularly participates. There is a standard agenda for the meeting. It begins with the on-call physician report, followed by the on-call psychiatrist report, the on-call psychologist report, report from hospital liaison nurses, report of individuals sent to emergency room (if any), review of follow0up on actions assigned at prior meetings, a reminder of ISP and pre-ISP meetings for the day, a list of missed appointments and the reasons and action plans for those, and additional notes. Observation at one meeting showed that even though many of these items are listed on the agenda as reports, they actually were observed to include much discussion across disciplines. Technical terms were explained as needed to ensure that all participants understood the diagnoses and treatments so could participate in discussions of the implications for action. An example of the interdisciplinary nature of the meeting involved Individual #579. The on-call psychiatrist report presented information on the individual who, the evening before, had been screaming and making delusional statements. The psychologist had remained with the individual and had discussed the situation with the psychiatrist. The psychiatrist reported that medications were not used, and the individual eventually calmed. The psychologist will review the behavior plan. Based on this report and the observation, there was integrated discussion involving the psychiatrist, behavior analyst, nurse practitioner, and Director of Habilitation Services. Follow up of a meeting the IDT the next day (the day of the observed Morning Medical Debriefing) was documented in a column for that in the minutes. Furthermore, notes included in the minutes of the 4/10/13 Morning Medical Debriefing added more information provided by the behavior analyst about the individual's delusion behavior. Another example of the improvement to follow up was that the PNMT was made aware of changes in status through participation by the PNMT lead and PNMT RN in the Morning Medical Debriefing. Information from this meeting was then brought to the weekly PNMT meeting for further discussion, and shared with the IDT as indicated if not already discussed by the IDT.	

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		The addition of a psychologist to the meeting participants addressed a recommendation that had been made in the last monitoring report. The addition of a column in the minutes to document follow up also addressed a recommendation from the last report. In addition, the Facility had established a Change of Status form that tracks referrals to the IDT during sick call and follow up from the IDT. <u>Other Integrated Committees and Workgroups</u> • The Infection Control Committee showed an integrated core membership, which was comprised of the CNE, NOO, QA Nurse, Medical Director, Unit Nurse Managers, Food Services Director, Housekeeping Director or designee, Maintenance Director or designee, and Pharmacist. The Infection Control Nurse chaired the Committee. The Monitoring Team's review of the Infection Control Committee Meetings for 7/31/12, 11/30/12, and 2/28/13, showed progressive improvement in substance, discussion, and dispensation of issues from the previous minutes reviewed. • The Skin Integrity Committee was comprised of an integrated core membership, which included: CNE, NOO, QA Nurse, Infection Control Nurses, Hospital Liaison Nurse, Unit Nurse Managers, Medical Director or designee, Habilitation Director or designee, Pharmacist, Residential Services Representative. The Skin Integrity Nurse chaired the Committee. • The Nurse Educator and Habilitation staff taught Medication Administration for Individuals with Developmental Disabilities with dysphagia and/or swallowing difficulties jointly. <u>Examples of Integrated Planning</u> There were other examples of integrated planning. • As reported in Provision J2, PTRs were attended by psychiatry, psychology, nursing, QDDPs, DSPs and other disciplines, and sometimes by family members/guardians (via telephone). Primary Care Physicians (PCPs) attended PTRs when their schedules allowed. At a PTR observed by the Monitoring Team, the psychiatrist reviewed with the team information that had been gathered by team members that contributed to the diagnostic understanding of the individuals. However, combined case formulation was in early stages, and there were examples in which such collaboration was not evident, as examples in Provision K5 indicate. The process shows promise for establishing consistent integrated planning and joint case formulation as it evolves. • Provision J2 also reports that the IDT came together to reassess care when there was a change in status, and such meetings were key opportunities to reassess diagnosis. The Monitoring Team attended a change-of-status meeting on	

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		4/08/13 for Individual #323 who had a reemergence of challenging behavior during a change in anticonvulsant medicines. Among other things, the IDT, including the psychiatrist and PCP, reflected carefully on the implications of the developments on the individual's diagnosis. • As reported in Provision J3, during the visit the Monitoring Team had a first opportunity to see the new formatting during the PBSC meeting that took place on 4/08/13 and was provided with BAIPs for Individuals #170, #186, #286, and #398 who took psychotropic medications. The presentation of psychiatric information in the four BAIPs had a consistent format. In four of four cases (100%), the case formulation was an integrated statement that contained summary information about the psychiatric and psychological assessments and treatments, and the relationship between the two, and the formulation section provided the needed clarity about the roles of psychological and psychiatric treatments. • As reported in Provision K3, 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. • Individual #323 had very complex epilepsy and had been maintained on 5 anticonvulsants including Phenobarbital for many years. Outside consultation was obtained and recommendations were followed by the PCP. Changes in behavior were noted, some positive and some negative. A Reiss screen indicated the possibility of psychopathology and a change of status ISPA (as an IDT ISPA) conference was held. Medicine, psychiatry, psychology and other disciplines participated. The possibility of the changes in anticonvulsants as a cause was raised. A treatment plan was suggested that would involve the various medical disciplines (medicine, neurology and psychiatry) and colleagues from other disciplines as well. The proposal was for care to be focused in the neurology clinic, where the psychologist would report on any correlations between changes in anticonvulsants and changes in behavior. The neurologist, PCP and the psychiatrist would all be present to collaborate/coordinate accordingly. • As reported in Provision O2, BSSLC's PNMT RN conducted assessments in response to all changes in status and discussed the results during the PNMT meeting. Based on these discussions, if PNMT involvement was felt to be needed then the IDT was contacted so that a joint meeting would occur to discuss the findings of the assessment, concerns of the PNMT, and how the PNMT could support the IDT by providing a focused or full assessment or by merely discussing the issue and providing guidance to the individual's IDT. As a result, initiation and receipt of the referral occurred simultaneously and well within	

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		five working days. Another method in which the PNMT was made aware of changes in status was through participation by the PNMT lead, and PNMT RN in the morning medical meeting. Information from this meeting was then brought to weekly PNMT meeting for further discussion and shared with the IDT as indicated if not already done so. However, for zero of nine individuals (0%) in Sample O.2, all recommendations by the PNMT were addressed/integrated in the ISPA, Action Plans, IRRFs and IHCPs. While 100% of the recommendations were clearly integrated as part of the ISPA and were included as part of the risk action plans primarily in the form of following the PNMP; recommendations were not clearly linked or integrated into the IHCPs. • Both PT and the PCP assessed individual #478. As a result, the IDT developed a plan to address and increased number of falls that included treatment for spasticity as part of the plan. • It was positive to find through interview, observation, and review of records of hospitalized and/or recently hospitalized individuals that the Hospital Liaison Nurse had continued to perform the positive practices identified at the last compliance review, including participation at the Medical Morning Meetings to update the team on individuals' hospital status; participation at individuals' pre and post hospitalization Interdisciplinary Support Plan Addendum (ISPA) meetings; and involvement in ISPA meetings completed on individuals from hospitals. The Monitoring Team attended a Post-Hospitalization ISPA meeting for Individual #284. All relevant team members attended and actively participated. The team reviewed Individuals #284's acute change in status, updated his Integrated Risk Ratings, and identified any needed changes in services and supports as a result of the hospitalization. <u>Integration of Services into ISPs and Programs</u> As noted in Provision F2a, the Monitoring Team found that, although teams were making progress in their efforts to identify and incorporate individuals' preferences and work in a more integrated manner, none of the twelve plans reviewed for this section (0%) integrated all of the protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. The Monitoring Team observed two ISPs and two ISP preparation meetings during the on-site visit. There was some progress noted in this area. The best example of potential integration among these was the ISP Preparation meeting for Individual #545: • There was a good integrated discussion regarding the individual's weight as it related to various causes, as well as interventions such as dietary management, reduction of psychotropic medication, increased exercise and active leisure pursuits in the community such as walking in the park and dancing. Staff across all disciplines participated in the discussion, including the DSP.	

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		Other examples that demonstrated that ISPs still failed overall to consistently integrate all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for an individual included: • For Individual #286, whose ISP annual meeting was held during the monitoring visit, there were missed opportunities for effective integration. The Behavior Assessment and Intervention Plan (BAIP) discussed during the meeting included replacement behaviors focused on communication, but the Speech/Language Therapist at the meeting had not been consulted in its development and was not familiar with its content. Similarly, the BAIP did not address the behaviors reported to be at least partially causative for the frequent falls. An additional example of integration found in an ISP was that the Self-Administration of Medication program for Individual #170 involved prompting manual sign for medication, which provided additional opportunity to implement a sign language specific service objective for encouraging producing manual signs. Also, as reported in Provision R2, the SLPs and psychologists continued to improve collaboration n the development of behavioral supports and direct/indirect SLP interventions with alternative or augmentative communication systems. Behavior Services and Speech developed a PBSP/Communication Assessment Checklists that was designed to improve consistency between the two documents and assist in identifying areas in which there is crossover between the two disciplines. Three SAPs developed by Speech and Behavior Services were reviewed and found to be much improved in their consistency as well as the level of detail provided to staff regarding implementation. However, as reported in Provision S1, there remained examples in which lack of integration was evident. For example, the communication assessment for an individual indicated that the individual could not consistently follow verbal, one-step commands. The SAP included verbal directions and prompts. Furthermore, as reported in Provision R2, relevant communication assessments for a sample of individuals with PBSPs and communication deficits were usually included in PBSPs, but they were not included in ISPs. <u>Examples of the Need for Improved Integration</u> • As reported in Provision O7, zero of 23 individuals in the records sampled for the provision contained evidence of indicators integrated as part of the IHCPs to assess the individual's PNM status. The IHCP did not contain criteria for referral to the PNMT, Nursing or other related services (such as Habilitation Therapy). • As reported in Provision P2, in three of three of the ISPs or ISPAs reviewed	

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		(100%), skill acquisition programs that had been recommended in the OT/PT assessment were present, but skill acquisition programs continued to be rarely identified as part of the Habilitation Assessment. The Habilitation Assessments continued to focus primarily on supports to mitigate risk or provide support and did not identify potential areas in which skills such as ADLs could be addressed. • Five of nine individuals from Sample O.2 did not have a clear PNMT discharge process from which information contained as part of the PNMT consultation was shared with the IDT. • Although the Hospital Liaison Nurse attended the meeting reported above, she was not informed by the IDT's Qualified Developmental Disability Professional (QDDP) of the meeting. She stated that this frequently happened. The Monitoring Team just happened to be notified of the meeting and informed her. It is essential that the QDDPs' inform the Hospital Liaison Nurse of all pre and post-hospitalization meetings because she contributes vital information regarding individuals' health status as result of the acute change of status leading to the necessity for hospitalization. • Assessments were not completed in time to permit review by all members of an individual's IDT prior to the annual ISP planning meeting. In a sample of 12 ISPs reviewed, as reported in Provision F1c, only one (8.3%) had all assessments included and completed on a timely basis, at least 10 working days prior to the ISP annual meeting. <u>Conclusion</u> The Facility had made great strides in establishing integrated clinical services. To ensure that individuals receive the clinical services they need and achieve substantial compliance, these processes will need to be maintained and to evolve; assessments will need to be timely so they can be reviewed by other clinicians in preparation for annual ISP planning and for other decisions about treatments and services; and ISPs, skill acquisition programs, and other treatment and interventions should show consistency and participation across clinical disciplines' assessments and plans.	
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	<u>Policies</u> In response to a document request for a copy of any Facility policy that guides Facility clinicians in performing and documenting reviews of recommendations from non-Facility clinicians, 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	Noncompliance

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	recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	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. Also, as noted in the report of the July 2012 compliance visit, the Facility did have a set of guidelines revised in November 2011. These guidelines were limited to medical consultations. Although the report of the July 2012 compliance visit commented on a draft of new guidelines, no further information was provided at the current visit to indicate whether any changes had been implemented. Per interview with facility physicians, there are almost no non-medical consultations, since physicians must order most; the process had not changed since the last visit. <u>Review of Consultations by Facility Clinicians</u> The Monitoring Team reviewed a sample of 13 consultation reports for nine individuals (Individuals #24, #170, #220, #239, #305, #323, #444, #461, and #597). For each (100%), there was documentation of review by the Facility PCP (12 reports) or psychiatrist (one report). Nine of 13 (69%) included documentation of review on the consultation report and an integrated progress note (IPN), two of 13 (15%) were documented only on the consultation report, and two (15%) were documented only in an IPN. For 11 of 13 (85%) there was documentation of whether there was or was not agreement with the recommendation. In one of the two cases in which there was no documentation of agreement, discussion was to be done, but no follow up note was found in the record to document the discussion. Of the 11 for which there was documentation, the recommendations were accepted in all cases (100%). There was documentation of referral to the IDT for only one consultation (8%), the 2/20/13 consultation for Individual #239; with the recently established process for review of consultation and provision of information to the IDT from Morning Medical Debriefing (that began in February 2013), this would be expected to increase (if documentation of referral to the IDT is included in the IPNs). The Facility had established a tracking system for follow-up of recommendations from non-facility clinicians. This should also ensure consistency of review by facility clinicians continues. It might also provide the Facility with data to assess whether referrals are being made to IDTs when needed. <u>Conclusion</u> The Facility has approached substantial compliance. The Facility should ensure policies and procedures for review by facility clinicians are in place and that referrals are made to	

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		the IDT as needed. Given the current practices, these should not be difficult improvements to make.	

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

1. Revise the policy on minimum common elements of clinical care to provide greater guidance on integration of planning or carrying out services and supports. (Provision G1)
2. Assist QDDPs and IDTs to ensure services and supports are integrated, and that any conflicts between services and information from assessments are reconciled or rationale is provided. (Provision G1)
3. Improve timeliness of completing clinical assessments so they can be reviewed by all disciplines. (Provision G1)
4. Ensure referral of consultant recommendations is made to the IDT as appropriate and that documentation is made of IDT decisions. (Provision G2)

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. BSSLC Self-Assessment (3/21/13) 2. BSSLC Action Plan (3/11/13) 3. Presentation Book for Section G 4. BSSLC Policy H.1 Minimum Common elements of Clinical Care 10/29/12 5. Minutes of Morning Medical Debriefing of 4/9/13, 4/10/13, and 4/11/13 6. Table of Assessment Filing—Number of Times filed later than 10 working days (14 calendar days) for meetings between 8/1/12 and 2/28/13 **People Interviewed:** 1. Interview of Mary Ann Brett, MD, Director of Medical Services, Arthur Austin, MD, Adolfo Carvajal, MD, Malcolm Lochiel, MD, Martha Hare, DP/RN/FNP, and Penny Foerster, RN 4/10/13 **Meeting Attended/Observations:** 1. Morning Medical Debriefing 4/9/13 2. ISP Annual Planning Meeting for Individual #286 3. Meetings attended by Monitoring Team members noted in several report Sections
	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. In conducting the self-assessment, BSSLC used audit tools for some provisions. These included the Section I audit tool used to identify whether assessments began within five days of an individual being determined at risk; the self-assessment reported that 60% of assessments complied with that standard. The Facility reviewed the results of the External Medical audit and reported that accuracy related to active problem lists was 92% (although the Monitoring Team found several examples in which not all diagnoses were listed) and that 90% of diagnoses clinically fit and are consistent with ICD-9/DSM IV (partially consistent with the Monitoring Team's findings of consistency with ICD-9/DSM IV but a lower percentage of assessments fully supporting diagnoses). The Facility also reported similar data from the Internal Medical audit. These monitoring tools were included in self-assessment of Provisions H1 and H2. For those, the information was useful. However, the information on assessments was limited to timeliness and did not address comprehensiveness of the assessments. In addition to data from audit tools on timeliness of assessments, the Facility provided data on timeliness of scheduled assessments for the annual ISP. The self-assessment did not report the source of the data for tracking timeliness, but the data were inconsistent with data from the Table of Assessment Filing provided

	in the document request. No other data or information from audit tools were used in this self-assessment. Data on development of clinical indicators (and perhaps on outcomes of those indicators as a measure of timely intervention), on samples of individuals to determine timeliness of modification of treatments in response to clinical indicators, or on system wide health status for targeted conditions (using clinical indicators that would have allowed the Facility to assess whether measures put in place were achieving their intended effects) might all improve the value of the assessment in helping the Facility determine areas for action. In addition, there was no indication of the contribution of the Quality Assurance Department in gathering and trending information for this assessment. The Self-Assessment found no provisions in compliance. The Monitoring Team concurs. The Facility provided an Action Plan that reported actions being taken to achieve compliance. Actions were not thorough or complete. There was no indication that the Facility had identified outcomes that would indicate compliance and the actions needed to achieve them. As a result, actions were not comprehensive. For example, for Provision H1, one step was to track "all required assessments on facility database"—a useful step—and the other was to "Monitor and develop corrective action as necessary"—without indication of how that would be done. For Provision H2, the action was "Continue current activities." For Provision H4, the action was "Develop Clinical Indicators for the following clinical disciplines: Medical, psychiatry, psychology, nursing, and habilitation services." While this appropriately recognized the breadth of requirements of the provision, it did not provide the steps needed to determine those in a clinically justified manner. Actions for the remaining provision were all appropriate and would lead toward compliance but, similarly, were not comprehensive.
	Summary of Monitor's Assessment: The Facility continued to make progress in addressing several provisions of this Section. The development of processes to meet several requirements was moving forward. The lack of timeliness of assessments was a significant barrier to meeting the requirements of several provisions. As noted, timeliness of assessments continued to be variable. Assessment practices did not provide assessments 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. Comprehensiveness of assessments had improved but still required additional improvement. Improvements were found particularly in nursing and PT/OT assessments. In general, medical diagnoses were supported by the assessments and evaluations, with some exceptions. Diagnoses generally were consistent with ICD-9 and DSM IV nomenclature. However, improvement is needed in ensuring the diagnoses are listed on the Active Problem List and in the annual medical summary.

	Timely assessments and revisions in treatment were found in response to hospitalizations. Follow up was clear in regard to malignancy, status epilepticus, and acute conditions, but less clear for aspiration pneumonia and falls. Development and use of clinical indicators to assess individual health care had continued. Clinical indicators were in place for six chronic conditions, including diabetes mellitus, osteoporosis, hypertension, seizure disorder, lipid disorders, and constipation. Development of these indicators had continued since the last compliance visit. One area of progress was the inclusion of review of co-morbidity, such as tracking the lipid panel for individuals with diabetes. Continued work will be needed to ensure the clinical indicators are consistently reviewed and used to make treatment decisions. Also, the development of clinical indicators for additional conditions is in process and should continue. The use of aggregated information on clinical indicators to identify systemic health care issues and areas to target for improvement is in early stages and needs continued development. The Facility has developed policy to address these issues. Further policy development would be helpful, both at the Facility level and statewide.

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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 continued to be variable. As reported in Provision F1d, 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 QDDPs to complete the ISP Guide five days before the ISP annual meeting that would have enabled IDT members to review before the meeting, nor were assessments completed with sufficient thoroughness. The Facility provided at table of assessment timeliness by specific assessment and living unit. Percent of assessments filed later than 10 working days prior to ISP annual planning meetings ranged from 0% for the APEN, comprehensive psychiatric evaluation/update, functional skills assessment, psychological assessment/evaluation, self-administration of medication, and structural/functional behavioral assessment to 96% for vocational assessment (the only assessment for which more than 50% were timely). In the sample of 12 ISPs reviewed for Provision F1c, only 1 (8.3%) had all assessments included and completed on a timely basis, at least ten working days prior to the ISP	Noncompliance

#	Provision	Assessment of Status	Compliance
		annual meeting. This sample included the two ISP annual meetings observed during this site visit. The Monitoring Team also requested the assessments available on the shared drive for a sample of individuals with ISP annual meeting scheduled within ten working days of the date of our request. The number of available assessments ranged from four to ten. Only one of four (25%) had a current Medical Assessment, none of four (0%) had a Psychological Assessment or Update and none of the four (0%) included a PSI. The most consistently available assessments included Habilitation Therapies, Communication, Nursing and Dental, although even each of these were present for only three of the four (75%) individuals. None of the 14 individuals in a sample (0%) in Provision S1 had been provided an intellectual assessment within the past five years. The most recent intellectual assessment had been completed in 2005, and several of the intellectual assessments were at least 20 years old. Two of the 14 individuals in the S1 sample (14%) had been provided with a Psychological Evaluation in the previous 12 months. For both of those individuals the most recent intellectual and adaptive assessments were over 20 years old. Comprehensiveness and adequacy of assessments had generally improved but still required additional improvement. • Fifteen comprehensive psychiatric evaluations (CPEs) were reviewed. Facility psychiatrists gave increased attention to diagnostic justifications, which have continued to improve. DSM criteria for the proposed diagnoses were cited often and the diagnoses were discussed with those criteria in mind. Discussions were substantive and reflected the excellent diagnostic skill of the psychiatrists. Nine of 16 (56%) of the CPEs had good justification for all cited DSM diagnoses. Good case formulations were present in seven of fifteen (47%) evaluations. Most of the others (except Individual #360, where the formulation was missing) had good case summaries but not formulations. • Seven of seven individuals' Admission Comprehensive Nursing Assessments were evaluated for comprehensiveness and accuracy using the Nursing Care Annual/Quarterly Nursing Assessment Monitoring Tool, which found an overall compliance percentage rating of 98.2%. • Nine of nine PNMT assessments/reviews for individuals in Sample O.2 (100%) were initiated at a minimum within five working days of the referral and completed in no more than 30 days of the date initiated, or no more than 45 days in extenuating circumstances. • The status of behavioral assessments was mixed. In general, psychological	

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		assessment reports did not reflect current intellectual and adaptive testing. However, there had been meaningful improvement in behavioral assessments that reflected a new combined format for behavior assessment and intervention. • PT/OT assessments had become more comprehensive. Areas needing improvement included listing of medications and potential side effects relevant to functional status, comparisons of current status with previous assessments and the effectiveness of supports and services, and discussion of the individual's potential to develop new functional skills and expand current abilities. • Similarly, communication assessments, while generally timely, also did not consistently include comparison to status in prior assessments or discussion of potential to develop new communication skills. <u>Extent to which to which assessments are conducted in response to significant changes:</u> The Monitoring Team found that there were some instances in which assessments were being updated in response to significant changes. For example, in five of the five individual records reviewed from Sample O1 (100%), when an individual experienced a change in status that would initiate a referral to the Physical and Nutritional Management Team (PNMT), there was evidence of an IDT referral to the PNMT within five working days of the ISPA meeting. In addition, BSSLC's PNMT RN conducted assessments in response to all changes in status and discussed the results during the PNMT meeting. As reported in Provision L1, eight cases were selected by the Monitoring Team, from a list of all individuals admitted to an acute care hospital during the reporting period. The selected cases were based upon high acuity conditions, such as bowel obstruction, pneumonia, and cardiovascular conditions. All eight cases (100%) included post hospital physical assessment, and documentation indicating that an ISP had been convened to discuss the hospitalization. However, assessments were not always done when indicated by a change in status. For example, as reported in Provision P3, zero of three individuals reviewed by the Monitoring Team who experienced falls were appropriately reviewed by the IDT. Individuals who experienced multiple falls did not have evidence of team discussion regarding the situation in which the falls occurred and factors potentially impacting the occurrence.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the	Diagnoses were consistent with the current versions of the DSM and ICD classification systems nomenclature. <u>Use of Diagnostic and Statistical Manual (DSM) Diagnoses and Support for Diagnoses:</u>	Noncompliance

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	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.	The Monitoring Team reviewed the Active Problem Lists (APLs) of individuals in Sample J1 (refer to Section J). Twenty-one of 22 (96%) had APLs with correct DSM terminology. The exception was Individual #304, whose APL diagnosis included an organic mood disorder, and older term that is not part of the DSM IV. The Psychiatric Treatment Review (PTR) remained the place where most of the routine psychiatric care was provided. Several disciplines participate and provide information that contributes to diagnostic understanding of the individual; observation of a PTR on 4/10/13 confirmed this to be the case. However, although all individuals who had psychiatric evaluations had individual face-to-face examination with the psychiatrist, and psychiatrists typically reviewed records from the Facility and from other treatment settings before making a diagnosis, comprehensive psychiatric evaluations (CPEs) were in place for only 70% of individuals who were followed by psychiatry. Thus, it was not possible to ensure that diagnoses clinically fit psychiatric assessments, as not all had been completed. Furthermore, even with improvement in CPEs, nine of 16 (56%) of the CPEs had good justification for all cited DSM diagnoses. Finally, although there remained five individuals with NOS diagnoses excluding Pervasive Developmental Disorder NOS (two of whom were new admissions), this was an improvement since the last compliance visit, when there were 36 individuals with unresolved NOS diagnoses. Appendix B guidelines require that NOS diagnoses be addressed within 60 days, so continuing work is needed on this issue. <u>Use of International Classification of Diseases (ICD) Diagnoses and Support for Diagnoses:</u> Although diagnoses were consistent with ICD classifications, there were a number of instances in which diagnoses were not listed on the APL or in the annual medical summary, as reported in Provision L1. In some cases, the individuals were listed in a response to the document request as having a diagnosis that was not listed on the APL. For IDT decision-making to be well informed, it is essential that diagnoses be consistently listed so that IDT members can easily access them. • From a list of all individuals reported to have degenerative spine disease, the first five individuals (#390, #88, #223, #226, #258) were selected, and their clinical record reviewed to assess the Facility's management of degenerative spine disease. The diagnoses listed on the annual medical summary indicated zero out of five cases (0%) as having a diagnosis of degenerative spine disease. This included Individual #390, who had a CT of the spine on May, 2011, which demonstrated significant, multilayer degenerative changes. • Despite multiple cases of recurrent aspiration pneumonia diagnosed in	

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		Individual #318, there was no formal diagnosis of recurrent aspiration pneumonia list as a diagnosis on the annual medical summary • Individual #461, was provided a PEG tube, and was noted to have a diagnosis of dysphagia, per PT assessment; however, the annual medical summary did not include dysphagia as a diagnosis. • Of four cases of status epilepticus reviewed, an ICD diagnosis was indicated on the annual medical summary for one (25%). In general, medical diagnoses were supported by the assessments and evaluations, with some exceptions. Although there had been significant improvement in management of chronic conditions, including (as reported in Provision L1) osteoporosis and seizure disorder, there remained cases in which diagnoses either were not made or in which additional assessment was needed. • As noted above for Individual #318, no diagnosis of recurrent aspiration pneumonia was listed despite multiple recurrences. • Of the seven cases identified as having osteoporosis, zero out of the seven cases (0%) had clinical documentation demonstrating a standardized assessment for the underlying cause of low bone density. Improvements had occurred in assessment, diagnosis, and diagnostic justification for both medical and psychiatric diagnoses. Continuing progress and completion of assessments and evaluations should bring the Facility into or near substantial compliance.	
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.	Several sections of this report document improvements in timely implementation of treatments and interventions but also document examples in which treatments and interventions were not provided timely or were not clinically appropriate based upon assessments and diagnoses. As reported in Provision L1, the Facility could not provide accurate information as to clinical diagnosis of Individuals. Without the ability to track diagnoses in real time, the Facility did not have a means to ensure accurate and efficient reporting of medical diagnoses, and to track whether changes in diagnosis lead to timely medical treatment. Two processes show promise of ensuring diagnoses lead to timely medical treatment. The Morning Medical Debriefing, in particular, brought several disciplines together to review changes in health status and to identify issues that need to be referred to IDTs. The active participation of physicians at most annual ISP planning meetings also provided an opportunity to share among IDT members information that could affect decisions about treatment and intervention, but the ISPs reviewed did not consistently include a comprehensive discussion of the clinical issues and how they affect supports	Noncompliance

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		and services. The Monitoring Team looks forward to seeing how these two processes affect timeliness of intervention as they continue to evolve, but cautions that the Facility must have a means to track diagnoses and related treatment. Still, improvement was clear in many areas of medical care. • The Facility had significantly improved on its follow-up on hospitalizations. Following hospitalizations, the IDT had met, and discussed issues related to the hospitalization; and the medical practitioner's documentation was exceptional. The Monitoring Team is most complimentary to the administration, nursing staff, and medical practitioners for their exceptional follow-up, and continuity of care of individuals admitted to acute hospitals. • Of four cases of status epilepticus reviewed, a medical plan was well documented on the annual medical summary in four out of four cases (100%). Note, however, that there was documentation indicating that the medical provider followed up on all episodes of reported seizure activity in one out of four cases (25%). • Of five individuals with reported history of malignancy reviewed by the Monitoring Team, five out of five (100%) demonstrated efficacious follow-up for history of malignancy by the medical practitioner. Five out of five cases (100%) noted clinically appropriate follow-up with a medical specialist for history of malignancy. Five out of five cases (100%) noted clinically appropriate diagnostic follow-up for malignancy. • Of eight acute medical conditions reviewed by the Monitoring Team, all included a detailed initial assessment of the acute medical condition. Four out of eight cases (50%) included documented evidence to support follow-up by the medical practitioner, through resolution of the acute medical condition. Of the five cases that were determined by the Monitoring Team to require diagnostic evaluation, five out of five (100%) were provided diagnostic evaluation. However, there remained areas in which it was not clear that medical treatments were provided timely. • For individuals with degenerative spine disease reviewed by the Monitoring Team, there was a clinically appropriate plan delineated on the annual medical summary for degenerative spine disease in one out of five cases (20%). There was a physical therapy (PT) assessment, specifically addressing degenerative spine disease in zero out of five cases (0%), and there was a PT plan specific to address degenerative spine disease in zero out of five cases (0%). • For individuals whose cases of pneumonia were reviewed by the Monitoring Team, there was evidence to indicate that the Facility evaluated the need for a follow-up swallowing assessment, barium swallow study, or other diagnostic to	

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		help determine the etiology, or worsening etiology of the underlying cause of pneumonia, in zero out of zero cases (0%). There were follow-up x-rays, or other diagnostics to determine resolution of pneumonia in three out of six cases (50%). There was a well defined, and delineated clinical action plan to address pneumonia, and the underlying cause of pneumonia in zero out of six cases (0%). • For Individual #485, there was a significant delay in arranging for an external gastrointestinal consultation, which was ordered in November, 2012, but for which there was no evidence to support that this consultation had been obtained, Issues were also found with timeliness of other clinical interventions. • As reported in Provision O2, two of 5 Individuals (Sample O.5) who were recommended to have a Modified Barium Swallow Study (MBSS) were provided with such study in a timely manner. Individuals had delays in excess of 10 months before receiving recommended MBSS. • As reported in Provision K8, no individuals had been identified as in need of counseling services and no counseling plans had been developed. However, a full-time employee had recently been hired by the Facility to provide counseling services. A concern would be whether the lack of identifying individuals in need of counseling services was due to the lack of availability of the service rather than to lack of actual need. • As reported in Provision R3, for zero of five individuals (0%) reviewed, recommendations or revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress. Progress or lack of progress was not clearly monitored and documented.	
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.	Development and use of clinical indicators to assess individual health care had continued. Clinical indicators were in place for six chronic conditions, including diabetes mellitus, osteoporosis, hypertension, seizure disorder, lipid disorders, and constipation. Development of these indicators had continued since the last compliance visit. One area of progress was the inclusion of review of co-morbidity, such as tracking the lipid panel for individuals with diabetes. This sophisticated approach could provide a means to integrate information from all areas of health care to contribute to better assessment and care, especially if it eventually expands to other clinical areas such as behavioral and dental services. There was a tracking sheet that listed each individual and all of these conditions that each individual was diagnosed as having. As reported in Provision L1, the Facility had incorporated medical management elements into the internal medical provider quality	Noncompliance

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		assurance audit process. In interview, the Medical Director reported that the Facility is still working on how to aggregate and review systemic data and use those data to make decisions on health care practices. The Facility is also beginning the process of establishing standards for quality of care for individuals. In the Self-Assessment, the Facility reported on establishment of indicators by clinical departments. • Physician indicators were in draft. • Nursing, Occupational Therapy, Physical Therapy, and Communication Therapy were complete. • There were no clinical indicators for Psychiatry, Dietary, and Dental services. Examples of use of clinical indicators of both process and status were evident in Nursing. • Individuals who required Pneumonia and Zostavax vaccines were tracked; it was not yet possible to determine the percentage of individuals requiring these vaccines were immunized, as the immunization database was not fully populated yet. Data were available for influenza vaccinations, including reasons for vaccinations not done, as well as for tuberculosis skin testing. • The Facility maintained a tracking system/database for tracking skin integrity/pressure and non-pressure ulcer data, including stages of pressure ulcers. As reported in Provision P2 for OT/PT services, measurable outcomes were included as part of the OT/PT direct plan of service (but were not included as part of the ISP or ISPA). However, even for completed indicators, there was not always evidence they were being used. For example, as reported in Provision R3, progress or lack of progress in communication was not clearly monitored and documented. As reported in Provision M5, three of six (50%) IHCPs identified appropriate clinical indicators to be monitored and the frequency of monitoring. Although the Facility showed continued progress in establishing and using clinical indicators for both individual care and review of systemic status of health care, the Facility has not yet achieved substantial compliance with this provision.	
H5	Commencing within six months of the Effective Date hereof and with	The Facility reported that several actions to monitor health status of individuals had been continued.	Noncompliance

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	full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	• The Morning Medical Debriefing discusses hospitalizations and returns, calls received by the covering physician, and status of any individual when the PCP or other participant in the meeting determines the need for consultation or communication with the other participants. 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 format for the minutes had been revised by adding a column that asks whether IDT follow up is needed, and, if so, a request is made for minutes of IDT meetings to determine what follow up actions were established. • The Facility had established a Change of Status form that tracks referrals to the IDT during sick call and follow up from the IDT. • 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. • The tracking sheets for chronic conditions provide a resource for reviewing the health status of individuals. These should be expanded to additional conditions. As noted in interview, the Facility is also beginning the process of establishing standards for quality of care for individuals. Establishment of such standards, if implemented consistently and evaluated through a quality assurance monitoring process, should greatly improve monitoring of health status of individuals. Although outside the realm of direct health care, review of behavioral data could have implications regarding the need for review of individual health status that could affect behavioral status. Since the last compliance visit, BCBAs began monthly review of PBSP data. This review process was initiated in March 2013. In addition, the Facility reported that PBSP data and other relevant information was entered into a spreadsheet. This spreadsheet also included monitoring ratings, Progress Note comments, and IOA data. As documented in several provisions, the processes in place at the Facility did not yet ensure that changes in status lead to action. • Problems with timeliness of assessments affected the accuracy of knowledge of health care status of individuals. • Although the at risk process using the Integrated Risk Rating Form (IRRF) had improved, the at-risk process had not yet developed to the phase of being able to identify and use the clinical indicators necessary to reliably determine risk level, show whether or not individuals' action plans were successful, or effectively monitor the health status of individuals. The completion of the Integrated Risk Rating Form (IRRF) at the time of the ISP and subsequent changes to IRRF based	

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		on ISPAs, as well as requests for review by the ICST would provide opportunities to capture information that demonstrated the health status of individuals was being monitored. • Individuals with multiple instances cited in Provision L1 of pneumonia and in Section P of falls did not lead to additional assessments or to changes in diagnosis. For example, Individual #286 fell four times leading up to a fifth fall which resulted in injury before there was evidence of the IDT meeting. The Facility needs to continue progressing in developing processes to monitor health status, with attention to ensuring that changes in health status lead to assessments and changes in diagnosis as appropriate.	
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.	As noted above, the Facility had begun to develop and collect data on a set of clinical indicators. However, it was not clearly evident that treatments and interventions were consistently modified in response to clinical indicators. As noted in Provision H4, indicators were not consistently identified or monitored. Additional examples include: • As reported in Section O, zero of the 23 individuals' records in samples O.1 and O.2 (0%) contained evidence that the progress and status of individuals with PNM difficulties and the effectiveness of the individuals' plans was monitored based on objective clinical data identified in the individuals' IHCPs/risk action plans, IPNs and data from the PNM related monitoring forms, nor did the IHCPs contain criteria for referral to the PNMT, Nursing or other related services. • As documented in Provision P3, for 0 of 14 individuals (0%) with PNMPs or SAPs, there was evidence that their progress was reviewed and documented based on the action plan in the ISP/ISPA at least monthly. The monthly QDDP note simply stated that service was provided. No more detail regarding the implementation of the services, the effectiveness, or the need to revisit identified concerns was contained within the monthly review. Clinical indicators, and their implications for modifying treatments and interventions, were not documented. • As reported in Provision S1, training data remained poor. It was not evident that the Facility was able to identify and implement an effective strategy to document skill acquisition. As a result, it was generally not possible for the IDT to determine when an individual was benefiting from teaching and developing functional skills. • As reported in Provision R2, zero of 25 ISPs reviewed (0%) included information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports/interventions involving the SLP. • As reported in Provision R3, zero of 20 individuals (0%) receiving indirect Speech Services were provided with comprehensive progress notes that contained each of the expected indicators.	Noncompliance

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		This provision of the SA also requires the IDT to meet if a significant change in the individual's status has occurred to determine if the ISP needs to be modified, and make the modification as appropriate. The Monitoring Team found there were a number of examples in which the IDT should have taken assertive action to address the needs for services, supports and protections but did not. BSSLC IDTs needed to be attentive to emerging needs and take assertive action sooner rather than later. One of the most significant of these findings concerned Individual #286. At the ISP Preparation meeting on 3/13/13, it was identified there was discrepancy regarding the number of falls the individual had experienced in the past year. The QDDP had documented four falls, while the Habilitation Therapist had completed an extensive review of the record in addition to the falls log and found the number to be significantly higher. No changes were made or suggested at that time to modify the IRRF falls rating which was set at medium, nor were any immediate protection strategies discussed according to the minutes. There was an Action Plan documented in the ISP Preparation minutes as a result was to further analyze the causes of the falls in order to minimize risks of a serious injury. This was to be completed by 3/27/13. The Comments for this section included a compilation of these twelve falls, which led to an assumption by the Monitoring Team that this had been completed with the suggested timeframe. Given this assumption, the Monitoring Team reviewed the record to verify the IDT had taken appropriate action in meeting to review the falls and make needed changes to ensure the individual's protection. No documentation of such a meeting was found. At the ISP annual meeting on 4/10/13, it was learned the individual had recently experienced another fall and sustained significant injuries requiring hospitalization. It was also noted the falls data included in the ISP Preparation meeting had not actually been compiled until after this most recent fall had occurred, well after the 3/27/13 noted completion date. At the ISP annual meeting, as a part of the IRRF proceedings, data reviewed indicated the individual had in fact experienced 16 falls in the past year, including two that occurred after the ISP Preparation meeting. The IDT did at the time of the annual meeting appropriately raise the risk rating to High, but had tentatively agreed to set the goal for the upcoming year as having the individual experience less than 16 falls. This would not be an acceptable standard. This series of events was of great concern to the Monitoring Team. It indicated the IDT had not recognized nor engaged each other in discussing falls that were occurring on an ongoing basis; had not acted in a timely manner to assess the falls assertively brought to its attention by the Habilitation Therapist; and did not set an appropriate expectation	

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		regarding the individual's protection going forward.	
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. Although this policy had been initiated in November 2010, it had not yet been completed and implemented. BSSLC had implemented a revised Policy H.1 Minimum Common Elements of Clinical Care: Ensuring Integration of Clinical Care. This policy defined minimum common elements of clinical care. The definition included that care is provided timely in accordance with assessments andor evaluation provided by all clinical disciplines, in accordance with diagnoses derived from the assessments or evaluations and comply with DSM and ICD nomenclature, and that interventions will be clinically appropriate and timely. The policy continued by identifying: • Requirements for assessments or evaluations by the Pharmacist, Nursing, the PCP, the Psychiatrist, the Psychologist, Habilitation Therapy, Speech-language pathology staff, the Audiologist, and dental staff. • The requirement for diagnoses to be consistent with corresponding assessments or evaluations and with DSM and ICD nomenclature, and to be documented in the APL, annual medical assessment, and PTR or CPE. • That treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses. Specific requirements were established for nurses to respond to acute changes in status, for PCPs to complete assessments if indicated, for other clinical disciplines to respond to acute changes, for nurses to complete a detailed assessment on each individual following discharge from a hospital, for the PNMT nurse to perform a post-hospitalization evaluation and for the PCP to perform an assessment for a hospitalization involving PNM problems, for the Psychiatrist to collaborate with the Psychologist and IDT in developing non-pharmacologic interventions for management of behavior issues, and for the dental staff to perform an evaluation if requested by the PCP or nurse. • That clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner, with all clinical disciplines developing and tracking clinical indicators for acute and chronic healthcare conditions and providing and revising interventions as indicated. • That each discipline department collects data to monitor services and individuals' care, and analyzes those data to identify opportunities for improvement. This policy covers most requirements of Section H. As reported throughout this Section and in other Sections of this report, not all requirements were yet fully implemented. It would be useful for the Facility to establish indicators of these requirements to use in	Noncompliance

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		assessing the status of compliance with the policy. In addition, it might be helpful for the Facility to include in either policy or procedure the whole set of activities that come together to meet all the requirements of this Section, including the Morning Medical Debriefing; the use of clinical indicators as part of assessments and evaluations, the risk rating process, and monitoring of individual status; the databases and systems that track diagnoses and indicators individually and aggregate them to assess systems and identify areas for improvement, and other practices that may emerge. The Monitoring Team would like to make one recommendation for the policy. It assigns responsibility for establishing clinical indicators of efficacy and monitoring of those indicators to each discipline department. Although these departments should have primary responsibility for those actions because of their clinical knowledge and their responsibilities for monitoring progress, the Facility should consider how to make this process more interdisciplinary (because the status of individuals in relation to specific health and clinical issues may affect status in other health areas).	

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

1. Use the current 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. Identify and implement processes to review clinical assessments for comprehensiveness and quality. (Provision H1)
3. Continue develop a comprehensive list of clinical indicators across all clinical disciplines.
4. When clinical indicator data suggest unacceptable results, there should be evidence that the current treatment plan was altered by performing additional assessments and diagnostics or modifying therapeutic regimens (H6).
5. Develop action steps to complete implementation of Policy H1. (Provision H6 and Action Plan)

The following are offered as additional suggestions to the Facility:

1. Consider how to make the process of establishing clinical indicators of efficacy and monitoring of those indicators more interdisciplinary. (Provision H6)
2. Consider using the Medical Morning Debriefing as an opportunity 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 (3/21/13) 2. BSSLC Action Plan (3/11/13) 3. Section I Presentation Book (undated) 4. DADS Policy 006.3 At Risk Individuals (12/7/12) 5. BSSLC Policy I.2 At-Risk Individuals 2/1/13 6. List of risk ratings for Individuals (undated) 7. Record reviews of Individuals #65, #86, #173, #184, #188, #195, #253, #284, #305, #330, #367, #411, #453, and #474 **People Interviewed:** 1. Kori Kelm, Director of Habilitation Therapies 2. Tracy Searle, Physical Therapist Assistant **Meetings Attended/Observations**: 1. Quality Assurance/Quality Improvement Council 4/10/13 2. ISP annual planning meeting for Individual #599
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section I. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section I, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included the DADS Section I Statewide Monitoring Tool. o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. o The monitoring tools included adequate methodologies, such as observations, interviews, and record reviews. o The Self-Assessment identified the sample(s) sizes, but did not include the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). Sample sizes were adequate to consider them representative samples. o The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The self-assessment did not identify staff/positions that were responsible for completing the audit tools. o The Monitoring Team could not determine if staff responsible for conducting the

	audits/monitoring had been deemed competent in the use of the tools and were clinically/programmatically competent in the relevant area(s). o The Monitoring Team could not determine if adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of the tools. ▪ Used other relevant data sources and/or key indicators/outcome measures, primarily the risk database. ▪ The Facility presented data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Presented findings based on specific, measurable indicators. o Measured the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. From the self-assessment it did not appear the Facility QA department conducted any Section I monitoring. ▪ The Facility rated itself as being in compliance with the Provision I.1 of Section I. This was not consistent with the Monitoring Team's findings. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. ▪ Actions were reported as in process, complete, or not started. ▪ The Facility data identified areas of needed improvement, primarily additional staff training. ▪ The actions did provide a set of steps likely to lead to compliance with the requirements of this Section.
	Summary of Monitor's Assessment: The BSSLC processes to demonstrate compliance with this section of the SA had improved in some areas and regressed in others. The most notable improvements were in the areas under supervision of the Habilitation Therapies Department. Since the last review the Facility initiated an At-Risk Individuals policy to guide the risk assessment process. 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. Having written policy and procedural direction should facilitate more consistent performance across the Facility, which would be expected to address the types of issues enumerated in this report. Although the Monitoring Team observed IDT participation and discussion during the risk discussion at the ISP meeting it attended, the decision-making was limited to primarily one team member. 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.

#	Provision	Assessment of Status	Compliance
I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	The 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 Since the last review the Facility developed an At-Risk Individuals policy (2/1/13) to guide the risk assessment and review process. In its last report the Monitoring Team noted that the lack of written policy and procedural direction may be a significant contributory cause to the types of issues preventing compliance. The Monitoring Team is pleased to see the Facility had addressed this policy deficiency. From data presented under Provisions I.2 and I.3 the implementation of this policy appears to have had only limited effect. 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 nurse leading the integrated risk rating section of the meeting dominated the discussion 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. The IDT let the physician overrule what appeared to be the consensus risk rating for falls. Based on the Individual's medical history and diagnoses, several diagnostic assessments should have been completed before her annual meeting to provide an accurate status, for example, a Dexa Scan for osteoporosis, a balance evaluation, and an environmental evaluation in the context of hazards which may contribute to falls. Although the Monitoring Team observed IDT participation and discussion during the risk discussion at the ISP 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 data. At-risk data was not being fully incorporated into program plans. As reported in Section O, for none of nine individuals in Sample O.2, were all recommendations by the PNMT	Noncompliance

#	Provision	Assessment of Status	Compliance
		addressed and integrated in the ISPA, Action Plans, IRRFs and IHCPs. Additional information and data regarding risk assessments and risk mitigation can be found in Sections J, K, L, M, O, and P of this report. Based on this review this Provision is not in compliance. Low compliance rates, as reported by the Facility in its self-assessment and as validated by the Monitoring Team in Provisions I.2 and I.3 indicate the "risk screening assessment and management system" required under Provision I.1 is not yet effective.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	Review of 14 records (Individuals #65, #86, #173, #184, #188, #195, #253, #284, #305, #330, #367, #411, #453, and #474) 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 12 (86%) individuals. Records that did not contain documentation of this requirement included: Individuals #86 and #195. This was an improvement from what was reported (67% compliant) in the last monitoring report. The Facility self-assessment reported a compliance rate of 60% from its monitoring. The records of these 14 individuals were reviewed to determine if changes in circumstance should have resulted in changes to an at-risk assessment, rating, and plan. For nine Individuals (64%), the IDT determined through review that the changes in circumstance did not require changes in the at-risk rating, and mitigation plan. There were five (36%) 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 three of the five (60%) individuals. Records that did not contain documentation of this requirement included: Individuals #86 and #195. Based on a review of records of six individuals (Individuals #184, #284, #330, #411, #453, and #474) for whom assessments had been completed to address the individuals' at risk conditions, five (83%) included an adequate nursing assessment to assist the team in developing an appropriate plan. This was not the case for Individual #184.The five nursing assessments referenced above were deemed minimally adequate by the Monitoring Team. Specific examples of areas needing improvement are found in Section M of this report. One nursing assessment (Individual #184) was deficient in that the clinical data used to support the risk rating was not sufficient. Based on a review of records of five individuals (Individuals #86, #188, #195, #253, and #305) for whom assessments had been completed to address the individuals' physical and nutritional management at risk conditions, all five (100%) included an adequate physical and nutritional management and/or OT/PT assessment to assist the team in	Noncompliance

#	Provision	Assessment of Status	Compliance
		developing an appropriate plan. The following provides an example of an assessment that was comprehensive: Individual #253 was assessed by the PNMT regarding head of bed elevation. Upon completion the IDT met and the plan was fully and timely implemented. Other risk issues identified by the Monitoring Team are noted in Sections J, L, M, O, and P of this report. This Provision is not in substantial compliance because the IDT was not consistently responding to a change in status and adjusting risk action plans accordingly. The Facility self-assessment rated this Provision as not in compliance. Based on this review the Monitoring Team determined this Provision was not in compliance.	
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.	Based on a review of 14 records (Individuals #65, #86, #173, #184, #188, #195, #253, #284, #305, #330, #367, #411, #453, and #474) there was documentation that the Facility: ▪ Established and implemented a plan within fourteen days of the plan's finalization, for each individual, as appropriate in nine (64%)) cases. Records that did not contain documentation of this included Individuals #195, #474, #65, #173, and #367). The compliance rate reported in the last review was 67%. The Facility self-assessment did not report a compliance rate. ▪ Implemented a plan that met the needs identified by the IDT assessments in six (43%) cases. Records that did not contain documentation of this included Individuals #195, #411, #474, #453, #184, #65, #173, and #367. The compliance rate reported in the last review was 58%. The Facility self-assessment did not report a compliance rate. ▪ Included preventative interventions in the plan to minimize the condition of risk in seven (50%) cases. Records that did not contain documentation of this included Individuals #411, #474, #453, #184, #65, #173, and #367. The compliance rate reported in the last review was 50%. The Facility self-assessment reported a compliance rate of 51%. ▪ When the risk to the individual warranted (four cases), the Facility took immediate action in four (100%) cases. The compliance rate reported in the last review was 50%. The Facility self-assessment did not report a compliance rate. ▪ Integrated the plans into the ISPs in nine (64%) cases. Records that did not contain documentation of this included Individuals #253, #195, #65, #173, and #367. The compliance rate reported in the last review was 75%. The Facility self-assessment did not report a compliance rate. ▪ In seven (50%), the risk plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. Records that did	Noncompliance

#	Provision	Assessment of Status	Compliance
		not contain documentation of this included Individuals #474, #453, #184, #195, #65, #173, and #367. The compliance rate reported in the last review was 42%. The Facility self-assessment did not report a compliance rate. ▪ In five (36%) 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 #474, #184, #330, #253, #188, #195, #65, #173, and #367. The compliance rate reported in the last review was 50%. The Facility self-assessment did not report a compliance rate. ▪ Included the clinical indicators to be monitored and the frequency of monitoring in seven (50%) cases. Records that did not contain documentation of this included Individuals #474, #184, #330, #195, #65, #173, and #367. The compliance rate reported in the last review was 25%. The Facility self-assessment reported a compliance rate of 44%. Compliance rates are insufficient to demonstrate substantial compliance with this provision. Low compliance rates, as reported by the Facility in its self-assessment and as validated by the Monitoring Team also indicate the "risk screening assessment and management system" required under Provision I.1 is not yet effective. The Facility self-assessment rated this Provision as not in compliance. Based on this review the Monitoring Team determined this Provision was not in compliance.	

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

1. The Facility should assure all IDTs are provided with continued 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 competency based training and job coaching on implementation of the At Risk policy and its incorporation into the ISP process. (Provisions I.1, I.2, and I.3)
2. Ensure that appropriate and timely assessment and revision of the ISP is done for any individual whose level of risk is revised as the At-Risk Individuals policy is implemented. (Provisions I.1, I.2, and I.3)

SECTION J: Psychiatric Care and Services	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. BSSLC Self-Assessment (3/21/13) and Action Plans (AP) (3/11/13) 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 (8/30/11) 4. DADS Policy and Procedures 001.1 Use of Restraint (4/10/12) 5. Section J Audit Tool – State Office Format (used starting 12/2012) 6. BSSLC Psychiatric Treatment Review Form (revised 1/2013) 7. BSSLC Consent for Use of Psychotropic Medication for Behavior Support (revised 3/01/2013) 8. BSSLC Psychiatric Medication Treatment Plan (PMTP); new form, (started 3/01/2013) 9. BSSLC Psychiatric Progress Note (revised 2/2013) 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. Minutes of the Pharmacy and Therapeutics Committee (P&TC) and the Psychotropic Medication Oversight Committee (PMOC), since the last compliance visit 13. A list of individuals prescribed intraclass polypharmacy and interclass polypharmacy, including the names of medications prescribed and each medication's start date 14. A tabulation that compared rates of Facility use of polypharmacy over the period from January 2010 until the present 15. 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 16. A list of individuals who had medical support plans and dental support plans, to reduce the need for

	pre-treatment sedation 17. The number and percentage of individuals who had dental procedures, who also received pre-treatment sedation, oral or total intravenous sedation (TIVA) 18. A list of all individuals screened for tardive dyskinesia with Dyskinesia Identification System (DISCUS) evaluations 19. A list of all individuals screened with Monitoring of Side Effect Scale (MOSES) side effects evaluations 20. DISCUS forms done over the past year that were rated "5" or higher 21. A list of individuals diagnosed with tardive dyskinesia and the Active Problem List (APL) for each of those individuals 22. A list of neurology clinic appointments for individuals with both psychiatric and neurological problems, and psychiatrist participation in the neurology clinic appointments 23. Sample J1: Record Reviews for Individuals #24, #30, #33, #39, #86, #112, #121, #167, #186, #239, #242, #243, #304, #321, #347, #398, #402, #450, #468, #514, #546, #590. The sample was comprised of 10 individuals selected by the Facility and considered to be clinically stable on their psychotropic medications, eight individuals who were newly admitted to the Facility and four individuals who had complex pharmacotherapy and long-term medication side effects. Materials reviewed for each individual were a. Social History b. Most recent Comprehensive Psychiatric Evaluation (CPE) (Appendix B format if done) c. Most recent Annual Psychiatric Review/ Annual Psychotropic Medication Review d. Most recent Positive Behavior Support Plan (PBSP)and Functional Behavior Assessment (FA) e. Most recent Individual Support Plan (ISP) f. Most recent Annual Medical Summary g. Most recent APL h. All Psychiatric Medication Reviews for the past six months i. All MOSES and 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, ISPA) 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 24. Sample J2: Information on 34 psychotropic medications approved by HRC during the review period. They were for Individuals #15 (Geodon), #42 (Latuda), #59 (Ambien), #75 (Ativan), #118 (Latuda), #144 (Latuda and Cymbalta), #151 (Invega), #173 (Klonopin and Zoloft), #230 (Remeron), #239 (Zoloft), #242 (Zoloft and Ativan), #243 (Risperdal, Ativan, and Cymbalta), #276 (Latuda), #316 (Depakote), #367 (Trazodone), #379 (Zyprexa), #402 (Risperdal and Depakote), #425 (Zyprexa and

Naltrexone), #467 (Lamictal), #468 (Klonopin, Risperdal, Lithium and Tenex), #543 Risperdal), #546 (Celexa), and #590 (Abilify and Tegretol). Materials reviewed included:

a. Information from the clinical record (e.g., progress notes, psychiatric treatment reviews, ISPAs) that helped the Monitoring Team understand 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. PBSC and HRC review of the psychotropic medication proposals
e. Revised PBSP

25. Sample J3: 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
26. A list of all meetings and rounds that were typically attended by the psychiatrist, and which categories of staff always attend or might attend
27. A list and copy of any new forms used by the psychiatrists
28. 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
29. Description of administrative support offered to psychiatrists (e.g. secretarial and administrative scheduling of psychiatric consultations
30. External consultation notes for Individual #323, regarding care for epilepsy

People Interviewed:

1. Reeba Chacko, MD, Staff Psychiatrist
2. Terry Hancock, Department Head, Psychology
3. Karla Kuusisto, MD, Staff Psychiatrist
4. Victoria Morgan, MD, Lead Psychiatrist
5. Johanna Schroeder, RN, Nurse Educator/Compliance Nurse
6. Joy Sorenson, RN ,Case Manager Supervisor
7. Debra Williams, RN, CNE

Meetings Attended/Observations:

1. 4/8/13 PBSC meeting
2. 4/8/13 IDT meeting to consider psychiatric consultation, Individual #323
3. 4/9/13 ISP meeting, Individual #599
4. 4/9/13 Meeting with Ms. Schroeder, Ms. Sorenson, and Ms. Williams to review procedures for side effect screens
5. 4/9/13 PMOC meeting
6. 4/10/13 PTR meeting, Dr. Chacko

Facility Self-Assessment:

	The Facility submitted a self-assessment for Section J dated 3/21/13. In its self-assessment for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment 2) the results of the self-assessment and 3) a self-rating. For Section J the Facility did not use monitoring/auditing tools. Instead, the Facility relied on reports from Facility committees, tracking systems, and databases to describe what had occurred during the review period. Data reported included information from psychiatry departmental databases that listed the psychiatric diagnoses of individuals who received care from psychiatrists (including dates and relevant details of any changes in diagnosis), completion dates for psychiatric evaluations, dates of annual psychiatric updates and each individual's assignment to a particular psychiatrist, and listing of all psychiatric medications used across the Facility as part of treatment programs (including completion dates for initial and annual renewals of informed consent). There were also updates from Facility Committees such as PMOC, the Restraint Reduction Committee (RRC) and the Quality Assurance Quality/Improvement (QA/QI) Council data meetings. These provided information on how the Facility was setting processes to respond to SA requirements, and data reported to those committees on progress made on relevant SA provision items. Many of the data sources cited by the Facility as materials used for the self-assessment were cited for more than one provision item. The various sources are listed below, arranged by topic. 1. The Facility reviewed CPEs for all individuals at the Facility receiving psychotropic medications to determine if all had been evaluated and diagnosed in a clinically justifiable manner. The Facility reported that 93 of 140 (66%) had the required diagnoses in place. The Facility also reported that DADS Lead Psychiatrists met and agreed to implement a standardized tool that will allow psychiatrists to audit the content and quality of psychiatric assessments. The Facility reported that a scheduled external peer review scheduled for February was postponed. 2. For appropriate use of medication, the Facility (1) reviewed psychology and psychiatry databases to ascertain whether all individuals who were medicated had behavioral treatment plans in place, and whether medication treatments listed target symptoms. The Facility also reviewed records of each of the two episodes of emergency chemical restraint. 3. For review of pre-treatment sedation the Facility reported that information regarding pre-treatment sedation was now discussed at the Restraint Reduction Committee, but there was not yet a system in place to track and analyze pre-treatment sedation. 4. For Reiss Screen use, the Facility reviewed psychiatry and psychology departmental records for admissions and for new referrals to psychiatry and discharges from the psychiatry clinic. 5. For determination of proper procedure for new medication approvals, the Facility reviewed the use of ISPA templates for new medications, and the Facility reviewed ISPAs for new medications and consents for new medications. In March 2013 the Facility showed that 136 of 141 individuals (96%) had current medication consents. 6. For evaluation of the use of nursing screens for medication side effects (MOSES and DISCUS), the Facility reported that it planned audits for physician review of the screens, but those reviews had not yet started.

	7. For efforts to minimize unnecessary polypharmacy the Facility reviewed monitoring data for Facility-wide use of polypharmacy and reported on reductions in the amount of such polypharmacy and reported on the implementation of a polypharmacy justification section in the PTRs. 8. The Facility continued to track psychiatrists' participation in neurology clinics to assure continuity of care. A specialized report to identify all individuals treated with anticonvulsants for both seizures and for psychiatric indications and an audit to monitor psychiatrists' responses to neurology clinic recommendations were planned but not yet implemented. The materials reviewed provided information on the internal Facility process, and provided useful quantitative information from Facility databases. Little information was provided, however, that addressed the quality of services provided. For example, there was no use of clinical indicators that would have allowed the Facility to assess whether measures put in place were achieving their intended effects. In the absence of the use of monitoring/auditing tools and/or a more detailed description of how records were reviewed and determinations were made, it was difficult to get more than a broad overview of progress made. The Facility also provided an AP that reported actions being taken to achieve compliance. The AP was comprehensive since it addressed all the major issues the Monitoring Team had identified in previous reports as needing attention. In some provisions the AP offered good actions steps that could move the Facility toward compliance. For example, the Monitoring Team's had commented on the need to improve diagnostic justifications and case formulations in CPEs (Provisions J2 and J6). The action step listed by the Facility was an outside peer review (planned for February 2013 but postponed). Such a peer review would be excellent way for the Facility to assess quality. For other provisions, however, actions steps would have moved the Facility forward toward compliance more quickly, had they been more detailed. For example, there was a Facility AP to "review implementation of local ISPA shells for pre-treatment sedation." The evidence required by the AP was QA data, but no further details were provided. The action step would have been stronger had it specified how implementation would be assessed. Would the measures be whether the planned program sessions took place? The Individual's willingness/ability to participate in the program? Successful completion of program session? Would there be measures to assess whether the program had measurable effects on the end goal of minimizing the need for pre-treatment sedation program outcomes? Would there be reviews of progress at the IDT and the Facility review levels? None of these issues were spelled out. A similar lack of detail was present in many places in the AP. As a result, the Monitoring Team had only a limited understanding of the specific steps to be taken by the Facility in its efforts to progress toward substantial compliance, and the Facility did not state an action of specifying measures of implementation. For 12 of 15 provisions, the Facility's Self-Assessment led to a self-rating that was the same as that of the Monitoring Team. For Provisions J11 and J14, the Facility rated for substantial compliance but the Monitoring Team did not agree. In each case the Monitoring Team found that substantial progress had been made but there were remaining items that needed attention. For Provision J12 the Facility did not rate for substantial compliance since planned QA audits were not yet in place. The Monitoring Team

	agreed that such QA audits were important but the Settlement Agreement (SA) did not require them. The Monitoring Team assessed Provision J12 on the basis of whether the Facility provided what was required by the SA and found that it had done so. Accordingly, the Monitoring Team found the provision to be in substantial compliance.
	Summary of Monitor's Assessment: During the current review period only Provision J12 came newly into a status of substantial compliance with the requirements of the SA; individuals who needed side effect screens had received them, and these were generally reviewed and signed by prescribers. Good clinical judgment was evident for review of findings during interdisciplinary meetings and for determinations of need for additional screenings. Provisions J1 and J15 continued to be in substantial compliance. Considerable progress was made for many provisions even though the relevant provisions had not yet come into substantial compliance with all provision requirements. Those areas of progress were for the following provisions: • Provision J2 required CPEs for all individuals who took psychiatric medications. Progress on doing so had stalled, but the Facility developed a plan to focus more of the available psychiatric time on the important task of CPE completion. • Provision J3 required that when psychotropic medications were used, there needed to be a treatment program in place. For that reason, it was important for the Monitoring Team to understand how the treatment programs were constructed and presented, and to assure that they properly described the psychiatric component of the treatment. During the review period the Facility introduced Psychiatric Support Plans (PSPs), and enhanced the IRRF Behavioral Healthcare section. • Provision J4 required efforts to minimize the need for medical pre-treatment sedation. Action Plans (APs) to do so were now reviewed by PBSC. • Provisions J9 and J10 required an IDT process which made new medication plans and consents for those plans possible. Progress was made for both provisions. • Provision J11 required that polypharmacy regimens needed to be justified or eliminated. The Facility had introduced a polypharmacy justification section into PTRs that provided a place for psychiatrists to present their thinking about the need for polypharmacy and/or plans for its elimination. • Provision J13 required medication treatment plans. The Facility introduced PMTPs that provided needed plans. • Provision J14 spelled out requirements for informed consent for medication and the Facility introduced improvements to the informed consent form.

#	Provision	Assessment of Status	Compliance
J1	Effective immediately, each Facility	<u>Qualifications and Experience of the Psychiatrists</u>	Substantial

	shall provide psychiatric services only by persons who are qualified professionals.	Drs. Morgan and Chacko, whose qualifications were reviewed in previous reports of the Monitoring Team, continued as Lead Psychiatrist and Staff Psychiatrist, respectively. The Facility was able to secure locum tenens coverage from Dr. Karla Kuusisto. Dr. Kuusisto was an experienced psychiatrist who was a graduate of the University of Texas in Austin and the Texas Medical Branch at Galveston. She completed her residency training in psychiatry at the New York University & Bellevue Medical Center. Dr. Kuusisto had considerable experience with intellectual and developmental disability psychiatry, dating back to her training at Bellevue Hospital. In the early part of her career Dr. Kuusisto worked in community clinics in New York, where she had extensive experience working with individuals with intellectual disabilities. More recently, Dr. Kuusisto had worked as a local tenens psychiatrist at the Mexia SSLC (August 2011 through September 2011 and November 2011 through February 2012), and at the San Angelo SSLC (July 2012 – September 2012). She has been working at the Facility since October 2012. Drs. Chacko, Kuusisto and Morgan were all licensed to practice medicine in Texas and were all board certified in psychiatry by the American Board of Psychiatry and Neurology. Dr Chacko was also board certified in child psychiatry. All psychiatrists had the training credentials, licensure and experience required by the SA. All three psychiatrists 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, PMOC and P&TC. <u>Monitoring Team's Compliance Rating</u> On the basis of the above, the Facility remains in substantial compliance with the requirements of the SA.	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.	<u>Facility Use of Psychotropic Medications</u> One hundred thirty-two of 293 (45%) of individuals who lived at the Facility received psychotropic medications. All needed to have clinically justified evaluations and diagnoses. <u>The Process for Evaluation and Diagnosis</u> All individuals who had psychiatric evaluations had individual face-to-face examination with the psychiatrist. Prior to making a diagnosis, psychiatrists typically reviewed records from the Facility and from other treatment settings. The psychiatrists also obtained information from family members. Psychiatrists obtained information that contributed to the diagnosis in the course of their day-to-day work in the various settings and meetings where individuals were seen and their care discussed.	Noncompliance

		PTRs remained the place where most of the routine psychiatric care was provided. Starting in 2013, routine PTRs were conducted quarterly. Previously they were held monthly. Monthly PTRs continued to be held for children and psychiatrists and could always add individuals to the scheduled quarterly PTR on the basis of need. PTRs were attended by psychiatry, psychology, nursing, QDDPs, DSPs and other disciplines, and sometimes by family members/guardians (via telephone). Primary Care Physicians (PCPs) attended PTRs when their schedules allowed. If they were not able to do so the psychiatrist had the opportunity to consult with them at many other venues, including the medical morning report. The Monitoring Team observed a PTR on 04/10/13 during which Individuals #234, #308, #367, #388, #402, and #479 were reviewed. Several of the individuals reviewed were new admissions, and the psychiatrist reviewed with the team information that had been gathered by team members that contributed to the diagnostic understanding of the individual and in one case related to information received from another Facility where the individual had been previously treated. When there was a change in an individual's healthcare, the IDT came together to reassess care, and such meetings were key opportunities to reassess diagnosis. The Monitoring Team attended a change-of-status meeting on 4/08/13 for Individual #323 who had a reemergence of challenging behavior during a change in anticonvulsant medicines. Among other things, the IDT, including the psychiatrist and PCP, reflected carefully on the implications of the developments on the individual's diagnosis. PBSC meetings provided an opportunity to review integration of behavioral health since the Head of Psychology led the meetings and the Lead Psychiatrist attended. The Monitoring Team observed the PBSC meeting that took place on 4/08/13. The meeting was led by the Department Head of the Psychology Department, and the meeting was attended by members of her department including the IDT psychologists of individuals under review. In some cases, nurse case managers and qualified developmental disability professionals (QDDP) also attended the meeting. 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. ISPs provided an opportunity for the IDT (including the psychiatrist) to come together with individuals and families to review progress and to plan future support. The Monitoring Team observed the ISP for Individual #599, on 4/08/13. Psychiatric information was provided via the integrated risk discussion for polypharmacy and side effects (the Individual had no polypharmacy but there was a medication side effect) and behavioral health discussion. Discussions by the psychiatrist with other IDT members about differentiation of the individual's yelling/rapid breathing from other symptoms	

		measured by psychology on a scale for anxiety and mood helped clarify the reasons for ongoing diagnoses of autism and anxiety. The Medical Morning meeting was a daily meeting attended by on-call clinicians, and representatives of various disciplines. The Monitoring Team attended the Medical Morning Meeting on 04/09/13. The meeting was fast-paced and focused on acute medical care. Nonetheless, at that meeting too, there 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 J8. <u>Facility Efforts to Provide Evaluations and Track Key Information</u> 1. <u>CPEs in place:</u> In July 2012, Comprehensive Psychiatric Evaluations (CPEs) were in place for 95 of 141 (67%) of the individuals who were followed by psychiatry. As of 2/28/13, the Facility reported that 93 of 140 (66%) of the individuals treated by psychiatry had (CPEs) in place. The Facility reported that efforts to complete the CPEs but that the process were hindered by a staffing shortage in psychiatry. The Facility noted that the change in department practice from monthly PTRs to quarterly reviews was expected to improve efficiency and increase the completion rate for psychiatric evaluations. 2. <u>Use of Diagnostic and Statistical Manual (DSM) diagnoses throughout the clinical record:</u> The Monitoring Team reviewed the APLs of individuals in Sample J1. Twenty one of 22 (96%) had APLs with correct DSM terminology. The exception was Individual #304, whose APL diagnosis included an organic mood disorder, and older term that is not part of the DSM IV. 3. <u>The use of NOS diagnoses:</u> The Monitoring Team reviewed the 15 CPEs done since the last visit. NOS diagnoses continue to be present in some of those including in new evaluations. For more details see Provision J6. 4. <u>Tracking of key information in enduring documents:</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. The plan at that time was to: a. Develop Psychiatric Treatment Plans (PTP) that would include pertinent psychiatric information needed for the long term record. PTPs would be updated annually and also when new medications or diagnoses were introduced. b. Implement annual psychiatric updates for CPEs. The Facility reported that due to a staffing shortage in psychiatry progress on the above issues was limited. Annual updates were done for 34 of 140 (24%) of the individuals followed by psychiatry. The Monitoring Team was informed there had been no data analysis of the completion rate for annual psychiatric	

		updates. Also, the Facility had not yet developed or implemented a formal psychiatric treatment plan that would be incorporated into the ISP. The Facility did note that the new DADS ISP format had a psychiatric review subsection (see discussion under Provision J8) but commented that no QA data was available regarding its use. Psychiatric Medication Treatment Plans were introduced in March 2013. PMTPs are reviewed under Provision J13. 5. <u>The process to track diagnoses and diagnostic update:</u> The system in place at the Facility was that psychiatrists made changes in diagnoses during PTRs, annual reviews, and elsewhere in the course of day-to-day work. However, there was no a system in place to update the permanent Facility records in real time, and it was the primary care physician, not the psychiatrist, who had the final authority regarding the diagnoses of record. In 2012 the Psychiatry Department developed a 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 details of that process were described in the last report of the Monitoring Team. Generally, the process involved the psychiatrist, psychiatry assistant, administrative support, AVATAR clerk and psychologist. The system was intended to assure that data systems for (1) psychology department files, (2) psychiatry department files, and (3) the AVATAR system all contain the same information. The process was intended to assure that when the psychiatrist made a change in diagnosis, the PCP was informed, and had written an update in the APL in the individual's record. The PCP also dictated the change into the AVATAR during the next scheduled annual update. The Monitoring Team check on the timeliness and accuracy of the process by performing two analyses: a. The Monitoring Team reviewed records of the 10 individuals who had changes in diagnosis in January 2013. APL's of seven of 10 (70%) individuals had the revisions on a newly printed APL or via a handwritten update of the existing APL. b. The Monitoring Team further reviewed records of the 14 individuals in Sample J1 who had lived at the Facility for some time. All had APLs and 10 of 14 (71%) had CPEs. CPE and APL diagnoses were the same in eight of 10 (80%) of the cases. The exceptions were Individuals #30 and #304. <u>Monitoring Team's Compliance Rating</u> As described above, the Monitoring Team found 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. However, the progress of completing CPEs had stalled as had the process to resolve NOS diagnoses. Manual updates of APLs need improvement. These matters needed further attention and the Facility remained in non-compliance on this provision.	

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<tr><td>J3</td><td>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.</td><td><u>Treatment Plan Information on Psychiatric Diagnoses and Treatment</u>
The key requirement of the provision was that medications should not be used as a substitute for a treatment program. At the Facility, the behavioral treatment program had long been termed the Positive Behavior Support Plan (PBSP). Materials provided to the Monitoring Team contained lists of individuals who had PBSPs and a list of individuals who took psychotropic medications. These showed that all individuals who took psychotropic medications had PBSPs.

PBSPs reported on the psychiatric diagnosis and psychotropic medications given to individuals. The key place where decision making on psychotropic medications took place was the PTR meeting, attended by psychology and psychiatry along with other disciplines. In those meetings the psychologist provided behavioral tracking data that informed the psychiatrist and IDT's decisions about medication management. That information was later summarized in PBSP reports.

Since data reported and discussed in PTR was later reported on in the PBSP, the Monitoring Team has commented in previous reports that medication information was best presented and shared when the formatting of the information for the two meetings was the same.

The template in use for PTR presentation at the time of the visit contained the following key elements:

<table><tr><td>Axis I Psychiatric Diagnosis</td><td>Psychiatric Symptoms (in the new PMTP – "targeted psychiatric symptoms ")</td><td>Rating Scale (In the new PMTP- "Treatment Efficacy Measure data or scale")</td><td>Psychotropic Medication</td></tr></table>
The Monitoring Team reviewed Sample J1 to see if information in PTRs and in PBSPs was presented in the same format. Comparisons were possible for sixteen of the 18 individuals (comparisons could not be made for two individuals who had been admitted recently and had not yet had a PTR). Overall, only two of 16 (13%) individuals had the same formatting and information in PTRs and PBSPs. Both psychology and psychiatry departments were aware of the problem and were working to make the needed corrections. Of note, the two individuals who did have the same information were both newly admitted (Individuals #242 and #243). That was encouraging, since it showed that the Facility was already moving toward a more uniform presentation of information.

<u>Facility Changes in Behavioral Treatment</u></td><td>Noncompliance</td></tr>
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		At the time of visit, the Facility was in the process of transition to a different format called Behavioral Assessment and Intervention Program (BAIP), described in more detail in Section K of this report. Not all individuals who took psychotropic medications needed such an intervention plan and for those individuals the Facility was in the process of implementing Psychiatric Support Plans (PSP). During the visit the Monitoring Team had a first opportunity to see the new formatting during the PBSC meeting that took place on 4/08/13 and was provided with BAIPs for Individuals #170, #186, #286, and #398 who took psychotropic medications. The presentation of psychiatric information in the four BAIPs had a consistent format. There was a section of background information, a section on history of behavior and intervention, a case formulation, and then a table of information that contained key psychiatric information that had columns for Axis I psychiatric diagnosis, psychiatric symptoms related to the diagnosis, rating scales (if any), and psychotropic medication. In four of four cases (100%), the case formulation was an integrated statement that contained summary information about the psychiatric and psychological assessments and treatments, and the relationship between the two. In all cases the DSM diagnosis was provided, a functional assessment of the challenging behaviors was provided and when necessary there was clarification about whether the challenging behaviors were related to operant learning, psychopathology, or both. The Monitoring Team found that for purposes of psychiatry – and more specifically for the requirements of provision J3 of the SA – all four examples (100%) of the BAIPs contained the information that was needed, and the formulation section provided the needed clarity about the roles of psychological and psychiatric treatments. Additional information about active treatment is contained in the ISP and other documents. The Monitoring Team was also provided with nine examples of the new PSPs, for Individuals #19, #113, #158, #300, #492, #517, #536, #538, and #545. PSPs contained the psychiatric diagnosis and medication information in the format displayed above that was shared with the PTR presentation. That was a positive step. The PSPs also contained psychiatric background information, case formulation, history of behaviors, interventions and psychoactive medications and psychiatric symptoms to be tracked by rating scales. Based on this initial viewing of the PSP format, it appears to contain the critical elements for psychology/psychiatric integration. <u>Appropriate Use of Medication</u> To review Facility processes, the Monitoring Team observed three different types of clinical meetings: The Monitoring Team attended the PTR for Individuals #234, #308, #367, #388, #402, and #479 that took place on 4/10/13. The meeting was attended by psychiatry, psychology, and nursing; the discussion was clinically relevant and discussion about the	

		need for medications took place, whether or not the individual formally met the agreed upon criteria for polypharmacy. Individual #402 took only two psychotropics of different classes and thus did not meet the definition of intraclass polypharmacy. Nonetheless, there was discussion about the need for Risperdal, the psychiatrist noted that hyperprolactinemia was likely a side effect, and she commented that once Depakote levels were therapeutic, she would challenge the Risperdal. This reflected good practice. The Monitoring Team also attended an ISP for Individual #599, on 4/09/13. In that setting that psychiatrist provided detailed information about medications via the behavioral health section of the IRRF. The psychiatrist presented a written document that provided details of the Individual's medications (Risperdal and Ativan) and presented data on their efficacy in treating the presumed anxiety. There was a good clinical discussion between clinicians and with the Individual's LAR as to whether the individual's yelling and rapid breathing indicated anxiety. The meeting was a good demonstration of careful and thoughtful use of medication that was integrated into the overall treatment plan. The discussion demonstrated appropriate use of medication. <u>Medications used for staff convenience</u> The Monitoring Team addressed whether medication was used for staff convenience by examination of the records, and by observations made during PTRs and other activities during the visit, and by interviews with staff. There was no evidence that medications were used for staff convenience. <u>Medications used for punishment</u> To determine whether this was ever done, the Monitoring Team considered observations made during the tour, and reviewed the records of the 18 individuals in Sample J1. There was no evidence that medications were used for punishment. <u>Chemical Restraint</u> There were two uses of chemical restraints during the review period. The first episode was for Individual #402 on 2/13/13. Documentation provided to the Monitoring Team included IPNs that documented efforts to manage the individual's aggression with behavioral techniques, pre-restraint consult by the psychologist on call, orders from the medical attending for use of medication (Ativan), Crisis Intervention Restraint Checklist, and the Crisis Intervention Face-to-Face Assessment and Debriefing form. On the review section of the debriefing form the psychiatrist documented that the individual was monitored by the nurse on duty as well as 1:1 staff, and the IDT met on 2/19/13 to address physical restraint, chemical restraint and additional interventions such as psychotropic medication titration. Vital signs were not obtained by the nurse during the two hours following the restraint; the nurse did document that the individual was agitated and did not allow the vital signs but was monitored closely and did not show any evidence of physical distress. Vital signs were done five hours after the medication, when	

		the individual had deescalated and allowed the vital signs to be taken. The second episode of chemical restraint took place for Individual #460 on 8/16/12. The appropriate clinical protocols were followed. The psychiatrist and medical physician were involved early in the crisis and participated in the decision making, many efforts were made to use behavioral redirection techniques, and the chemical restraints (Ativan) were used only after those efforts failed. The psychologist provided a pre-restraint consult, and the crisis intervention restraint form was used to document the medical intervention and the monitoring for safety by the nurse. Following the incident the debriefing was carried out with substantive input from the psychiatrist. <u>Monitoring Team's compliance rating</u> Good clinical care was evident, there was no evidence of use of medication for staff convenience or punishment and some progress has been made in documentation issues but, as outlined above, some issues remain. The Facility had introduced a new format for behavioral healthcare plans; those plans were present for only a few individuals. For those reasons the provision remains in noncompliance.	
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>Rates of use of pre-treatment sedation</u> The Facility reported that between 8/01/2012 and 2/28/2013 there were 823 dental procedures, for an average of 103 procedures per month. Twenty seven of 823 procedures (3.2 %) utilized involved administration of TIVA and two of 823 procedures (0.24%) utilized oral pretreatment. The Facility reported that there were 24 incidents of medical pretreatment sedation. All uses of pre-treatment sedation and TIVA were considered to be medical restraints. <u>Monitoring for safety during medical restraint</u> Facility procedures to monitor for safety during medical restraint procedures were described in DADS Nursing Protocols: Pretreatment and Post Sedation monitoring, Nursing Protocol: Post anesthesia care and Nursing Protocol Post Anesthesia Care – REACT Scoring System. The nursing protocols for safety spelled out that for oral pre-treatment sedation monitoring for safety included a baseline nursing evaluation that included a full set of vital signs, and mental status, gait, balance, and coordination. Vital signs measurements were then to continue every 30 minutes until departure from the home/unit. Upon return to the home from the procedure monitoring was to continue every 30 minutes x2, then every 2 hours x2, then every four hours, for a minimum of 24 hours. For TIVA, the protocol required post TIVA assessment prior to release from the infirmary with vital signs every 15 minutes for an hour, then every 30 minutes until a REACT score (a measure of alertness) of 8 or higher was reached. At that point the individual could return to the home. Monitoring on the home was to continue every hour for two hours	Noncompliance

		then every shift for 72 hours. In April 2012 DADS put into effect a Medical/Dental Restraint Checklist. The checklist consolidated nursing and DSP documentation related to the restraint into one place and provided needed prompts about the time intervals before the next safety check. The time line on the Medical Restraint Checklist continued for 24 hours. Since monitoring for safety needed to continue for 72 hours in the case of TIVA, additional documentation was needed for those procedures. Such documentation was made at the Facility on exiting nursing checklists for post-sedation monitoring. The Monitoring Team reviewed the procedures for safety for 10 individuals. These included: • Dental pretreatment sedation for Individuals #170 (IM lorazepam on 2/22/13), and #462 (oral lorazepam on 8/31/12) • Medical pretreatment sedation for Individuals #193 (oral hydroxyzine on 9/14/12), #238 (lorazepam and hydroxyzine on 10/11/12), #419 (IM Versed for on 9/13/12), #473 (Geodon on 1/25/13 for an eye exam), and #492 on 01/25/13 for an eye exam • TIVA for Individuals #133 (12/05/12), #152 (09/12/12), #153 (08/15/12), #293 (11/08/12), and #453 (10/10/12) Nursing monitoring was present for 10 of 10 (100%) of the cases, but the measurements and observations were not documented in a consistent manner. The medical restraint checklist was used in only six of ten (60%) of the cases and amongst those only four followed the guidelines provided for the forms. That meant that appropriate documentation was provided for only four of ten cases (40%). Common errors included failure to provide the needed vital signs for the duration of the required period, absence of baseline vital signs, and intervals of time during the timeline where vital signs were needed but not done. During the visit a meeting was held with BSSLC nursing staff. There was agreement that documentation of nursing checks for safety should be on the Medical/Dental Restraint Checklist for the first 24 hours and that following TIVA additional nursing assessments would be documented on post-sedation vital sign checklists. <u>Status of Development of Plans to Minimize the Need for Pre-Treatment Sedation:</u> The Facility informed the Monitoring Team in the Self Assessment that it had identified "a system disconnect regarding pre-treatment sedation tracking. It was identified that there was no consistent method of collecting, organizing and analyzing pre-treatment sedation." The Facility also reported that a corrective action plan had been implemented to address the problem. The intent of the corrective action plan was for all individuals who require pretreatment sedation to have a behavioral plan to reduce the need for	

		pretreatment sedation. The plans would be presented to and reviewed by the BPSC. The Facility reported that there were ten individuals who had plans in place. During the visit the Monitoring Team attended the monthly PBSC meeting, during which there was a scheduled review of an eleventh plan, for Individual #101. The plan was presented as an ISP Action Plan for Reduction of Restraint. The plan was written using plain and readable language, and the goal/desired outcome was for "(the individual) to be able to tolerate dental treatment without the use of sedation." The plan distinguished between a tooth brushing program that was developed to improve the Individual's oral hygiene and which was already in place, and a planned assessment "to determine (the Individual's) specific needs related to dental appointments." The next step would then be to "develop a dental action plan based on the dental assessment to support (the individual) in attending dental appointments," followed by "implement dental action plan to support (the individual) in attending dental plans." During the visit the Monitoring Team was also provided with an ISP Action Plan for Reduction of Restraint for Individual #238, dated 3/25/13. The plan was very similar to the one written for Individual #101, and that suggested that a consistent process was being used. The process is at an early stage and compliance will require an actual plan that includes actions associated with the Individual's ISP and that there be evidence the plan has been implemented (e.g. data sheets that can confirm the plan had been implemented as designed). <u>Monitoring Team's Compliance Rating</u> Progress for this provision lags behind others, but there is now clarity about the Facility process, and steps are being taken to provide the needed plans to minimize unnecessary use of pre-treatment sedation. In addition to providing the steps identified in the plan for Individual #101 and others in similar situations, there needs to be development of steps to assess the efficacy of the plans, to be taken at both the individual and Facility levels. In regard to medical monitoring for safety, documentation should be on the medical restraint checklist and post sedation checklist. Pending the needed work, the provision remains in noncompliance.	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	<u>Psychiatric Staffing</u> At the time of the visit there were three psychiatrists at the Facility, Drs. Chacko, Kuusisto, and Morgan. Dr. Chacko worked 40 hours/ week, Dr. Morgan worked 20 hours/week, and Dr Kuusisto worked 30. The total level of effort was 2.25 FTEs of psychiatric time. Administrative support was offered to the psychiatrists by • One psychiatry assistant that assisted with scheduling and preparing PTRs, tracked diagnostic changes at PTRs, prepared psychotropic medication consents and PMTPs for review by the psychiatrists, coordinated neurology clinics for	Noncompliance

		psychiatrists, printed/copied/psychiatry documents and attended IDT meetings to obtain information as directed by psychiatrists. • One associate psychologist I/psychiatry assistant that scheduled PTRs and attended IDT meetings and assisted with the departmental database management, performed internal audits for psychiatry, compiled and sent out Axis I diagnostic change reports, coordinated PMOC meetings prepared data reports for QA/QI meetings, and assisted the Lead Psychiatrist with meetings and activities related to the SA. • One behavioral health administrative clerk that transcribed PTR dictations and other psychiatry reports, updated the psychology department database with information about psychotropic medications, and provided PBSC administrative support. <u>Determination of Required FTEs</u> 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 PMOC and P&TC and physician's meetings, ISPs, and Individual Support Plan Addenda (ISPAs), and to respond to clinical/administrative issues that concerned psychiatry. Current psychiatric staffing is at the level of 2.25 FTEs. <u>Team's Compliance Rating</u> The Facility has not shown evidence that it is able to provide the services required by the SA with the current level of staffing, so the finding of noncompliance cannot be changed at this time.	
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.	<u>Appendix B evaluations Completed</u> As of 2/28/13, the Facility reported that CPEs were in place for 93 of 140 (66%) of the individuals followed by psychiatry. <u>Review of Completed Evaluations</u> Fifteen CPEs were completed between 07/15/12 and 04/05/13 and reviewed by the Monitoring Team. These were for Individuals #86, #123, #149, #170, #234, #243, #286, #360, #388, #398, #402, #468, #488, #521, and #599. CPEs reviewed were six to ten single spaced pages and they followed the recommended format. In the previous report the Monitoring Team had commented on the need to complete needed evaluations and to focus efforts on improvements in diagnostic justifications, case formulations and resolution of NOS diagnoses. Those items were the focus of the	Noncompliance

		current review. Facility psychiatrists gave increased attention to diagnostic justification. DSM criteria for the proposed diagnoses were cited often and the diagnoses were discussed with those criteria in mind. Discussions were substantive and reflected the excellent diagnostic skill of the psychiatrists. Nine of 16 (56%) of the CPEs had good justification for all cited DSM diagnoses. NOS diagnoses, excluding Pervasive Developmental Disorder NOS (PDD-NOS), were present in five cases, two of whom were new admits. In the case of the new admissions, it was reasonable to use NOS diagnoses for a period of time while information was being gathered, but the SA guidelines for Appendix B required that NOS diagnoses be addressed in a timely manner (i.e. within 60 days). Good case formulations were present in seven of fifteen (47%) evaluations. Most of the others (except Individual #360, where the formulation was missing) had good case summaries but not formulations. The differences between the two were cited in the previous report. Some formulations were very good. They were for Individuals # 149, #243, #488, and #599. In each of these cases, the psychiatrist not only summarized findings but also synthesized information in a way that emphasized critical elements of the case, brought together elements from current and past evaluations, and provided an integrated understanding of the individual. That understanding established a foundation for the treatment recommendations that followed. The evaluations for Individuals #488 and #599 also illustrated the road ahead for much of the remaining work on many parts of Section J. The evaluations provided good summaries of what was known about care to date, and they included discussion about reflect what needed to be done to provide the best available treatment. Those reflections can be the basis for targeted medication trials that are informed by data-based treatment outcome measures. <u>Monitoring Team's Compliance Rating</u> Psychiatric standards of care at the Facility are high, and that is reflected in what were generally very good CPEs. The Monitoring Team's continued focus on diagnostic justifications – which have continued to improve – was due to the need to have good justifications in place to facilitate meaningful and data based treatment trials. NOS diagnoses must be addressed per the requirements of the SA (see Appendix B evaluation guidelines) and CPEs must be provided for individuals who need them. Although continued improvements were noted, the provision was not yet in compliance with what was required by the SA.	
J7	Commencing within six months of the Effective Date hereof and with	<u>Reiss Screens for Individuals who lived at the Facility</u> The Facility had previously reported that it had completed the Reiss Screen process for	Noncompliance

	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.	all individuals who live at the Facility, with the exception of the individuals who were followed by psychiatry and who were treated with psychotropic medications. Individuals seen by psychiatry were not screened, since those individuals were already required to have CPEs. During the last visit the Monitoring Team confirmed that the screening was done properly. Two individuals had failed the screens, and both subsequently had the required CPEs. <u>Reiss Screens for Recent Admissions</u> Since the last visit there were twelve admissions. These were Individuals #114, #148, #239, #234, #242, #243, #347, #388, #402, #468, #546, and #590. Of those, all but Individual #114 took psychotropic medications. That individual had a Reiss Screen and the results were negative. <u>The Role of Reiss Screen for Ongoing Screening for Psychopathology and for Clinical Change of Status Evaluations</u> In addition to screening individuals on admission, Facility procedure was to use the Reiss Screen to screen individuals who live at the Facility, when individuals had a change in status and the individual was not previously followed by psychiatry or had not been seen by psychiatry for at least a year. During the review period there were four such change-of-status evaluations, for Individuals #8, #14, #101, and #188. Two of those individuals, #8 and #188, had elevated scores that exceeded cut-off values on the Reiss Screen and both are now under the care of Facility psychiatrists. Individual #101 did not have elevated Reiss scores and did not need a psychiatric referral. Individual #14 did not have elevated Reiss scores, but that individual was nonetheless referred to psychiatry and was under the care of a Facility psychiatrist at the time of the visit. A fifth evaluation took place during the visit, for Individual #323. That individual was an example of a good integrated care and is discussed under provision J8. The Facility used the Reiss Screen to routinely follow-up on the status of individuals who had been discharged from the psychiatry clinic. The screenings were done six months after clinic discharge. Such screenings were done for Individuals #67, #412, and # 470. None exceeded clinical cut-off values. <u>Monitoring Team's Compliance Rating</u> The Facility's use of Reiss Screens was appropriate. The Facility did not provide Reiss Screens to assess the need for psychiatric treatment for individuals who already receive such treatment. However, those individuals did need to have psychiatric evaluations and not all have received one. The most recent data provided to the Monitoring Team was for 2/28/13, at which time psychiatric evaluations were in place for 95 of 141 (67%) of individuals who needed them. The need to complete the remaining psychiatric	

		evaluations is the only matter that prevents this provision from obtaining a rating of substantial compliance.	
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	Provision J8, through its focus on combined assessment and case formulation, is the place where the Monitoring Team was focusing its review on integrated care throughout the Facility process. <u>Combined Behavioral Case Formulations</u> Combined case formulations, typically between psychology and psychiatry, is a best-practice technique to assure that a common understanding is in place regarding which aspects of the individual's clinical presentation are best explained as learned behaviors and which reflect psychopathology. Formulations were typically one or two paragraphs, referred to the DSM diagnosis, and for each of the aspects of the individual's behaviors they discussed whether the behaviors were best accounted for by psychological vs. psychiatric understandings (or both). The Monitoring Team reviewed the PBSPs of the 14 individuals in Sample J1 who had lived at the Facility for some time. Six of 14 (42%) had combined case formulations in place. <u>Combined Care at PTRs</u> This was reviewed under Provisions J3 and J11. The team process and collaboration between the behavioral disciplines remains strong at the key function of the PTR. <u>Integrated care at Morning Medical Meetings</u> The Monitoring Team attended the meeting on 04/09/13, and the observations were consistent with the positive observations made during the last meeting. The discussion was balanced between, and integrated across, the clinical disciplines and helped contribute to a continuity of interdisciplinary care for individuals who were experiencing stress or behavioral crisis (as evidenced by reports from on-call clinicians from the various disciplines) and medical disciplines (again via on-call clinician's reports and reports on individuals who received care from area hospitals). <u>Integrated Care at Change of Status Evaluations</u> Unexplained change in an individual's level of functioning is one of the settings where combined assessment was most important. On 4/08/13 the Monitoring Team observed a meeting for Individual #323 who had recently had increases in self injurious behavior, and she had also had changes in her anticonvulsant medication. Management of the individual's difficult-to-control seizures had been guided by a consulting epileptologist, and one anticonvulsant had recently been discontinued. Very different clinical formulations were offered to explain the increase in self injury. These included early dementia, increased alertness due to a reduced amount of inadvertent sedation that might have been related to the discontinued anticonvulsant, and coincidental development of new psychopathology. At the end of the meeting all agreed that the best	Noncompliance

		working formulation for the patient was that the changes in behavior were related to the epilepsy management and that psychology would monitor and advise the PCP. This was a case of well integrated care. In the previous report the Monitoring Team had indicated that further progress was needed in five areas and these areas were revisited: 1. <u>Bio-psycho-social case formulations in CPE:</u> The Monitoring Team commented that the psychiatric case formulation needed to be broader, and were strongest when they touched on many areas of functioning, including psychological and social variables. Review of CPEs done during the review period is provided as part of Provision J6 and the results are generally positive. 2. <u>Coordination of behavioral and pharmacological care:</u> It was positive that medication treatment plans have now been put in place. That took place only weeks before the visit, so the Monitoring Team has not yet been able evaluate them. The use and analysis of treatment efficacy measures - necessarily a process that is shared by psychology and psychiatry – is still under development (see provision J11 and J13). 3. <u>Integrated care at the level of the ISP:</u> The Facility clarified that improvement in that area has been a major focus for psychiatry, and the vehicle for improving psychiatric information improvement in that area was the psychiatric contribution to the IRRF. The Monitoring Team asked for and received IRRF reviews done in March and April, 2013 for Individuals #61, #113, #120, #286, and #599. 4. <u>Integrated care to minimize the need for medical restraint/pretreatment sedation:</u> As reported under Provision J4, progress in that area lags behind others. Nonetheless, a good process appears to be in place for the development of the needed plans to reduce the need for medical restraints, a topic which necessarily involves both the entire behavioral healthcare team, the medical team and of course, dental. 5. <u>Facility level review of polypharmacy:</u> In the previous report the Monitoring Team had noted the need for psychiatrists to defend/justify the need for particular pharmacotherapy, in order to make Facility level review possible. As reported under provision J11, there has been significant progress in this area but the process of polypharmacy justification at the PTR level was still very new and needed further attention. <u>Monitoring Team's Compliance Rating</u> Processes for improving integrated care were ongoing and the Facility was encouraged to continue to focus on the areas listed above. Progress was made, but the Facility is not in full compliance at this time.	
J9	Commencing within six months of the Effective Date hereof and with	This provision item required that specific clinical issues needed to be discussed and decided by the IDT, before the implementation of a proposed PBSP.	Noncompliance

	full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	The process in place at the Facility was that discussion about elective new medication typically took place at the PTR. That was followed by an IDT meeting held for the purpose of providing needed details about the proposed medication. The IDT meeting was led by the QDDP and the agenda was guided by and documented on an ISPA "shell" for new medications. The contents of that shell were: 1. Behavioral status 2. History, previous interventions and results 3. Health status 4. Medical pathology 5. Psychosocial and environmental conditions 6. Functional Assessment 7. Psychiatric summary 8. Current medications 9. Risk assessment 10. Decisions/recommendations Next, the informed consent for medication and Medication Response Profile MRP (replaced in March 2013 by the PMTP) were prepared and presented to the LAR by the psychiatrist. The documents were then reviewed by PBSC and HRC. To satisfy the requirements of Provision J9, three requirements must be met. 1. <u>The PST and psychiatrist should determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition:</u> At the Facility, those interventions were reviewed and documented by the IDT in the ISPA for new medication and reviewed by the HRC. The Monitoring Team reviewed Sample J2 (new medications) to see if the needed determinations were made before the medication was implemented. a. ISPA review: For this analysis the Monitoring Team selected only the medication proposals for individuals in Sample J2 who had lived at the Facility for some time. There were 19 medication proposals, for 16 individuals. Three of nineteen (16%) medication proposals did not have ISPAs, leaving only 16 medications proposals, for 13 individuals. Analysis of the medication proposals that did have the required ISPAs showed that 10 of 16 medications (63%) provided the needed information. Presented in another way, ISPA information was provided for only 10 of the 19 (53%) of medication proposals. b. HRC review of previous interventions was present in 19 of 19 (100%) medication proposals. HRC review of less intrusive approaches previously used was markedly	

		improved. However, the substantive review of available treatments needed to happen at the level of the IDT and to have taken place at the time that the proposed medication was reviewed. 2. The PST and psychiatrist should determine whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone: ISPAs contained no item that directly addressed that issue. The issue was addressed indirectly by the "Behavioral Status" items of the ISPA, which discussed behavioral treatments that were in place. In the context of a request for a new medication one could infer that both the new medication and the existing behavioral treatments were needed. Fifteen of 16 (94%) of the medication proposals that included ISPAs provided information on current behavioral treatment. The March 2013 revision of the informed consent did contain a listing of "adjunctive treatments." However, that form was not in use during the majority of the review period and was not used for any of the cases provided by the Facility for review. 3. 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: For all individuals, the treatments in question were addressed in the PBSP and ISP documents (see discussion under Provision J3). Monitoring Team's Compliance Rating There needs to be attention to assure that ISPAs for new mediation addressed the requirements of the Provision. Progress had been made, but additional progress is needed and the provision remains in non-compliance.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are	Per the language of the provision, before the 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. Risk Benefit Analyses At the Facility, those interventions were reviewed and documented by the IDT in the ISPA for new medication and reviewed by the HRC. a. ISPA review: The ISPA shell for new medications (see Provision J9) contained an item titled "Risk Assessment." The Monitoring Team reviewed the 19 proposals for new medication for individuals who had lived at the Facility for some time. ISPAs were provided for 16 of 19 (84%) of the medications. In some cases there was a very good discussion of risk associated with treatment vs. risks of not providing the treatment (for example, the ISPA for Individual #144, for Latuda). In other ISPAs, however, there was only a statement about whether the	Noncompliance

	likely to be less effective or potentially more dangerous than the medications.	individual was at "high risk," possibly along the lines of the IRRF. While the two evaluations were related, they were not the same. Overall, an adequate risk vs. risk assessment was found in 11 of 16 (69%) new treatment proposals that contained an ISPA. b. Risk vs. risk assessment was also a component of HRC review. That was present in 19 of 19 (100%) of cases. The revision of the informed consent form that was put in place in March 2013 has added sections that explicitly address risks of treatment and risks of non-treatment. That was an excellent addition. Among other things, it documents direct communication between the treating physician and the LAR. However, that form was not in use during the review period. <u>Alternative treatments:</u> The document for informed consent included an entry for treatment alternatives. The Monitoring Team reviewed the consent form for the 19 proposals for new medications. Alternative treatments were noted in 13 of 19 (68%) of the consents for treatment. In some cases there was a good presentation about what might be done in the future, as an alternative to the new medication. In others, however, there was only a listing of what had been tried in the past. <u>Monitoring Team's Compliance Rating</u> The Facility is close to compliance and all elements appear to be in place. To achieve substantial compliance, there needs to be attention to the details listed above, including assurance that the ISPA addressed the needed risk vs. risk assessment.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that	<u>Process in Place for Facility-level Review</u> PMOC continued to meet on a monthly basis, and it was the principal venue for Facility-wide review of medication practices and polypharmacy. Participation in the PMOC included pharmacy, psychiatry, medicine, nursing, psychology, and quality assurance. The Facility-level review augmented reviews of polypharmacy that took place at the level of the IDT, where polypharmacy was reviewed in many venues. For example, individuals were reviewed for polypharmacy at PTRs (see discussion for Provisions J3, J9, and J10), and polypharmacy was part of the discussion about proposed new medications (see Provisions J9, J10, J13 and J14), and via the IRRF discussion, polypharmacy was also a focus at ISPs (see discussion under Provision J8). At the time of the last report the Monitoring Team noted that while Facility- wide statistics showed a modest decline in rates of polypharmacy, it was sometimes difficult for the Monitoring Team to understand the treating psychiatrist's rationale for using polypharmacy. This was particularly problematic since the language of the provision	Noncompliance

	medications that are not clinically justified are eliminated.	specified the need for the Facility level review to ensure that polypharmacy regimes were clinically justified and to ensure that medications that were not clinically justified were eliminated. To determine whether the polypharmacy was clinically justified, there needed to be a statement as to the reason(s) that individuals' needed the polypharmacy. The Monitoring Team commented that that Facility needed to refocus PMOC activities to focus on the requirements of the provision. The Facility responded to the comments of the Monitoring Team in two ways. First, the template for PTR review was modified to include a section in which the psychiatrist was asked to comment on the clinical justification for any polypharmacy regimen. Second, the Facility revised both the content of the PMOC reports to committee members and the way that committee member's time was utilized during the monthly meetings. Each change is reviewed below: <u>Review of Polypharmacy Justifications</u> The Facility modified the PTR document in January 2013. For individuals who were treated with polypharmacy, a section was added for polypharmacy justification. The Monitoring Team requested, received and reviewed PTR documents for all individuals who had polypharmacy who had such PTR in February 2013. There were 37 reviews. In 37 of 37 (100%) of the cases the polypharmacy reviews provided the psychiatrists thoughts about the choice of medications. In most cases the psychiatrists provided a good summary of the pharmacotherapy and in many cases they provided thoughts about future medication management plans including plans to reduce unnecessary polypharmacy. For example, for Individual #259 the psychiatrist wrote: "In the past (the Individual's) symptoms have been controlled on various medications. However, she developed adverse reactions to some medication, such as lithium, which were discontinued. Currently, she is on polypharmacy because she is on 2 medications from the class: antipsychotics. (The Individual) has been on two antipsychotics since 2006. At different times her previous psychiatrists tried to taper down the Risperdal or Quetiapine, with the goal of eliminating polypharmacy. (The Individual's) challenging behaviors would increase and the medication would be increased again. I am re-evaluating her medications, since the antipsychotics do not seem to be effective in controlling her behavior. In January 2013 the IDT agreed to a trial of a mood stabilizer (Depakote). However, the Depakote was stopped due to a decreased platelet count." This was a careful and thoughtful note which illustrated the process which lies ahead. The psychiatrist's plan is to reduce the need for multiple antipsychotics by providing a potentially more effective alternative treatment. In the short term the proposed alternative actually would actually increase the amount of polypharmacy. However, the	

		more effective treatment would then allow a longer- term reduction in medication, including the number of antipsychotics. That was an honest and realistic plan. The difficulties already encountered with the introduction of Depakote (and the likelihood of substitution of an alternative mood stabilizer) made it clear that that the process will necessarily take time, but that was unavoidable. For the most part the notes were exactly what were needed. However, going forward, Facility psychiatrists must keep in mind that potentially justified polypharmacy and justified polypharmacy are not the same thing. For example for Individual #41 the psychiatrist wrote, "He does meet the criteria for polypharmacy but the medications are each from a different class. " The implied justification is that additive pharmacotherapy is rational and necessary. But the assertion of necessity must be demonstrated, not presumed. In many notes the necessity was documented, for example by past treatment experience. For Individual #41 and some others it was not. The establishment of good measures to assess treatment efficacy should help psychiatrists in their future determinations of the need for polypharmacy. <u>Changes in the PMOC proceedings:</u> In response to the comment of the Monitoring Team the Facility revised how data was provided to committee members for the monthly PMOC meeting, and it also revised the structure of that meeting to allow for review of the new material. As described in previous reports, the committee scheduled monthly reviews of clinical topics related to medication use (for example, review of Facility use of various classes of medication). That had not changed. During the meeting, committee members were now provided with a spreadsheet that provided a row by row listing of each individual who had a polypharmacy medication regimen, followed by a number of columns that represent the various months under review. Brief updates from prior month's changes (or reasons for no change) were included. The spreadsheet provided to committee members further categorized individuals with polypharmacy into two groups. One was a group of individuals who Facility psychiatrists felt needed the polypharmacy regime to avoid clinical deterioration. These individuals were considered by the Facility to be stable, and for whom the current medications were thought to be necessary to maintain the stability. The second category was on individuals who were "active" in the sense that there was an agreement that the individual likely was taking more medication than needed, and these individuals were undergoing active efforts to decrease one or more of the medications. A third category included recent admissions to the Facility. It seemed reasonable to consider those individuals separately, since their polypharmacy regimes were typically put in place by providers outside the Facility, and for new admissions it was important to allow a period of time during which Facility providers became familiar with the individual and the treatment that had been established for the individual.	

During the PMOC meeting attended by the Monitoring Team the committee reviewed the status of each individual who had a polypharmacy regimen. In the presentation each individual was presented on a separate row and columns represented steps taking in each of several previous months. The discussion was fast paced but also specific and detailed. The progress of all individuals with polypharmacy was reviewed over a period of about 45 minutes.

The committee also reviewed charts of general rates of interclass polypharmacy, intraclass polypharmacy, and total polypharmacy (a list of all individuals with polypharmacy, since some individuals were listed in both previously mentioned categories). During the meetings the committee then reviewed data for overall Facility utilization of various psychotropics. This was done via provision of a table of the total amount and average dose (per person treated with any psychotropic) of each psychotropic. This provided measures of which medications were favored by the Facility clinicians, and which were gradually being used more or less frequently.

The Monitoring Team found that the choice to re-focus much of the PMOC efforts on a review of the individual's polypharmacy regimen was very helpful. The fact that individual justifications were in place meant that those particulars did not need to be repeated, and allowed for good utilization of the committee member's time. Both the contents and process of the PMOC meeting that was observed was excellent.

<u>Review of Polypharmacy Data</u>
In the Self-Assessment the Facility provided data on several measures of Facility- wide polypharmacy. These included:

- The number of instances of intraclass polypharmacy has declined from a maximum of 19 instances in July 2012 to a rate of 12 instances in February 2013.
- The number of individuals with interclass polypharmacy has declined from 42 individuals in June 2012 to 39 individuals in February 2013.
- The number of individuals with any form of polypharmacy has declined modestly, from 44 in June 2012 to 42 in February 2013.
- The Facility rate of polypharmacy has declined from 37% of individuals treated with psychotropic medications in June 2012 to 33% in February 2013.

<u>Facility Level Monitoring for Dyskinesia</u>
On 12/31/12 the Facility revised the guidelines for PMOC. The revised document spelled out that the PMOC will review individuals with a diagnosis of Tardive Dyskinesia on a schedule determined by the Committee, but no less than annually. These reviews by PMOC were determined appropriate because of the need for close monitoring of medication practices in individuals diagnosed with dyskinesia. In the Self Assessment

		the Facility clarified that it did not yet have a Facility level QA process to ensure that side effect monitoring took place in response to the individual's changing needs. During the visit that Monitoring Team reviewed the records of diagnoses of four individuals who were prescribed antipsychotic medication and who are also diagnosed with dyskinesia. Those were Individuals #30, #86, #167, and #186. Three of the four (75%) individuals had had the dyskinesia properly coded on the APL. Individual #30 did not. While all individuals had disorders that could justify the use of antipsychotic medication despite the dyskinesia, annual psychiatric reviews and/or PTRs did not specifically address that issue. Two of the individuals were part of the group that had polypharmacy justifications that were reviewed by the Monitoring Team. The dyskinesia was cited in one of the two cases, but specific discussion of the need for antipsychotic treatment despite the dyskinesia was not. The issues noted above should be part of PMOC reviews of individuals with dyskinesia. <u>Monitoring Team's Compliance Rating</u> There has been substantial progress in this provision, and the overall rate of polypharmacy continued to decline. The Facility added a polypharmacy justification section to the PTR format. The new section provided psychiatrists with a place to clarify whether polypharmacy regimes were being eliminated and if not, why they were clinically necessary. However, the new section had been in place for less than 3 months, and therefore covered only one cycle of quarterly PTRs. The Facility is now close to achieving substantial compliance and it is a realistic possibility for the Facility to achieve that status during the coming review period. To do so there need to be improvements in some of the polypharmacy justifications (see paragraph above about Individual #41 and similar cases) and the procedures in place need to be maintained and prove to have positive outcomes (reductions in polypharmacy without bad outcomes for individuals).	
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.	At the Facility, MOSES evaluations were required at a minimum of every six months, and DISCUS evaluations were required (for individuals who took medications that can cause tardive dyskinesia) at a minimum of every three months. Facility screening for dyskinesia included all individuals who took Reglan, a medication prescribed for non-psychiatric indications that can cause dyskinesia. Physicians needed to review and sign the side effect screening forms. There is a DADS draft policy that states that MOSES and DISCUS side effect screens would be provided following a change in medication dose, as determined by the psychiatrist. The Facility had already begun to do so. <u>Completion of MOSES and DISCUS Screens</u> The Monitoring Team reviewed the Facility's list of individuals who received MOSES and DISCUS evaluations. The lists confirmed that individuals who needed side effect screens	Substantial Compliance

		had received them, including individuals who took Reglan. <u>Quality of Completion of Side Effect Rating Scales</u> The Monitoring Team next reviewed the records of the 22 individuals in Sample J1. That sample represented 16% of individuals who took psychiatric medications. For Sample J1 20 of 22 individuals (91%) had both the MOSES and DISCUS administered with the required frequencies. For the group of 22 individuals there were 37 MOSES evaluations and 34 of 37 (92%) were signed by the physician. However, in four of the 37 cases (11%) the physician did not complete the prescriber review section of the form. Both the review and signature were needed. Overall, the MOSES forms were completed and reviewed by the physician in 30 of 37 (81%) of the cases. For the same group of individuals there were 50 DISCUS evaluations; 49 of 50 (98%) were completed and signed by the physician. The Monitoring Team reviewed administrations of the side effect screen that were done in response to a change in medication dose. Ten of 22 (45%) of the individuals had at one or more side effect screen in response to a dose change. Review of PTR notes showed that physicians, determinations of which individuals needed the additional screens appeared to reflect good clinical judgment. The Monitoring Team reviewed PTRs for all individuals in Sample J1. PTRs included a section on side effects that showed how IDTs reviewed the MOSES and DISCUS screens that had been done during the review period. PTR notes documented active discussions about findings from the screens, and psychiatrists commented on actions taken to minimize any side effects. The Monitoring Team also attended PTRs on 4/10/13 and observed how information about side effects was discussed by IDT members. 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. 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. Four individuals were diagnosed with tardive dyskinesia. All were followed by psychiatry. The pathophysiology of tardive dyskinesia is such that the same medications that cause dyskinesia can also mask the effects, and thus lower DISCUS ratings. For that reason when those medications are reduced, for example during efforts to minimize unnecessary polypharmacy, DISCUS scores may actually go up rather than down. Review of PTR documents of individuals from Sample J1 who had dyskinesia showed that psychiatrists were attentive to that issue. Further comments about PMOC monitoring for dyskinesia were included under Provision J11.	

		<u>Training for Side Effect Rating Scales</u> During the visit the Monitoring Team met with members of the nursing staff to review the training provided to nurses on the administration of the side effect rating scales. Training on the rating scales was provided in a half-day block of time during the nurses' orientation. It included viewings of training videotapes for DISCUS ratings that were made by the author of the tool. Nurses viewed a video that demonstrated the various side effects and how that are rated, and nurses also viewed a video in which an examination was shown and the trainee was asked to provide a rating. The video then provided feedback on how an expert rater would have assessed the movement problems. The Monitoring Team inquired about the training of the trainers (nurse case managers and/or nurse educator). The Facility responded that trainings were given by experienced raters, and the Facility responded that it was looking into acquiring outside trainings for this purpose. The Facility should consider doing periodic interobserver reliability checks for MOSES and DISCUS ratings, to assure the continued quality of the nurse ratings for side effects. For the same reasons, the Facility should also consider putting in place annual retraining for the MOSES and DISCUS raters. <u>Monitoring Team's Compliance Rating</u> MOSES and DISCUS reviews were provided to individuals who needed them, including individuals who took Reglan. The screens were done by nurses and physicians reviewed and signed the results, typically within two weeks. Side effects screens were discussed during PTRs, as were QDRRs done by the pharmacy that also contained information on MOSES and DISCUS. PTRs included IDT reviews of side effect screens and the psychiatrist often included information about side effects in the PTR documentation. The Monitoring Team found that that Facility is now in compliance with the requirements of this provision. Facility efforts to obtain outside training for nurse case managers/nurse educators should continue. This is important to the Facility's ability to continue to provide good quality screens.	
J13	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological	Effective March 2013 the Facility has introduced PTMPs. They will be used for new and renewed medications and will be reviewed by the HRC along with consent forms for psychotropic medication. A template and a sample for the new document were provided to the Monitoring Team. The Monitoring Team compared the PTMP with the requirements of the provision, as follows: <u>Clinically justifiable diagnosis or specific behavioral pharmacological diagnosis</u>: The PTMP has a place for (1) the Axis I diagnosis, (2) the treatment rationale and (3) treatment formulation (psychiatric, behavioral or both).	Noncompliance

	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.	Timeline for the therapeutic effects of the medication to occur: The PMTP has an entry for "expected drug response" and the sample provided by the Facility listed the type of medication and the expected time for therapeutic effects to be achieved. Objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy: The PMTP has an entry for "Treatment Efficacy Scale – Data or scale." The Facility clarified that if a rating scale will be used, it will be named. The Facility clarified that "data" meant that an operationally defined behavior(s) that the psychiatrist and IDT have decided to use as a marker for treatment response will be the agreed upon measure for treatment efficacy. If so, it will be named in this section. By whom, when and how the monitoring (for efficacy) will occur: The PMTP form clarified that "An evaluation of treatment efficacy will be conducted to determine if the medication dose should remain the same or be increased or decreased. Treatment response will be evaluated during PTRs or as clinically warranted." How often the monitoring will occur (as often as necessary based on the individual's current status and/or changing needs, but no less often than quarterly): The PMTP stated that the monitoring will take place during PTRs or as clinically warranted. PTRs take place at least quarterly. PMTPs have been in use only since March 2013. The Facility provided the Monitoring Team with the PMTPs written to date. Two were for new medications and 12 were for annual renewal of medication. Combined, there were 14 PMTPs of nine individuals. PMTPs provided information on the proposed medication, the psychiatrist diagnosis that was relevant for the medication, the target psychiatric symptoms identified by the psychiatrist, and designation of whether (1) a scale or (2) "data" or both would be used to assess efficacy. The Facility clarified that in this case "data" meant that an observable behavior would be selected to correspond to one or more of the targeted psychiatric symptoms listed. Many of the plans listed "data" as a measure for treatment efficacy but did not specify what the data was that would be tracked. It is possible that the Facility thought that what data would be measured was clear since the psychiatrist had already listed "target" symptoms. But that was not sufficient. For example, the psychiatrist might have listed that the psychiatric target symptom was "mania," but that does not clarify the operationally defined behavior that would be measured. Examples of behavior that could be defined and measured in the usual manner could be could be	

		nighttime sleep, extent of pacing (severity/frequency) and so forth. Monitoring Team's Compliance Rating The development of the PMTP represented significant progress. PMTP/PTR medication tables should specify behaviors selected as indicators of treatment response (currently referred to broadly in those documents as "data." For now, the provision must remain in non-compliance.	
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.	Facility Policy DADS Policy and Procedure 007.02 Psychiatry Services (08/30/11) detailed that "State Centers must obtain informed consent (except in the case of emergency) prior to administering psychotropic medications (or other restrictive procedures)." The Policy also stated that State Centers must provide education about medication when appropriate to individuals, their families, and LARs according to accepted guidelines." Status of Progress on the Provision In the report for the July 2012 visit, the Monitoring Team stated that the Facility was close to substantial compliance on the provision item. The Monitoring Team stated that to achieve compliance, the Facility needed to improve the risk vs. risk discussion for new medications, the presentation of information to the HRC, and presentation of treatment alternatives, including the possibility of no medication treatment. Those items were reviewed under Provisions J9 and J10, the requirements of which overlap with Provision J14. The discussion for those provisions clarifies work that remains incomplete. In the materials provided to the Monitoring Team prior to the visit the Facility noted that effective 3/01/2013 the Facility had revised the informed consent form. The new form was improved by the addition of entries for risk of treatment and risk of non-treatment. Informed Consent Presentation of Risk vs. Risk information During the visit the Monitoring Team requested copies of all consents for new medications that had been reviewed after 03/01/13 and that used the new forms. There were 18 medications, for six individuals. Four were new admissions (Individuals # 123 #234, #388, and #582). Two were for individuals who lived at the Facility (Individuals #42 and #568). The consent forms were much improved. The new form added explicit presentation of risk information and risks of non-treatment. The latter was done via check off boxes for common risks (an increase in frequency, duration and/or intensity of challenging behaviors, an increase in psychiatric symptoms, and an increased risk of injury to self/others) and also a place for individualized ("other") information. The information was provided for all the individuals. The Facility clarified that while the Lead Psychiatrist training had conducted training for the psychiatrists on 03/04/13 about the use of the new consent and PMTP forms, their use was not yet part of a finalized BSSLC procedure.	Noncompliance

		Treatment Alternatives: Please see discussion on this matter provided under Provision J10. The issues discussed for that provision also apply here, since informed consent is not possible without presentation of treatment alternatives. Also, the wording on the consent item for treatment alternatives should be revised. One check-off box is for taper/discontinue; that is not an alternative treatment. When appropriate, "treatment alternative" to the proposed medications should include non-medication alternatives and/or no medication treatment. HRC review of Medication Prior to the visit the Monitoring Team requested copies of informed consent and HRC review for all psychotropic medications newly started during the review period, and all were reviewed. There were 19 medications for 16 individuals. Signed consent forms were present for all medications. The consent form provided the needed information about the diagnosis, medication, reason for use of the medication and possible side effects. These elements had previously been presented adequately and that did not change. The presentation of information to HRC had improved considerably. In the previous report the Monitoring Team had noted that the HRC had not provided needed information about risk, for example, medication side effect information that was specific to the medication under review. In the current HRC reviews: • Information about the risk of taking the medication (typically side effects) was present for 19 of 19 (100%) of the medication. In each case the review was specific to the medication under review • Information about risk of not taking the medication was present for 19 of 19 (100%) of the medications • Information about less intrusive approaches previously attempted was present for 19 of 19 (100%) of the medications Monitoring Team's Compliance Rating As outlined above, progress continued but some work remained on the wording for the Informed Consent form for medications. The Facility is close to achieving Substantial Compliance.	
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	Facility Policy DADS Psychiatry Policy 007.2 (08/30/2011) addressed the topic of integrated care between psychiatry and neurology as follows: "*The neurologist and psychiatrist must coordinate the use of the medications, through the IDT process, when medications are prescribed to treat both seizures and a mental health disorder."* Steps Taken to Promote Neurology and Psychiatry Integration	Substantial Compliance

	are prescribed to treat both seizures and a mental health disorder.	Per the Facility Self Assessment, an internal QA process to monitor the psychiatrist's response to neurology clinic recommendations was in the process of development but was not yet in place. <u>Review of Individuals Supported by Psychiatry and Neurology</u> The Monitoring Team reviewed the care of five individuals who took seizure medication for both neurological and psychiatric indications. They were Individuals #185, #332, #411, #510, and #588 (Sample J3). Materials reviewed included both psychiatry and neurology clinic notes. The results were: • Individual #185: Neurology clinic notes documented a necessarily complex anticonvulsant regimen (VNS and Lamotrigine for seizure, Tegretol and topiramate as dual purpose medications); labs were tracked including anticonvulsant levels for both topiramate and carbamazepine and the anticonvulsants were properly characterized in psychiatry notes as dual purpose medications. The psychiatrist's notes from 11/30/12 reflected needed coordination with neurology about Tegretol dosing as the Topamax regimen became established. • Individual #332: the neurology notes contained needed information about seizure history (most recent in August 2012) and labs (therapeutic for Tegretol). Information documented by the neurologist about ER visit shows he was well informed. PTR notes accurately described the Tegretol as a dual purpose medication. Notes from the psychiatrist about drug interactions between Tegretol and Luvox (PTR, 10/23/12) showed active involvement of the pharmacy that contributed to integrated care. • Individual #411: The individual had been titrated off Phenytoin in favor of Valproic Acid. There had been no seizures since and the neurologist commented that he would defer to the psychiatrist to titrate the dose which is currently 2000 mg/day via g-tube. Labs were monitored and the role of the medication in the individual's psychiatric and neurological care was properly described in the PTR note as a dual purpose medication. • Individual #510: Neurology clinic notes tracked seizure frequency. In the note for 7/31/12 the neurologist's comment about Keppra and possible aggression reflected attention to issues shared by psychiatry and neurology. In the PTR notes the Tegretol was properly characterized as a dual purpose medication. • Individual #588: Neurology notes demonstrated that the information about seizures was properly tracked by the clinic. PTR description of the use of Depakote correctly identified the anticonvulsant as a dual purpose medication. <u>Monitoring Team's Compliance Rating</u> Overall, the formatting for the neurology clinic with information about labs, seizures and current meds showed that the neurologist was provided with the needed information	

		and the neurology clinic was well managed. Communication between the neurologist and psychiatrist was good. The Facility continued to provide a structure that facilitated the complex coordination needed when anticonvulsant medications were prescribed for both psychiatric and neurological indications, and the clinic and IPN showed that the needed coordination took place. The provision remains in substantial compliance.	

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

1. Improve process for manual updates of APLs. (Provision J2)
2. Present medication information in PTRs and BAIPs/PSPs in the same format. (Provisions J2 and J13)
3. Document safety information for medical restraint in a consistent manner, for example by using the Medical Restraint Checklist and Post Sedation Checklist forms. (Provision J4)
4. Action Plans to reduce the need for pre-treatment sedation need to be followed by evidence that the plan has been implemented (e.g. data sheets that can confirm the plan had been implemented as designed). (Provision J4)
5. There needs to be a Facility-wide system to assess whether the plans to reduce the need for pre-treatment sedation are effective. (Provision J4)
6. Review use of ISPAs for new medications to assure that relevant requirements are addressed. (Provisions J9 and J10)
7. Assure that polypharmacy justifications in PTRs address polypharmacy as addressed by the SA. (Provision J11)
8. PMOC should review the clinical justification for continued use of psychotropic medications that can worsen existing dyskinesia. (Provision J11)
9. Physicians should complete the "Prescriber Review" section of the MOSES side effects screen. (Provision J12)
10. PMTPs/PTR medication tables should specify the behaviors selected as indicators of treatment response. (currently referred to broadly as "data")(Provision J13)
11. The informed consent form for medication should be corrected – medication taper and discontinuation are not treatment alternatives. (Provision J12)
12. When appropriate, "treatment alternatives" to the proposed medications should include non-medication alternatives and/or no medication treatment. (Provision J14)

The following are offered as additional suggestions to the Facility:

1. The Facility should consider doing periodic interobserver reliability checks for nurses doing MOSES and DISCUS ratings, to assure the continued quality of the side effects ratings. (Provision J12)
2. The Facility should consider putting in place annual retraining for the MOSES and DISCUS raters. (Provision J12)

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. BSSLC Self-Assessment (3/21/2013) 2. BSSLC Action Plan (3/11/2013) 3. BSSLC Policy III.1.a – Psychological Services (12/10/2010) 4. BSSLC April 2013 Presentation notes 5. Minutes for the Positive Behavior Support Committee (06/11/2012 – 02/25/2013) 6. Documents that were reviewed included the annual ISP, ISP updates, Specific Program Objectives (SPOs), Positive Behavior Support Plans (PBSPs), Structural and Functional assessments (SFAs), Behavior Assessment and Intervention Plans (BAIPs), 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. The following individuals were included in the review. Individual #30, #115, #118, #153, #173, #217, #283, #286, #293, #309, #316, #353, #379, #381, #398, #411, #423, #425, #427, #429, #449, #460, #467, #486, and #492. 7. The Facility identified nine individuals for whom had been developed Behavior Assessment and Intervention Plans (BAIPs). The BAIP is intended to replace the SFA and PBSP. The nine people included in the sample included Individuals #286, #293, #316, #398, #411, #423, #425, #427, and #429. 8. A sample of records for review of structural and functional assessments included 12 records (Individuals #173, #286, #293, #316, #381, #398, #411, #423, #425, #427, #429, and #460). 9. A sample of records for review of psychological assessments included 17 records (Individuals #30, #115, #118, #153, #173, #217, #283, #309, #353, #379, #381, #398, #411, #449, #460, #486, and #492). **People Interviewed:** 1. Terry Hancock, PhD – Chief Psychologist 2. Donna Bradley·Schrick, MA, LPC – Behavior Analysit I 3. Jana Lehrman, MA – Associate Psychologist III 4. Vickie Morgan, MD – Psychiatrist 5. Kim Littleton – ADOP 6. Cheryl Powell – Human Rights Committee Chair 7. Direct Support Professionals: Approximately 25 staff were interviewed in Program Services, as well as Bowie Springs, Childress Terrace, Driscoll Gardens, and Fannin Villa residences. **Meetings Attended/Observations:** 1. Positive Behavior Support Committee (PBSC) 2. Behavior Services/BCBA Meeting 3. Human Rights Committee (HRC) 4. Restraint Reduction Committee

	5. Observations were conducted in Program Services, as well as Bowie Springs, Childress Terrace, Driscoll Gardens, and Fannin Villa residences.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section K. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section K, in conducting its self-assessment, the Facility: ▪ Did not document the use of monitoring/auditing tools. The Self-Assessment, however, did identify the sample sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population. The sample sizes were adequate to consider them representative samples. The specific tools used in the review were listed for some provisions but not for all uses; for example, the FBA/PBSP Evaluation Tool was listed for Provision K1, but there was no indication whether a specific tool was used to review progress notes for Provision K4 or psychological assessments for Provision K6 . ▪ Did use other relevant data sources. For example, the Facility used tracking databases and spreadsheets for psychological evaluations, behavior assessments and interventions, and peer review ratings of PBSPs. ▪ The Facility did not consistently present data in a meaningful or useful way. Specifically, the Facility's Self-Assessment: o Did not present findings consistently based on specific, measurable indicators. As indicated above, although sample sizes were reported, the Facility did not indicate which tools or metrics were used in the review. Without information about tools and metrics, it was not possible to identify specific, measurable indicators. o Did not distinguish data collected by the QA Department versus the program/discipline. Due to the lack of information about specific indicators or tools, it was not possible to determine whether data were derived solely from Psychology Department or if QA data were used as well. ▪ The Facility rated itself as being in compliance with the following provisions of Section K: Section K.2 and Section K.6. This was not consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with the following provisions: Section K.2. This section related to the presence of a qualified Director of Psychology. BSSLC had met substantial compliance on this section for the past four site visits. In relation to Section K.6, the Monitoring Team did not find that the Facility's documentation supported the claim of substantial compliance. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. ▪ The majority of Actions were described as In Process, although several items did not include any statement of status. ▪ The Actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. In the majority of cases, steps of the Actions reflected quantitative rather than qualitative

	goals. For example, the first Action under Section K.6 stated "Integrate Structural Functional Assessment (SFA) and Annual Psychological Evaluation into one seamless document". This was an important goal, but the Facility provided no means of determine if the Action had been completed with adequate quality.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at BSSLC from 4/07/2013 through 4/12/2013. 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. Areas in which the Facility demonstrated progress included the following. • Structural and Functional Assessments reflected improvement across most measured elements. The areas of lowest rating involved the adequate identification of functions and functionally equivalent replacement behaviors. • Positive Behavior Support Plans (PBSPs) reflected improvement in several areas, including the provision of background information, and the provision of intervention strategies addressing establishing operations, setting events, and antecedents. • The Facility had hired several Board Certified Behavior Analysts, bringing the total employed by the Facility to five. Despite these areas of progress, there were areas in which the Facility had not improved substantially from previous site visits. In addition, in other areas the documentation provided by the Facility was incomplete. • Documentation provided by the Facility reflected that fewer individuals had current assessments of intellectual ability and adaptive skills. • The Facility continued to lack a system for determining if staff were trained to implement the behavior interventions for which they were responsible. It was clear that BSSLC was making multiple, serious efforts to improve the quality of services at the Facility. In several areas these efforts were effective. The documentation provided by the Facility, however, at times reflected that efforts at tracking and coordinating improvements were incomplete or inadequately monitored. In order to achieve substantial compliance with the Settlement Agreement, the Facility must act diligently to ensure that changes are well coordinated and complement existing efforts and systems.

#	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	Historical Perspective 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	Noncompliance

	individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	individual had obtained a graduate degree from a behaviorally-oriented program but was not pursuing certification. In January 2012, only two psychologists were BCBAs. Of the remaining Behavior Services staff, 13 met the criteria for pursuing board certification; only five were pursuing board certification. At the time of the July 2012 site visit, only one BCBA remained on staff at BSSLC--Dr. Terry Hancock, Chief Psychologist. <u>Current Site Visit</u> At the time of the current site visit, it was reported that the Facility employed five Board Certified Behavior Analysts, including the Chief Psychologist, out of 13 staff eligible to participate in classes and sit for the board certification exam. This was substantially higher than found during the previous site visit. Of the remaining eight staff lacking board certification, only one was currently enrolled in BCBA courses. It was reported by the Facility, however, that an additional four staff would be enrolling in classes in June 2013. If these four staff do enroll, that would increase the percentage of staff pursuing board certification to 63%, slightly higher than found during the previous site visit. The Facility identified one psychologist as "not responsible for writing behavior programs and will not require a BCBA(.)"	

	1/2010	7/2012	4/2013
Percent of staff who were BCBAs	0%	9%	38%
Percent of staff lacking BCBA who were pursuing board certification	26%	60%	13%
Percent of staff who were BCBAs or were pursuing board certification	26%	64%	46%

Facility policy (BSSLC Policy III.1.a dated 12/10/2010) required that the PBSP author be demonstrably competent in applied behavior analysis but did not include that the PBSP author must be a BCBA. The Facility indicated, however, that all 173 current PBSPs at a minimum had been reviewed by a BCBA. As of 2/15/2013, the Facility required that PBSPs were developed at least in part by a BCBA. Despite the requirement for demonstrable competence and the reported involvement of a BCBA in PBSP development, Facility documentation from the peer review process indicated that PBSPs at the time of initial review reflected areas in which substantial improvement was necessary. The peer review process did include a requirement that all PBSPs meet requirements upon final revision. As indicated in Provision K.9, however, not all PBSPs satisfied all requirements. Therefore, it was not demonstrated that the PBSPs at BSSLC promoted growth, development, and independence; minimized regression and loss of

		skills; and ensured safety, security and freedom from undue restraints. The BCBA credential alone is not sufficient to ensure that PBSPs are adequate. In order to satisfy the requirements of the Settlement Agreement, BSSLC must address weaknesses in the PBSPs and ensure that all individuals requiring a PBSP are provided with an intervention plan likely to promote desired behavior and greater independence. Nevertheless, increasing the number of staff with or pursuing BCBA certification should help improve PBSPs.	
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	At the time of the site visit, BSSLC employed a full-time director of Behavioral Services--Terry Hancock, Ph.D. Dr. Hancock was extensively experienced in the field of intellectual and developmental disabilities, was licensed as a Psychologist in Tennessee, and had earned board certification as a behavior analyst. Based upon her credentials and demonstrated competence, the employment of Dr. Hancock by BSSLC satisfies this Provision of the Settlement Agreement.	Substantial Compliance
K3	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish a peer-based system to review the quality of PBSPs.	The role of the peer review committee has been briefly defined in the professional literature as follows. *"In cases in which withholding or implementing treatment involves potential risk, Peer Review Committees and Human Rights Committees play distinct roles in protecting client welfare. Peer Review Committees, comprised of experts in behavior analysis, impose professional standards to determine the clinical propriety of treatment programs." (The Right to Effective Behavioral Treatment. Van Houten, R. et.al. 1988. Journal of Applied Behavior Analysis, 21, 381-384.* In order to meet these goals, an organization or Facility must ensure that the necessary resources are available, policies and procedures are implemented, and demonstrably competent staff participates. In addition, steps must be taken to ensure that the implementation of peer review does result in interventions that adhere to acceptable practices. <u>Historical Perspective</u> 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	Noncompliance

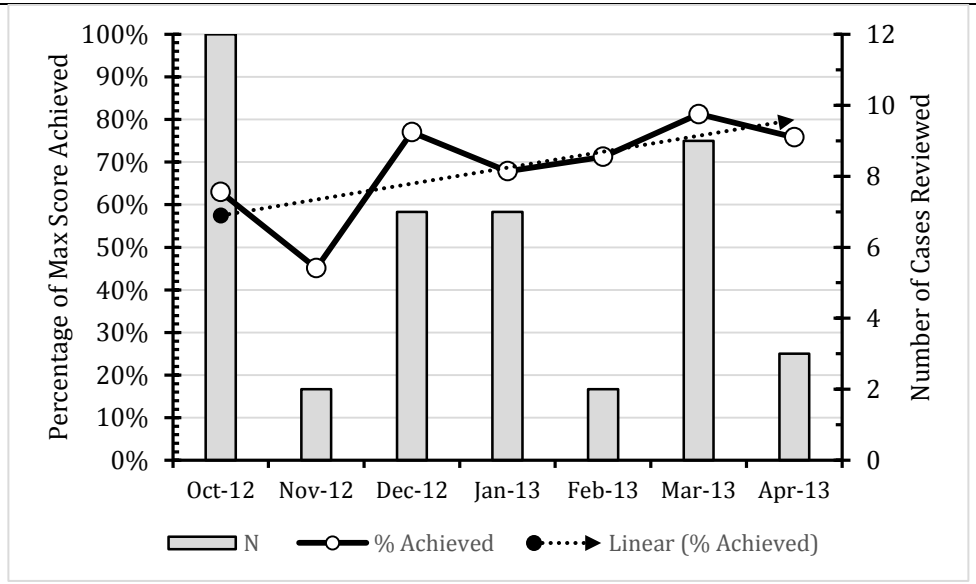
		internal peer review. • The Facility had in place a policy regarding the organization and function of internal peer review. • The Positive Behavior Support Committee (PBSC), which provided internal peer review, was comprised of BCBAs, as well as other disciplines directly associated with behavior assessment 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 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. Reviews conducted during the July 2012 site visit revealed only modest improvements in the peer review process at BSSLC. A review of 20 recent PBSPs revealed a continuation of the deficits noted during previous site visits, such as poor rationale for interventions, limited use of appropriate training procedures for replacement behaviors, and a lack of treatment expectations. <u>Current Site Visit</u> Observations and record reviews conducted during the current site visit revealed	

substantial improvements in the peer review process at BSSLC since the previous site visit. 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.

The Facility had implemented a rubric as part of the peer review process in July 2012. Rubric ratings for all PBSPs listed in the Psychology Department tracking database from April 2013 and October 2012 were selected as a sample. Ratings reflected improvement across all competencies in the rubric.

Area of Competency	Percentage Achieved 10/2012	Percentage Achieved 04/2013
Individual Fully Identified/Described	75.9	88.9
Rationale for PBSP	65.6	91.7
Measurable Goals and Objectives	66.7	81.5
Structural/Functional Assessment	72.8	75.6
A Written PBSP	46.2	54.5
Program Implementation and Evaluation	63.9	88.9
Rights Protection	58.3	77.8
Average of all Competencies	63.0	84.5

In addition to the comparison of individual competency areas in October 2012 and April 2013, the mean percentage of overall competency ratings for each month beginning with October 2012 were reviewed. The data from this review reflected that PBSPs and related assessments had improved.



The data upon which this review was based presented certain limitations. For at least three of the months in the sample, only three or fewer PBSPs were reviewed by the PBSC (note that in its self-assessment, the Facility reported on only the three months that had at least eight reviews, as the Facility recognized the larger number was needed to reduce the chance of error from the small sample). In addition, personnel changes during the months included introduced variability in how the ratings were conducted. Reviews of behavior interventions conducted by the Monitors as part of the current site visit (see Provisions K5 and K9) also reflected broad improvements. Based upon this evidence and the temporal association between changes to the PBSC process and improvements in behavior interventions, it was suggested that the internal peer review process had contributed to the improvements in the PBSPs.

Despite the quality of the internal peer review/PBSC process, the addition of the rating rubric, and the improvement in the behavior interventions, as indicated by most subscale percentages and by the overall compliance percentage, some elements of the behavior assessments and intervention plans continue to need improvement. For example, the percentage of achieved competence in regard to the PBSP remained below 55% for April 2013. The Facility should not rely only on overall compliance in assessing whether any improvements are needed but should also look at peer review ratings of essential and desired components of PBSPs. This will help the Facility continue to strengthen and improve the quality and effectiveness of PBSPs, on which there has already been progress.

		In addition, the Facility did not report on an external peer review process. External peer review is essential to meet the requirements of this provision.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	<u>Historical Perspective</u> During both the baseline visit and first compliance visit, it was noted that data collection for PBSPs at BSSLC consisted primarily of narrative reporting and was inadequate to the task of measuring behavior and determining the need for or benefit from interventions. At the time of the second compliance site visit, BSSLC had implemented 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. During the July 2012 site visit, in a sample of 30 records, BSSLC demonstrated progress in relation to individually analyzed target behaviors, graphing of treatment data, and timely revisions of PBSPs. None of the items monitored as part of the Settlement Agreement review process had approached the levels necessary for substantial compliance. <u>Current Site Visit</u> At the time of the current site visit, The Facility reported changes in the monitoring of PBSP effects. Due to the increased number of BCBAs, it was indicated that BCBAs began monthly review of PBSP data. This review process was initiated in March 2013. The addition of monthly review by BCBAs and a formalized approached to tracking appeared to be a positive step forward. Unfortunately, a spreadsheet for only one individual was provided as an example by the Facility. Furthermore, only three PBSP Progress Notes were submitted. Without a broad sample of tools and procedures, it was	Noncompliance

		not possible to assess compliance with the Settlement Agreement for the Provision.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	<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. In July 2012, the number of individuals with an intellectual assessment within the past five years had increased to 153. Only 90 individuals had an adaptive skills assessment completed within the previous 12 months. <u>Current Site Visit</u> During the current site visit, tracking tools provided by BSSLC reflected that 15 individuals, 5% of the 293 individuals living at the Facility, had received both current intellectual and current adaptive behavior assessments. Of the individuals listed in the Facility tracking tool, 68 (23%) were considered to have a current intellectual assessment at the time of the current site visit. Concerning adaptive behavior assessment, only 43 of the 293 individuals (15%) were identified as having an adaptive behavior assessment completed in the past year. In order to more closely examine the assessment practices at BSSLC, a sample of ISPs and all assessments completed as part of the ISP process were requested for 17 individuals. These individuals were 12 individuals whose ISPs were reviewed for Section F of this report, plus the three individuals reviewed for Provision C7 due to number of restraints, plus two individuals selected by the Monitoring Team following observation in the course of the site visit (see Documents Reviewed #9). In the documentation provided by the Facility for those 17 individuals, the documentation for only six individuals included any psychological assessment report. Furthermore, only three individuals had	Noncompliance

psychological assessment reports that reflected current intellectual and adaptive testing.

	1/2010	7/2012	4/2013
A Psychological Assessment had been completed.	0%	39%	35%
The Psychological Assessment was less than one year old	0%	23%	18%
The Psychological Assessments contained findings from an intellectual test administered within the previous five years.	0%	39%	18%
The Psychological Assessments contained findings of adaptive assessment conducted within one year prior to the date of the Psychological Assessment.	0%	23%	18%

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 17 records was selected to determine the degree to which this was achieved.

	1/2010	7/2012	4/2013
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%	40%	18%
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%	30%	18%

It was unclear based upon the information obtained from BSSLC whether the data for intellectual and adaptive behavior assessments were complete. The Facility Self-Assessment reflected that 154 individuals (68% of the Facility population) had current intellectual and adaptive behavior assessments, a figure substantially different from the Facility's own tracking tool. However, because the IQ/Adaptive Behavior database included individuals who have moved into the community or are deceased, it was difficult to make a comparison. In addition, it was unclear whether the lack of psychological assessment information in the sample of 17 ISPs reflected that the reports/testing had not been completed or that the Facility had not provided all

requested documentation.

Due to the discrepancies within the BSSLC documentation, it was not possible to offer further review of compliance with the Settlement Agreement.

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 relation to the SFA. By July 2012, however, the Facility had lost much of the previously gained progress. The majority of areas rated reflected substantial declines in performance. Of particular concern was the increased reliance upon abbreviated SFAs, the lack of direct observation in the assessment process, and the failure to integrate findings into a coherent hypothesis regarding the behavioral function.

Current Site Visit
During the current site visit, 12 records were selected as a sample of Structural and Functional Assessments (SFAs) at BSSLC. This sample included nine assessments selected by the Facility that reflected a new combined format for behavior assessment and intervention called the Behavior Assessment and Intervention Plan (BAIP). In addition, PBSPs for three individuals from the C.7 review were included. Based upon a review of these 12 intervention plans, it was suggested that the Facility had achieved meaningful improvement in many areas of their behavior assessment efforts. Data reported in the following table include all 12 records.

	1/2010	7/2012	4/2013
Assessment or review of biological, physical, and medical status	0%	50%	100%
Review of personal history	0%	20%	100%
A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis	0%	40%	100%
The process or tool utilizes both direct and indirect measures	0%	40%	92%

Identification of setting events and motivating operations relevant to the undesired behavior	0%	10%	92%
Identification of antecedents relevant to the undesired behavior	0%	40%	92%
Identification of consequences relevant to the undesired behavior	0%	40%	92%
Identification of functions relevant to the undesired behavior	0%	40%	75%
Summary statement identifying the variable or variables maintaining the target behavior	0%	40%	67%
Identification of functionally equivalent replacement behaviors relevant to the undesired behavior	0%	40%	75%
Identification of preferences and reinforcers	0%	90%	100%

Although all areas included in the table above had improved, three remained noticeably lower than the rest. The limitations noted in these three areas are discussed below.

Identification of functions In order to provide interventions likely to change undesired behavior, it is necessary to identify the primary function or functions of that undesired behavior. The function of behavior is typically addressed through a combination of direct (observation-based) and indirect (informant-based) procedures. As indirect procedures are often less accurate, it is important that findings from indirect assessments be reviewed with caution and supported by direct assessments. It was not evident from the provided documentation that BSSLC had always used necessary caution in the use of indirect assessments.

- For Individual #398, the Questions About Behavioral Function (QABF), an indirect assessment rating scale, was administered to four informants. The findings of the QABF were not conclusive, with at least two functions rated nearly the same. The higher of these two functions was selected as the most likely function. However, an examination of ratings revealed that the selected function was slightly higher due to the information provided by a single informant whose rating different substantially from the other informants. Under such circumstances, it is often recommended that additional informants be added or other steps taken to insure the accuracy of the ratings. No such steps were taken in this example, and the report did not acknowledge the unusual pattern in the ratings.
- For Individual #411, a single informant influenced the QABF ratings in much the

same manner note for Individual #398. For Individual #411, however, the issues was complicated by the very limited use of direct observation to confirm the findings of the QABF. Only two 20-minute observations of the individual were conducted as part of the assessment. During neither of the observations was the undesired behavior displayed, substantially limiting the value of the observations.

Summary statement identifying maintaining variables A structural and functional assessment should include a statement summarizing the assessment findings and presenting any data that may limit the accuracy of those findings. Due to the limitations noted in the use of indirect assessments, the summary statement needed to address those limitations. The summary statements in four BAIPs (Individuals #293, #316, #398, and #411) did not address evident assessment limitations.

Identification of functionally equivalent replacement behaviors In order to change undesired behavior effectively, a behavior intervention must be able to strengthen replacement behaviors; replacement behaviors are desired behaviors that serve the same function as the undesired behavior. To identify replacement behaviors, there must be an accurate assessment of the function of the undesired behavior. As noted above, there were instances in which BSSLC had not identified functions thoroughly or accurately.

As the identification of the function of the undesired behavior is a core component of the functional assessment process, the utility of the intervention is questionable when the identification of function is not conducted well. Despite the improvements noted in the assessment of behavior, BSSLC must attend to the quality of the functional assessments before substantial progress can be achieved.

It was noted during the previous site visit that the Facility had achieved progress in relation to integrating mental illness into the assessment of operant behavior. The Facility continued to progress in this area at the time of the current site visit, albeit at a slow pace.

	1/2010	7/2012	4/2013
Screening for psychopathology, emotional, and behavioral issues	0%	10%	58%
Differentiation between learned and biologically based behaviors.	0%	20%	33%
Identification of behavioral indices of psychopathology	0%	20%	33%
Use of one or more assessment tools with evidence of validity in use for	0%	10%	17%

people with intellectual disabilities					

As noted in the table above, only slightly more than half of the reviewed plans indicated to involve symptoms of mental illness included an adequate screening for mental illness as part of the assessment. In some circumstances, there was no screening information regarding mental illness. In other cases, a screening process was documented, but it was not clear that all symptoms had been included or reported.

There were also substantial limitations in the process of identifying the behaviors that are due to mental illness, those that are due to environmental circumstances, and those that are due to a combination of the two. When assessments identify the source of a problem behavior, the probability of offering an effective intervention is substantially increased. The limitations evident in BSSLC introduced do not increase probability of effective interventions.

- For Individual #286, the case formulation provided by the psychiatrist in the BAIP posited that aggression was due to hallucinations and delusions. There was no evidence provided to support this conjecture, and the case formulation went on to state that due to communication deficits it was not possible to determine if the individual experienced symptoms of psychosis. The functional assessment indicated the potential function of aggression to be gaining attention. No attempt was made in the BAIP to address the discrepancies.
- For Individual #316, the case formulation indicated that the individual was prescribed antipsychotic medication to treat hallucinations. No support for the presence of hallucinations was provided in the case formulation. The functional assessment did not include hallucinations. Although hallucinations are typically not eliminated through behavior intervention, the manipulation of establishing operations and setting events can reduce the prevalence or intensity of hallucinations. Without the inclusion of hallucinations in the assessment process, the potential for behavioral intervention was not provided.
- As reported in Provision J8, of PBSPs reviewed for 14 individuals, six of 14 (42%) had combined case formulations in place.

Documentation provided by BSSLC also indicated that the Facility made extensive use of rating scales to track symptoms of mental illness. When it is determined that rating scales will be used, it is crucial that the most appropriate scales be selected and that efforts be made to track the validity of the ratings provided. In many such circumstances, rating scales developed for individuals with intellectual and developmental disabilities are considered more appropriate than those that are developed for the typical population. For none of the 12 individuals included in the sample of SFAs for Provision K.5 was a rating scale used to assess mental illness that was designed for people with intellectual and developmental disabilities.

		Based upon the available information, it was evident that BSSLC had achieved meaningful progress in Provision K5. In several areas, however, the Facility demonstrated an inability to implement the procedures necessary to achieve Substantial Compliance.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	Based upon the information presented in Provision K5, documentation in the record continued to reflect that psychological assessments were not based upon complete clinical and behavioral data.	Noncompliance
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	Historical Perspective In July 2011, the Behavior Services department continued to have Robert Guercio, MA complete intellectual and adaptive assessments, and incorporate the findings of those assessments into psychological evaluation reports. Current Site Visit At the time of the current site visit, 10 individuals had been admitted to the Facility since the previous site visit. Of those 10 individuals, seven (70%) had been provided psychological assessments, including findings of intellectual and adaptive ability testing, within 30 days following their admission. The remaining three individuals (30%) had not been provided a psychological assessment at the time of the site visit. Robert Guercio, MA, continued to provide psychological assessments for the Facility. Due to the specific limitations in the assessment process noted in Provision K5, as well as discrepancies between various BSSLC documents for tracking the completion of psychological assessments and testing, it was not possible to determine the extent to which the Facility was in compliance with Provision K7 of the Settlement Agreement.	Noncompliance
K8	By six weeks of the assessment required in Section K.7, above, those individuals needing psychological services other than PBSPs shall receive such services. Documentation shall be provided in such a way that progress can be measured to determine the efficacy of treatment.	Historical Perspective 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. By July 2012, BSSLC had 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 reflected no change in the treatment plans or services delivered since July 2011. Current Site Visit At the time of the current site visit, BSSLC reported that Hazel Leigh McRae was no	Noncompliance

longer providing counseling services to individuals living at BSSLC. A full-time employee had recently been hired by the Facility to provide counseling services. At the time of the site visit, however, it was unclear whether any individuals had been identified as in need of counseling services and for whom counseling plans had been developed. Although the Facility provided a list of eight individuals with plans, the Presentation Book stated that the BCBA group would work with a newly-hired department therapist to set up counseling plans, but those were not completed yet.

	7/2012	4/2013
Needed services (other than PBSPs, e.g. counseling) identified in the psychological assessment are implemented within 6 weeks of the assessment.	100%	0%
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)	0%	0%
Services are goal directed with measurable objectives and treatment expectations.	0%	0%
Services reflect evidence-based practices.	0%	0%
Services include documentation and review of progress. If service includes individual or group sessions, progress review includes note in record, or specific data for each session.	0%	0%
Service plan includes "fail criteria"—criteria, such as lack of progress on objectives, or number of sessions without meeting the learning goal that will trigger review and revision of intervention.	0%	0%
Service plan includes process to generalize skills learned or intervention techniques to living, work, leisure, and other settings, including homework or staff training as appropriate.	0%	0%
Service is identified in ISP and, if applicable, PBSP.	100%	0%
Staff who provide therapeutic interventions are qualified to do so through specialized	100%	0%

training, certification, or supervised practice.				
Staff who assist in therapy, or who supervise homework or milieu activities, receive training and monitoring from qualified therapists	0%	0%		

The Facility reported that a variety of non-PBSP intervention formats were in the process of being developed. These new intervention formats included the following.

- Psychiatric Support Plans These plans were proposed as a means to provide supports and assistance to individuals whose mental illnesses were effectively managed by pharmacologic means and who demonstrated few challenging, operant behaviors.

  At the time of the site visit, only two plans had been developed. Two plans are not sufficient to develop conclusions about the interventions. A preliminary review, however, revealed the following factors.
  - The plans did not provide a specific treatment plan or course of action.
  - The plans did not provide treatment expectations with success and failure criteria.
  - The plans did not clearly address the signs and symptoms of all mental illness diagnoses for which psychotropic medications were prescribed.

- Environmental Plan These plans were proposed as means to address environmental factors that contributed to challenging behaviors for the majority of individuals in a specific environment. At the time of the site visit, only one plan had been developed. One plan is not sufficient to develop conclusions about the interventions. A preliminary review, however, revealed the following factors.
  - The assessments addressed both the environment and the individual, and each individual in that environment was provided a separate intervention plan.
  - The plan provided a means for data collection.
  - The plan provided a means for evaluating treatment efficacy.
  - The plan primarily involved contingent and non-contingent reinforcement, modification of setting events, and protective measures.

  Skill Acquisition Plans These were proposed as a means to provide detailed instructions on how to teach replacement behaviors identified in PBSPs. At the time of the site visit only two plans were provided although the Facility Self-Assessment indicated three plans had been developed.

  Two plans are not sufficient to develop conclusions about the interventions. A

		preliminary review, however, revealed the following factors. o It was not evident that the instructions included all probable responses by the individual to which staff might need to respond. For example, only two specific variations on an incorrect response were provided. o The programs reflected a general discrete-trial format and reflected the findings of various assessments including the structural/functional assessment and a formal preference assessment. Although the Facility had not demonstrated measurable progress toward substantial compliance with the Settlement Agreement, obvious steps had been taken toward expanding 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 resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	Informed consent requires that the consenter be provided with sufficient information about the proposed intervention to formulate a decision about whether or not to grant consent. In most situations, the consenter must be provided with the following information. • Implications of going without treatment and of treatment being postponed for different periods • The range of accessible diagnostic or treatment options • The benefits each option offers • The possibilities of diagnostic false results or treatment failures • The risks and discomforts of diagnostic or treatment options even when successful • Short-term injuries that diagnostic or treatment failures may cause • Long-term effects of diagnostic or treatment options, favorable and unfavorable, separating probabilities from possibilities It is the responsibility of the Facility to conduct the assessments essential for informed consent. 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.	Noncompliance

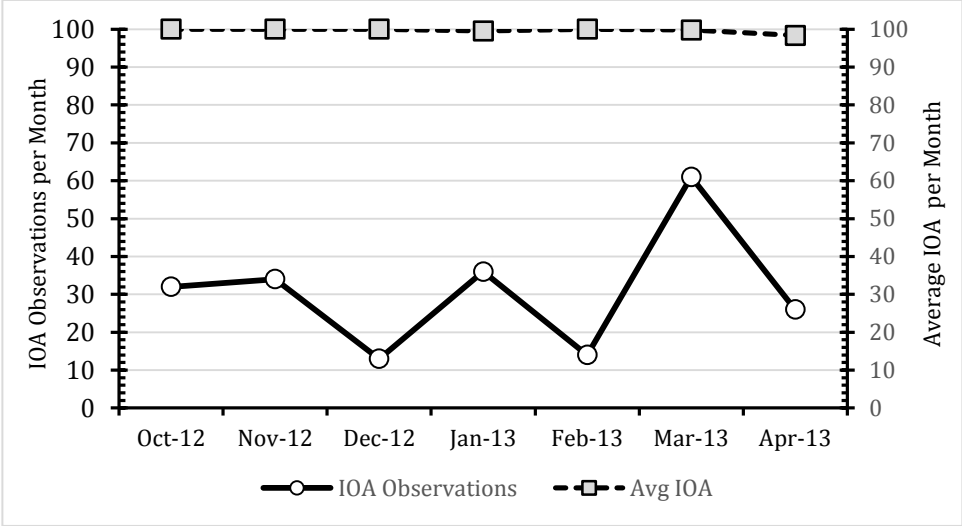
Current Site Visit

For the current site visit, a sample of nine individuals were selected by the Facility as a sample of PBSPs. This sample involved nine interventions selected by the Facility that reflected a new combined format for behavior assessment and intervention called the Behavior Assessment and Intervention Plan (BAIP). Based upon a review of the nine BAIPs, it was suggested that BSSLC had achieved meaningful progress in several areas.

	1/2010	7/2012	4/2013
Rationale for selection of the proposed intervention	0%	60%	100%
History of prior intervention strategies and outcomes	0%	0%	100%
Consideration of medical, psychiatric and healthcare issues	0%	20%	89%
Operational definitions of target behaviors	0%	90%	100%
Operational definitions of replacement behaviors	0%	90%	100%
Description of potential function(s) of behavior	0%	70%	67%
Use of positive reinforcement sufficient for strengthening desired behavior	0%	30%	100%
Strategies addressing setting event and motivating operation issues	0%	20%	89%
Strategies addressing antecedent issues	0%	70%	89%
Strategies that include the teaching of desired replacement behaviors	0%	60%	89%
Strategies to weaken undesired behavior	0%	100%	100%
Description of data collection procedures	0%	0%	0%
Baseline or comparison data	0%	0%	89%
Treatment expectations and timeframes written in objective, observable, and measureable terms	0%	30%	0%
Clear, simple, precise interventions for responding to the behavior when it occurs	0%	50%	100%
Plan, or considerations, to reduce intensity of intervention, if applicable	0%	0%	100%
Signature of individual responsible for developing the PBSP	0%	100%	100%

		Despite the considerable improvement in several areas, in three crucial areas the Facility had not progressed beyond the levels of performance demonstrated at the previous site visit, and in one area had experienced a substantial decline. Description of potential function As noted in Provision K5, the Facility had not consistently provided indirect assessments that allowed for a clear identification of behavior functions. Although all of the BAIPs in the sample included a section for describing the functions of the target behaviors, the lack of adequate assessment made the accuracy of decisions about function unclear. Description of data collection procedures To ensure that data are accurate, it is important to provide precise data collection instructions. If such instructions are not made available, then the probability of data errors increases due to deviations in procedures, incorrect identification of targets, or failure to record data at the correct time. In nine of nine BAIPs (100%), data collection instructions consisted only of the single phrase, "Document on the Behavior Data Sheet." There is an individualized data sheet for every individual with a behavior plan. There is one sheet per shift (24 hour data collection) and includes the specific targeted behavior for each individual, specific replacement behavior for each, reinforcers delivered, and sleep data. However, the PBSP itself does not include instructions. Treatment expectations and timeframes Treatment expectations involve identifying the level of performance required to allow for treatment decisions. Typically, treatment expectations involve specific success and failure criteria, as well as timeframes within which the determination is to be made. It is therefore critical that the measures included in the treatment expectations are consistent with the data collection method identified in the intervention plan. In nine of nine BAIPs (100%), the identified data collection method was partial-interval. In partial-interval data collection, if the target behavior occurs at any time in a specific interval, that interval is counted as a display of the target behavior. Even if the target behavior occurs multiple times during the interval, that interval is counted as only a single display. This can result in a substantial underestimate of the displays of the target behavior, especially if the intervals are longer than a few minutes. As indicated, all BAIPs used partial-interval data collection. In addition, however, in seven of seven of the BAIPS (100%), treatment expectation criteria were stated as total frequencies rather than a percentage of intervals. As a result, it would not be possible to determine when success or failure criteria had been reached. Based upon information obtained during the current site visit, the Facility had demonstrated progress in several areas. Due to weaknesses involving data collection, identification of functions, and treatment expectations, however, the Facility had not met	

		the requirements for substantial compliance.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	Historical Perspective During previous site visits, BSSLC demonstrated consistent improvement in data graphing practices other than in relation to the presentation of IOA data. In January 2012, other than the lack of IOA data, the graphs were described as excellent. In July 2012, however, the sample of graphs reflected substantial declines in meeting criteria, including the presentation of IOA data, the proper development of vertical axes, and the lack of condition change markers. Current Site Visit At the time of the current site visit, the Facility reported changes in the monitoring of PBSP effects. Due to the increased number of BCBAs, BCBAs began monthly review of PBSP data. This review process was initiated in March 2013. In addition, the Facility reported that PBSP data and other relevant information was entered into a spreadsheet. The addition of monthly review by BCBAs and a formalized approached to tracking appeared to be a positive step forward. Unfortunately, a spreadsheet for only one individual was provided as an example by the Facility. Furthermore, only three PBSP Progress Notes were submitted. Without a broad sample of tools and procedures, it was not possible to assess compliance with the Settlement Agreement for the Provision. In relation to treatment integrity and IOA, the Facility reported that between August 2012 and February 2013 PBSPs were implemented with an average of 98.1% compliance. It was also reported that 208 lOA sessions revealed an average reliability of 88%. A review of Facility tracking data revealed an average of 31 IOA observations per month beginning in October 2012, with a range of 13 to 61 observations per month.	Noncompliance

		 The actual number of active PBSPs per month was not available. It was reported by the Facility that at the time of the site visit there were 173 active PBSPs. Using 173 as an estimate for monthly active PBSPs, the current rate of IOA observations would allow for only two IOA observations per year for the majority of PBSPs. Two IOA observations per year would not be adequate for essentially any behavior intervention. Some PBSPs for intensive behaviors could require multiple observations per month. Therefore, the current IOA observation practices at BSSLC were not sufficient. Due to the lack of documents, it was not possible to determine the extent to which Provision K10 complied with the Settlement Agreement. Based upon IOA practices, however, the Facility had not achieved substantial compliance.	
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. BSSLC did not provide an aggregate report of readability statistics for PBSPs. The Facility tracking spreadsheet for PBSP reviews reflected that 42 PBSPs had been reviewed since October 1, 2012. The tracking spreadsheet revealed that only nine of 42 PBSPs (21%) had been provided a readability rating. The average readability score for these nine PBSPs was grade 8.39. Although this was an acceptable average score, the lack of reported ratings for all reviewed PBSPs prevented this Provision from a determination of compliance with the Settlement Agreement.	Noncompliance
K12	Commencing within six months of	During the current site visit, BSSLC reported that Behavioral Foundations classes had	Noncompliance

	the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	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. The Facility also reported a variety of areas in which staff training was weak. • No system was available to ensure that "pulled staff" were competent to implement PBSPs. • No system was available to ensure that "float staff" were competent to implement PBSPs. • No system was available to ensure that all staff had been trained on a PBSP before the PBSP was implemented. • On average, the Facility began training staff on PBSPs within 18 days of plan approval, with a range of zero to 59 days. In order to assess staff knowledge of PBSPs, interviews were conducted with 16 staff at various locations on the BSSLC campus. Of the 16 staff interviewed, one (6%) was able to identify at least one individual in the area with a PBSP and described that PBSP in detail. PBSP data books were reviewed in the same 16 locations, with one PBSP selected by chance from within the PBSP data book. None of the 16 reviewed PBSP data sheets was recorded up to the current shift at the time of the review. Based upon documentation, observations, and staff interviews, there was little indication that the Facility was prepared to ensure 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 five staff who possessed board certification as a behavior analyst. This represented approximately one BCBA for every 59 individuals residing at the Facility and fell short of the required ratio of one BCBA for every 30 individuals. If all staff positions eligible for BCBA credentialing were filled by a BCBA, the Facility would have one BCBA for every 23 individuals residing at the facility. BSSLC currently employed 7.5 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. Facility tools for monitoring staff and departmental performance, as well as adherence to policy and regulations, should be routinely assessed for accuracy. In circumstances where tracking information is found to be inaccurate, the Facility should act to ensure that existing errors are corrected and the tracking systems are modified to avoid further error. (Provisions K.3, K.4, K.5, K.6, K.7, K.10, and K.11)

2. The Facility should continue efforts to expand the number of BCBAs within the Psychology Department. (Provisions K.1 and K.13)
3. The Facility should ensure that peer review includes external as well as internal review. (Provision K.3)
4. The Facility should ensure that all individuals living at the Facility are provided with intellectual and adaptive assessments as part of a comprehensive Psychological Evaluation upon admission and when required thereafter. (Provisions K.5 and K.7)
5. Facility staff must possess the skills to assess the quality of behavior assessments. When assessments are found to be inadequate or inconclusive, Facility staff must be able to identify and conduct the additional assessments necessary for the development of effective behavior interventions. (Provision K.5)
6. The Psychology Department in conjunction with the Psychiatrist must ensure that behaviors reflective of mental illness are integrated into the assessment of challenging behavior. (Provision K.5).
7. Efforts to provide non-PBSP interventions, such as Environmental Plans and Replacement Behavior Plans, as well as counseling, should be continued. (Provision K.8)
8. PBSPs should reflect adequate data collection measures, including IOA and treatment integrity, and contain treatment expectations that are compatible with the data being collected. (Provisions K.4, K.9, and K.10)
   The Facility should aggressively pursue the development and implementation of staff training on learning, behavior intervention strategies, and formal intervention plans. In addition, the Facility should develop and implement a system for tracking staff training that can be used to determine if staff are prepare to perform their job duties. (Provision K.12)
9. The Facility should aggressively pursue the development and implementation of staff training on learning, behavior intervention strategies, and formal intervention plans. In addition, the Facility should develop and implement a system for tracking staff training that can be used to determine if staff are prepare to perform their job duties. (Provision K.12)

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. BSSLC Self-Assessment (3/21/13) 2. BSSLC Action Plan (3/21/12) 3. Presentation Book, April 2013 4. BSSLC Administrative Death Review Committee, Policy: I4.b (no date) 5. BSSLC Clinical Death Review Committee, Policy: I.4.c (no date) 6. BSSLC Death/Discharge Summaries for Deceased Individuals #109, #114, #497 #78, #207, and #192 7. BSSLC Quality Improvement Death Review of Nursing Services and recommendations for Deceased Individuals #109, #114, #497 #78, #207, #192, and #372 8. BSSLC Unusual Incident Reports (URIs) for Deceased Individuals #497 #78, #207, and #192 9. Texas Department of State Health Services Vital Statistics Unit, Certificate of Death for Deceased Individuals #109, #114, #497 #78, #207, and #192 10. BSSLC Clinical Death Review Committee Meeting Minutes for Deceased Individuals #192, #207, #78, and #497 11. BSSLC Administrative Death Review Committee Meeting Minutes for Deceased Individuals #192, #207, #78, and #497 12. BSSLC Death Review Tracking Tools for Deceased Individuals #109, #114, #497 #78, #207, and #192 13. BSSLC Tracking of Nursing Recommendations Sheets for Deceased Individuals #109, #114, #497 #78, #207, and #192 14. Procedural Guidelines for Botox Injections, dated 8/3/12 15. Procedural Guidelines for PCP on call (11/15/2012) 16. Procedural Guidelines for Psychiatrist on call (10/15/2013) 17. Procedural Guidelines for the Morning Medical Debriefing Meeting (10/15/2012) **People Interviewed:** 1. Mary Brett, MD, Medical Director 2. Martha Hare, ANP 3. Malcolm Lochiel, MD 4. Debbie Williams, Chief Executive Nurse 5. Daniel Dickson, Director of Quality Assurance 6. Jill Quimby, RN, Quality Assurance Nurse **Meeting Attended/Observations:** 1. Morning Medical Rounds, April 19, 2013 2. ISP meeting for Individual #286 3. Observational rounds at living areas Bowie Springs A, B, C, and D; Childress Terrace A, B, C, and D; Driscoll Gardens A, B, C, and D 4. Settlement Agreement Medical and Nurse Monitors met with Medical Director, Chief Executive Nurse, Quality Assurance Nurse, and Quality Assurance Director to review and discuss Deaths occurring from 717/12 through to date, 4/10/13.
	Facility Self-Assessment:

	The Facility reported that the State Office is currently developing a new medical care policy, which will be incorporated into a pending "local" policy. The Facility also reported that it developed several "procedural guidelines" for the morning medical meeting, physician and psychiatrist on-call, and for the use of Botox injections. The Facility also reported developing algorithms for common clinical conditions. The Facility reported in its self-assessment, that it was "not yet in compliance", although "substantial progress has been made". The self-assessment, and action plan did not fully delineate all steps that the Facility had taken, and will take to gain substantial compliance with provision L. The Monitoring Team did attend the morning medical rounds, and reviewed the newly developed algorithms, finding both processes beneficial. The Monitoring Team would again like to suggest that the Facility develop a more meaningful action plan, perhaps using tools such as a Gantt chart, to better delineate all necessary steps planned, developed, and implemented, specific for gaining substantial compliance for Provision L.
	Summary of Monitor's Assessment: Per observation, discussion with clinical staff, and review of policies, procedures, and guidelines, and review of clinical records, the Monitoring Team clearly recognized the continued progress that the Facility had made and is working towards substantial compliance of Provision L. The entire medical staff, under the leadership of the medical director, has worked diligently on many areas. In particular, the Facility maintained a functional, and useful morning medical rounds, that integrates all clinical, and habilitation services, and enables much better follow-up on acute and serious health care conditions. The medical staff provided outstanding following-up on hospitalizations, and ensures efficacious continuity of care for those individuals hospitalized. The Monitoring Team noted significant improvement with assessing acute medical conditions. During the observation period, the Monitoring Team noted robust collaboration among primary care providers and other clinical disciplines. Noteworthy, was that medical practitioners had made modest improvements with their participation at ISP meetings. Despite this positive growth, the Monitoring Team concurs with the Facility's self-assessment, and has determined that the Facility continues to be noncompliant with Provision's L.1 through L.4. The Facility must continue to develop its medical practice, and it is paramount that the Facility enhance its practice in areas such as recurrent pneumonia, degenerative spine disease, and other common and serious issues that affect individuals with developmental disabilities. Further development is needed of Facility's internal and external medical audit process, to include medical management elements for the most common and serious conditions that occur in people with developmental disabilities. The mortality review process must be further developed, to ensure that all mortalities undergo a comprehensive review, as to the "root cause" of the death, and ensure that meaningful recommendations are developed to improve system issues. The Facility must develop and implement a medical quality assurance process, and further develop policies, procedures, and clinical guidelines, deemed necessary for operational needs. The Monitoring Team noted continued limitation of adequate examination rooms, including clinically appropriate examination tables that can accommodate individuals with developmental disabilities, and appropriate lighting. Over all, the Facility has continued to make progress towards substantial compliance with Provision L.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	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, reviewed clinical records, and observed individuals at their home. Specific issues addressed during this review period included seizure disorder, pneumonia, fractures, acute medical conditions, osteoporosis, follow-up to hospitalizations, degenerative spine disease, malignancy, and do not resuscitate order (DNR). In addition, medical administration was assessed, including a review of the Interdisciplinary Team (IDT) participation by medical practitioner, medical staff credentials and training, and the Facilities ability to manage clinical database elements. <u>Medical Practitioner Services / Medical Administration</u> 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. 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). With the exception of one CME event for GI motility issues, which was obtained by one physician, all CME reviewed was for general medicine, or psychotropic medication management, and there was no specific CME provided regarding individuals with intellectual or 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. The Facility maintained a current physician-advanced nurse practice agreement. The Monitoring Team interviewed three medical practitioners regarding availability of examination rooms, and medical equipment. The medical practitioners indicated that they mostly conduct examinations in the living area's and/or bedrooms, and there is no availability of adequate examination tables, exam room space, and other necessary equipment, such as appropriate lighting. The Monitoring Team visited all living areas, and determined that the Facility did not have adequate examination room space, appropriate examination room lighting, necessary examination table, that can accommodate individuals with physical disabilities. 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	Noncompliance

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		recommended that the Facility provide necessary examination room space, lighting, and examination tables, that can accommodate individuals with complex physical disabilities. Management of clinical database elements The Facility did not maintain a policy or procedure for managing clinical database elements. Furthermore, upon an onsite document request, the Facility could not provide accurate information as to clinical diagnosis of Individuals. Summary: It is essential that the Facility develop and implement a procedure to ensure accurate and efficient reporting of medical diagnosis, among other relevant clinical issues. Medical Clinician Participation in the Interdisciplinary Team Process To evaluate the medical clinician participation in the ISP process, the Monitoring Team attended the morning medical meetings; reviewed Individual Support Plans (ISP) for Individuals #39, #88, #223, #222, #258, #318, #305, #252, #431, #461, #61, #75, #34, #25, #460, #444, #481, #415, #89, and #567; and participated at an ISP meeting, for Individual #286. Medical Morning Debriefing Meeting 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 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. Summary: The Monitoring Team was impressed by the complement of professionals who attend the morning meetings, and with its review process. ISP Meeting The Monitoring Team observed an ISP meeting, on April 9, 2013, and noted that the Individual's primary care physician was in attendance, and participated at the meeting. As reported in Provision F1b, medical staff attended 67% of ISP meetings held during March 2013. Summary: The Monitoring Team was impressed that the medical practitioner participated, and was engaged in interdisciplinary discussions throughout the ISP meeting. The Monitoring Team recommends that the medical practitioner, prior to attending the ISP meeting,	

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		conduct a more detailed analysis and review of clinical issues. Review of ISPs The Monitoring Team reviewed a total of twenty annual ISPs that were selected by the Monitoring Team when reviewing clinical records for acute and chronic care conditions, and assessed whether or not clinically relevant information was well communicated within the context of the ISP and supporting documents, and whether the medical provider participated at the ISP meeting. Of the 20 ISPs reviewed, two out of twenty (10%) included a comprehensive review of the clinical issues and clearly delineated how the issues would impact the individual's life, and all necessary supports and services. The medical practitioner participated at the ISP in 7 out of 20 cases (35%). Osteoporosis From a list of all individuals who were reported to have a diagnosis of osteoporosis, the Monitoring Team selected the first and then every fifth individual, for a total sample of ten individuals, and requested the previous two bone density studies, current treatments, and diagnostic evidence that the underlying cause of low bone density was evaluated. Only nine of the ten sample cases were provided for review, as information for Individual #223 was not provided. Furthermore, the Facility did not have a protocol, policy, or guideline for the management of osteoporosis. Of the nine cases provided, two did not have a diagnosis of osteoporosis or osteopenia, despite being on the list of those treated for osteoporosis (Individuals # 390, and #429). Of the seven cases identified as having osteoporosis, four were treated with specific medication, such as a bisphosphonate (57%); six were treated with clinically appropriate doses of vitamin D and calcium (86%); seven out of seven cases had undergone a study for low bone density with in the past three years (100%); seven out of seven had undergone evaluation for vitamin D, calcium, and alkaline phosphatase levels (100%); and zero out of the seven cases had clinical documentation demonstrating a standardized assessment for the underlying cause of low bone density. Summary: The Facility had significantly improved its follow-up and management of osteoporosis. The Monitoring Team strongly recommends that a clinical protocol be developed and implemented, that includes routine screening of all Individuals at risk, and includes guidance for the evaluation of low bone density, prior to initiating treatment. Hospitalizations To assess the Facility's ability to ensure continuity of medical care through a	

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		hospitalization, eight cases were selected by the Monitoring Team, from a list of all individuals admitted to an acute care hospital during the reporting period. The selected cases were based upon high acuity conditions, such as bowel obstruction, pneumonia, and cardiovascular conditions. All eight cases (100%) included complete and comprehensive hospital transfer forms, hospital liaison reports, medical practitioner's documentation indicating communication with hospital medical staff, and post hospital physical assessment, and documentation indicating that an ISP had been convened to discuss the hospitalization. Summary: The Facility had significantly improved on its follow-up on hospitalizations. The hospital liaison process consistently documented, and reported on the individuals wellbeing, during the hospitalizations; there was an efficacious hospitalization transfer form completed for each hospitalizations; the IDT had met, and discussed issues related to the hospitalization; and the medical practitioner's documentation was exceptional. The Monitoring Team is most complimentary to the administration, nursing staff, and medical practitioners for their exceptional follow-up, and continuity of care of individuals admitted to acute hospitals. <u>Seizure Disorder</u> To assess the Facility's management of seizure disorder, the clinical records of all individuals who experienced one or more episodes of status epilepticus were reviewed. Of the five reported cases of status epilepticus, the Monitoring Team was provided clinical information for only four individuals, that included the annual medical summary, most recent annual ISP, the most recent two neurology consultations, medical providers' notes indicating follow-up on reported seizure activity, EEG reports completed within the past three years, seizure reports for the past six months, past six months of laboratory data, and current medication list. Clinical information for Individual #576 was not provided. Of the four cases reviewed, three out of four indicated timely follow-up with consulting neurologist, as recommended (75%); zero out of four included an EEG study obtained within the past three years (0%); laboratory data was provided in zero out of four cases (0%); an ICD-9 diagnosis was indicated on the annual medical summary in one out of four cases (25%); a specific medical plan was well documented on the annual medical summary in four out of four cases (100%); there was documentation indicating that the medical provider followed up on all episodes of reported seizure activity in one out of four cases (25%); seizure records were completed in four out of four cases (100%); the annual ISP included a comprehensive review of the Individual's seizure disorder, and	

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		documented all associated clinical concerns, and required supports and services, in zero,\ out of four cases (0%) Summary: In general, the Facility continued to improve with regard to the management, and follow-up on seizure disorder. With the exception of one case, Individual # 474, cases were provided neurology consultations, as recommended. Individual #67 had exceptional follow-up on seizure activity by the advanced nurse practitioner. The Facility must enhance medical practitioners assessment following seizure activity, ensure that periodic diagnostics, such as EEGs are obtained, and ensure that accurate diagnosis of the type of seizure disorder is well documented. <u>Fractures</u> From a list of all fractures that were reported during the reporting period, the first five cases were reviewed. Of the five cases, four out of five (80%) indicated that the medical provider conducted a comprehensive physical assessment of the fracture; in zero out of five cases (0%), did the medical provider document the etiology, and/or causality of the fracture (0%); in zero out of five cases (0%) was there documentation by the medical provider through full resolution of the fracture; there was documentation that the ISP reviewed the fracture in three out of the five cases (60%); and in zero out of five cases (0%) did the ISP document the actual etiology, and /or causality of the fracture. Summary: It should be noted that ISP documentation for follow-up on the fracture for Individual #460 was excellent, and preventive measures for fractures were well reviewed for Individual #61. It is essential that the medical provider document follow-up through full resolution of fractures, and document, as best as possible, the etiology/causality of the fracture, and propose necessary supports and services to help mitigate additional fractures. This level of assessment was not evident for the cases reviewed. In one particular case, Individual #75, there was marked delay in medical follow-up, despite persistent pain, edema, and movement limitation. The Facility should review this case particular case, and develop a strategy to ensure individuals prolonged period of acute symptomatology, are reassessed, and specialty intervention obtained immediately. <u>Degenerative Spine Disease</u> From a list of all individuals reported to have degenerative spine disease, the first five individuals (#390, #88, #223, #226, #258) were selected, and their clinical record reviewed to assess the Facility's management of degenerative spine disease.	

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		The diagnoses listed on the annual medical summary indicated zero out of five cases (0%) as having a diagnosis of degenerative spine disease; there was a clinically appropriate plan delineated on the annual medical summary for degenerative spine disease in one out of five cases (20%). There was a physical therapy (PT) assessment, specifically addressing degenerative spine disease in zero out of five cases (0%), and there was a PT plan specific to address degenerative spine disease in zero out of five cases (0%). There was an ISP that clearly delineated degenerative spine disease as a clinical concern, and listed all necessary supports and services to address the issue, in zero out of five cases (0%). There were periodic diagnostics to monitor for the progression of degenerative spine disease in one out of five cases (20%); and there was periodic assessment by a specialist in the field of degenerative spine disease, in zero out of five cases (0%). Individual #390 had a CT of the spine on May, 2011, which demonstrated significant, multilayer degenerative changes, and recommended follow-up with an MRI. There was no MRI follow-up, no follow-up by a specialist in this field. There was no comment on the medical assessment, PT assessment, or ISP. Individual #223, was diagnosed with "spastic quadriplegia", but there was no plan to address this condition, which is known to have a positive correlation with degenerative spine disease. Summary: The Monitoring Team has commented on the limited attention towards neuromotor conditions on previous reports, and is concerned that no progress has been made in this area. The Facility must immediately develop and implement a strategy to clinically address neuromotor conditions, including degenerative spine disease. <u>Pneumonia</u> To assess the Facility's ability to manage cases of pneumonia, the Monitoring Team reviewed clinical records of the first three Individuals who sustained a case of pneumonia with in the reporting period (Individuals #318, #305, #255, #96, #461, #431). Of the six cases, an ISP meeting was conducted to address the individual's development of pneumonia in zero, out of six cases (0%). There was evidence to indicate that the Facility evaluated the need for a follow-up swallowing assessment, barium swallow study, or other diagnostic to help determine the etiology, or worsening etiology of the underlying cause of pneumonia, in zero out of zero cases (0%). There were follow-up x-rays, or other diagnostics to determine resolution of pneumonia in three out of six cases (50%). There was a well defined, and delineated clinical action plan to address	

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		pneumonia, and the underlying cause of pneumonia in zero out of six cases (0%). Examples of issues in which more aggressive action related to pneumonia or risks for pneumonia was needed, or more comprehensive and accurate documentation should have been provided, included the following: • Despite multiple cases of recurrent aspiration pneumonia diagnosed in Individual #318, there was no formal diagnosis of recurrent aspiration pneumonia list as a diagnosis on the annual medical summary, and there was no specific medical plan delineated for recurrent pneumonia. • Individual #305 has a history of recurrent pneumonia, and multiple medical conditions that predispose to pneumonia. These issues are not defined on the annual medical summary, and there was no specific plan outlining action steps to help mitigate recurrent pneumonias from developing. On 11/29/12, the Individual was referred to a pulmonologist for follow-up for recurrent pneumonia, but was not seen until 3/6/13, and at that time the pulmonologist recommended specialized procedures, including tracheostomy, and fundoplication. This delay in assessment by the specialist is unacceptable in this Individual. • Individual #255 underwent a swallow study on 3/21/13, which recommended "ground" diet texture, however, at the time of this review, the Individual was on a "chopped" texture. The Monitoring Team was provided a list of all Individuals who experienced a case of pneumonia, and their diet, and this Individual was reported to be on a chopped diet. Also, review of the clinical record demonstrated inconsistent documentation of the Individual's diet texture. • Individual #461, was provided a PEG tube, and was noted to have a diagnosis of dysphagia, per PT assessment, however, the annual medical summary did not include dysphagia as a diagnosis, nor was there a medical plan in place for dysphagia. Summary: Based on review of the clinical records, the Monitoring Team continues to have concern over the assertiveness of addressing cases of pneumonia, recurrent pneumonia, and Individuals at risk for pneumonia.; The Facility must immediately improve on its overall medical management of pneumonia, and the underlying cause of pneumonia. All individuals diagnosed with pneumonia must be assertively assessed as to the cause of their pneumonia, be provided all necessary consultation, promptly, and be monitored closely through full resolution of active pneumonia. The IDT should assertively follow-up on all cases of pneumonia. <u>Malignancy</u>	

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		The clinical records of all individuals with reported history of malignancy were reviewed (Individuals #444, #89, #481, #415, #567). Of the five cases, five out of five (100%) demonstrated efficacious follow-up for history of malignancy by the medical practitioner. Five out of five cases (100%) noted clinically appropriate follow-up with a medical specialist for history of malignancy. Five out of five cases (100%) noted clinically appropriate diagnostic follow-up for malignancy. Five out of five cases (100%) indicated diagnosis of malignancy on the annual medical summary. Four out of five cases (80%) delineated a specific clinical objective for malignancy on the annual medical summary. However, only one out of five cases (20%) documented a comprehensive overview of the malignancy diagnosis, how the diagnosis impacts the individual, and all necessary supports and services required for the on-going management of history of malignancy. Summary For all cases reported, the medical practitioner provided excellent, on-going follow-up for the diagnosis of malignancy, and ensured that clinically relevant consultations and diagnosis were provided to the individuals. The ISPs did not include specific comments on the diagnosis of malignancy, potential on-going risk, and all necessary supports required for the management of malignancy. The Facility should enhance documentation of follow-up of malignancy cases, and ensure that associated risk and all necessary supports and services are well delineated within the context of the ISP. <u>Acute Medical Follow-up</u> To assess the Facility's ability to manage acute medical conditions, the Monitoring Team requested all clinical practitioner's notes, associated consultation reports, and diagnostic results, following a specific acute medical condition. The sample selection was determined by the Monitoring Team, based on the acuity of the clinical issue, from a list of all acute medical conditions reported during the previous six months. A total of eight individuals were assessed (Individuals #489, #106, #75, #318, #392, #160, #485, and #167) Out of the eight cases, eight out of eight (100%) included a detailed initial assessment of the acute medical condition. Four out of eight cases (50%) included documented evidence to support follow-up by the medical practitioner, through resolution of the acute medical condition. Of the five cases that were determined by the Monitoring Team to require diagnostic evaluation, five out of five (100%) were provided diagnostic evaluation. Of the three cases that the Monitoring Team determined that a medical consultation was required, three out of three (100%) were referred for consultation. The Monitoring Team was concerned over the significant delay in arranging for an	

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		external medical consultation for Individual #485. In this case, A GI consultation was ordered on 11/1/12, and there was no evidence to support that this consultation had been obtained, by the time of this review. Summary: By review of eight cases of acute medical conditions, the Facility demonstrated excellent initial triage, and appropriate use of diagnostics, and referral to specialists, when clinically indicated. The Facility should also enhance its follow-up of acute medical conditions through full resolution of the condition. <u>Do Not Resuscitate Orders</u> The Monitoring Team assessed the Facility's management of evaluating, initiating, and follow-up on Do Not Resuscitate Orders (DNR). The Facility was asked to provide a list of all individuals with a DNR order, and the clinical rationale for the DNR. In addition, during an interview with the medical director, the Monitoring Team was informed that the Facility did not have a formal process in place to review the need, and determine continued need, for DNR orders, and that a formal ethics review process had not yet been established. Both of these issues were reported to be in development. It was reported that the Facility had 17 active DNR orders. Of the 17 individuals with a DNR order, a specific, qualifying condition was clearly delineated in 4 out of the 17 cases (24%); in the 17 cases, a specific category of DNR, such as full DNR, no compression only, no intubation, and no chemical resuscitation, was indicated in zero out of 17 cases (0%). Summary: The Facility must address its management of DNR status by developing a formal policy, procedure, and review committee to address all initial and continued prescribing of DNR status. There must be a qualifying condition, such as an identified terminal disease process, or a functional impairment that would result in resuscitation efforts to cause significant harm to the individual and the risk of resuscitation efforts would outweigh potential benefits. Also, the DNR process should include specific type of DNR; for example, a DNR could be for no compression only, no intubation only, no chemical resuscitation, or a combination, including full DNR status. <u>Immunization</u> To assess the Facility's process for immunization, the Monitoring Team discussed current process with the medical director, reviewed the Facility's draft policy titled Medical Services / Infection Control: Individual Infection Control Program 4.1.6 (no date), and reviewed the immunization records for the first ten individuals on the Facility's roster. The Facility's draft policy that addresses the immunization practice at the Facility does	

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		not reflect recommended guidelines per the CDC. For example, there was no guidance or reference as to what vaccination are required, specific documentation practice on how to document vaccinations, and specific criteria on determining immunization status. Of the ten immunization records: • Five out of ten cases (50%) indicated that the individual was current with a combination of tetanus and diphtheria. • Eight out of ten (80%) were current with influenza vaccine. • Zero out of ten (0%)were documented in accordance with CDC guidelines, specific to documentation of vaccinations, and immunization status. The Facility must ensure that it adheres to CDC guidelines with regards to documenting immunization status, vaccination history, and maintaining vaccination records. The CDC is very clear on these issues. Also, the Facility must develop an efficient mechanism to ensure that it is able to identify the immunization status of individuals served, for tracking and trending purposes. This information is especially important in times of outbreaks of communicable disease.	
L2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall establish and maintain a medical review system that consists of non-Facility physician case review and assistance to facilitate the quality of medical care and performance improvement.	To assess 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 Facility's progress with the current medical director, reviewed the external medical provider quality assurance audits, and reviewed the Facility's mortality review process. <u>External Medical Provider Quality Assurance Audits</u> The Facility had one external medical provider quality assurance audit during the reporting period, which occurred November 6, 2012. A total of five medical clinicians were assessed by a chart audit conducted by external physicians. Audits were conducted on the five medical clinicians who were practicing at the Facility during November 2012. Of the five medical clinicians, five out of five (100%) attained a compliance score of 80% or greater, which is a facility designated passing score, for non-essential elements, and one out of five (20%) attained a facility designated passing score of 100%. There were a total of three medical management elements evaluated during this audit period: constipation, seizures, and UTI. Only four of the five medical practitioners were evaluated for medical management elements, and of the four practitioners, zero out of four (0%) attained a facility designated passing score of 100%. There were 45 issues identified as noncompliant, and physicians were to review, and remediate all 45 deficiencies. At the time of this review, 39 remediation actions (87%) had been completed. The medical director informed the Monitoring Team that the results of the audits are discussed with each medical practitioner; however, there was no formal	Noncompliance

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		process to incorporate the audit process into the medical clinician's annual assessment, and there was no established accountability for persistent lower then acceptable performance. Summary: The audit process has continued to improve, by the addition of the addition of medical management elements. The Monitoring Team recommends that the medical management elements be developed for all common, and serious medical conditions that occur in Individuals with intellectual disabilities. Also, the Facility should develop a formal process to incorporate results of the medical audits into the medical provider's performance review, and ensure that all remediation actions are completed timely. <u>Mortality Review</u> The Monitoring Team met with Medical Director, Chief Executive Nurse, Quality Assurance Nurse, and Quality Assurance Director to review and discuss the Facility's Death Review policies and processes, as well as death information provided for review. The meeting was observed by 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 nursing recommendations resulting from the URIs and Quality Improvement Death Review of Nursing Services. Unfortunately, although the nursing recommendations resulting from these reviews were relevant, they were not included as recommendations in the Clinical and/or Administrative Death Review Committee Reports. Few medical recommendations were included in the Clinical and/or Administrative Death Review Committee Reports. Neither were recommendations found for other relevant disciplines, such as Physical and Nutritional Management Services. It was of significant concern to find that the few medical recommendations were not tracked either by the Quality Assurance Nurse or Medical Director. This concern was discussed with the Quality Assurance Director, who stated often the recommendations were not stated in terms that could be measured and tracked. He agreed to follow up with the relevant disciplines to assist them in stating recommendations in terms that are measurable, so that the data can be tracked, analyzed, and trended over time in order to make systemic improvements in the death review process. The Monitoring Team will follow-up on this issue at the next compliance review. The quality and relevance of recommendations made by all relevant disciplines are reported later in this report. Since the compliance review, July 23-27, 2012, seven deaths had occurred at the Facility. The Monitoring Team's findings included:	

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		• Of the seven deaths, the average age was 62.9 years (ages varied from 12 to 77years of age). Four of seven (57%) 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 were potentially preventable. • For six of seven (86%), Department of State Health Services – Vital Statistics Unit, Death Certificates were completed and available for review. The cause of individuals' deaths on the Death Certificates are listed in the chart below: 1. Immediate cause of death: Pneumonia Underlying cause of death: Hypocalcemia 2. Immediate cause of death: Dementia Significant condition contributing to death: Chronic Obstructive Lung Disease 3. Immediate cause of death: Hypoxia Underlying causes of death: Cardiorespiratory Arrest and Chronic Bronchitis 4. Immediate cause of death: Cardiopulmonary Arrest Underlying causes of death: Chronic Lung Disease/Pulmonary Fibrosis, Recurrent Aspiration Pneumonia, and Peg Tube Status Significant conditions contributing to death: Cerebral Palsy, Renal Failure, and Hypoalbunimenia 5. Immediate cause of death: Complications of Cerebral Palsy Associated with Prematurity 6. Immediate cause of death: Laparoscopic Colorectal Resection for Rectal Prolapse Condition leading to the cause of death: Acute Respiratory Distress Syndrome (ARDS), Adrenal Insufficiency, and Perforated Sigmoid Diverticuli and Peritonitis Significant conditions contributing to death: ARDS 7. No Certificate of Death yet completed due to recent death: Probable cause of death: Chronic Lymphocytic Leukemia • 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 The Quality Assurance Nurse continued to maintain: ▪ A Death Review tracking Sheet for each death indicating when the various timelines were due and completed for required components of the death review policies. ▪ 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. ▪ Tracking of Nursing Recommendations Sheet for nursing	

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		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. All recommendations for each death of six deaths were relevant to the findings found in the various death reports reviewed and were carried out through to resolution. There had not yet been time to complete recommendations for one a recent death (4/4/13). o The Facility did not have a tracking system in place to track medical, administrative, and/or other relevant disciplines' recommendations identified in the Clinical and/or Administrative Death Reviews. As noted in the above report, recommendations identified by the Quality Assurance Nurse for nursing were not included in the Clinical Death Review Committee Reports, although they were relevant to the findings in the URI and Quality Improvement Death Review of Nursing Services Reports. o Four of seven (57%) decedents were enterally nourished. o Four of seven (57%) decedents had Medical Histories/Chronic Diagnoses of Aspiration and/or Dysphagia. o Four of the seven (57%) deaths occurred in the hospital. o Three of seven (43%) deaths occurred at the Facility under hospice care. o Seven of seven (100%) decedents had Do Not Resuscitate (DNR) orders prior to illness/incident. o Six of seven (100%) decedents had DNR orders at the time of death. o One of seven (29%) decedents had an autopsy performed. The Autopsy results were pending. o Six of seven (86%) deaths had Unusual Incident Reports completed. One Unusual Incident Report was pending due to a recent death (4/4/13). o Seven of seven (100%) deaths had Quality Improvement Death Review of Nursing Services Reports completed by the Quality Assurance Nurse within five working days, per policy. o Seven of seven (100%) deaths were determined not unusual. According to the Quality Improvement Death Review of Nursing Services Report, the manner of one death remains under investigation pending the Autopsy Report. However, the UIR Report documented the death was not unusual. The URI Report should be amended when the manner of death is determined in order to the ensure accuracy of the report. o Clinical Death Review Committee Meetings were conducted within 14 working days of the deaths, except when an autopsy was performed, and then reviews are due within 45 calendar days. Two of six (33%) deaths due for reviews were not completed. Four of six (67%) deaths reviews were completed after due dates. One of the seven deaths occurred on 4/4/13 was	

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		not due until 4/24/13. o In four of four (100%) Clinical Death Reviews Committee Meetings completed, an external physician participated. o Administrative Death Review Committee Meetings were conducted within the required 21 calendar days after receipt of the minutes from the Clinical Death Reviews, except when an autopsy is performed, and then reviews are due within 52 calendar days. One of four (25%) deaths due for review was completed on time. Three of four (75%) deaths due for review were completed after the due date. o Zero of four (0%) deaths reviewed by Administrative Death Reviews 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. It is important to note that another death occurred on 4/10/13 during the onsite compliance review and is not included in this report since the required reviews were not completed. The Monitoring Team will review the outcome of the death review reports and recommendations at the next compliance review. 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 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 is 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	

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		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 an onsite discussion with the State Office Nursing Coordinator, she related that the State was still 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, and that all deaths are tracked and trended, as part of regular system review of deaths at the Facility. Summary 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;	To assess compliance for Provision L3, the Monitoring Team discussed the Facility's action steps with the medical director, reviewed the most recent internal medical provider quality assurance audit, and reviewed the Facility's newly developed algorithms for clinical indicators. The Facility had made significant improvement with Provision L.3, of the SA. In addition to completing round six, of the internal medical provider quality assurance audit, in November, 2012, the Facility is in the process of developing clinical data tracking sheets,	Noncompliance

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	initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	that will enable meaningful medical quality assurance process to be developed. At the time of this review, the Facility had developed data tracking sheets for osteoporosis, diabetes, seizure disorder, hypertension, lipid disorders, and constipation. This process had yet to be implemented. Furthermore, the Facility had incorporated medical management elements into the internal medical provider quality assurance audit process. <u>Internal Medical Provider Quality Assurance Audits</u> One of the five medical practitioners (20%) was reported to had gained 100%, which was the Facility's determined score for compliance of essential compliance elements; and four out of five medical practitioners (80%) were reported to have achieved a Facility determined passing score of 80% or greater for non-essential compliance issues. The Monitoring Team was not provided with specific data regarding physician compliance with medical management elements. Summary: As with the external medical provider quality assurance audits, the Facility should develop medical management elements for all common and serious medical conditions that occur in Individuals with intellectual disabilities. Also, the Facility should develop a formal process to incorporate results of the medical audits into the medical providers performance review, and ensure that all remediation actions are completed timely. <u>Medical Quality Assurance Process</u> The medical director reported that the Facility had not developed a medical quality assurance process, but is working diligently to develop a process. At the time of this review, the Facility developed data tracking sheets for osteoporosis, diabetes, seizure disorder, hypertension, lipid disorders, and constipation. The Facility continues to develop additional tracking sheets for all commonly occurring and serious medical conditions that occur in individuals with intellectual disabilities, and will be incorporated into a robust medical quality assurance process. The Monitoring Team reviewed the current draft versions of the data tracking sheets, and recommends that the tracking sheet for osteoporosis include a section to assess if the underlying etiology of low bone density was assessed. Summary: The Facility had made significant headway towards substantial compliance for Provision L.3, by developing clinical tracking forms, and by beginning the process to develop a robust medical quality assurance process. Compliance will require that medical quality indicators, such as the clinical tracking forms currently developed, be developed and implemented for common and serious medical conditions that occur in individuals with developmental disabilities, and by ensuring that clinical quality indicators are	

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		incorporated into a medical quality assurance process.	
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	The Monitoring Team discussed the Facility's policies, procedures, and guidelines, with the medical director, who informed the Monitoring Team that the State Central Office was developing a new policy for health care; however, at the time of this review, the draft policy was still being developed. Subsequently, the Facility has discontinued work on its previous policy, entitled Physician Procedures, and Best Practice Guidelines, and will incorporate the State Policy into a comprehensive local policy for health care, once the State Policy has been completed, and approved for implementation. The Facility reported that it had developed several procedural guidelines: • Procedural Guidelines for PCP on call (11/15/2012) • Procedural Guidelines for Psychiatrist on call (10/15/2013) • Procedural Guidelines for the Morning Medical Debriefing Meeting (10/15/2012) • Procedural Guidelines for Botox Injections, dated 8/3/12 Summary: The Monitoring Team recognized the benefit of the four newly developed clinical guidelines, and strongly encourages the Facility to further develop guidelines for all clinically relevant activities conducted by medical practitioners at the Facility. The Monitoring Team looks forward to reviewing implementation of the pending policy for health care, at the next SA on-site review.	Noncompliance

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

1. Implement a process that helps ensure continuing education in the area of developmental disabilities. The process does not need to be specific for developmental disabilities, but should include medical issues that are common to individuals with developmental disabilities, such as cerebral palsy, degenerative spine disease, musculoskeletal conditions, aspiration pneumonia, etc. (Provision L.1)
2. The Facility must enhance its ability to manage clinical database elements. For example, the Facility must be able to have efficient access to all clinical conditions, pending and provided consultations, and immunizations records. (Provision L.1)
3. The Facility must ensure adequate space to conduct physical examinations, that ensures privacy, appropriate lighting, and specialized examination tables that accommodate individuals with complex development disabilities. (Provision L.1)
4. The ISP process must be improved, so that clinical issues are well delineated, and include notation on how the condition affects the individual's life, and all necessary supports and services required to support the individual for the condition. (Provision L.1)
5. Develop a guideline or procedure on addressing osteoporosis, by ensuring a robust screening process of all individuals, guideline for treatment, and diagnostic evaluation to help determine underlying etiology of low bone density before initiating treatment. (Provision L.1)
6. As with all acute medical conditions, the medical practitioner should evaluate an individual following seizure activity. (Provision L.1)
7. Ensure that prompt consultation is recommended and obtained for all clinical issues that require external consultations. (Provision L.1)
8. Ensure that all clinical issues noted are delineated as a diagnosis, and that there is a comprehensive clinical action plan noted on the annual medical

assessment. (Provision L.1)

9. Immediately develop, and implement a clinical process to better address all neuromotor conditions, including degenerative spine disease, and cerebral palsy. (Provision L.1)
10. Immediately develop, and implement a clinical process that enables a robust follow-up, by the medical practitioner, of all cases of pneumonia; and ensures that all necessary diagnostics, PT/OT assessments, and external consultations are promptly provided to assess potential causes, and/or worsening conditions that predispose the individual for pneumonia; and that all necessary clinical action steps are developed, and implemented to reduce the incidence of pneumonia. (Provision L.1)
11. Medical Practitioners must follow-up on all acute medical conditions, though full resolution. (Provision L.1)
12. Immediately develop and implement a formal policy, procedure, and review committee to address all initial and continued prescribing of DNR status. There must be a qualifying condition, such as an identified terminal disease process, or a functional impairment that would result in resuscitation efforts to cause significant harm to the individual, and the risk of resuscitation efforts would out weight potential benefits. Also, the DNR process should include specific type of DNR, for example, a DNR could be for no compression only, no intubation only, no chemical resuscitation, or a combination, including full DNR status. (Provision L.1)
13. Enhance the immunization process by incorporating CDC guidelines on determining immunization status, documenting vaccinations, and maintaining immunization records. (Provision L.1)
14. Develop medical management elements for the most common and serious medical conditions that occur in individuals with intellectual disabilities, and ensure that a reasonable number are assessed, alternately, at each external and internal medical provider audits. (Provisions L.2 and L.3)
15. Ensure that all action plans for deficient medical provider audits are completed timely. (Provisions L.2 and L.3)
16. Develop a mechanism to incorporate results of the medical provider audits into the medical providers performance review. (Provisions L.2 and L.3)
17. Enhance the mortality review process by ensuring a comprehensive review of each death is completed, and robust action plans are developed for areas of deficiencies. (Provision L.2)
18. Ensure that the Facility tracks and trends all deaths, on a regular basis. (Provision L.2)
19. As part of medical quality assurance to evaluate system issues related to medical services, develop and implement a medical quality assurance process that tracks, and trends common, and serious medical conditions that occur in individuals with intellectual disabilities. (Provision L.3)
20. Following approval of the DADS draft policy for health care, the Facility should incorporate it, and further develop local policies, procedures, and clinical guidelines, to address health care issues, and practice standards at the Facility. Policies, procedures, and guidelines must reflect current standard of care practice, and be fully implemented at the Facility. (Provision L.4)

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, updated: 3/6/13 2. BSSLC Section M Action Plan, updated: 3/7/13 3. BSSLC Section M Presentation Book 4. Texas Department of Aging and Disability Services, State Supported Living Center Policy: Most Integrated Setting Practices, Policy Number: 018.1, Date: 3/31/10 5. BSSLC: Nursing Care: Completing/Routing Fall Evaluation Form, Date: 12/20/12 6. BSSLC Medical Services/Infection Control: Reporting of Infections and Communicable Diseases Policy, adopted from ICR-MR Interpretive Guideline, State Regulations/Texas Department of Health Services. Standard ICP Practice, no date 7. BSSLC Nursing Department Organizational Chart 8. BSSLC Nursing Department Staffing Analysis Report, 7/1/12 to 2/28/13 9. BSSLC Nursing Ratios-Direct Care Nursing Schedule, as of 2/20/13 10. BSSLC Minimum Staffing Report, 7/1/12 to 2/28/13 11. BSSLC Professional Staff by Individual, 2/13/13 12. BSSLC Summary of Contact Nurses Hours, 7/1/12 to 2/28/13 13. BSSLC Summary of Nursing Staff Overtime, 7/1/12 to 2/28/13 14. BSSLC Nurse Case Managers Meetings, 4/9/13- 4/11/13 15. BSSLC Nursing Meeting Minutes, July 2012-February 2013 16. BSSLC Nurse Managers Duties 17. BSSLC Infection Control Committee Meetings. 7/31/12, 11/30/12, and 2/28/13 18. BSSLC Infection Control Wheelchair Cleaning Procedures, Implemented: 8/2/12 19. BSSLC Antibiogram, 6/1/12- 2/28/13 20. BSSLC Infection Control Prevention and Practices Workbook, no date 21. BSSLC Immunization Record Database, Printed: 3/5/13 22. BSSLC Staff Tuberculosis (TB) Screening Compliance Report, 3/7/13 23. BSSLC Staff Annual Flu Compliance Report, no date 24. BSSLC Staff Hepatitis B Vaccination Status Report, 3/4/13 25. BSSLC Infection Control Monitoring Tools Instructions for Handwashing and Environmental Rounds 26. BSSLC List of Monitoring Tools for Medication Administration 27. BSSLC Medication Administration Monitoring Tool Summary/Analysis, June 2012-November 2012 28. BSSLC Medication Variance Data by Individual 29. BSSLC Ten most recent Medication Variance Reports 30. BSSLC Pharmacy and Therapeutics Committee Meeting,7/26/12, 10/25/12, 1/31/13, and 4/11/13 31. Infection Control Rounds Summary Reports, June 2012-February 2013 32. BSSLC Employee Infections Report, 3/4/13 33. BSSLC Nursing Audit Workgroup Meeting Minutes, 10/11/12 34. Medication Variance Committee Meeting Minutes, with supporting data, 6/26/12, 7/24/12,8/21/12, 9/25/12, 10/30/12, 11/27/12, 12/18/12, 1/29/13, 2/26/13, and 3/26/13 35. BSSLC Medication Variance Database and Supporting Data, June 2012-February 2013

	36. BSSLC Meetings Regarding Program Compliance, October 2012-November 2012 37. BSSLC Emergency Medical Checklist Summary, July 2012-January 2013 38. BSSLC Mock Medical Emergency Drill Instructors 39. BSSLC List of Location of Automated External Defibrillators (AEDs) 40. BSSLC Mock Emergency Medical Drill Summaries, July 2012-February 2013 41. BSSLC Emergency Drill Monthly Schedule, Completed Checklists, and supporting data, July 2012-February 2013 42. BSSLC Cardiopulmonary Resuscitation (CPR) Training Record for Heartsaver CPR Adult and Child AED Course, Revised: 12/4/12 43. BSSLC Course Due/Delinquent Report for Basic Life Support for Health Care Providers and CPR Basic, Printed: 3/6/13 44. BSSLC CPR/Emergency Response Committee Membership 45. BSSLC CPR/Emergency Response Committee Meeting Minutes, 7/26/12, 8/20/12, 10/2/12, 11/30/12, and 12/27/12 46. BSSLC Nursing Education Department Update, July 2012-April 2013 47. Review of Records for Active Skin Integrity Issues on Individuals: #96, #318, #566, and #481 48. Review of Records for Active Infections on Individuals: #165, #554, #413, #159, #133, #31, #154, #449, #19, and #96 49. Review of Records for Recently/Currently Hospitalized Individuals: #249, #15, #286, #284, and #422 50. Review of Records of Recently Admitted Individuals: #346, #402, #546, #239, #388, #243, and #148 51. Review of Records for Recently Community Living Placement Discharged Individuals: #467, #511, #264, #547, #434, #442, #20, and #181 52. Review of ten of the most recently completed Medication Variance Reports for Individuals: #160, #363, #13, #111, #460, #276, and #67 53. Comprehensive Review of Records for Individuals: #59, #599, #411, #305, #330, #445, #195, #141, #35, #554, #184, #154, #167, #25, #392, #395, #453, #331, #43, #318, #474, #284, #185, #11, and #206 **People Interviewed:** 1. Valarie Kipfer, RN, MSN, State Office Nursing Coordinator 2. Debra Williams, RN, Chief Nurse Executive (CNE) 3. Sara Colvin, RN, Nursing Operations Officer (NOO) 4. Joy Sorensen, RN, RN Case Manager Supervisor 5. Jill Quimby, RN, Quality Assurance (QA) Nurse 6. Daniel Dickson, QA Director 7. Johanna Schroeder, RN, Program Compliance/Nurse Educator 8. Joanne Guard, RN, Infection Control Nurse 9. Kellie Fitch, RN, Hospital Liaison Nurse 10. Nancy Witt, RN, RN Shift Manager, Assistant Nurse Educator 11. Leona Sian, RN, RN Shift Manager/Durable Medical Equipment Nurse 12. Johnnie Johnson, RN, Nurse Manager, Childress Terrance 13. Stephanie Hintzel, RN, Nurse Manager, Driscoll Gardens 14. Jane Barnett, RN, Nurse Manager, Bowie Springs

	15. Tammy Pavlu, RN, Nurse Manager Cottages Estates 16. Susan Fletcher, Lead RN Case Manager, Fannin Villa 17. Numerous Staff Nurses 18. Trey Knittel, PharmD, RPh, Clinical Pharmacist 19. Robin Blankenburg, RPh, Director of Pharmacy 20. Mary Anne Brett, M.D., Medical Director **Meeting Attended/Observations:** 1. Meeting with Nursing Leadership to review Presentation Book, 4/8/13 2. Medication Room and Medication Administration Record Notebook observations/inspections in Bowie A, Driscoll D, Childress B, Cottage B, and Fannin C, 4/8/13 3. Morning Medical Meeting, 4/9/13 4. Medication Administration Observations in Driscoll D at 4:00 p.m. Pass, 4/9/13 5. IDT Meeting Regarding ISP for Individual #599 6. Meeting to review Nursing QA Monitoring Status with Key Staff, 4/10/13 7. Meeting to Review Medication Variance with Key Staff, 4/10/13 8. Meeting to Review Death Reviews and Processes, 4/10/13 9. Medication Administration Observations in Fannin B at 4:00 p.m. Pass, 4/10/13 10. IDTA/Post Hospital Meeting for Individual, #284 11. CPR Committee Meeting, 4/11/13 12. Pharmacy and Therapeutics Committee Meeting, 4/11/13
	Facility Self-Assessment: For Section M, in conducting its self-assessment, the Facility: ▪ Used the statewide Facility Self-Assessment Monitoring Tools. The monitoring/audit tools the Facility used to conduct its self-assessment included: Twelve Nursing Care Monitoring Tools, Facility Self-Assessment Monitoring Tools for Medication Room and Medication Administration audits, and statewide Medication Administration Observation Tool. ▪ These monitoring/audit tools included sufficient indicators to allow the Facility to determine compliance with the Settlement Agreement. ▪ The monitoring tools included sufficient methodologies, such as observations, interviews, record reviews to determine status of compliance with the respective monitoring processes. ▪ The Self-Assessment did not identify the sample(s) sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall. The sample sizes were adequate to consider them representative samples. The number for percent of sample size of individuals/records as compared to the overall population was not included in the Self-Assessment. The percentage of compliance for each data item monitored on the various monitoring and/or observation tools was provided by months, quarters, and overall percentage of compliance. Although this information was not provided, the Facility had a formalized procedure for conducting monitoring and/or observing each tool. ▪ The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. The following staff/positions were responsible for completing the audit tools: The Chief Nurse Executive, Nursing Operations Officer, RN Nurse Case Manager Supervisor,

	Specialty Nurses, Nurse Managers, and Quality Assurance Nurse. ▪ The staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and were programmatically competent in the relevant area(s). ▪ Sufficient inter-rater reliability process had been established between the various Facility staff responsible for the completion of the tools. ▪ The Facility used other relevant data sources and/or key indicators and/or outcome measures. For example, these included databases that showed the percentage of compliance with assessments, percent of nurses who had completed training classes, and number of pressure ulcers. ▪ The Facility consistently presented data in a meaningful and useful way. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators. The data provided an indication of the areas of strength, weakness, or the status of progress? The indicators clearly identified what was being measured or the criteria used for measurement? o Consistently measured the quality as well as presence of items. o Distinguished data collected by the QA Department versus the Nursing Department. The Facility's Self-Assessment stated they were not in compliance with Provisions M.1, M.3 and M.5 and were in substantial compliance with Provisions M.2, M.4, and M.6; the Monitoring Team concurs with their findings.
	Summary of Monitor's Assessment: Based on the Monitoring Team's review of Provisions M.1, M.3 and M.3, progress was found toward compliance with the Settlement Agreement, although compliance had not yet been achieved. Provision M.1 had made the most significant progress, with most all of the various areas close to compliance as found in the following areas: The Nursing Department continued to maintain a stable and motivated staff, established staffing ratios continued to be met on all shifts. Significant progress was also made in the Quality Assurance Efforts, Documentation and Assessment of Acute Changes in Health Status, Hospital Liaison Activities, Infection Control Activities, and Skin Integrity Activities, as demonstrated in the report below. Although progress was made in these areas some continuing improvements were needed to meet compliance, as noted in the recommendations below. The Facility continued to maintain a robust Emergency Response System that went beyond the basic requirements of Emergency Response Policy. The Facility continued to refine and implement the Integrated Risk Rating Form and Integrated Health Care Plan Process but these processes had not fully matured to demonstrate compliance. Compliance with Provisions M.3 and M.5 will depend on the progress made toward compliance with the Integrated Risk Rating Form and Integrated Health Care Plan processes. Based on the Monitoring Team's review of Provisions M.2, M.4, and M.6 significant progress had been made in all of these provisions that led to substantial compliance ratings, as demonstrated in the report below. <u>Provision M.1:</u> This Provision contains multiple sections, many of which were found to have made significant progress since the last compliance visit. More than one of the sections would be very close to

	achieving substantial compliance if they were standalone items. The section for Assessment and Documentation of Individuals with Acute Changes in Status will require the most improvement because it relates to acute changes in status that are addressed through nursing care provided consistent with the 25 nursing protocols sufficient to meet the individuals health care needs. Five of the latest nursing protocols were too recently implemented to show compliance. In addition the Nursing Department was just beginning to monitor the protocols. At the time of the review, no audit data had yet been available for review. The Monitoring Team will continue to monitor nursing care provided to individuals who have acute changes in health care status in relation to the effectiveness of nursing protocols. The other sections in this Provision are close to achieving substantial compliance with minor improvements. Provision M.2: The Nursing Department had made significant improvement in the comprehensives and accuracy of the Annual/Quarterly Comprehensive Nursing Assessment. All (100%) of the RN Case Managers had completed the state mandated Physical Assessment Class and were continuing to review assigned chapters from the Mosby Physical Assessment. The Monitoring Team's review of 25 most recently completed Annual and/or Quarterly Comprehensive Nursing Assessment audited against the statewide Nursing Care Annual and/or Quarterly Nursing Assessment Monitoring Tool found an overall percentage rate of 94%, which was consistent with the Facility's Self-Assessment findings. Provision M.3: The Facility continued implementing and refining the Integrated Risk Rating Form and Integrated Health Care Plan Processes. Individuals' health care plans, in relation to identified risk ratings and problems, varied in the format used for the plans, i.e., some plans were documented on Health Maintenance Plans (HMPs), some on the IHCP, and for some health care plans both were used. Therefore, it was not possible to accurately determine which health care plan was actually followed or the status of compliance with any given health care plan. The Acute Care Plans were still used and were continuing to individualize and incorporate the relevant nursing protocols and primary care providers' orders that required ongoing nursing intervention into the plans. However, there was a continued need for improvement. The Nursing Discharge Summaries and plans of care need continued improvement. There needs to be guidelines developed to define the RN Case Managers' role and responsibilities for developing individuals' plans of care for transition into community living. Provision M.4: The Nursing Department continued to maintain a comprehensive system for conducting and tracking competency-based nursing education for New Nurse Orientation, annual refresher training, as well as other required ongoing training. The Nurse Training Tracking Database used identified the status of each nurses' training and, for nurses who had not yet completed the required training, projected dates for completion. The database also tracked the overall percentage of nurses trained on each required topic, and, for training not completed, a projected date for completion. All nurses had been trained on the 25 nursing protocols. Protocols were fully implemented and were incorporated into relevant health care plans. The Nursing Department was in the process of implement Nursing Protocol Audits, which had not yet produced data to evaluate their effectiveness. Provision M.5: As was found with Provision M.3, the Facility continued implementing and refining the Integrated Risk Rating Form and Integrated Health Care Plan Processes. Much of the compliance with this

	Provision is contingent on the Facility's compliance with these processes. As all IDTs implement and refine these processes, the Monitoring Team will continue to monitor compliance with the Settlement Agreement. Provision M.6: The Facility demonstrated substantial compliance with this Provision. The Facility had operationalized the State's Medication Variance Policy, 053, i.e., Pharmacy Services and Safe Medication Practices: Medication Variances, N.12. There was documented evidence that 98% of nursing staff responsible for medication administration practices were trained on the policy. All Unit/Cottages were inspected using the standardized Supported Living Center Medication Room and Medication Administration Record Audit Tool. The outcome of the audit found that the Units substantially complied with requirements. Medication Administration Observations were found in compliance with following the individuals' PNMPs and standards of safe administration practices. Medication Administration for Individuals with Developmental Disabilities with dysphagia and/or swallowing difficulties was taught jointly by the Nurse Educator and Habilitation staff. At the time of the compliance visit, 94% of the nursing staff responsible for administering medication had been trained with a projected completion date of June 2013. 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 critical decisions regarding medication variances and developed local and systemic plans of correction, as indicated.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify	Monitoring Team Findings The Monitoring Team validated the information presented in the Facility's Self-Assessment through: Review of the information presented in Section M.1's Presentation Book; Review of documents requested; Meetings/interviews with Chief Nurse Executive, Nursing Operations Officer, Nurse Educator/Program Compliance Nurse, QA Nurse, Hospital Liaison Nurse, RN Case Manager Supervisor, and Nurse Managers; Review of individuals' records; and Observations. Relevant Self-Assessment data were updated during the onsite compliance visit. The Facility's Self-Assessment stated they were not in substantial compliance with Provision M.1 and the Monitoring Team concurs with their findings. This Provision of the Settlement Agreement requires the Facility to address various areas of compliance in order to meet requirements of the provision. These requirements include: staffing, quality assurance efforts, assessment and documentation of individuals with acute changes in status, availability of pertinent medical records, infection control, and mock medical drills and emergency response system. Additional information regarding the nursing assessment, development, and implementation of health care plans is found below in Provisions M.2 and M.3 reports. Information and recommendations regarding nursing documentation on restraint usage is included above in Provision C.5 of the report. Information and recommendations regarding nursing documentation for the death review process is reported above in Provision L.2.	Noncompliance

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	changes in status.	<u>Staffing:</u> • At the time of the review, the Facility census was 293. There were a total of 118.5 budgeted nursing positions, which remained unchanged from the last compliance. At the time of the visit there were 65 RN positions and 47 LVN positions filled. • The Nursing Department continued to maintain a stable and highly dedicated and motivated staff. Since the last compliance review, the Nursing Department had added another Infection Control Nurse. The Nurse Educator had taken a new position as the Program Compliance Nurse. Another Nurse Educator was hired with the effective date of employment, 4/16/13. This nurse was also a certified wound care specialist, who will assist the Skin Integrity Nurse to manage wound care and pressure ulcers. • As found in previous compliance reviews, the Nursing Department's Administrative and Management staff continued to have an excellent and effective method of monitoring and analyzing staffing patterns daily on each unit/cottage, and shifts. For the past eight months the established staffing ratios were met for all units/cottages and all shifts. • The current turnover rate reported for all nursing was 25.3% (unit nurses 24.30% and professional staff 0.9%) based on an eight month average. The reasons for nurses leaving were to be closer to home, to return to school, or were terminated. Because of the lack of availability of LVNs in the area, those positions were difficult to fill. The availability of RNs in the area was greater. The CNE stated there was some consideration to convert some of the LVN positions to RN positions because those positions would be easier to fill. Converting to RNs will also allow the Nursing Department greater flexibility in the activities that the nurses can carry out. • 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 number of nursing staff. • A detailed list of the Nurse Managers Duties was developed and explained responsibilities for meeting substantial compliance with Section M Provisions. <u>Quality Assurance Efforts:</u> Since the last compliance review, there was a continued effort to make improvements in the monitoring procedures, which included: • A Program Compliance Nurse was hired to assist the CNE with all aspects of the Settlement Agreement and subsequent recommendations. • On 10/11/12, the Audit Workgroup began meeting with the frequency needed to address all aspects of Section M, Settlement Agreement requirements for compliance. The membership of the Audit Workgroup included the Program Compliance Nurse, CNE, NOO, QA Nurse, Nurse Educator, and RN Case Manager Supervisor. Issues discussed with disposition included revision of the	

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Nursing Care Monitoring Tools, and action plans needed for all Section M Provisions to move forward toward compliance with the Settlement Agreement. It was evident from the Monitoring Team's review of Section M, that the efforts put forth by the Audit Workgroup and moved the Nursing Department forward toward compliance with all Section M Provisions of the Settlement Agreement.

A State Supported Living Center (SSLC) Nursing QA Audit Process was developed, which was a collaborative effort with the Quality Assurance Department and the Nursing Department in order to standardize the process statewide. This new process began in January 2013. The process was further explained in a meeting with the Facility QA Director, CNE, NOO, Program Compliance Nurse, QA Nurse, and Shift Manager.
In January 2013, there was a statewide reduction of 12 Nursing Monitoring Tools and Instructions to six. This was done to provide facilities with more accurate and consistent data for analysis and trending: SOAP Format Documentation; Urgent Care/ER/Hospitalizations; Infection Control; Acute Illness and Injury; Annual (Quarterly) Nursing Assessment; and Care Plans.
Since the Nursing Monitoring Tools were reduced and revised, longitudinal data was not yet available. There were data available for March 2013 that showed:

<table>
<tr><th>Nursing Care Monitoring Tools</th><th>Nursing Percentage</th><th>QA inter-rater Percentage of Agreement</th></tr>
<tr><td>Acute Illness and Injury</td><td>86%</td><td>74%</td></tr>
<tr><td>Urgent Care, ER, Hospitalization</td><td>83%</td><td>88%</td></tr>
<tr><td>Annual Nursing Assessments</td><td>95%</td><td>92%</td></tr>
<tr><td>Infection Control</td><td>87%</td><td>84%</td></tr>
<tr><td>Seizure Management</td><td>85%</td><td>73%</td></tr>
<tr><td>Urinary Tract Infections</td><td>33%</td><td>82%</td></tr>
<tr><td>SOAP Documentation</td><td>95%</td><td>73%</td></tr>
<tr><td>Averages</td><td>81%</td><td>N/A</td></tr>
</table>
The new QA process described above appears promising. Although an overall percentage was derived, it should not be used as a true measurement of overall compliance, since it was noted above that the percentage for Urinary tract Infections fell far below 80%. Instead, each health condition should be considered separately. The Monitoring Team will review progress made toward compliance with the new process at the next compliance visit.

The statewide Nursing Workgroup was in the process of developing Protocol Card Audit Tools. To date, five audit tools have been developed. The BSSLC Nursing Department was in the process of implementing the tools. They selected four of the five Protocol Audit Tools to start with, which were for: Respiratory Distress/Aspiration; Seizures; Urinary Tract Infection; and Pre-Treatment/Post-Sedation. Since monitoring of the Protocol Card Audit Tools had only recently begun, there was no reportable data yet available for review. The Protocol Card Audit Tools criteria measured all of the required information contained on each protocol card monitored and should be effective in determining adherence to the protocols. The Monitoring Team will review

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		the status of training/implementation on the new protocol, as well as outcome data derived from the Protocol Card Audits at the next compliance review. Refer to Provision M.6 regarding information for Self-Audits on Medication Administration Records, Medicine Room Checklists, and Medication Administration Observations. <u>Availability of Pertinent Records:</u> The Monitoring Team completed a comprehensive record review for Individuals: #59, #599, #411, #305, #330, #445, #195, #141, #35, #554, #184, #154, #167, #25, #392, #395, #453, #331, #43, #318, #474, #284, #185, #11, and #206 and found: • There was no difficulty in accessing the records at this compliance review, with the exception of the missing February 2013, Aspiration Trigger Data Sheets for Individual #167. • The problems found, as reported in previous reviews, were the illegibility of the individuals' names and demographic information printed on the records by the use of an addressograph card/machine. • Documentation errors were not consistently corrected according to standards of practice. • The times of the entries were occasionally missing on the Integrated Progress Notes. • The nursing staff occasionally failed use the military time on the entries of the Integrated Progress Notes, as required by the Nursing Services Policy. <u>Assessment and Documentation of Individuals with Acute Changes in Status:</u> Since the last compliance review, the Nursing Department continued to demonstrate 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. This was best demonstrated through the Monitoring Team's attendance at the Morning Medical Meeting, Post-Hospitalization Interdisciplinary Team (IDT) meeting, and ISP Meeting referred to later in the report. The Facility continued to use the Clinician IDT Referral Form that was implemented at the last compliance was review. This form was completed by the nursing staff when individuals were sent to sick call, placed on the front of the charts for the primary care providers (PCPs) to use if they identified individuals with significant acute change in health status who required IDT meetings to further assess individuals' risk rating; and to identify any needed additional supports and services. When the PCPs identified individuals' with significant acute changes in health status who required IDT meetings, the completed forms were sent to the individual's Qualified Developmental Disability Professional (QDDP) to schedule the meetings. <u>Seizure Activity:</u> Since the last compliance review, the Nursing Department had made significant improvement in recording seizure activity on the Seizure Records with accompanying documentation in the Integrated Progress Notes describing the seizure activity, assessment and follow up until the individuals returned	

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		to baseline function. The Monitoring Team reviewed Seizure Records and accompanying Integrated Progress Notes that had occurred over the past three months for Individuals: #43, #185, and #331 and found: • Twenty one of 21 (100%) Seizure Records were completed correctly. • Twenty one of 21 (100%) Seizure Records had accompanying Integrated Progress Note that demonstrated that the Seizure Protocol was follow through to resolution in all incidences of individuals' seizure activity. <u>Hospitalization, Emergency Room Visits, and Transfer Activity:</u> The Monitoring Team reviewed the Hospital and Emergency Room Records, accompanying Integrated Progress Notes, and other related documents for hospitalizations and emergency room visits that had occurred over the past three months on individuals who had significant acute changes in health status: Individuals: #392, #43, #167, and #331. The Findings included: • Four of four (100%) individuals' records for who experienced acute change in health status showed when the direct support professionals or the nurses identified an acute changes in health, they promptly completed a focused nursing assessment for the changes and promptly notified the respective PCP of assessment findings in accordance with the "When contacting the PCP Protocol." The PCPs responded promptly and assessed the individuals and sent them to the emergency room and/or hospital via Emergency Medical Services for further evaluation and treatment. • Four of four (100%) individuals' records showed that the Hospitalization, Emergency Room, and Transfer Policy and relevant protocols were followed through to resolution. • Two of two (100%) hospitalized individuals' records showed documentation that the Hospital Liaison Nurse made daily contact with hospitalized individuals and hospital personnel either through visit to the hospital to observe the individuals or by telephone. The Hospital Liaison Nurse documented daily findings in each individual Integrated Progress Notes, which were shared with the IDT. • Four of four (100%) individuals' records demonstrated that the required post-hospitalization and/or emergency room visit comprehensive nursing assessments were completed per policy, including the Physical Nutritional Management Team Nurses' Post Hospital Assessment/Evaluation. The Physical Nutritional Management Team (PNMT) Nurse completed Post Hospital Assessments/Evaluations on two of the individuals who were discharged from the hospital. o It was of concern that the PNMT Nurse documented in the PNMT Nurse Post-Hospital Assessments/Evaluations that Individual #167's assessment was completed for a post-surgical abdominal wound for a colectomy while he setting upright in a chair. She documented that Individual #392's assessment for a post-surgical internal fixation of the right femur fracture was done while sitting in a recliner. It was questionable how the PNMT Nurse could accurately complete focus assessments on the post-surgical wounds while sitting up, apparently fully clothed. The PNMT Nurse should complete assessments	

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		in an environment conducive to allowing individuals' privacy, positioning for comfort, the visibility of the wounds; as well as the ability to efficiently make other pertinent assessments. • Four of four (100%) individuals' records showed documentation that Acute Care Plans were initiated upon return from the hospitalizations and/or emergency room visits and direct support professionals were trained on the respective plans for the identified problems subsequent to their hospitalizations and/or emergency room visits. The respective Acute Care Plans were individualized sufficient to meet the individuals' health care needs; and incorporated relevant nursing protocols and PCP orders. There was documentation in the individuals' Integrated Progress Notes, as well as on the Acute Care Plans that they were followed through to resolution. <u>Hospital Liaison Activities:</u> It was positive to find through interview, observation, and review of records for hospitalized and/or recently hospitalized individuals that the Hospital Liaison Nurse had continued to perform the positive practices identified at the last compliance review. Activities included: Attendance and participation at the Medical Morning Meetings to update the team on individuals' hospital status; attendance and participation at individuals' pre and post hospitalization Interdisciplinary Support Plan Addendum (ISPA) meetings; served as a backup to the PNMT Nurse to complete PNMT Nurse Post-Hospitalization Assessments/Evaluations; maintained the Hospital and Emergency Room Visit Tracking Log to ensure the following items were addressed: • Integration of services; • Completion of the required documentation, which included follow up on information related to the Nursing Hospitalizations, Emergency Room Visits, Transfers, and Discharges Protocol; • Completion of PNMT Nurse Post-Hospitalization Assessments/Evaluations; • Completion of the Hospital Liaison Reports; • Completion of ISPAs meetings on discharged individuals; and • Completion of other pertinent hospitalization/emergency room visits and discharge requirements. Further documented evidence of the Hospital Liaison Nurse's activities included reviews of hospitalized or recently discharged individuals' records. It was positive to find continued improvement in compliance with the Hospital, Transfer and Discharge Nursing Policy. Records reviewed on Individuals: #249, #286, #422, #284, and #15 who were or were recently/currently hospitalized found: • The Hospital Liaison Nurse maintained daily contact either by visits or telephone calls with hospital personnel regarding hospitalized individuals' health status and course of treatment. The information was documented in the Integrated Progress Notes and shared with the individuals' IDT. The Hospital Liaison Nurse was backed-up the Nurse Educator and by the campus nurses on weekends/holidays or at other times when she or the Nurse Educator were not available. • The Monitoring Team attended a Post-Hospitalization ISPA meeting for Individual #284, where the Hospital Liaison Nurse described his hospital course and health status at discharge. Individual	

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		#284, a 47 year old man was recently admitted, treated, and discharged for abdominal pain secondary to gaseous distention, atrial fibrillation, and hyponatremia. All relevant team members attended and actively participated. The team reviewed Individuals #284's acute change in status, updated his Integrated Risk Ratings, and identified any needed changes in services and supports as a result of the hospitalization. A review of Individual #284's records found that all requirements for pre and post hospital nursing assessments, Hospital Liaison Nurse hospital visits and Integrated Progress Notes, and the PNMT Nurse Post Hospital Assessments/Evaluations were completed according to the Hospitalizations, Emergency Room Visits, and Transfers Policy and other related nursing protocols. Although the Hospital Liaison attended the meeting she was not informed by the teams' Qualified Developmental Disability Professional (QDDP) of the meeting. She stated that this frequently happened. The Monitoring Team just happened to be notified of the meeting and informed her. This was discussed with the CNE who promptly notified the QDDP Director of the failure to notify the Hospital Liaison Nurse of the post-hospitalization meeting. It is essential that the QDDPs inform the Hospital Liaison Nurse of all pre and post-hospitalization meetings because she contributes vital information regarding individuals' health status as result of the acute change of status leading to the necessity for hospitalization. The Monitoring Team will follow-up on this issue at the next compliance visit. • The Hospital Liaison Nurse coordinated the use of agency sitters for individuals who were hospitalized out of town. • The Facility formed a collaborative team, which included the Facility Director, CNE, NOO, Hospital Liaison Nurse, Infection Control Nurse, QA Nurse, and Scott and White-Brenham Hospital. The purpose of the collaborative team was to improve the continuity of care for individuals while in the hospital. Issues of discussion included standardizing consent forms and improving communication between the two facilities. • The Hospital Liaison Nurse served as the Nursing Department representative on the Human Rights Committee. She also completed the monthly Section I Audit Tool on post hospitalized individuals, which was reported to the QA/QI Committee. Refer to the above Assessment and Documentation of Individuals with Acute Changes in Status for additional information regarding compliance with hospitalizations, transfers, and discharges protocol/policy. <u>Infection Control Activities</u> The Monitoring Team validated the Infection Control information presented in the Facility's Self-Assessment through: Review of the Infection Control information presented in the Provision M.1 section of the Section M Presentation book; Infection Control Committee Meeting Minutes and other related documents requested; and meetings/interviews with the Chief Nurse Executive, Nursing Operations Officer, QA Nurse, Program Compliance Nurse, and Infection Control Nurses.	

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		Since the last compliance review, significant progress had been made in the overall structure and organization of the Infection Control Program. An additional Infection Control Nurse was hired, which no doubt contributed to the improvements found. In addition to the positive practices found at the last compliance visit, additional improvements included: • The responsibilities for managing the Infection Control Program were divided between the two Infection Control Nurses. A detailed job description of duties was developed for each Infection Control Nurse, including a list of shared responsibilities. • Handwashing Observation Tool was revised in November 2012 to reflect Center for Communicable Disease (CDC) Center recommendations. Monthly handwashing data for July 2012 through February 2013 were analyzed, with deficiencies identified, and the corrective actions taken reported. • The Infection Control Database to record Environmental Rounds' information was revised on 3/7/13, to ensure that all relevant data were collected and reported into the database. Infection Control Environmental Rounds were completed quarterly in all areas of the campus, June 2012 through February 2013, with deficiencies identified, and the corrective actions taken reported. • On 8/2/12, a Procedure for daily Cleaning of Wheelchairs was developed and implemented, which applied to all personnel responsible for cleaning wheelchairs. The distribution and training of relevant staff was not provided for review. • On 8/10/12, Guidelines Maintaining a Sanitary Environment was developed and implemented, which applied to all personnel responsible for cleaning procedures and waste disposal. The distribution and training of relevant staff was not provided for review. • Since September 2012, the Facility began maintaining air scrubbers in living units according to manufacturer's recommendations. • In September 2012, guidelines were developed, implemented, and training provided to the nursing staff, and other relevant disciplines' staff were trained on a new Procedure for Isolation Management/Audit Tool Instructions. Kits were purchased to hang outside individuals' doors when there was need for isolation. The kit contained all the necessary equipment and supplies. In addition, an Isolation Audit Tool was developed to ensure isolation was maintained when isolation was ordered by the physician. The Risk Manager was responsible for conducting the audits. At the time of the compliance review no isolations were ordered, nor was there any audit data available. A summary of audit information was provided for September 2012 through February 2013, which identified deficiencies and corrective actions taken when isolation was ordered. • In July 2012, guidelines were developed, implemented, and all relevant nurses trained on a comprehensive Real-Time Process/Audit for tracking infections when antibiotics were ordered. The Real-Time Process/Audit had continued to undergo refinements to make it more effective. The process included the RN Case Managers notifying and providing a copy of Acute Care Plans (ACPs) for Infections to the RN Case Manager Supervisor for review. She forwarded the ACPs to the respective Infection Control Nurse for review and follow-up. The Pharmacy sent the Infection Control Nurses Antibiotic Reports twice a week. The Nurse Managers sent the Infection Control	

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		Nurses completed Infection Control Forms when the ACPs were resolved that described the disposition of the infection. This information was tracked in a Reporting Infection and Communicable Disease Database. This essentially served as a reliability check to ensure that all infectious/communicable diseases were reported, ACPs were clinically sufficient to address the infectious/communicable diseases, and the Antibiotic Therapy Protocol was followed through to resolution. The Real Time Process/Audit appeared promising, with the exception that a daily Antibiotic Report, as opposed to twice as week, would provide a more timely reliability check. The Monitoring Team will review the Real Time Process/Audit progress at the next review, when it is expected there will be analyses and trending data available for Real Time Audits. o The Monitoring Team met with the Infection Control Nurses and reviewed the ACPs for nine Individuals: #165, #554, #413, #133, #31, #154, #449, #19, and #96, who currently had active infections. The Interview with the Infection Control Nurses and review of ACPs, accompanying Physicians' Orders, and Integrated Progress Notes (IPNs) demonstrated and validated that the Real Time Process, as described above, was consistently implemented and followed. However, it was discussed that the Infection Control Nurses should document on the care plans that they were reviewed, along with any correction or comments made and when indicated they should write a note in the INPs regarding the management of infections. The Infection Control Nurses agreed that this would be a good practice and immediately began documenting their review on the ACPs and in the IPNs. This review and discussion showed significant progress made by the Infection Control Nurses from the previous compliance reviews. Refer to Provision M.3 for Monitor's review of the nine records above. • On 8/15/12, BSSLC SSLC (Nursing) Guidelines were revised to include Guidelines for Reporting Infections/Communicable Diseases, including pinworms and pharyngitis. The total guidelines were taught in New Nurse Orientation and at the annual nursing refresher training. • One Infection Control Nurse attended training in Amarillo, Texas on October 18-19, 2012, entitled "2012 Summer Essentials of Infection Control and Prevention." She also attended a seminar on September 26, 2012 entitled "Infection Control in Long Term Care." • In October 2012, an additional full-time Infection Control Nurses was added. • Both Infection Control Nurses attended a workshop on November 9, 2012 at the Heartland Tuberculosis Center on the campus of the Texas Center for Infectious Diseases in San Antonio, Texas. • On 10/25/12, the Infection Control Nurses attended the Physician's meeting and provided each physician and the nurse practitioner an Immunization Notebook. The Immunization Notebooks were to be used as a guide for current vaccines and immunizations according to CDC guidelines. The Infection Control Nurse will keep the notebooks current with CDC guidelines. • The AVATAR Immunization Database was in the process of being updated and populated by nursing's administrative assistant, who reported it was a slow process with other competing priorities and duties. This is a labor intensive process. It is essential that the Facility have current and functional Immunization Database for clinicians to readily identify when routine	

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		immunizations were due and maintained up to date. It would be helpful to the Nursing Department if the Facility could provide additional human resources to assist in populating the AVATAR Immunization Database. • Individuals who required Pneumonia and Zostavax vaccines were tracked and those needing the vaccines were identified and immunized. It was not possible to determine what percentage of individuals requiring these vaccines were immunized. Perhaps, when the Immunization Database is totally populated, the percentage of individuals can be determined. The status of other immunizations were reported as: o 94% of individuals were current with the annual flu vaccination. 2.5% did not receive the flu vaccine because of allergies to eggs. 3.5% of the individuals' families had not returned the consent or phone calls, even after at least three attempts. o 35% of the employees had received the annual flu shot. The flu vaccination was not mandatory for employment. However, in January 2013, the Facility had flu cases in each home in Driscoll where very medically challenged individuals reside. As a result a plan of correction will be implemented for the 2013-2014 flu seasons for declinations and those receiving flu vaccines at an alternate location. Further, the required Facility Influenza Data Sheet was reported to State Office on 1/16/13, as validated through review of a copy provided in the document request. The data included the number of individuals who had received influenza vaccinations, number of confirmed cases of influenza type A and/or B, and status of administering Tamiflu to confirmed cases of influenza. o 100% of the individuals were current with Tuberculosis Skin Testing (TST). There were four individuals who converted in the past year. They were administered the Quantiferon Gold test for confirmation of the positive TSTs and were started on INH as a prophylaxis. o As of 2/28/13, 99.5% of the employees were current on TST, including those who had follow-up for positive TSTs. The Infection Control Nurse reported there was one employee on military leave and two employees were on extended leave. These employees will receive TST after returning from leave. o Hepatitis B Vaccines series were not a mandatory requirement for employment. However, the Hepatitis B Vaccines series were available through the Employees Health Clinic. The percentage of newly hired employees that declined the Hepatitis B Vaccine B series was approximately 2-3%. Currently, it was reported that employees were in the process of completing the Hepatitis B Vaccine series but the number of employees was not provided for review. • The Infection Control Nurse continued to update the Antibiogram (oral and injectable antibiotics) specific to BSSLC, which was developed based on cultures and sensitivities every six months. They attended and presented the Antibiogram results at the Pharmacy and Therapeutic Committee meeting for review and discussion. Refer to Provision M.6 for information related to its use. Infection Control Committee Meetings: The Infection Control Committee met in 3 of 3 (100%) scheduled quarterly meetings.	

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		• Infection Control Committee showed an integrated core membership, which was comprised of the CNE, NOO, QA Nurse, Medical Director, Unit Nurse Managers, Food Services Director, Housekeeping Director or designee, Maintenance Director or designee, and Pharmacist. The Committee was chaired by the Infection Control Nurse. • The Monitoring Team's review of the Infection Control Committee Meetings for 7/31/12, 11/30/12, and 2/28/13, showed progressive improvement in substance, discussion, and dispensation of issues from the previous minutes reviewed. The only exception found was the lack of reporting of infectious/communicable trend data and disposition in the body of the minutes. However, the Infection/Communicable Disease Database Reports, summaries of trend data, and corrective actions taken to mitigate identified trends by unit were found attached to the minutes. Therefore, it was not possible to determine the disposition of the Committee. This issue was discussed with the Infection Control Nurses. The infectious/communicable disease data, including state reportable infections/communicable diseases, summaries of trend data, and corrective actions taken to mitigate trends should be reported in the body of the Infection Control Committee Minutes. In addition to identifying unit/local infectious/communicable disease trends, data should also be reviewed and analyzed for systemic trends and corrective actions taken to mitigate such trends, if identified. Infection Control Training: The CTD's Due/Delinquent List indicated that 21 employees were due/delinquent in annual Infection Control refresher training. The Facility should ensure due/delinquent employees on Infection Control refresher training are brought up to date as soon as possible. <u>Skin Integrity Activities:</u> The Monitoring Team validated the Skin Integrity information presented in the Facility's Self-Assessment through: Review of information presented in the Section M Presentation book; review of Skin Integrity Committee Meeting Minutes and other related documents requested; interviews with the Chief Nurse Executive, Nursing Operations Officer, QA Nurse, and Program Compliance Nurse; and observation of individuals with active pressure ulcers and review of their records. Relevant Self-Assessment data were updated during the onsite compliance visit. Findings included: • In September 2012, the Skin Integrity Committee recommended using National Pressure Ulcer Advisory Panel (NPAUP) Guidelines for pressure ulcer staging. BSSC adopted the guidelines on 10/3/12. • The Pressure Ulcer Management Guidelines were revised to include current generally accepted skin integrity management practices. • Training records showed that 100% of the nursing staff had received training on the revised Pressure Guidelines, including the National Pressure Ulcer Advisory Panel (NPAUP), 2009 pressure ulcer staging guidelines. The primary care providers (PCPs) were also trained on these NPAUP pressure staging guidelines. • The Facility maintained a tracking system/database for tracking skin integrity/pressure and non-	

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pressure ulcer data, including stages of pressure ulcers defined by the National Pressure Ulcer Advisory Panel (NPAUP), 2009 and whether pressure ulcers were Facility or Hospital/Long Term Acute Care acquired. The Skin Integrity Nurse analyzed and trended pressure and non-pressure ulcers data monthly/quarterly and longitudinally to identify local and systemic trends. As described in the chart below July 2012 through February 2013:

	07-2012	08-2012	09-2012	10-2012	11-2012	12 2012	01 2013	02 2013
Number of Individuals with Pressure Ulcers - (Unduplicated)	3	3	4	2	3	1	0	2
Number of **Pressure Ulcers** - acquired in the facility	1	3	6	3	3	1	0	2
Number of **Pressure Ulcers -** acquired outside the facility	4	4	1	0	0	0	0	0
Stage I —A persistent area of skin redness (without a break in skin) that does not disappear when pressure is relieved.	0	0	0	0	0	0	0	0
Stage II —A partial thickness loss of skin layers that presents clinically as an abrasion, blister or shallow crater.	2	2	2	2	2	0	0	1
Stage III —Full thickness skin lost, exposing the subcutaneous tissue - presents as deep crater with or without undermining adjacent tissues.	2	0	0	0	0	0	0	1
Stage IV-Full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	0	0	1	1	1	1	0	0
Unstageable-Full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed	1	2	3	0	0	0	0	0
Suspected Deep Tissue Injury	0	3	2	0	0	0	0	0

As the chart demonstrates, there has been a significant decrease in the number of unduplicated pressure ulcers, in all stages and pressure ulcers occurring in and outside the Facility. It was reasonable to deduce that the revised and implemented Pressure Ulcer Management, along with having 100% of the nursing staff trained on the guidelines had resulted in an improvement in the quality of care and a progressive decrease in the occurrence and severity

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		of pressure ulcers. • On July 19, 2012, the Skin Integrity Nurse and the Shift Nurse Manager/Durable Medical Equipment Coordinator attended a webinar on Pressure Ulcer Documentation; Telling a Complete, Accurate and Legally Defensible Story, sponsored by Creighton University and NPUAP. • The Skin Integrity Nurse and the Shift Nurse Manager/Durable Medical Equipment Coordinator attended the NPUAP National Conference in February 2013. At the time of the compliance review, the April 2013 monthly Decubitus Tracking Report for the Facility had four unduplicated individuals with various stages of pressure ulcers, of which three were Facility acquired and one was hospital acquired: There was one with a stage IV pressure ulcer, two with stage III pressure ulcers, and one with suspected deep tissue injury of the right heel. The Monitoring Team, accompanied by the Shift Manager and Nurse Manager, observed and reviewed records for Individual #96, who had a stage III pressure ulcer of the fifth toe, and Individual #318, who had a stage IV pressure ulcer of the right greater trochanter; the observation demonstrated that the quality of care and documentation had improved significantly since the last compliance review. For example: • The Monitoring Team observed the wound dressings to be dated and initialed when changed. The wounds were clean and dry and showed evidence of healing. The staff nurses observed were able to describe their plans of care and the probable causes of the pressure ulcers. A review of the records showed that the pressure ulcers were assessed on each shift, with the size and status of healing documented when the dressings were changed. The RNs assessed the ulcers' status of healing at least weekly, using the Pressure Ulcer Scale for Healing (PUSH) Scores. The size and description of the ulcer was recorded on the Pressure Healing Record, PUSH Tool 3.0, Pressure Healing Graph, and E-Z Graph. Acute Care Plans (ACP) for Skin Integrity Impairment were developed and implemented. ACPs were individualized and integrated, and were clinically sufficient to meet Individuals wound care needs, incorporating the Skin Integrity Protocol and physician's orders. The direct support staff were trained on the ACPs. Individuals were also being followed by the Wound Care Physician. Skin Integrity Committee Meeting Minutes: Since the last review, the Skin Integrity Committee conducted 3 of 3 (100%) scheduled monthly/quarterly meetings. The Skin Integrity Committee was comprised of an integrated core membership, which included: CNE, NOO, QA Nurse, Infection Control Nurses, Hospital Liaison Nurse, Unit Nurse Managers, Medical Director or designee, Habilitation Director or designee, Pharmacist, Residential Services Representative. The Committee was chaired by the Skin Integrity Nurse. Skin Integrity data were presented at Skin Integrity Committee meetings for review, discussion, and development and implementation of corrective action plans for identified trends to reduce and/or eliminate the incidences of skin integrity issues/pressure and non-pressure ulcers locally, and systemically. The Monitoring Team validated this information through a review of the quarterly Skin Integrity Committee Meeting Minutes for: 6/1/12, 9/12/12, 12/5/12, and a specially called meeting on 1/25/13. Although the meeting was well integrated with relevant	

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		disciplines, the dietitian's signatures were notably missing from the meetings' sign-in rosters, although a habilitation representative consistently attended the meetings. Because sound nutrition is essential to wound healing, the dietitian should be an integral committee member of the Skin Integrity Committee to evaluate the nutritional status of individuals' with wounds and/or pressure ulcers. Refer to Provisions M.1, M.2, M.3, and/or M.5 for additional reporting on acute and/or chronic skin integrity issues. <u>Emergency Response Activities:</u> The Monitoring Team validated the Emergency Response information presented in the Facility's Self-Assessment through: Review of the Emergency Response information presented Provision M.1 of the Section M Presentation book, review of Emergency Response Committee Meeting Minutes and other related documents requested, and meetings/interviews with Emergency Response Committee members. As was found the last compliance review, the Facility had maintained the positive practices previously identified and reported by continued adherence to the Emergency Response, Policy Number: 044.2, along with making additional improvements to their emergency response system that went beyond the requirements of the policy. The Facility's Self-Assessment data reported was validated through staff interviews, observations, document review, and the Monitoring Team's attendance at the CPR/Emergency Response Committee Meeting on 4/11/13. In addition to the data provided and validated in the Facility's Self-Assessment other improvements found included: • A review of the CPR/Emergency Response Committee Meeting Minutes and the Monitoring Team's attendance at the Committee meeting on 4/11/13, continued to find that the Committee was dedicated to continuously improving their emergency response system. The Committee was chaired by the CNE. The Committee's integrated core membership was comprised of Medical Director or designee, QA Nurse, Risk Manager, Unit Nurse Managers, CTD Director, Residential Services Representative. A view of the minutes and attendance at the meeting further revealed that all relevant aspects of the Facility's emergency response system were addressed, 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. At the 4/11/13 Committee meeting the CNE gave a debriefing on the actual code that occurred on 4/8/13. The report included a detailed account minute by minute of the emergency response from the time the code was called until the Emergency Medical Services arrived and the individual was transported to the emergency room. The information was derived from information from the video camera, lead strips printed from the AED, Code Drill Records, and staff interviews. The staff's response time performance was commendable. The Committee also discussed the need for individuals' Do Not Resuscitate determination to be reviewed by the Ethics Committee. A recommendation to do so will be forwarded to the appropriate staff. • The American Heart Association's Heartsaver CPR Adult and Child AED Course was revised, 12/4/12. The chain of survival was changed from the Airway-Breath-Compression (ABC's) of CPR	

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		to Compressions-Airway-Breathing (CAB's) of CPR. On 4/8/13, The Monitoring Team conducted inspections/observations of emergency equipment in Bowie A, Driscoll D, Childress B, Cottage B, and Fannin C, accompanied by the CNE, NOO, Nurse Shift Manager, and respective Unit Nurse Managers. All of the required emergency equipment was present and in good working order, daily Emergency Equipment and AED Checklists were checked daily and the Walkthrough Emergency Checklists by the Risk Manager were checked monthly per policy. The staff nurses were observed operating the emergency equipment. All staff nurses demonstrated competency in operating the emergency equipment, with exception of one staff nurse. This staff nurse showed a lack of familiarity in operating the emergency equipment. However, she had only completed orientation by approximately a month. As a result the nursing leadership, who also observed her performance, agreed she needed more training on the use of the emergency equipment and will ensure she receives retraining. The NOO stated that specific nurses were assigned to daily check the equipment. Consequently, the NOO immediately changed the procedure and sent a directive to the Nurse Managers to rotate the schedule so that all nurses were checking the emergency equipment in order to ensure all staff nurses maintained competency. The Nurse Managers were responsible for providing oversight to ensure competency in checking emergency equipment was maintained. A copy of the directive sent to the Nurse Managers was provided to the Monitoring Team. It was positive to have the nursing leadership accompany the Monitoring Team while observing the staff nurses operate the emergency equipment; this way they were able to make the same observations and to take immediate corrective action for any identified deficiencies. The Monitoring Team's review of the CTD Course Due/Delinquent List, printed 3/6/13, showed one employee was due/delinquent in BLS for Health Care Providers training. The list for Basic CPR showed 21 employees were due/delinquent. The Facility's discipline leads responsible for employees who were due/delinquent for Basic CPR training should ensure that the training is brought up to date as soon as possible. With the exception of the employees found due/delinquent in Basic CPR, 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. 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 significant progress toward achieving compliance in most, if not all, of the various sections contained in this Provision.	
M2	Commencing within six months of the	<u>Monitoring Team Findings:</u> The Monitoring Team validated the Nursing Assessment information presented in the Facility's Self-	Substantial Compliance

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	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.	Assessment through: Review of the Nursing Assessment information presented in Provision M.2's Presentation Book; review of documents requested; meetings/interviews with Chief Nurse Executive, Nursing Operations Officer, Program Compliance Nurse, RN Case Manager Supervisor; and review of medical records. Relevant Self-Assessment data were updated during the onsite compliance visit. The Facility's Self-Assessment stated they were in substantial compliance with Provision M.2 and the Monitoring team concurs with their findings. Since the last compliance review it was evident that the RN Case Manager Supervisor had concertedly put forth effort working with the RN Case Managers to improve the timeliness, consistency, and accuracy of the Annual and Quarterly Comprehensive Nursing Assessments. According to the Provision M.2's Self-Assessment the Nursing Care Annual Nursing Assessment Tool showed a quarterly compliance percentage of 84% in July 2012, 93% in October 2012, and 91% in January 2012. Comparison of the Nursing to QA Nurse Inter-Rater Reliability Tracking and Trending Reports for the Nursing Care Annual Nursing Assessment showed the following percentage of agreement: 95% in June 2012, 84% in July 2012, 95% in August 2012, 95% in September 2012, 96% in October 2012, 95% in November 2012, and 93% in December 2012. Based on these findings the Facility determined they were in compliance with this Provision. This was consistent with the Monitoring Team's findings, with the exception of Nursing Discharge Summaries completed for transition into the community setting, which are reported in Provision M.3. The Monitoring Team reviewed Admission Comprehensive Nursing Assessments for seven recently admitted Individuals: #346, #402, #546, #239, #388, #243, and #148, which found: • Seven of seven (100%) individuals' Admission Comprehensive Nursing Assessments were completed within 30 days of admission. • Seven of seven individuals' Admission Comprehensive Nursing Assessments were evaluated for comprehensiveness and accuracy using a list of 48 items that essentially matched the items in the Facility's Nursing Care Annual/Quarterly Nursing Assessment Monitoring Tool, which found an overall compliance percentage rating of 98.2%. Nearly all specific items of the 48 items on the monitoring tool were found compliant on all seven assessments, with only a few being found noncompliant on any assessment. This was consistent with the Facility's Self-Assessment findings. The Admission Comprehensive Nursing Assessments showed significant improvement from previous compliance reviews, which indicated that the corrective actions taken over the past months were effective. The Monitoring Team reviewed the most recently completed Annual and/or Quarterly Comprehensive Nursing Assessments of a sample selected from the Facility's At Risk List for individuals identified at high risk health conditions and from each unit/cottage, for 25 Individuals: #59, #599, #411, #305, #330, #445, #195, #141, #35, #554, #184, #154, #167, #25, #392, #395, #453, #331, #43, #318, #474, #284, #185, #11, and #206, which found: • Fourteen of 16 (88%) Annual Comprehensive Nursing Assessments were completed on time,	

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		according to Facility policy. However, the annual ISP schedule was fluid and subject to changing dates. Therefore, it was difficult to ascertain with certainty if the two annual assessments that were not found completed within 10 working days were late or if the annual ISP dates were changed. • Twenty four of 27 (89%) Quarterly Comprehensive Nursing Assessments were completed on time, according to Facility policy. The same was true for the three quarterly nursing assessments that were not found to be completed on time because those dates may have also changed. • Twenty five of the last completed Annual and/or Quarterly Comprehensive Nursing Assessments were reviewed using a list of 48 items that essentially matched the items in the Facility's Nursing Care Annual/Quarterly Nursing Assessment Monitoring Tool and found an overall percentage of compliance 94%. This was relatively consistent with the Facility's most recently completed quarterly (January 2013) Nursing Care Annual Quarterly Comprehensive Nursing Monitoring data reported by nursing for an overall compliance of 91% with a 94% inter-rater reliability agreement by the QA Nurse, as reported in the Self-Assessment findings. To determine whether any specific item was not consistently compliant, the Monitoring Team reviewed each of the 48 monitoring items contained in the monitoring tool on each of the 25 assessments. Of those, 43 (90%) of the items were compliant on more than 90% of the assessments reviewed (that is, only five specific items were noncompliant on more than two of the assessments). Examples of some key indicators that were compliant on more than 90% of assessments included: o Twenty five of 25 (100%) records showed items on the tools for addressing completed the Annual/Quarterly Nursing Comprehensive Nursing Assessments were completed by RNs. o Twenty four of 25 (96%) records showed items on the tool for addressing documented evidence in the Annual/Quarterly Comprehensive Nursing Assessments that the RN(s) completing conducted a deliberate and systematic collection of fata to identify individuals' current health status of all actual and potential health problems and nursing diagnoses. o Twenty three of 25 (92%) records showed items on the tools for addressing Nursing Recommendations (each diagnosis identified, the reason for the diagnosis and general approaches and summarized Self-Administration of Medication (SAM) objectives) incorporated into Health Management Plans (HMPs) and/or Integrated Health Care Plans. Nursing interventions were problem focused, individualized, and documented in the HMPs and/or Integrated Health Care Plans. o Twenty five of 25 (100%) records showed items on the tools for addressing the use a standardized form were completed on a standardized form. o Twenty five of 25 (100%) records showed items on the tools for addressing the date and name of the RN(s) who completed the Annual/Quarterly Comprehensive Assessment were included. o Twenty five of 25 (100%) records showed items on the tools for addressing documented evidence that the Annual/Quarterly Comprehensive Nursing Assessments were sent to the Qualified Developmental Disability Professionals (QDDPs) were completed. • Of the 48 monitoring items contained in the monitoring tool, a trend of items identified on the tool	

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		falling at or below 90% included: o Twenty one of 25 (84%) records showed items on the tools for current active medical diagnoses/conditions were updated on the Annual/Quarterly Comprehensive Nursing Assessment Reports. o Twenty five of 25 (100%) records showed items on the tools for addressing pain were completed. Six of these indicated a history of pain. Of these six, two of six (33%) reported the severity of pain, scale used, type, frequency, location, and whether they received medication for pain. o Twenty-five of 25 (100%) records showed items on the tools for addressing constipation. Of those, 24 individuals were reported as having constipation. Of these 24 assessments, 16 (67%) documented the dates of individuals' last bowel movement. o Twenty five of 25 (100%) records included Analyses of Data. Twenty-two of these 25 (88%) analyzed current information. For three of the Analyses of Data, all completed by the same Nurse Case Manager, summaries were copied verbatim from previous annual/quarterly nursing assessments with minimal, if any, updating for the current annual/quarterly assessments' data; the summaries occasionally contained data from previous years that had no historical significance . Although this only involved three of the nursing assessments, data should not be copied verbatim without updating data. o Twenty two of 25 (88%) records showed items on the tools for addressing Section XI Nursing Summaries were based on current information. Three Nursing Summaries, all completed by the same Nurse Case Manager, were copied verbatim from previous annual/quarterly summaries with little, if any, updated current clinical data related to identified nursing problems/diagnoses (risk ratings), individuals health status relative to the problems, and effectiveness of their health care plans Although this only involved three of the nursing assessments, data should not be copied verbatim without updating data. Since the last compliance review, although there were a few items on the monitoring tool that fell at or below 90% compliance, significant improvement was found overall in the completeness, accuracy, and quality of the Admission, Annual and/or Quarterly Comprehensive Nursing Assessment, and nearly all items demonstrated greater than 90% compliance with items reviewed. This indicates the Facility has achieved substantial compliance with requirements of Provision M.2.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions	<u>Monitoring Team's Findings:</u> The Monitoring Team validated the Nursing Assessment information presented in the Facility's Self-Assessment through: Reviewed the Nursing Assessment information presented in Provision M.3's Presentation Book; reviewed documents requested; meetings/interviews with Chief Nurse Executive, Nursing Operations Officer, Program Compliance Nurse, RN Case Manager Supervisor; and review of medical records. Relevant Self-Assessment data were updated during the onsite compliance visit. The Facility's Self-Assessment stated they were not in substantial compliance with Provision M.3 and the Monitoring team concurs with their findings.	Noncompliance

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	annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	Since the last compliance review, the Facility had continued to implement and improve/refine the Integrated Risk Rating Form (IRRF) and Integrated Health Care Plan (IHCP) Processes. The Monitoring Team reviewed the most recently completed Annual and/or Quarterly Comprehensive Nursing Assessments for 25 individuals (Individuals #59, #599, #411, #305, #330, #445, #195, #141, #35, #554, #184, #154, #167, #25, #392, #395, #453, #331, #43, #318, #474, #284, #185, #11, and #206), which found: • The Annual and/or Quarterly Comprehensive Nursing Assessments consistently identified in Section X Nursing Problems/Diagnoses relevant high and/or medium risk ratings, as well as other problems/diagnoses requiring ongoing nursing intervention. The health status of individuals' health care plans, in relation to their identified risk ratings and problems, were consistently summarized in Section XI. • The Monitoring Team reviewed Individuals' health care plans in relation to identified risk ratings and problems, which varied in the format used for the plans, i.e., some plans were documented on Health Maintenance Plans (HMPs), some on the IHCP, and for some health care plans both were used. Therefore, it was not possible to accurately determine which health care plan was actually followed or the status of compliance with any given health care plan. The Monitoring Team will follow-up on the status and implementation of the IHCP process at the next compliance review. Refer to Provision M.5 and Section I for more information regarding the status of the IRRFs and IHCPs. The Monitoring Team reviewed ACPs, Physician's Orders, and IPNs for Individuals: #165, #554, #413, #133, #31, #154, #449, #19, and #96 who had active infections at the time of the onsite compliance visit and found: • Seven of nine (77%) records showed the physicians were promptly notified of signs and symptoms of infections. • Nine of nine (100%) records showed ACPs were promptly initiated upon diagnoses of infection and treated with antibiotic therapy. • Eight of nine (89%) records showed baseline data described circumstances leading up to the diagnoses of infections with description of the infections. • Eight of nine (89%) records showed goals were described in objective and measurable terms that indicated the desired outcomes as a result of care provided. • Six of nine (67%) records showed ACPs were individualized and integrated with other relevant disciplines clinically sufficient to meet health care needs and to provide staff with sufficient information to manage infectious/communicable diseases. Three of the nine records should have included more preventative measures to follow to prevent the spread of infections. • Eight of nine (89%) records showed ACPs incorporated Antibiotic Protocol and Physicians. Orders, as applicable. • Nine of nine (100%) records showed the direct support professionals (DSPs) were trained on the	

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		ACPs. • Eight of nine (89 %) records showed documentation in the IPNs that the ACPs were followed as designed. • Four of nine (44%) records showed documentation in the IPN that ACPs were initiated and DSPs were trained on the plans. • One of three (33%) records showed that the IDTs were notified of individuals with the potentially communicable infections. Concerns identified from the record reviews: • Individual #133 had a staph infection of the peg tube stoma but the ACP failed to include preventative measures for the nurses and DSPs to wear gloves, and/or to take other preventative measures when bathing, and/or when otherwise coming in contact with the wound site. There were no instructions to ensure that contaminated stoma dressings were properly disposed of in biohazard waste. There was no documentation in the IPNs that the IDT were notified of the communicable staph infection of the stoma. • Individual #31 had abscesses on both thighs but the ACP failed to include preventative measures for the nurses and DSPs to wear protective gloves, and/or to take other preventative measures when bathing, and/or when otherwise coming in contact with the wound sites. There were no instructions to ensure that contaminated dressings or materials used were properly disposed of in biohazard waste. • Individual #19 was missing documentation of assessments on all shifts for 4/5/13. • Individual #154 was diagnosed and presumptively treated with antibiotics for Acute Pharyngitis. Although his presenting signs and symptoms were assessed and documented by the nurse and included complaints of a painful sore throat, fever, and red throat with yellow spots, there was no physician order to perform a throat culture to rule out strep throat. There was no documentation in the IPNs that the IDT was notified of this potentially communicable infection. The ACP included DSP instructions to, "Encourage him to cover his mouth and nose when he coughs or sneezes, to dispose of all tissues appropriately, and to wash his hands or use hand sanitizer afterwards and frequently during the day." These instructions were not sufficient to protect the spread of infections to others in the home. According to the recently developed guidelines for acute pharyngitis, other preventative measures should have been included in the ACP to prevent the potential spread of the infection to others in the home. The nursing staff should be retrained on the pharyngitis guidelines to ensure they incorporate these guidelines into ACPs for Acute Pharyngitis when caring for individuals diagnosed with acute pharyngitis. In addition, the Nursing Department should ensure that all relevant IDT members are notified of potentially infectious/communicable diseases until they are either ruled out or confirmed. • Occasionally, the entries on the IPNs did not include the time they were documented. • Occasionally, the side effects/adverse reactions, and effectiveness of the antibiotic therapy and full set of vital signs were not documented in the IPNs each time individuals were assessed according to the Antibiotic Protocol. These items should be consistently assessed and documented in each note until the infections are resolved.	

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		• Frequently, multiple health problems were documented into one entry; making it difficult to determine the status of any one single health problem. If multiple health problems are documented into one single entry, they should be organized separately in the notes or a separate entry made in order to clearly identify the status of each health problem. This was discussed with the CNE and Infection Control Nurses who agreed to take this recommendation under advisement. This issue will be followed-up at the next compliance review. The Monitoring Team reviewed eight Nursing Discharge Summaries and accompanying Discharge Packets for Individuals: #511, #467, #249, #547, #434, #442, #20, and #181, who were discharged/transitioned in to the community since the last compliance visit. Findings included the following: • Six of eight (75%) assessments showed that comprehensive assessments for clinical risk indicators were completed for each specific health item contained on the Nursing Discharge Summaries within 45 days of discharge. • A current nursing assessment was conducted for six of eight (75%) of the individuals prior to discharge/transferring to the community. • Two of eight (25 %) individuals' health status in relation to each significant identified health clinical indicators was thoroughly summarized such that the receiving agency could understand their present health status in order to respond to their health care needs. • Three of eight (38%) individuals' Discharge Packets contained Integrated Risk Rating Assessments or Integrated Risk Rating Forms (IRRFs) within 45 days of discharge. • One of eight (13%) individuals' Discharge Packets contained Active Risk Plan or Integrated Health Care Plans (IHCPs) updated within 45 days of discharge. • Six of eight (75%) of the summaries completed included the required, "Special Instructions: for Medication techniques (likes/dislikes, crushed, etc.), triggers/signs/symptoms of illness/behaviors (how I communicate when I don't feel well or what makes me angry, etc.,), and special techniques to have them be cooperative. Other pertinent information (i.e.: special behaviors and what they mean, how I communicate, signs and symptoms of pain, etc.). • Four of eight (50%) provided training on health care plans sufficient to meet individuals' health care needs for identified nursing diagnoses/problems, and recommendations for future health care needs. • Eight of eight (100%) individuals' health care plans showed documentation that the Facility RN Case Managers or designees provided training to the receiving agency's nurse and/or other designated agency staff. It is important to point out that the Facility did not have instructions for completing the Nursing Discharge Summary form beyond the few instructions printed on the last page of the form related to special instructions. Therefore, it was not surprising to find the deficiencies identified above. The Most Integrated Setting Practices Policy was reviewed with the State Office Nursing Coordinator. It was discovered there were no instructions that identified the RN Case Managers role and responsibilities	

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		for completing the Nursing Discharge Summary form. She agreed that more specific instructions should be developed. The Monitoring Team will follow-up at the next compliance visit to see if instructions were developed and implemented for completing the Nursing Discharge Summary and if there were improvements made in the quality and comprehensiveness of the summaries. The State Office Nursing Coordinator and Facility's Nursing Department should provide the RN Case Managers with guidelines and training for completing the Nursing Discharge Summary and health care plans for community placement. Examples of issues of concern identified in the above review: • Individual # 511: The initial Nursing Discharge Summary was completed on 12/12/12 with an update 1/15/13. However, the summary was not updated to reflect the potentially dislocated lens of the left eye that was identified on a CT of the head in the emergency room when he was seen for prolonged seizure activity. The Nursing Discharge Summary's Consult Summary appeared to be cut and pasted from previous reports. It stated that a vision exam was completed upon admission to the Facility and a follow-up full exam was to be completed in a year. Another exam was scheduled for 12/14/12. Following the 12/14/12consult, the IDT recommended a follow-up with an ophthalmologist to review possible left lens dislocation and to complete a full examination with a community provider. The Diagnostic Testing/screening Summary indicated he was seen by the neurologist 12/12/12, who recommended that he begin on a therapeutic dose of Depakote for new onset seizure disorder. The summary stated lab testing would be ordered frequently after the initiation of this medication to determine the therapeutic dosage of medication. There was no update before discharge in the nursing summary to indicate that the lab testing was done. These are essential issues that the RN Case Managers should have updated before discharge into the community on 1/15/13. In addition, the last Integrated Risk Rating Assessment and Risk Action Plan contained in the Discharge Packet were dated 5/8/12. These items should have been updated at least 45 days prior to discharge.	
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.	<u>Monitoring Team Findings:</u> The Monitoring Team validated the Nursing Education information presented in the Facility's Self-Assessment through: Review of the Nursing Education information presented in the Section M Presentation Book; and meetings/interviews with Chief Nurse Executive, Nursing Operations Officer, QA Nurse, and Nurse Educator/Program Compliance Nurse. Related Self-Assessment data were updated while onsite. The Facility's Self-Assessment stated they were in substantial compliance with Provision M.4 and the Monitoring Team concurs with their findings. <u>New/Revised State/Local Policies, Procedures, Processes, and Protocols:</u> • BSSLC State Supported Living Center Guidelines (Nursing), Revised: 8/15/12 • BSSLC Pharmacy Services and Safe Medication Practices: Medication Variance Policy, N.12, Implemented: 12/31/12. • BSSLC Nursing Care: Completing/Routing Fall Evaluation Form, Date of Implementation: 12/20/12. • BSSLC Pressure Ulcer Management Guidelines, Revised: 12/6/12	Substantial Compliance

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		• BSSLC Algorithms developed for: Exposure involving blood, tissue, or body fluids that are potentially infectious; Abuse and Neglect Allegations; and Reported Sexual Incidents. • Statewide Release of five additional nursing protocol cards: Suspected Fractures/Dislocation, Hypoglycemia, Pain, Emergency/Hospital Transfers, and Fall Suspected Fall. • In January 2013, there was a statewide reduction of 12 Nursing Monitoring Tools and Instructions to six. This was done to provide facilities with more accurate and consistent data for analysis and trending: SOAP Format Documentation; Urgent Care/ER/Hospitalizations; Infection Control; Infection Control; Acute Illness and Injury; Annual (Quarterly) Nursing Assessment; and Care Plans. • Statewide Nursing QA Audit Process was a collaborative effort with the Quality Assurance and Nursing Department in order to standardize the process statewide. Refer to Provision M.1, Infection Control Activities, for the Infection Control Program's new/revised procedures/processes reported since the last compliance review. <u>Training Activities:</u> • 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 training, a date for completion was projected, and included the overall percentages of nurses trained. • The Monitoring Team's interview with the Nurse Educator and review of Section M.4 Presentation Book, Nursing Training Database, competency-based training materials and records, validated the training reported in the Facility's Self-Assessment. In addition, the Nurse Educator provided updates on the status of increased percentage of training that had occurred since the Self-Assessment was completed on 3/6/13. o The nursing staff had completed 100% the required annual refresher training as described in the Nursing Education Handbook and BSSLC SSLC (Nursing Guidelines. Overall, all required training met the criterion of at least 95%. There was a projected completion training date for any remaining required training. o Ninety-eight (98%) had been trained on BSSLC Pharmacy Services and Safe Medication Practices: Medication Variance Policy, N.12. Implemented: 12/31/12. There was documentation that nurses who were not trained on the policy were on extended leave. o One hundred percent of the RN Case Managers and RNs had been trained and checked off on the state mandated Physical Assessment Class. The Physical Assessment Class will be taught and checked when new RNs are hired as part of New Nurse Orientation. o The first three body systems, Abdomen and Chest and Lungs, and, Musculoskeletal System assigned from the Mosby Physical Assessment Textbook were completed with 100% of the RNs competency based tested on the chapters. o Ninety two percent of the RNs had completed the State's mandated Medication Administrating related to dysphagia and swallowing difficulties. This was a recently	

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		introduced training requirement. As explained in the Self-Assessment and by the Nurse Educator, "Due to the restriction in class size and seven hours of class time, a limited amount of nurses was able to attend at one time. However, the plan was to be 100% completed by 6/1/13." o In October 2012, 100% of the nursing staff responsible for administering medications had received training on Administering and Documenting Per Necessary (PRN) Medications. o At the time of the compliance review, 74% of the nurses had completed the State's mandated Documentation Class. Due to the Nurse Educator assuming the responsibility as the Program Compliance Nurse, it was projected that these classes would resume upon the appointment of the hiring of a new Nurse Educator on 4/16/13. • It was positive to find since the last compliance review, that the Nurse Educator no longer sends incidental training materials to the nursing staff by email to read and sign the training rosters to verify that the training materials were read. This procedure has been corrected. Now the Nurse Educator either provides the training material or gives it to the Nurse Managers to provide to the nursing staff with the return of signed training rosters to validate and document the training. • One hundred percent (100%) of the nursing staff had received training on the 18 previously released and reported protocols. Five additional statewide protocol cards were recently released for: Suspected Fractures/Dislocation, Hypoglycemia, Pain, Emergency/Hospital Transfers, and Fall Suspected Fall. The Nursing Education Department was in the process of training the nursing staff on the additional protocols. However, the percentages of nurses trained were not tabulated at the time of the compliance visit. The Monitoring Team will review the status of training on the new protocol at the next compliance review. The addition of new protocols is a dynamic and functional process as the need arises and should not negate substantial compliance as long as there is evidence that all nursing staff continue to be trained on any additional nursing protocols and there was documented/observable evidence protocols were implemented into actual clinical practice sufficient to address the health status of individuals served. The statewide Nursing Workgroup was in the process of developing Protocol Card Audit Tools. To date, five audit tools have been developed. The BSSLC Nursing Department was in the process of implementing the tools. On 3/28/13 the Audit Process was revised. They selected four of the five Protocol Audit Tools to start with, which were for: Respiratory Distress/Aspiration; Seizures; Urinary Tract Infection; and Pre-Treatment/Post-Sedation. The process for auditing all monitoring tools is described above in Provision M.1, Quality Assurance Activities. Since Protocol Card Audit Tools have only recently begun, there was no reportable data yet available for review. The Monitoring Team will review the status of training on the new protocols at the next compliance review. <u>Implementation of Policies and Protocols</u>	

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		The Monitoring Team's review showed that the 18 nursing protocols previously developed and trained were fully implemented. As mentioned above, the addition of new protocols is a dynamic and functional process as the need arises and should not negate substantial compliance as long as there is evidence that all nursing staff continued to be trained on any additional nursing protocols and there was documented/observable evidence they were implemented into actual clinical practice sufficient to address the health status of individuals served. The Implementation was demonstrated in a variety of way, including: • Review of training records for nursing policies, procedures, processes, and protocols reported above. • Observation of nursing carrying on their person the nursing protocol cards. • Interviews with unit staff nursing regarding their knowledge and understanding of the content of the protocols. The nurses reported that they found functionally useful in assessing and documenting health conditions and/or situations contained on the various protocol cards. • The required assessment and documenting items were being incorporated into health care plans and found documented in the Integrated Progress Notes review. For example: for individuals who experienced a significant or acute change in status, nurses consistently performed appropriate and complete assessments as dictated by the symptoms in alignment with nursing protocols: o Of individuals that had wound/skin integrity issues, _four_ of _four_ (100%) records showed documentation of development and implementation of individualized Acute and/or Skin Integrity Care Plans sufficient to meet individuals' skin integrity care needs, including incorporation of relevant nursing protocols, PCP/Wound care orders when applicable, and staff training. o Twenty one of 21 (100%) Seizure Records were completed correctly. o Twenty one of 21 (100%) Seizure Records had accompanying Integrated Progress Note that demonstrated that the Seizure Protocol was follow through to resolution in all incidences of individuals' seizure activity. o Five of Five (100%) individuals' records for who experienced acute change in health status showed when the direct support professionals or the nurses identified an acute changes in health, they promptly completed a focused nursing assessment for the changes and promptly notified the respective PCP of assessment findings in accordance with the "When contacting the PCP Protocol." o Four of four (100%) individuals' records showed that the Pre-Hopsitalization Assessments for Hospitalization, Emergency Room, and Transfer Policy and relevant protocols were followed through to resolution. o Four of four (100%) individuals' records demonstrated that the required post-hospitalization and/or emergency room visit comprehensive nursing assessments were completed per policy, including the Physical Nutritional Management Team Nurses' Post Hospital Assessment/Evaluation. o Four of four (100%) individuals' records showed documentation that Acute Care	

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		Plans were initiated upon return from the hospitalizations and/or emergency room visits and direct support professionals were trained on the respective plans for the identified problems subsequent to their hospitalizations and/or emergency room visits. The respective Acute Care Plans were individualized sufficient to meet the individuals' health care needs; and incorporated relevant nursing protocols and PCP orders. There was documentation in the individuals' Integrated Progress Notes, as well as on the Acute Care Plans that they were followed through to resolution. o In addition, The Monitoring Team attended a Post-Hospitalization IDT/ISPA for Individual #284. The team reviewed Individuals #284's acute change in status, updated his Integrated Risk Ratings, and identified any needed changes in services and supports as a result of the hospitalization. A review of Individual #284's records found that all requirements for pre and post hospital nursing assessments, Hospital Liaison Nurse hospital visits and Integrated Progress Notes, and the PNMT Nurse Post Hospital Assessments/Evaluations were completed according to the Hospitalizations, Emergency Room Visits, and Transfers Policy and other related nursing protocols. o Eight of nine (89%) records for individuals with acute infections showed ACPs incorporated Antibiotic Protocol and Physicians. Orders, as applicable. There was documentation in the Integrated Progress Notes that ACPs were followed. The degree of adherence to the nursing protocols was reported in the other appropriately related Provisions.. Care was consistent with protocols for infection control, seizures, and other conditions, assessment and documentation followed the protocols, and the requirements in various protocols for reporting to the medical practitioner were followed. Furthermore, the review of individuals' care did not reveal any significant inconsistencies with the protocols. The Facility's Self-Assessment stated they were in compliance with this provision. The Monitoring Team concurs that this Provision was in substantial compliance. As reported above substantial compliance was demonstrated through the Monitoring Team's independent review of the Section M Presentation Book, staff interviews, direct onsite observations of nursing care, and review of documents to verify that the Nursing Department had continued to maintain positive practices toward the development and implementation of nursing policies, procedures, processes, protocols and training.	
M5	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a	<u>Monitoring Team Findings:</u> The Monitoring Team validated the Risk Management information presented in the Facility's Self-Assessment through: Review of the Risk Management information presented in the Provision M.5 section of the Presentation Book; review of documents requested; meetings/interviews with the Chief Nurse Executive, Nursing Operations Officer, QA Nurse, Program Compliance Nurse, and RN Case Manager Supervisor; attendance at an ISP Meeting and ISPA Post-Hospital Discharge Meeting; and review of individuals' medical records. Relevant Self-Assessment data were updated during the onsite compliance visit. The Facility's Self-Assessment stated they were in substantial compliance with	Noncompliance

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	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.	Provision M.5 and the Monitoring Team concurs with their findings. Since the last compliance review, the Facility had continued to implement and improve/refine the Integrated Risk Rating Form (IRRF) and Integrated Health Care Plan (IHCP) Processes. The Facility's Self-Assessment stated that the State Office continued to provide training on the revised IRRF and IHCP Processes. These processes continued to be piloted in various areas across campus. The Monitoring Team reviewed six recently Integrated Risk Review Forms and Risk Action Plans for Individuals #411, #284, #474, #453, #184, and #330: • Zero of six (0%) identified significant changes in health status since the last review; however, this was difficult to determine based on the available documentation. • Six of six (100%) had comprehensive interdisciplinary assessment completed. However, some of the baseline data rationales that supported the risk ratings were more clinically comprehensive than others. The format for reporting baseline data continued to vary from unit to unit and from IDT to IDT. • Five of six (83%) assessments provided data that helped identify risk ratings. • Five of six (86%) ISPs sufficiently addressed all of individuals' identified risk ratings. • Three of six (50%) IHCPs 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. • Two of six (33%) IHCPs were clinically sufficient to meet the needs for the individuals' identified IRRFs. • Two of six (33%) IHCPs included preventative interventions to minimize individuals' identified risk rating conditions. • Three of six (50%) IHCPs were sufficiently integrated among all appropriate disciplines. • Zero of six (0%) changes were made in individuals' services and supports for all identified risk ratings. • Three of six (50%) IHCPs contained functional and measurable objectives in the ISPs to measure efficacy of the plans. • Three of six (50%) IHCPs identified appropriate clinical indicators to be monitored and the frequency of monitoring. • Example: Individual # 576 did not have a Risk Action Plan accompanying the Integrated Risk Rating, on 6/13/12. Plans resulting from the risk ratings were included in the ISP; however, 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 ISPs, IRRFs, and IHCPs, 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	

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		disciplines, if compliance is to be achieved regarding the IRRFs and IHCPs processes. The Monitoring Team will follow-up on the status and implementation of the IHCP process at the next compliance review. The Monitoring Team attended the ISP/IRRF meeting for Individual #599 using the revised process and forms for the meeting. The following observations were identified: • All relevant IDT members, including Individual #599 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. • All staff were present at the ISP who worked with Individual #599. • There was some general improvement in the IRRF process. The IHCP was not completed at the time of the ISP. The RN Case Manager did a good job conducting the IRRF. However, there was very little overall participation by the team. • The IDT used the Risk Level Guidelines when determining risk levels, but for some of the risk ratings the IDT should have applied clinical judgment to data when rating risks. For example: o Individual #599 was rated at low risk for infection although she was rated at medium risk for urinary tract infections, of which she had two within the past year. The RN Case Manager suggested that she be rated at medium risk for infection but the team agreed to continue to rate her at low risk for infection. Clinical judgment should have overridden the risk rating guidelines, which stated, two or fewer episodes requiring treatment in the past year." o Individual #599's Fall and Fracture risk was rated low but should have been rated medium because contributing fall risk indicators were not adequately explored and discussed based on her history of three falls within the last year, coupled with last DEXA Scan October 2011 of the heel, which does not adequately evaluate for osteoporosis of the spine and hips. Individual #599 needs a full body DEXA scan for accurate evaluation for a 5I year old white female who was post-menopausal, which increases risk of developing osteoporosis leading to risk of fractures. Additionally, she had three falls in the past year; one was attributed to being kicked by a peer and then fell. There was no further exploration of contributing factors causing the other two falls, such as environmental hazards or balance problems. o Individual #599 was rated at low risk for constipation because she received laxatives twice a day and rectal suppositories as needed if no bowel movements for three days. There was no discussion by the dietitian or other team member regarding the possibility of adding dietary measures to enhance bowel elimination and the potential to reduce or eliminate in the use of laxatives and/or suppositories. According to the Risk Guidelines to be rated at low risk she would have to have bowel elimination problems managed with diet. Based on history of requiring laxatives twice a day and rectal suppositories as needed, Individuals #599 should have been rated at least at medium risk. o Individual #599 was rated medium risk for pain secondary to dysmenorrhea, for which she was prescribed over the counter medication for pain and was reported to be effective. It was	

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		mentioned that she had uterine fibroids. She is 51 years old and could be peri-menopausal. There was no clinical data included for her last pap smear. There was no recommendation for a gynecological consult to evaluate the status of the uterine fibroid, peri-menopausal status, or for routine pap smears. Although there was some general improvement in the IRRF process, the Facilities' IDTs should exercise more clinical judgment in correlating relate areas of risk. <u>Aspiration Trigger Data Sheets:</u> At the last compliance review, there were numerous deficiencies found in completing the Aspiration Trigger Data Sheets. The Facility's Self-Assessment stated that the RN Nurse Case Managers were assisting with educational training need of the direct support professionals on the Aspiration Trigger Data Sheets and that the RN Case Manager Supervisor was available to consult on problems with the trigger sheets. The Monitoring Team reviewed Aspiration Trigger Data Sheets completed over the past three months for Individuals #392, #318, #185, ##331, #43, #35, #141, #284, and #167, and found there was little if any significant improvement in completing individuals trigger sheets from the past compliance review. Findings included: As was recommended at the last compliance review, the Nursing Department, Program Director and Habilitation Director 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 and to take corrective action as indicated.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and	<u>Monitoring Teams Findings:</u> The Monitoring Team validated the Medication Administration information presented in the Facility's Self-Assessment through: Review of the Medication Administration information presented in the Provision M.6 section of the Presentation Book; review of documents requested; meetings/interviews with the Chief Nurse Executive, Nursing Operations Officer, Pharmacy Director, Clinical Pharmacist, Medical Director, QA Director, QA Nurse, Program Compliance Nurse, and Nurse Managers; attendance at the Pharmacy and Therapeutics Committee Meeting; inspections/observations of units' Medication Rooms; Review of Units' Medication Administration Notebooks; and conducted Medication Administration Observations. Relevant Self-Assessment data were updated during the onsite compliance visit. The Facility's Self-Assessment stated they were in substantial compliance with Provision M.6 and the Monitoring Team concurs with their findings. <u>Medication Variance Policies and Procedures and Training</u> • Since the last compliance review, July 2012, the Facility had operationalized the State's Medication Variance Policy, 053, i.e., Pharmacy Services and Safe Medication Practices: Medication Variances, N.12, Implementation Date: 12/31/12.	Substantial Compliance

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	training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	• The Monitoring Teams review of the Facility's signed Training Rosters for the months of January 2013 and February 2013 validated that 98% of the nursing staff responsible for administering medications had received training provided by the Clinical Pharmacist on the Medication Variances, N.12, Policy, according records provided. Nurses that had not received the training were noted to be on extended leave. Training on the Policy was included in the New Nurse Orientation and at the annual nursing competency-based refresher training. • The Monitoring Team's review of the Facility's signed Training Rosters for October 2012 validated that 100% of the nursing staff responsible for administering medications had received training on Administering and Documenting Per Necessary (PRN) Medications. • At the time of the compliance review, according to the Facility's signed Training Rosters, 92% of the nurses had received the State's mandated Medication Administrating related to dysphagia and swallowing difficulties. This was a recently introduced training requirement. As explained in the Self-Assessment and by the Nurse Educator, "Due to the restriction in class size and seven hours of class time, a limited number of nurses were able to attend at one time. However, the plan is to be 100% complete by 6/1/2013." Medication Administration for Individuals with Developmental Disabilities with dysphagia and/or swallowing difficulties was taught jointly by the Nurse Educator and Habilitation staff. • The Monitoring Team's review of the Facility's signed Training Rosters validated that 100% of the Nurse Managers responsible for overseeing medication administration practices received refresher training by the Pharmacy on Cart Refill and Count (Reconciliation) Process and Checking Emergency Medications. <u>Medication Variance Committee Meetings:</u> • On 4/10/13, the Monitoring Team's nurse and physician met with the Chief Nurse Executive, Nursing Operations Officer, Pharmacy Director, Clinical Pharmacist, Medical Director, QA Director, QA Nurse, Program Compliance Nurse, and Nurse Shift Manager to review and discuss medication variance practices and the status of compliance with the Settlement Agreement since the last compliance review. The staff updated/described changes made to identify medication variances problems, improvements made in practices/processes, and corrective actions taken to mitigate the incidences of medication variances, as well as to meet compliance with the Settlement Agreement. The review and discussion also included information from the March 26, 2013, Medication Variance Committee Meeting, which was conducted prior to this onsite compliance review. • The Monitoring Team's review of the monthly Medication Variance Committee Meeting minutes for June 2012 through February 2013, found that the Committee was chaired jointly by the Clinical Pharmacist and Nursing Operations Officer. Since a Pharmacy Director was recently hired, she will replace the Clinical Pharmacist in chairing the meeting. The committee meeting will be chaired jointly and did an excellent job reporting medication variances, and analyzing and trending monthly and quarterly Medication Variance Data Reports by: department, severity levels, types of medication variances, classification of medications, and contributing factors for Units/Cottages, homes, shifts, and facility-wide. Local and systemic plans of correction were implemented, when	

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		indicated. This information was attached to the minutes. • The outcome of the discussions and findings of the Medication Variance Committee Meeting were further reviewed and discussed at the quarterly Pharmacy and Therapeutic Committee Meetings, as documented in the minutes. The Infection Control Nurse continued to develop and present the Antibiogram at the Pharmacy and Therapeutics Committee meetings regarding the sensitivity/susceptibility of antibiotics prescribed for specific organisms. The Antibiogram reported organisms that had 30 or more isolates. The Committee decided that the Antibiogram would only need to be updated annually as opposed to every six months since there probably would not be that much change within a six months period. This was further validated on 4/11/13; during the Pharmacy and Therapeutic Committee meeting attended by the Monitoring Team while onsite. Refer to Provision N.8 regarding additional information regarding the Pharmacy and Therapeutic Committee Meetings. • Since the last compliance review, the Monitoring Team found that continued notable improvements were made as identified through discussion and review of Medication Variance and Pharmacy and Therapeutics Committee Minutes, as well as other documents reviewed and observations conducted: o A formalized progressive Disciplinary Plan was developed and implemented for nurses who commit repeated and/or serious medication variance, i.e., any variance occurring on one day is considered an occurrence; after three occurrences performance counseling is provided; if variances continue, positive performance disciplinary level 1, then level 2, and possible Decision Making Leave (DML). However, depending on the severity level the medication variance can cause disciplinary action to go straight to DML. Since the last compliance review, there was documentation of a case in which the Facility took action appropriate to this policy. o The Monthly Medication Variance Committee included in the minutes: reviews; discussions of analyses; and trending of medication variances, along with any required local and systemic corrective actions. This was performed by departments, severity levels, types of medication variances, classification of medications, contributing factors, multiple variances committed on individuals, QA reports, and nursing self-audits of medication rooms and Medication Administration Records. The Nurse Managers continued to provide a Unit/Cottage report of medication variances occurring in their respective areas, as well as results of self-audits, along with corrective actions taken to mitigate variances and deficiencies found on the self-audits, when indicated. o Decisions were made regarding identifying systemic analysis and plans of correction. Due to the difference between the populations served in the various Units/Cottages related to demographics, medications rooms, prescribing patterns (e.g., Driscoll had more individuals with G-tube, Cottages medication rooms were very small, Bowie often relied on "pulled" staff or agency), it was difficult to analyze and aggregate data to identify systemic issues and to make value-added change. The Committee decided to look for systemic issues within each unit. Analysis of other facility-wide variances, such as storage variances, prescribing variances and dispensing variances occurred at a systemic level.	

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		o A new Medication Variance Database was developed and implemented, which captured the same information as the previous database. The new database put all departments' medication variances into one central database. Previously, each discipline entered their data in separate databases, and then merged the data monthly into one report. The new database eliminated the potential for disciplines to duplicate entries of medication variances, which could result in inaccurate reporting. The new Medication Variance Database began generating reports in September 2012. o Individuals were identified who had multiple missed/omitted or other types of medication variances. Case analyses were completed to determine probable contributing factors, along with plans of corrective action to prevent the reoccurrence of multiple variances. o Individuals who had missed/omitted anticonvulsant, antipsychotic, anticholinergics, and benzodiazepines were tracked. This information was sent to the designated BCBA, who became a member of the Medication Variance Committee. o The physicians were reporting their medication variances as opposed to relying on the pharmacy to report them. The Medical Director was investigating medication variances and taking corrective action with the responsible physicians. o Individual Treatment Administration Records (TARs) were developed and implemented that replaced the previous treatments records. <u>Medication Variances Reported:</u> • The Facility continued to maintain an excellent Medication Variance Database to record, track, analyze, trend, and 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, by individual, and type of medication for which the variance occurred. The reports also included monthly ratios of medication variance to total doses of medication administered. The Medication Variance Database reported variance data monthly, quarterly, and longitudinally. Medication variance data reported was presented in tabular, graphic, and narrative forms. • At the last compliance review, there was a significant increase in the number of nursing medication variances reported in June 2012. The increase was due to the change in reporting all unexplained/not reconciled medications returned to the pharmacy. Furthermore, in September, October, and November 2012, nurses began reporting uncharted medications found on the Medication Administration Records as medication variances. A Reconciliation Procedure was put in place in collaboration with the Pharmacy to investigate, both by nursing and the pharmacy, any medications found in the medication cart drawers, at the time they were found; at cart exchange a staff nurse, along with pharmacy staff, checks the medications supplied to ensure the right number and correct medications were resupplied. Corrective action was taken on the spot to reconcile any identified discrepancies, as well as when the Nurse Managers complete their weekly Medication Room and Medication Administration Notebook audits. For all unexplained/not reconciled medications found in the drawers a Medication Variance Report was completed. Medication	

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Overage Reports were also completed either by nursing and/or the pharmacy when medications were returned to the pharmacy with an explanation of the reason for return. Additionally, any time medications were found not documented, i.e., if they were not circled and explained on the back of the Medication Administration Records, a Medication Variance Report was completed. There was copious documented evidence provided and reviewed that showed concerted efforts were put forth campus-wide to correct these two issues. Including the copies of local and systemic corrective actions taken at the monthly Medication Variance Committee Meetings. Consequently, since June 2012, there has been a some progressive decrease in the incidences of medication variances across all departments, particularly nursing; as the data chart below shows:

Medication Variances by Disciplines – June 2012 through February 2013

	2012-06	2012-07	2012-08	2012-09	2012-10	2012-11	2012-12	2013-01	2013-02
Dental	NA	NA	NA	2	NA	NA	NA	2	1
Medical	20	16	14	10	21	14	6	6	14
Nursing	246	84	85	89	152	103	74	90	67
Other*	NA	NA	4	NA	1	NA	NA	NA	NA
Pharmacy	11	28	27	33	34	45	29	31	10
Total	277	128	130	134	208	162	109	129	92

Other* not specified.

The Monitoring Team reviewed ten of the most recently completed Medication Variance Reports for Individuals: #160, #363, #13, #111, #460, #276, and #67. Findings include:
Medication Variances Reports, Sections A through P were completed as follows:

- Ten of ten (100%) reports were completed correctly for Section A, dates and locations of the variances.
- Ten of ten (100%) reports were completed correctly for Section B, node of variances.
- Ten of ten (100%) reports were completed correctly for Section C, type of variances.
- Ten of ten (100%) reports were completed correctly for Section D. Severity Index, categories describing circumstances or events that have the potential to cause variances. Of which nine (90%) were Category B (A variance occurred but the medication did not reach the individuals.) One was for Category C (A variance occurred that reached the individual but did not cause individual harm.)
- Ten of ten (100%) reports were completed correctly for Section E, department responsible for the variances.
- Ten of ten (100%) reports were completed correctly for Section F, patient profile information (individual's Name, case number, home, age, and gender) and notification of physician (physician's name, date and time of notification and physician's comments' if any).
- Ten of ten (100%) reports were completed correctly for Section G, product information (name of medication, dose form, strength, number of doses missed, route of administration, and medical provider's actual order).

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		o Ten of ten (100%) reports were completed correctly for Section H, staff information (name of staff involved in the variances, shift variances occurred on, whether staff was working overtime, staff floating to home, or agency staff). o Ten of ten (100%) reports were completed correctly for Section I, notification of physicians', including physician's names, date and time of notification, and physician comments. o Nine of ten (90%) reports were completed correctly for Section J, additional data relating to the variances, (including data that helps identify why the variances occurred). However, in two of the reports the additional data explaining why the variances occurred were written in Section H, the staff information. o One of one (100%) reports was completed correctly for Section K, for the one Category C variances. In the one completed Section K, the variance was categorized as a Category C (A variance occurred that reached the individual but did not cause individual harm.) and the PCP ordered an alteration for time medication was to be administered. However, completion of Section K was not indicated for the variances related to the Severity Index for Categories A or B where the medication did not reach the individual and where there were no PCP orders or indication for further monitoring and/or interventions. o Section L, additional details on the level of care administered to the individual as a result of the variance was not applicable since there were no physician orders or other interventions required as a result of the variance reported in Section K. o Section M, completion of the section if the report related to an unreconciled variance. This section was not applicable because none of the variances were unreconciled. o Zero of ten (0%) of Section N, signature of departments supervisor completing the investigation because in Section N, the departments supervisor completing the investigation and the department supervisor that completed the follow-up, including the causes and corrective actions taken were one and the same. o Five of ten (50%) of Section O failed to include the causes of the variances and sufficiently describe the corrective actions taken. The supervisor simply stated, "Follow medication procedure". However, all medication variances were further review by the respective unit Nurse Manager and again at the monthly Medication Variance Committee Meetings, as reflected in the minutes. o There was no indication for Section P of the reports to be completed for individual/family notification because there was no Severity Index, Categories E through I reported. Although the few items on the Medication Variance Report were not completed thoroughly, this should not negate compliance with this Provision because there was evidence of further oversight and review of the Medication Variance Reports by the unit Nurse Managers as well as at the Medication Variance Committee Meeting, who conducted further review and took additional local and systemic corrective action when indicated. However, the Nursing Department should ensure that all Medication Variance Reports are filled out completely as indicated, including the contributing factors leading to the various types of medication variances, that they are thoroughly analyzed, trended, and local and systemic	

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		corrective actions are taken as indicated. <u>Self-Audits for Medication Administration Observations, Medication Rooms, and Medication Administration Records:</u> • The Facility had procedures for conducting audits and inter-rater reliability checks, reviewing, analyzing, and corrective action for Self-Audits on Medication Administration Observations, Medication Rooms, and Medication Administration Records. • Medication Administration Observations were completed quarterly on all nurses administering medication by the Nurse Managers, Shift Managers, and QA Nurse for inter-rater reliability. • The Medication Administration Observation Tool was revised on 12/1/12, in order to improve the effectiveness of the observation, i.e., critical items that must be performed 100% correctly when identified as "essential" on the tool. Nurses who failed to perform "essential" items correctly 100% of the time required retraining before continuing to administer medication. • Medication Observation Reports for the third quarter (July, August, and September 2012) showed an overall compliance rate of 99.6%. Reports for the fourth quarter (October, November, and December 2012) showed an overall compliance rate of 99.1%. Corrective action plans were included with reports, which validated that nurses who failed to perform the "essential" items 100% of the time were retrained. • The Monitoring Team's review of Medication Room Audit Reports for the third quarter (July, August, and September 2012) showed an overall compliance rate of 92%. Reports for the fourth quarter (October, November, and December 2012) showed an overall compliance rate of 98.6%. Corrective action plans were included with the reports, which validated that such actions were taken when deficiencies were identified. • The Monitoring Team's review of Medication Administration Records for the third quarter (July, August, and September 2012) showed an overall compliance rate of 97.3%. Reports for the fourth quarter (October, November, and December 2012) showed an overall compliance rate of 98.6%. Corrective action plans were included with reports, which validated such actions were taken when deficiencies were identified. These audits showed continued progress from the previous compliance review. <u>Monitoring Team's Inspection/Observation and Review of Medication Rooms and Medication Administration Notebooks:</u> • On 4/8/13, the Monitoring Team conducted inspections/observations of medication rooms, and Medication Administration Record Notebooks, Narcotics/Control Drugs Logs, and Glucometer Logs in Bowie A, Driscoll D, Childress B, Cottage B, and Fannin C, accompanied by the CNE, NOO, Nurse Shift Manager, and respective Unit Nurse Managers. The respective Nurse Managers were observed completing their weekly audits for Medication Rooms, Medication Administration Record Notebooks, Narcotic/Control Drug Logs, and Glucometer Logs. The results of these audits were consistent with the Facility's audit results reported above. There were only minor deficiencies found: On Childress B, a few medications were not initialed on individuals' Medication	

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		Administration Records on 4/2/13 at the 4:00 p.m. medication pass. This was attributable to a new agency nurse. On Fannin C nurses failed to initial a few days on individuals' Self-Administration of Medication Program Records. In both instances the Nurse Managers took immediate corrective action with the nursing staff and provided the Monitoring Team with documentation to validate that the corrective actions were taken. These inspections/observations demonstrated progress toward compliance. • The Monitoring Team's review of the above units/cottages Medication Administration Record Notebooks found that all (100%) medications prescribed to be administered at specific times, i.e., 30 minutes before meals, were highlighted in red. • It was positive to find that the Cottages' that had small and cramped medication rooms that emptied into the main living rooms, which contributed to distractions and individuals entering and grabbing medications, were in the process of being renovated to so that they will have medication rooms to allow adequate space to store medication and provide safe medication administration. The 14 medication room refrigerators that were ordered at the time of the last compliance review had been received and replaced the antiquated and malfunctions refrigerators. <u>Monitoring Team's Medication Administration Observations:</u> The Monitoring Team conducted Medication Administration Observations on 4/9/13 at the 4:00 p.m. medication pass on Driscoll D and on Fannin B on 4/10/13 at the 4:00 p.m. medication pass, accompanied by CNE, NOO, Nurse Shift Manager, and respective Unit Nurse Managers. The Facility's standardized Medication Administration Tool was used to evaluate the performance of nurses administering medications. Medications administered in Driscoll included medication administered both orally and enterally. Medications administered in Fannin B were all administered orally. All nurses observed successfully completed, with 100% compliance, the medication administration passes according to generally accepted standards of medication administration practices; including reviewing and following individuals' Physical and Nutritional and Management Plans. The direct support professionals assisted the nurses during the medication passes by bringing one individual at a time to the nurses for medications. All individuals were afforded privacy during medication administration. Individuals were treated with respect and courtesy by all staff. These observations demonstrated continued progress toward compliance. The Facility's Self-Assessment stated they were in substantial compliance with Provision M.6; the Monitoring Team found that significant improvement was made in both in medication administration practices and in the Facility's medication variances procedures and processes to track, analyze and provide local and systemic corrective action plans. Therefore, this Provision was found in substantial compliance. Although substantial compliance was found at this compliance review; in order for this Provision to continue to meet substantial compliance the positive practices found must be maintained, with a need to continue to demonstrate effective steps over time to mitigate medication variances. Further, the positive medication administration practices and medication variances procedures and processes demonstrated by this Facility are exemplary to their peers and should be recognized as such.	

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		Refer to Provision N.8 for additional information regarding medication variance.	

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

1. The PNMT Nurse should complete assessments in an environment conducive to allowing individuals' privacy, positioning for comfort, the visibility of the wounds; as well as the ability to efficiently make other pertinent assessments. (Provision M.1)
2. It would be helpful to the Nursing Department if the Facility could provide additional human resources to assist in populating the AVATAR Immunization Database. (Provision M.1)
3. The Facility should ensure due/delinquent employees on Infection Control refresher training are brought up to date as soon as possible. (Provision M.1)
4. Because sound nutrition is essential to wound healing, the dietitian should be an integral committee member of the Skin Integrity Committee to evaluate the nutritional status of individuals' with wounds and/or pressure ulcers. (Provision M.1)
5. The Facility's discipline leads responsible for employees who were due/delinquent for Basic CPR training should ensure that the training is brought up to date as soon as possible. (Provision M.1)
6. Although there was some general improvement in the IRRF process, the Facilities' IDTs should exercise more clinical judgment in correlating related areas of risk. (Provision M.5)

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. BSSLC Self-Assessment (3/21/13) 2. BSSLC Action Plan (3/21/13) 3. BSSLC Presentation Book, April 2012 4. Pharmacy Services and Safe Medication Practices N.12; Medication Variances, dated 12/31/2012 5. QDRR schedule 6. Psychoactive medication oversight committee meeting (PMOC) minutes for 4/14/2013 7. Tracking and trends analysis for chemical restraint use 8. P&TC minutes for April 2011, April 2012, July 2011, July 2012, April, 2013, January 2013 9. Medication variance committee meeting minutes, dated 11/27/2012, 12/18/2012, 1/29/2013, and 2/26/2013 10. Ten recently completed Medication Variance Reports for Individuals: #160, #363, #13, #111, #460, #276, and #67 11. Tracking and trends analysis for benzodiazepine use 12. Tracking and trends analysis for adverse drug reactions (ADR) 13. Tracking and trends analysis for medication variances 14. Drug utilization evaluation (DUE) schedule 15. Pharmacy department DUE audits 16. Copies of all DUEs provided during the review period **People Interviewed:** 1. Trey Knittel, PharmD, RPh (Clinical Pharmacist) 2. Robin Blankenburg, RPH (Pharmacy Director) **Meeting Attended/Observations:** 1. Pharmacy and Therapeutics Committee Meeting, 4/11/13
	Facility Self-Assessment: The following is a summary of the Monitoring Team's assessment of the Facility's self-assessment for Provisions N1, through N8. The Facility rated itself in substantial compliance for Provision N.1 by indicating that the prescriber had followed up on pharmacists' recommendations; while in some cases, the Monitoring Team noted during its review of single patient interventions, the prescriber would at times indicate that a clinical issue did not need specific follow-up, and the pharmacist did not question the clinical rationale. The Facility should assess the content of actions, to ensure clinical appropriateness. The Facility determined that it was not in compliance with Provision N.2, because QDRRs were not completed timely. The self-assessment was completed prior to the Monitoring Teams review, and subsequently, the Facility had rectified its staffing issue, and all QDRRs were updated. In addition, the

	Monitoring Team was provided a rational explanation for the original delays, and action plan to ensure that the Facility would not be delayed in completing QDRRs in the future. The Monitoring Team recommends that the Facility assess more then just completion of laboratory values, when assessing completeness of the QDRR process. The Facility should assess whether QDRRs provide a comprehensive review of medication management. Provision N.3: The Monitoring Team concurs with the Facility's self-assessment for Provision N.3. Provision N.4: The Monitoring Team agrees with the Facility's self-assessment for Provision N.4; however, the Monitoring Team would like to recommend that the Facility also assess whether the pharmacists ensure FDA approval for a drug or that the clinical rationale was documented. Provisions N.5 through N.8: The Monitoring Team is in agreement with the Facility's self-assessment for Provision N.5, N.6, N.7, and N.8
	Summary of Monitor's Assessment: The Monitoring Team would like to acknowledge the Facility's leadership, and staff involved in addressing Section N, and congratulates them for achieving substantial compliance. The Facility has developed and implemented many policies and procedures that have substantially improved the prescribing, dispensing, monitoring, and assessing of efficacy of medication usage at the Facility. The Facility's effort has contributed to the reduction of unnecessary medications, the monitoring, and management of side effects, and to addressing adverse effects of medications. The Monitoring Team would like to compliment the staff for their hard work, and diligence. The Monitoring Team has made several recommendations that it expects to see implemented in the near future, and will closely monitor for continued compliance at future compliance reviews. Provision N.1: The Monitoring Team concurs with the Facility's self-assessment of substantial compliance with Provision N.1. Single Patient Drug Interventions (SDIs) included a clinically appropriate recommendation by the pharmacist and documented evidence that the medical practitioner addressed the pharmacist's concern. The Monitoring Team stresses that the pharmacist must ensure that the prescribers had addressed recommendations in a clinically justifiable manner, and ensure that the prescriber's action plan is well documented. The pharmacist appropriately documented reviews of new medication orders for allergies, drug interactions, clinically appropriateness, and appropriate dose. Provision N.2: The Monitoring Team agrees with the Facility's self-assessment of substantial compliance with Provision N.2. The Facility had significantly fallen behind keeping up to date with completing QDRRs timely because of a resignation of a key staff member; however, since staffing had been restored for the past two months, the Facility had completely caught up on all delinquent QDRRs, and is up to date with all QDRRs. It is essential that the Facility maintain appropriate staffing, and assignment of duties, that will enable completion of QDRRs timely. The Monitoring Team was impressed by the continued high quality of the QDRR process, and will continue substantial compliance. Per discussion with the clinical pharmacist,

	there was a discrepancy with how the Facility determined risk factors for metabolic syndrome; however, continuing forward, the Facility is aware that individuals who have medical conditions that predispose to metabolic syndrome, such as hypertension, hyperlipidemia, and diabetes, despite being treated for the condition, are to be are considered positive risk factors for metabolic syndrome. Provision N.3: The Monitoring Team concurs with the Facility's self-assessment of substantial compliance for Provision N.3. There was documentation to indicate that the pharmacist comprehensively reviewed the one sole use of stat psychotropic chemical restraint for appropriate dose, provided justification, assessed risk and efficacy, and provided clinically appropriate recommendations. There was documentation that indicated that the prescribing medical practitioner had reviewed the use of the chemical restraint, commented on dose, appropriateness and potential alternative treatments, within the context of a team meeting. Use of benzodiazepines is reviewed monthly for each individual. Review of the Facility's trends analysis indicated a continued decrease in the use of benzodiazepines for psychiatric issues, but increased usage for spasticity. Review for each individual using polypharmacy documented justification for use. The Facility did provide an annual systems review for polypharmacy, as part of the PMOC meeting. The Facility did not provide a trends analysis for psychotropic polypharmacy. The Facility needs to develop and implement a trends analysis for the use of benzodiazepines and polypharmacy; indicate the rationale and provide recommendations to help mitigate the use of benzodiazepines, when clinically appropriate; and ensure that all risk factors for metabolic syndrome are included when assessing metabolic syndrome. Provision N.4: Because all samples reviewed were noted to have the prescribers' documented review, and included relevant action plans 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, as there were no such examples observed at this review. Provision N.5: Provision N.5 came into substantial compliance. Individuals who needed side effect screens had received them, and these were generally reviewed and signed by prescribers. Good clinical judgment was evident for review of findings during interdisciplinary meetings and for determinations of need for additional screenings. Provision N.6: The Facility provides a clinically relevant, and effective ADR process, and agrees with the Facility self-assessment of substantial compliance with Provision N.6; however, in addition, the Facility should notify LARs of ADRs that require medical intervention, and should implement its planned refresher training program for relevant staff. Provision N.7: The Monitoring Team agrees with the Facility's self-assessment of substantial compliance with Provision N.7 and compliments the Facility on developing and implementing a drug utilization and evaluation process that enables a high quality review of medication usage at the Facility, and provides prescribers with clinically relevant and important recommendations on the use of medications. Provision N.8: The Facility had developed an impressive medication variance process that was supported

	by a comprehensive and effective policy, and by a committee structure that tracked and trended medication variances by type and category, department, staff, living area and individual. Directors for nursing, medicine, and pharmacy provided a detailed analysis of their respective department's variances, and summarized remediation action and system improvement efforts. The Monitoring Team concurred with the Facility's self-assessment of substantial compliance with Provision N.8.

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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 continued compliance with Provision N.1, the Monitoring Team selected the first two single drug interventions (SDI) that occurred in November 2012, December 2012, January 2013, February 2013, and March 2013, and reviewed to ensure that the pharmacist clearly addressed the potential drug-drug interaction; and also the first two new medication orders that occurred in November 2012, December 2012, January 2013, February 2013, and March 2013, to ensure that the pharmacist effectively reviewed the medication order for appropriate dose, indication, side effects, and allergies. <u>Single Patient Drug Interventions (SDI)</u> For the ten SDIs, nine out of ten (90%) included a clinically appropriate recommendation by the pharmacist; and six out of ten (60%) included documented evidence that the medical practitioner addressed the pharmacist's concern. Summary: The Monitoring Team was pleased to see that pharmacists continued to address potential drug-drug, and other potential drug interactions by communication with the prescriber. In one particular case, that involved individual #460, the pharmacists raised concern of a potential serious drug reaction, caused by adding an antibiotic to an antipsychotic, and did not document that the prescriber addressed the issue in a clinically appropriate way. Although six out of ten cases demonstrated evidence of the prescriber actually addressing the pharmacist's concern, four out of ten lack the level of documented evidence needed. For example, Individual #460 was prescribed an antibiotic along with an antipsychotic, and there were no additional orders to either change the medications, or enhance monitoring by additional EKGs. Individual #186 was prescribed an antipsychotic while having a history of an elevated QTc interval (abnormal electrical conduction of the heart), and there was no further follow-up documented, or change in medication order. It is incumbent that the pharmacist check to determine that clinically appropriate action be taken by the prescriber, per the pharmacist's recommendation. The Monitoring Team will continue substantial compliance at this time, but will review this issue closely at future reviews. The Facility must ensure there is documentation to support that the medical prescriber had addressed the pharmacist's concern and recommendation, in a clinically appropriate way. The pharmacist cannot just "agree" with the prescriber indicating that there is no problem, and continue to dispense the	Substantial Compliance

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		medication without a clinically appropriate action taken. The Monitoring Team views these circumstances as meeting the criterion set forth in Section III.D of the Settlement Agreement. In this section, the parties included the following language: "Noncompliance with mere technicalities, or **temporary failure to comply during a period of otherwise sustained compliance**, shall not constitute failure to maintain substantial compliance." (Emphasis added.) As a result, the Facility has maintained the finding of Substantial Compliance with the understanding that for a substantial compliance rating to continue during the next review, the pharmacist must ensure there is documentation that the prescriber addressed the issue in a clinically appropriate way. <u>New Medication Orders</u> By reviewing new medication orders, and associated annual medical assessments, laboratory data, and diagnostics, including DEXA scans, and EKGs, the Monitoring Team noted that in all ten out of ten cases (100%), the pharmacist appropriately documented a review for allergies, drug interactions, clinically appropriateness, and appropriate dose. Summary: The Facility continues to be in substantial compliance with Provision N1, by ensuring appropriate clinical review of all new medication orders. Although the sample reviewed contained no examples of non-FDA uses of medications, the Monitoring Team discussed, during the meeting with the director of pharmacy, that the Pharmacy department must document a review of non-FDA uses of drugs, and when used off label, provide evidence the drug is being prescribed for an appropriate indication. Conclusion: The Monitoring Team concurs with the Facility's self assessment of substantial compliance with Provision N.1; however, compliance n the future will require that the pharmacist ensures that the prescribers had addressed recommendations in a clinically justifiable manor, and ensure that the prescribers action plan is well documented.	
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 assess the Quarterly Drug Regimen Review (QDRR) process, the Monitoring Team requested the first two QDRRs that were completed in November, December, January, February, and March, of this reporting period (individuals #465, #249, #392, #395, #69, #413, #286, #282, #293, #429), 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 reviewed the Facility's schedule of all completed and pending QDRRs. <u>QDRR Schedule</u> Review of the QDRR schedule indicated that the Facility had significantly fallen behind	Substantial Compliance

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		keeping up to date with completing QDRRs timely; however, for the past two months, the Facility had completely caught up on all delinquent QDRRs, and is up to date with all QDRRs. The pharmacy director, and clinical pharmacist, shared with the Monitoring Team that because of a resignation of a key staff member, they were unable to maintain the schedule, but since staffing had been restored, the Facility was able to resolve the delinquency issue. The Monitoring Team views these circumstances as meeting the criterion set forth in Section III.D of the Settlement Agreement. In this section, the parties included the following language: "Noncompliance with mere technicalities, or **temporary failure to comply during a period of otherwise sustained compliance**, shall not constitute failure to maintain substantial compliance." (Emphasis added.) As a result, the Facility has maintained the finding of Substantial Compliance with the understanding that for a substantial compliance rating to continue during the next review, QDRRs must continue to be performed timely according to the schedule. Summary The Monitoring Team is satisfied with the current completion status of QDRRs; however, the Monitoring Team strongly recommends that the Facility assess staffing issues related to completion of QDRRs, to ensure adequate staffing and assignment of duties that will continue to enable timely completion of QDRRs. <u>QDRR Review</u> Of the ten QDRRs reviewed, ten out of ten (100%) were completed timely; ten out of ten (100%) were appropriately signed by the pharmacist and prescriber/s; ten out of ten (100%) included a review of all clinically necessary issues, included bone density results, seizure activity, and review of EKGs, as necessary; ten out of ten (100%) commented on polypharmacy, the use of benzodiazepines, anticholinergics, and stat medication use, when clinically indicated; ten out of ten (100%) indicated a comprehensive review of laboratory data; of the three individuals on antipsychotics, the pharmacist commented on metabolic syndrome in three out of three cases (100%). Summary: The Monitoring Team was impressed by the continued high quality of the QDRR process, and will continue substantial compliance. Per discussion with the clinical pharmacist, there was a discrepancy with how the Facility determined risk factors for metabolic syndrome; however, continuing forward, the Facility is aware that individuals who have medical conditions that predispose to metabolic syndrome, such as hypertension, hyperlipidemia, and diabetes, despite being treated for the condition, are to be are considered positive risk factors for metabolic syndrome. In other words, being treated for a known risk factor, does not eliminate the risk, and must still be considered as a risk factor for metabolic syndrome.	

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		Conclusion: The Monitoring Team agrees with the Facility of substantial compliance with Provision N.2. It is essential that the Facility maintain appropriate staffing and assignment of duties that will enable completion of QDRRs timely. Also, ensure that all treated risk factors for metabolic syndrome, are considered as risk factors for metabolic syndrome.	
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 minute, from the May, June, and July psychoactive medication oversight committee meetings (PMOC) were reviewed. <u>Stat Medication Use</u> The Facility reported the use of only one psychotropic chemical restraint, during this reporting period (Individual #402). There was documentation to indicate that the pharmacist comprehensively reviewed the use of stat psychotropic chemical restraint for appropriate dose, provided justification, assessed risk and efficacy, and provided clinically appropriate recommendations. There was documentation that indicated that the prescribing medical practitioner had reviewed the use of the chemical restraint, commented on dose, appropriateness and potential alternative treatments, within the context of a team meeting, dated 2/19/2013. Summary: The Facility continued to provide excellent review of stat chemical restraints. <u>Benzodiazepine Use</u> The Monitoring Team selected the first ten individuals (Individuals #167, #1, #501, #471, #270, #27, #61, #255, #39, and #417), from a list of all individuals who were prescribed scheduled benzodiazepines, and reviewed the most recent QDRR, current medication list, and most recent psychiatric assessment. In addition, the Monitoring Team reviewed PMOC minutes for April, 2011 and April 2012, as well as longitudinal trends analysis, of the use of benzodiazepines, to determine whether the Facility tracked and acted on trends over time. Of the ten individuals who were prescribed benzodiazepines, ten out of ten (100%) indicated review for appropriate indication and dose, by a pharmacist; ten out of ten (100%) cases demonstrated evidence that the use, appropriateness, and strategies to reduce the use of benzodiazepine was reviewed and incorporated into the individual's	Substantial Compliance

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		QDRR. Review of the PMOC meeting minutes for April 10, 2012 and April 27. 2011, indicated a systems review of the use of benzodiazepines, and the Monitoring Team was informed that the annual systems review would take place at the May, 2013 PMOC meeting. In addition, the use of benzodiazepines is reviewed monthly, for each individual, at a psychiatric medication review. Review of the Facility's trends analysis indicated a continued decrease in the use of benzodiazepines for psychiatric issues, but increased usage for spasticity. Overall, 75% of all benzodiazepines were prescribed for non-psychiatric indications. Trends analysis data was not clearly defined. Summary: The Facility continued to review and monitor the use benzodiazepines at the Facility, and to develop strategies to help mitigate the use of benzodiazepines for scheduled psychiatric indications, when clinically appropriate. <u>Anticholinergic Use</u> The Monitoring Team reviewed the QDRRs, current psychiatric assessment, and current medication list of the first ten individuals, on a list of all individuals, who were prescribed anticholinergic medications (Individuals #96, #167, #286, #413, #163, #437, #189, #61, #517, and #39). In addition, the July 6, 2011 and July 7 2012 PMOC meeting minutes were reviewed for a Facility's system review of anticholinergic usage. The Monitoring Team was informed that anticholinergic use would be discussed at the July 2013 POMC meeting. A longitudinal trends analysis of anticholinergic use was provided for review, and indicated a significant reduction from higher risk anticholinergics, such as Benztropine, to more favorable anticholinergics, such as glycopyrolate. At the time of the review, of the ten cases, nine were actually prescribed an anticholinergic. Individual #437 was not prescribed an anticholinergic. Of the nine cases, nine out of nine (100%) indicated a comprehensive review, on the QDRR, that included review of indication, and appropriateness of anticholinergic use. Summary: The Facility continued to provide exceptional overview of the use of anticholinergic medication. <u>Psychotropic Polypharmacy</u> The Monitoring Team selected the first ten individuals (Individuals #367, #167, #52, #471, #61, #144, #187, #255, #39), from a list of all individuals who were prescribed	

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		psychotropic polypharmacy, and reviewed associated QDRRs, current medication list, and most recent psychiatric assessment. In addition, the April 9, 2013 PMOC minutes were reviewed, which demonstrated a systems review of psychotropic polypharmacy usage. Of the ten cases reviewed, there was documented evidence that the Facility justified the use of psychotropic polypharmacy, as part of the psychiatric treatment review in ten, out of ten cases (100%). Although the pharmacists documented a review of the "psychiatric treatment review note" for polypharmacy, in ten out of ten cases (100%), the pharmacist did not include a specific statement indicating appropriate use of polypharmacy on the QDRR. Summary: The Facility did provide an annual systems review for polypharmacy, as part of the PMOC meeting. The Facility did not provide a trends analysis for psychotropic polypharmacy. The Monitoring Team recommends that the Facility maintain a longitudinal trends analysis of the use of psychotropic polypharmacy, which will help demonstrate the Facility's effort to reduce polypharmacy. Also, the Monitoring Team recommends, for future compliance, that the pharmacist indicate, on the QDRR, if polypharmacy is appropriate, and recommendations to reduce polypharmacy, when clinically appropriate. <u>Monitoring of Metabolic Syndrome</u> The Facility generated alphabetic lists of individuals who were prescribed antipsychotic drugs, and who had a diagnosis of hypertension, diabetes, or hyperlipidemia. From the three lists, the first two individuals were selected, and the following documents were reviewed: most recent two QDRRs, current psychiatric assessment, current medication list, and last 12 months of laboratory data. Per discussion with the clinical pharmacists, it was determined that the Facility had excluded risk factors that were treated, if associated monitoring parameters were within normal limits. For example, if an Individual was diagnosed and treated for diabetes, and the blood sugars were controlled by medications, the Facility would not consider the diabetes as a risk factor. The Facility will, however, include such conditions as risk factors in the future. Of the six cases reviewed (individuals #167, #86, #305, #133, #517, #187), six out of six cases (100%) included a comprehensive review for metabolic syndrome, and provided clinically relevant recommendations for the prescriber, when clinically indicated. Summary:	

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		The Facility provides an excellent review of metabolic syndrome, and provides clinically relevant recommendations for consideration by the prescriber. For future reviews, the Facility must ensure to include treated conditions, such as diabetes, hypertension, and hyperlipidemia, as risk factors. Conclusion: The Monitoring Team concurs with the Facility's self-assessment of substantial compliance for Provision N.3. Continued compliance will require that the facility will develop and implement a trends analysis for the use of benzodiazepines and polypharmacy; indicate the rationale and provide recommendations to help mitigate the use of benzodiazepines, when clinically appropriate; and ensure that all risk factors for metabolic syndrome are include when assessing metabolic syndrome.	
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 determine if prescribers review and address pharmacists recommendations, the Monitoring Team reviewed the QDRRs selected for review for Provisions N3 of this report (Individuals #167, #86, #305, #133, #517, #187, #367, #167, #52, #471, #61, #144, #187, #255, #39, #96, #286, #413, #163, #437, #189, #1, #501, #270, #27, #39, and #417). Of the 27 QDRRs review, 27 out of 27 (100%) indicated appropriate clinical recommendations for the prescriber to consider; 27 out of 27 (100%) demonstrated review, and approval of the pharmacist's recommendation by the prescriber. Conclusion: Because all samples reviewed were noted to have the prescribers' documented review, and included 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, as there were no such examples observed at this review.	Substantial Compliance
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	At the Facility, MOSES evaluations were required at a minimum of every six months, and DISCUS evaluations were required (for individuals who took medications that can cause tardive dyskinesia) at a minimum of every three months. Facility screening for dyskinesia included all individuals who took Reglan, a medication prescribed for non-psychiatric indications that can cause dyskinesia. Physicians needed to review and sign the side effect screening forms. There is a DADS draft policy that states that MOSES and DISCUS side effect screens would be provided following a change in medication dose, as determined by the psychiatrist. The Facility had already begun to do so. <u>Completion of MOSES and DISCUS Screens</u>	Substantial Compliance

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		The Monitoring Team reviewed the Facility's list of individuals who received MOSES and DISCUS evaluations. The lists confirmed that individuals who needed side effect screens had received them, including individuals who took Reglan. <u>Quality of Completion of Side Effect Rating Scales</u> The Monitoring Team next reviewed the records of the 22 individuals in Sample J1. That sample represented 16% of individuals who took psychiatric medications. For Sample J1 20 of 22 individuals (91%) had both the MOSES and DISCUS administered with the required frequencies. For the group of 22 individuals there were 37 MOSES evaluations and 34 of 37 (92%) were signed by the physician. However, in four of the 37 cases (11%) the physician did not complete the prescriber review section of the form. Both the review and signature were needed. Overall, the MOSES forms were completed and reviewed by the physician in 30 of 37 (81%) of the cases. For the same group of individuals there were 50 DISCUS evaluations; 49 of 50 (98%) were completed and signed by the physician. The Monitoring Team reviewed administrations of the side effect screen that were done in response to a change in medication dose. Ten of 22 (45%) of the individuals had at one or more side effect screen in response to a dose change. Review of PTR notes showed that physicians, determinations of which individuals needed the additional screens appeared to reflect good clinical judgment. The Monitoring Team reviewed PTRs for all individuals in Sample J1. PTRs included a section on side effects that showed how IDTs reviewed the MOSES and DISCUS screens that had been done during the review period. PTR notes documented active discussions about findings from the screens, and psychiatrists commented on actions taken to minimize any side effects. The Monitoring Team also attended PTRs on 4/10/13 and observed how information about side effects was discussed by IDT members. 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. 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. Four individuals were diagnosed with tardive dyskinesia. All were followed by psychiatry. The pathophysiology of tardive dyskinesia is such that the same medications that cause dyskinesia can also mask the effects, and thus lower DISCUS ratings. For that reason when those medications are reduced, for example during efforts to minimize unnecessary polypharmacy, DISCUS scores may actually go up rather than down. Review	

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		of PTR documents of individuals from Sample J1 who had dyskinesia showed that psychiatrists were attentive to that issue. Further comments about PMOC monitoring for dyskinesia were included under Provision J11. <u>Training for Side Effect Rating Scales</u> During the visit the Monitoring Team met with members of the nursing staff to review the training provided to nurses on the administration of the side effect rating scales. Training on the rating scales was provided in a half-day block of time during the nurses' orientation. It included viewings of training videotapes for DISCUS ratings that were made by the author of the tool. Nurses viewed a video that demonstrated the various side effects and how that are rated, and nurses also viewed a video in which an examination was shown and the trainee was asked to provide a rating. The video then provided feedback on how an expert rater would have assessed the movement problems. The Monitoring Team inquired about the training of the trainers (nurse case managers and/or nurse educator). The Facility responded that trainings were given by experienced raters, and the Facility responded that it was looking into acquiring outside trainings for this purpose. The Facility should consider doing periodic interobserver reliability checks for MOSES and DISCUS ratings, to assure the continued quality of the nurse ratings for side effects. For the same reasons, the Facility should also consider putting in place annual retraining for the MOSES and DISCUS raters. <u>Monitoring Team's Compliance Rating</u> MOSES and DISCUS reviews were provided to individuals who needed them, including individuals who took Reglan. The screens were done by nurses and physicians reviewed and signed the results, typically within two weeks. Side effects screens were discussed during PTRs, as were QDRRs done by the pharmacy that also contained information on MOSES and DISCUS. PTRs included IDT reviews of side effect screens and the psychiatrist often included information about side effects in the PTR documentation. The Monitoring Team found that that Facility is now in compliance with the requirements of this provision. Facility efforts to obtain outside training for nurse case managers/nurse educators should continue. This is important to the Facility's ability to continue to provide good quality screens.	
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	To assess the Facility's ability to manage adverse drug reactions (ADR), the Monitoring Team reviewed all ADRs that occurred during the reporting period (Individuals #362, #243, #362 (two ADRs), and #528); reviewed P&TC minutes for April 11, 2013, and January 31, 2013; reviewed tracking and trends analysis for ADRs; and discussed the Facility's training of ADR reporting process with the clinical pharmacist and director of pharmacy.	Substantial Compliance

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	drug reactions.	Review of ADRs Of the four reported ADRs that occurred during the reporting period, four out of four (100%) included a comprehensive, and clinically appropriate review by the pharmacy. The adverse event was delineated in terms that enabled an understanding of the nature of the event in four out of four (100%) cases; the suspected medication that caused the ADR was identified and when necessary, an adverse drug reaction was documented on the individual's clinical record in four out of four (100%) cases; treatment for the drug reactions were clearly documented in four out of four cases (100%); notification to the physician was documented in four out of four (100%) cases. Regarding notification to the legally authorized representative (LAR), the pharmacy indicated "unknown" in all four cases; hence there was documentation to indicate that the guardian was notified of the ADR, and treatment for the ADR in zero out of four cases; The Facility assessed if the FDA should be made aware of the ADR in four out of four cases (100%), and reported three out of the four (75%) cases to the FDA. Summary: The Facility continued to provide an excellent review of ADRs, when reported to them. The assertive approach when assessing and treating individuals for ADRs is exemplary. Also, the Facility's reporting of potential serious issues to the FDA was well noted by the Monitoring Team. Even when the individual does not have a LAR, notice of ADRs that require medical treatment should be given to whoever provides consent, whether that is the individual, a family member or other advocate, or the facility director; the pharmacy should document that this notice was given. The Monitoring Team will require documented evidence of LAR notification of all ADRs that required medical treatment, and, or required notification to the FDA, for continued compliance at future Monitoring Team reviews. ADR Review at the P&TC meeting. Review of the P&TC meeting minutes demonstrated an excellent review of all reported ADRs. Four out of four (100%) ADRs reported during the reporting period were reviewed by the P&TC. Summary: The Facility performs an excellent review of all reported ADRs at the P&TC meetings. ADR Tracking and Trending The pharmacy department conducted a monthly trends analysis of all ADRs, and documented a trends analysis. Review of the trends data and analysis indicated a clinically appropriate systems review of ADRs. In addition, the pharmacy department also conducted its own quarterly adverse drug reaction audit, to ensure that all reported ADRs were appropriately followed up by the Facility.	

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		The Facility only reported a total of four ADRs during the reporting period, and the Monitoring Team is very concerned with the reporting of only four ADRs during that time period. The Facility reported that physicians, nurses, direct care staff, and pharmacists were provided training on identifying and reporting of ADRs, during the training period of new staff. The clinical pharmacists and director of pharmacy informed the Monitoring Team that they are in the process of developing a refresher training program for ADRs, for all staff, and that this program will be implemented in the near future. Summary. Trends analysis, and the quarterly ADR audits enabled a comprehensive systems review of ADRs. The Monitoring Team is concerned with the low number of ADRs reported by the Facility. As reported by the National Institute of Health, in a publication entitled Detecting Adverse Drug Events Using a Nursing Home Specific Trigger Tool; Ann Longterm Care, 2010; 18(5): 17-22, the annual number of ADRs reported by longterm care facilities, of 105 bed capacity can be as high as 135 ADRs per year. Extrapolating that data would suggest that a Facility with a population of 293 individuals could result in approximately 375 ADRs per year. The Monitoring Team encourages implementation of an annual refresher training for all physicians, nurses, pharmacists, and direct care staff, for future compliance by Monitoring Team. Conclusion: The Facility provides a clinically relevant, and effective ADR process, and agrees with the Facility self-assessment of substantial compliance with Provision N.6; however, the Monitoring Team does expect that all LARs are notified of ADRs that require medical intervention, and encourages the Facility to implement its planned refresher training program for relevant staff.	
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	To assess the Facility's drug utilization evaluation process (DUE), the Monitoring Team reviewed the DUE scheduled; a list of all scheduled and pending DUEs; copies of DUEs provided during the reporting period (valproate, denosumab, benztropine, lithium, Pradaxa, Zalpidem, and Azithromycin); copies of the P&TC minutes for 1/31/2013, and 4/11/2013; and the pharmacy's DUE audits. <u>DUEs</u> The Facility provided four scheduled DUEs (valproate, denosumab, benztropine, and lithium). Four out of four (100%) DUEs detailed a comprehensive review of the drugs' usage at the Facility; four out of four (100%) assessed appropriate indications for the use of the drug at the Facility; four out of four (100%) assessed potential contraindications of the drug; four out of four (100%) assessed appropriate dosing; four out of four	Substantial Compliance

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	accepted professional standards of care with regard to this provision in a separate monitoring plan.	(100%) listed clinically appropriate recommendations; and four out of four (100%) assessed for appropriate monitoring of laboratory values. The Facility provided DUEs for all relevant FDA advisories (Pradaxa, Zalpirdem, and azithromycin). Summary: The Pharmacy provides excellent DUEs for both scheduled and for FDA advisories, when relevant to the Facility. <u>Review of DUEs at the P&TC Meeting</u> The 1/31/2013 and 4/11,2013 P&TC minutes indicated review of DUE related issues, including a summary of DUEs implemented, FDA advisories, and review of the DUE schedule, as well as follow-up to recommendations. Summary: The pharmacy addressed all relevant DUE issues at the P&TC meetings, including a review of implemented DUES; a review of the DUE scheduled; follow-up to recommendation from DUEs; and issues related to FDA advisories, when indicated. <u>Pharmacy Audits of the DUE Process</u> The pharmacy department conducted its own internal audit, to help ensure that all DUEs had been developed and implemented. The internal audit for the reporting period indicated that the Facility was current for all necessary DUEs. Summary The Monitoring Team compliments the pharmacy for developing and implementing a process to ensure DUEs are provided as necessary. Conclusion: The Monitoring Team agrees with the Facility's self-assessment of substantial compliance with Provision N.7 and compliments the Facility on developing and implementing a drug utilization and evaluation process that enables a high quality review of medication usage at the Facility, and provides prescribers with clinically relevant and important recommendations on the use of medications.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular	To assess the Facility's medication variance process, the Monitoring Team reviewed the Facility's new policy for medication variances, entitled Pharmacy Services and Safe Medication Practices N.12; Medication Variances, dated 12/31/2012. The same sample of medication variance reports used to assess Provision M.6 was used to assess Provision	Substantial Compliance

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	documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	N.8. Also reviewed was the most recent trends analysis for medication variances, and medication variance committee meeting minutes, dated 11/27/2012, 12/18/2012, 1/29/2013, and 2/26/2013. <u>Medication Variance Policy</u> The Facility's policy for its medication variance process was determined to be comprehensive and clinically appropriate. The policy clearly outlined staff responsible for the DUE process;, and it delineated the types of variances (prescribing, dispensing, administration, documentation, transcribing, and non-reconcilable medications) and categories for the severity of medications variances. In addition, all necessary steps for assessing and reporting medication variances were well described, as was the process for staff remediation. Summary: The Facility maintains a functional and useful medication variance policy. Staff Training on Medication Variances: The Facility developed and implemented specific training on the reporting of medication variances, and at the time of this report, all pharmacists, nurses, and physicians had been trained on the reporting of medication variances. Verification of this training, which was provided to nurses in January and February 2013 and to medical staff on March 6, 2013, was assessed through review of training sign-in sheets. Documentation was provided that validated that 100% of the Nurse Managers responsible for overseeing medication administration practices received refresher training by the Pharmacy on Cart Refill and Count (Reconciliation) Process and Checking Emergency Medications. Furthermore, the Pharmacy department is developing a process to provide refresher training to all relevant staff, on the reporting process. Additional details regarding the Facility's training process for the reporting of medication variances can be found in Provision M.6, of this report. <u>Data and Trends Analysis for Medication Variance</u> The Facility conducted a comprehensive data analysis of all reported medication variances. In addition to reporting on the type and severity of medication variance, specific variances were broken down to the level of the living area, individual, department (including nursing, medical, dental, pharmacy, and other), and specific staff members involved in the medication variance. The reports also included monthly ratios of medication variance to total doses of medication administered. The Medication Variance Database reported variance data monthly, quarterly, and longitudinally. Medication variance data reported was presented in tabular, graphic, and narrative	

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		forms. Data provided for this reporting period included all medication variances through February 2013. For the past six months, the Facility reported a peak of 209 medication variances in October 2012, and a low of 92 medication variances in February 2013. At the last compliance review, there was a significant increase in the number of nursing medication variances reported in June 2012. The increase was due to the change in reporting all unexplained/not reconciled medications returned to the pharmacy. Furthermore, in September, October, and November 2012, nurses began reporting uncharted medications found on the Medication Administration Records as medication variances. A Reconciliation Procedure was put in place in collaboration with the Pharmacy to investigate, both by nursing and the pharmacy, any medications found in the medication cart drawers, at the time they were found; at cart exchange a staff nurse, along with pharmacy staff, checks the medications supplied to ensure the right number and correct medications were resupplied. Corrective action was taken on the spot to reconcile any identified discrepancies, as well as when the Nurse Managers complete their weekly Medication Room and Medication Administration Notebook audits. For all unexplained/not reconciled medications found in the drawers a Medication Variance Report was completed. Medication Overage Reports were also completed either by nursing and/or the pharmacy when medications were returned to the pharmacy with an explanation of the reason for return. Additionally, any time medications were found not documented, i.e., if they were not circled and explained on the back of the Medication Administration Records, a Medication Variance Report was completed. There was copious documented evidence provided and reviewed that showed concerted efforts were put forth campus-wide to correct these two issues, including the copies of local and systemic corrective actions taken at the monthly Medication Variance Committee Meetings. The Monitoring Team reviewed ten of the most recently completed Medication Variance Reports for Individuals #160, #363, #13, #111, #460, #276, and #67. Findings of completion of these reports include: • Ten of ten (100%) reports were completed correctly for Sections A through H. • Nine of ten (90%) reports were completed correctly for Section J. • For Section K, there was one Category C variance; this was completed correctly (100%). • Sections L and M were not applicable. • Five of ten (50%) of Section O failed to include the causes of the variances and sufficiently describe the corrective actions taken. The supervisor simply stated, "Follow medication procedure". However, all medication variances were further review by the respective unit Nurse Manager and again at the monthly	

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		Medication Variance Committee Meetings, as reflected in the minutes. • Section P was not applicable, as no variances met the severity categories E through I. The Monitoring Team is satisfied with, the medication variance process, follow-up of variances, remediation, and systems improvement. Furthermore, the number of medication variances has been reduced even though procedures to ensure more accurate reporting (including uncharted medications and medications returned to the Pharmacy) had been put into place. Summary: The Facility's data and trends analysis of medication variances is exemplary, and provides a comprehensive overview of all relevant elements of the medication variance process. <u>Medication Variance Committee Meeting Minutes</u> The Facility's Medication Variance Committee was developed specifically to follow-up on specific medication variances, and related systems issues. The Facility had developed, and implemented a robust committee process that helped to ensure assessment of all reported medication variances. Medication Variance Committee meeting minutes that were completed during the reporting period documented that department directors from all relevant departments, including pharmacy, nursing, and physician services, were present. The directors for nursing, pharmacy, and medicine were present at all four meetings (100% compliance). The Committee was co-chaired by the directors of pharmacy and nursing. Each department summarized its medication variance data and provided clinically appropriate analysis for the variances and remediation steps. Follow-up to remediation steps were well documented within the medication variance minutes. Specific issues addressed through data collection, and by the medication variance committee, included prescribing, dispensing, administration, reconciliation, and storage related issues. Further information regarding specific variances, including category and types of variances, and actions taken as a result of discussions of this committee, can be found in Provision M.6, of this report. <u>Pharmacy Activities to Reduce Medication Variances:</u> The pharmacy department had developed and implemented an internal audit process, whereby the pharmacy director reviewed all dispensing variances, tracks and trends dispensing variances, and then conducted a monthly meeting with pharmacists and technicians to review dispensing variances. Conclusion:	

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		The Facility had developed an impressive medication variance process that was supported by a comprehensive and effective policy, and by a committee structure, including the Medication Variance Committee, which meets monthly, and the P&TC meeting, that discusses medication variances quarterly; both committees reviewed data and trends analysis of medication variances by type, and category, department, staff, living area and individual. Directors for nursing, medicine, and pharmacy provided a detailed analysis of their respective departments variances, summarized remediation action and system improvement efforts.. The Monitoring Team determined concurred with the Facility's self-assessment of substantial compliance with Provision N.8.	

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

1. Pharmacy should ensure that the prescribers had addressed recommendations in a clinically justifiable manor, and ensure that the prescriber's action plan is well documented. (Provision N.1)
2. Review staffing issues for the QDRR process and ensure that QDRRs are completed timely. (Provision N.2)
3. Ensure that treated risk factors, such as hypertension, diabetes, and hyperlipidemia are included as risk factors for metabolic syndrome. (Provision N.2)
4. When conducting trends analysis for benzodiazepines, report absolute numbers and rates for specific benzodiazepines, total usage of benzodiazepines, and for specific indication, including, but not limited to, psychiatric, and neurological diagnosis. (Provision N.3)
5. Develop and implement a longitudinal trends analysis for the use of psychotropic polypharmacy, which can be used for systems improvements and reduction of polypharmacy. (Provision N.3)
6. The Pharmacist must indicate, on the QDRR, if the use of polypharmacy is appropriate, and provide recommendations to help mitigate polypharmacy, when clinically indicated. (Provision N.3)
7. Ensure that the legally authorized representative (LAR) is notified of all adverse drug reactions, and medication variances, that require medical treatment. (Provisions N.3, and N.8)
8. Ensure that all relevant staff have been trained and provided refresher training on the identification and reporting of ADRs. (Provision N.6)
9. Ensure that medication variance reporting forms are fully completed, and provide clinically appropriate narrative of the medication variance, and corrective action plan (Provision N.8)

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. BSSLC Self-Assessment, dated 3/21/13 2. BSSLC Action Plan 3/11/13 3. PNMP Policy (rev 11-14-2011) Record reviews: 4. Sample O.1: Individuals #65, #90, #94, #97, #149, #185, #205, #253, #259, #269, #281, #283, #318 and #449 5. Sample O.2: Individuals #21, #86, #112, #188, #195, #293, #305, #316, and #527 6. Sample O.3: Individuals #53, #91, 283, #318, #331, #453, #474, #557, #567, and #597 7. Sample O.4: Individuals: #8, #30, #45, #53, #86, #89, #97, #138, #160, #261, #269, #272, #281, #284, #299, #303, #318, #331, #395, #437, #446, #470, #472, #514, #517, and #599, 8. Sample O.5: Individuals #37, #67, #169, #249 and #599 9. Lists of individuals: a. Who cannot feed himself or herself and notation of any changes since the last review; b. Who require positioning assistance associated with swallowing activities and notation of any changes since the last review; c. Who have difficulty swallowing and notation of any changes since the last review; d. At high and/or medium risk for aspiration pneumonia and choking; e. With choking incidents since the last compliance review f. Who had a feeding tube inserted since the last compliance review g. Who were admitted to the hospital since the last compliance visit with admitting and discharge date and diagnosis h. Who were diagnosed with pneumonia or a respiratory difficulty since the last compliance review (include date and type) i. With falls in the last 12 months (date, location , type of injury)* j. With chronic respiratory infections k. With chronic dehydration l. With fecal impaction m. With pressure ulcers in the last 12 months (date, location and resolution) n. With fractures in the last year (date, location of fracture, status) o. Who were non-ambulatory or require assisted ambulation p. With wheelchairs for primary mobility q. With wheelchairs for transport r. Who use Assistive Devices for ambulation (type of device) s. With orthotic/braces 10. New PNMT members since last review, including a copy of their curriculum vita;

	11. Caseloads of PNMT dedicated and non-dedicated members. 12. List of medical consultants to the PNMT (e.g., medical doctor, nurse practitioner, or physician's assistant and PNMT meeting minutes and attendance sheets for presence and participation of a medical doctor, nurse practitioner or physician assistant, and other IDT members as needed or defined in Facility policy. 13. PNMT members and PNMT back up curriculum vitas 14. QA reports/matrix since the last compliance review 15. List of referrals to the PNMT since the last compliance visit 16. PNMT RN post hospitalization assessments completed since the last compliance visit. 17. PNMT assessment template 18. PNMT Action Plan template 19. IRRF template 20. IHCP template 21. List of new employees since last compliance visit and their PNM related performance check offs 22. List of staff assigned to train other staff on the PNM core competencies (i.e., foundational skills) and dates of training, including back-up training records (i.e., sign-in sheets and competency check-offs) 23. Facility documentation showing categories of staff requiring annual refresher training, numbers of staff requiring training, and numbers of staff who have successfully completed training; 24. PNM Monitoring Tool template 25. Last three months of PNM monitoring data (including date, activity monitored, time of monitor, person conducting monitor) 26. For Individuals in Sample: a. All ISPs in the last 12 months b. All ISPAs in the last 12 months c. All IRRFs in the last 12 months d. All IRRF Action Plans in the last 12 months e. IHCP/Action Plan f. QDDP Monthly Reviews for the last 6 months g. PBSPs h. Braden Scale forms i. Annual weight graph j. Nutrition tab, including assessments and reviews k. Head of Bed Elevation(HOBE) assessments l. PNMT assessments and any other PNMT documentation other than IPNs in the last 12 months, if not already submitted m. OT/PT assessments in the last 12 months n. SLP assessments, including Communication/AAC in the last 12 months o. 6 months IPNs p. Trigger sheets completed in the last 6 months, including the current one q. PNMPs in the last 12 months, including pictures r. Dining Plans in the last 12 months, including pictures s. Completed PNM-related monitoring sheets in the last three months

	t. Evidence of effectiveness monitoring completed within the last six months u. Aspiration Pneumonia Enteral Nutrition (APEN) in the last 6 months v. Plan for individuals who are returning to oral eating and supporting documentation for implementation of plan (i.e, staff training documentation, staff roles and responsibilities, specific triggers when the plan should be stopped; milestones for progress with the plan, documentation requirements to track progress, and frequency of subsequent assessments and staff responsible and monthly progress notes) w. Direct intervention plan and supporting documentation for implementation of the plan (i.e., monthly progress notes) x. Individual notebooks (PNM section) 27. PNMT Process Flow chart (not dated) **People Interviewed:** 1. Kori Kelm Physical Therapist (PT), Habilitation Therapy Director 2. Tracy Searles Physical Therapy Assistant (PTA), 3. Christina Koehn SLP 4. Dr. Karen Hardwick 5. Direct Care Professionals on (2) Childress, (2) Driscoll, and (2) Bowie. (4) Fannin **Meeting Attended/Observations:** 1. QA/QI Meeting 2. PNMT meeting 3. Mealtimes (Bowie, Childress, Fannin, and Driscoll) 4. Daily activities on Driscoll, Fannin, Childress, and Program Services
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section O, dated 3/21/13 and Action Plan dated 3/11/13. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section O, in conducting its self-assessment, the Facility: ▪ Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: Settlement Agreement Monitoring Tool for Section O. o This monitoring/audit tool did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. For example, as indicated through interview, the Self Assessment for Provision O.5 only included evidence of training for first and second shift while the Settlement Agreement requires the Facility to ensure that all direct care staff responsible for individuals with physical or nutritional management problems (which necessarily includes all three shifts) be trained; this information alone would not help the

	Facility determine shifts for which additional training would be required. o The monitoring tools did include adequate methodologies, such as observations, record review and staff interview. For example, the Settlement Agreement Monitoring Tool guidelines instructed the reviewer to review a PNMT assessment, staff training records, complete observation(s) of individual's PNMP being implemented, and conduct staff interviews to ask staff why the individual requires PNMP interventions. o The Self-Assessment did not identify the sample(s) sizes and the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). o The Self-Assessment did not state the following staff/positions who were responsible for completing the audit tools: such Facility therapists (i.e., OTs, PTs, and SLPs); therefore there was no evidence of staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools. ▪ The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not consistently measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance three of the provisions of Section O (Provisions O.1, O.4 and O.8). This was inconsistent with the Monitoring Team's findings. The Monitoring Team found BSSLC to not be in compliance with any of the provisions. o Provision O.1 was found to not be in compliance due to lack of a clear process in place that ensures as well as defines the PNMT's role in the QA collection and review process. o Provision O.4 was found to be not in compliance due to lack of implementation of PNMPs as it relates to intake and positioning. The data collected and presented by BSSLC is in question due to the large disparity between the Monitoring Team's observations and data presented through the collect of monitoring data. o Provision O.8 was found to not be in compliance due to lack of a clear pathway to oral intake. Individuals were still not consistently provided with the assessments they needed in a timely manner with the assessments resulting in a clear plan to the least restrictive intake. The Actions plans developed were felt to move BSSLC in the right direction towards compliance, however, BSSLC should continue to review the findings of the Monitor's report and revise the Action Plans as indicated to address all identified concerns. Methods to gauge quality and not just presence should be investigated and integrated as part of the Action Plan.
	Summary of Monitor's Assessment: Overall, there has been noted improvement with all provisions in Section O. 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. **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. PNMT assessments/reviews lacked evidence that all potential areas impacted by the change in PNM status were at a minimum reviewed/discussed as part of the PNMT meeting. **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 communication. **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. **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 on PNMPs and dining cards specific to the individual. Staff on third shift were not provided with the same level of training as those on first and second shifts. **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 was monitored across all three shifts. Additionally, the reliability of the acquired data is in question due to the large disparity in findings from BSSLC and that of the Monitoring Team. **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. There was limited evidence of indicators integrated as part of the IHCPs to assess the individual's PNM status as well as limited to no monthly review by the QDDP. **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 as has the pathway to oral intake but the information was not contained within the IRRF as an established plan of care.

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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 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	The following samples were utilized for Section O: Sample O.1 consisted of a non-random sample of 14 individuals who were chosen from a list provided by the facility of individuals they identified as being at a medium or high risk of PNM related issues [i.e., aspiration, choking, falls, fractures, respiratory compromise, weight (over 30 or under 20 BMI), enteral nutrition, GI, osteoporosis], require mealtime assistance and/or are prescribed a dining plan, were at risk of receiving a feeding tube, and/or who have experienced a change of status in relation to PNM concerns (i.e., admitted to the Facility Infirmary, if applicable, emergency room and/or hospital). Individuals within this sample could meet one or more of the preceding criteria. Sample O.2 consisted of nine individuals who were assessed, reviewed, and/or tracked by the PNMT over the last six months. Sample O.3 consisted of 10 individuals at BSSLC who received enteral nutrition. Some of these individuals might have been included in one of the other samples. Sample O.4 consisted of individuals observed in homes and day programs throughout the 24-hour day. This included random individual-specific observations as well as 20% of the individuals in Sample O.2. **PNM Policy and Role of the PNMT:** The Facility did not have a comprehensive PNM policy that included the following elements: ▪ Definition of the criteria for individuals who require a Physical and Nutritional Management Plan ("PNMP"); ▪ The annual review process of an individual's PNMP as part of the individual's ISP; ▪ The development and implementation of an individual's PNMP shall be based on input from the IDT, home staff, medical and nursing staff, and, as necessary and appropriate, the physical and nutritional management team; ▪ The roles and responsibilities of the PNMT; ▪ Description of the role and responsibilities of PNMT consultant members (e.g., medical doctor, nurse practitioner, or physician assistant); ▪ The requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs;	Noncompliance

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	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.	▪ Requirements for continuing education for PNMT members; ▪ Referral process and entrance criteria for the PNMT; ▪ Discharge criteria from the PNMT; ▪ Assessment process; ▪ Process for developing and implementing PNMT recommendations with Integrated Health Care Plans; ▪ The PNMT consultation process with the IDT; ▪ Method for establishing triggers/thresholds; ▪ Evaluation process for individuals who are enterally fed; ▪ PNMT follow-up; ▪ Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia; ▪ A comprehensive PNM monitoring process designed to addresses all areas of the PNMP, including: o Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk, o Definition of staff compliance monitoring process, including training and validation of monitors, schedule, instructions and forms, tracking and trending of data, actions required based on findings of monitoring (for individual staff or system-wide), o Identification of monitors and their roles and responsibilities, o 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, o Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician, and o Frequency of monitoring to be provided to all levels of risk. ▪ A system of effectiveness monitoring; and ▪ Description of a sustainable system for resolution of systemic concerns negatively impacting outcomes for individuals with PNM concerns. The system should include: o Requirements that the QA matrix include key indicators related to PNM outcomes and related processes; o Monitoring data from the QA Department as well as Habilitation Therapies and the PNMT is collected, trended, and analyzed; o Process for the Habilitation Therapies and the PNMT to present the identified systemic issue requiring resolution to entities with responsibilities for the resolution of such issues (e.g., Medical Morning	

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		meeting, QA/QI meeting): o A process for identifying who will be responsible for resolution of the systemic concern with a projected completion date (e.g., action plan). o Process to determine effectiveness of actions taken, and revision of corrective plans, as necessary and o If requested by the QA Department or QA/QI Council, development and implementation of additional monitoring, as appropriate to measure the resolution of systemic issues. An example of an indicator that was absent included how the PNMT assisted in the Quality Review process as it related to systemic PNM related issues. Although the QA portion may fall primarily outside the realm of PNM, the PNMT's role in reviewing and identifying these issues as well as their contribution to the QA component should be noted. Other policy indicators missing included but were not limited to: ▪ The requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs; ▪ Requirements for continuing education for PNMT members; ▪ Method for establishing triggers/thresholds; ▪ Evaluation process for individuals who are enterally fed; ▪ Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia; ▪ 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, ▪ Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician **Core PNMT Membership:** Based on interview with the Director of HT and review of PNMT minutes, the Facility PNMT did have the appropriate disciplines as defined in the Settlement Agreement. BSSLC had identified the Registered Nurse(RN), Physical Therapist(PT), Specch Language Pathologist (SLP), Occupational Therapist (OT), Physician (MD) and Senior Direct Support Professional (DSP-IV) as standing core members with back-up members identified for SLP, OT, and PT. **Consultation with Medical Providers and IDT Members** For nine of nine individuals in Sample O.2 (100%), evidence was provided of routine participation of medical staff in meetings, review of assessments, and other needed	

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		activities. For nine of nine individuals in Sample O.2 (100%), evidence was provided of routine participation of IDT members in meetings, review of assessments, and other needed activities. **Qualifications of PNMT Members** Eleven of 11 core and back up PNMT members (100%) were licensed to practice in the state of Texas. Eleven of 11 PNMT members (100%) had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. **Continuing Education** Five of five PNMT staff (100%) had completed at least 12 hours of continuing education directly related to physical and nutritional supports and transferrable to the population served within the past 12 months. Examples of continuing education included but were not limited to: ▪ PT attended: Issues with Evaluation and Treatment of Individuals with Developmental Disabilities ▪ SLP attended: Issues with Evaluation and Treatment of Individuals with Developmental Disabilities ▪ OT attended: Medication Administration and Issues in Evaluation and Treatment of Individuals with Developmental Disabilities ▪ RD attended: Dysphagia: A Growing Concern in Healthcare ▪ RN attended: Medication Administration and Issues in Evaluation and Treatment of Individuals with Developmental Disabilities **PNMT Meetings** From 11/6/12 to 2/26/13, of the 16 weeks, the team met on 16 of 16 weeks (100%). All core members of the PNMT were present for at least 80% of the meeting with the exception of the core SLP whose attendance was below 80%. It is important for each core member to participate regularly and consistently. Attendance by core PNMT members for 16 meetings conducted during the time frame from 11/6/12 to 2/26/13 was: ▪ Chairperson/Coordinator: 94% attendance by core member, 6% for back-up member, and 100% overall;	

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		▪ RN: 94% attendance by core member, 0% for back-up member, and 94% overall; ▪ PT: 94% attendance by core member, 6% for back-up member, and 100% overall; ▪ OT: 81% attendance by core member, 0% for back-up member, and 81% overall; ▪ SLP: 63% attendance by core member, 37% for back-up member, and 100% overall ▪ RD: 87% attendance by core member (there was no back up for RD) Other members identified by BSSLC as being core PNMT members had the following attendance figures: ▪ MD: 88% attendance ▪ DSP: 34% attendance The DSP IV who was a new member of the PNMT since the last compliance visit was not consistently present at the PNMT meetings. Sixteen of 16 PNMT meeting minutes (100%) include documentation of appropriate topics: a) referrals; b) review of individual health status; c) PNMT actions; d) follow-up; and e) outcomes/progress toward established goals and exit criteria for individuals in the sample. The Facility PNMT did not have a sustainable system fully implemented for resolution of systemic issues/concerns. Missing from the system was: ▪ How monitoring data from the QA Department as well as Habilitation Therapies and the PNMT was collected, trended, and analyzed; ▪ How Habilitation Therapies and the PNMT identified and presented systemic issues requiring resolution to entities with responsibilities for the resolution of such issues (e.g., Medical Morning meeting, QA/QI meeting).	
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	**Identification of PNM risk** Two hundred seventy one of 271 individuals (100%) who cannot feed himself or herself, who required positioning assistance associated with swallowing activities, who had difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems") had a PNMP. The Facility had a sustainable system to maintain and update lists of 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	Noncompliance

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	(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.	problems"). BSSLC has shown great improvement in identifying those individuals who are at risk and assigning the appropriate risk classification as it relates to issues related to PNM. Twenty-three of 23 individuals in Samples O.1 and O.2 (100%) were provided with an accurate risk score related to all of the PNM risk areas (i.e., respiratory compromise, GI, skin breakdown, falls, fractures, aspiration, and choking, or others relevant to specific individuals). Two of five Individuals (Sample O.5) who were recommended to have a Modified Barium Swallow Study (MBSS) were provided with such study in a timely manner. Individuals had delays in excess of 10 months before receiving recommended MBSS. For example: Individuals #599 and #67 had delays in receiving the MBSS of 10 months and 4 months. For Individual #37, the MBSS was postponed several times although there was continued evidence of dysphagia related concerns. This is an example of what was felt to be an overall lack of urgency or attention to detail by BSSLC. More examples are included in Provisions O.5 and P.1. **Physical and Nutritional Management Team Referral Process** Five of five individuals from Sample O.1 were appropriately referred to the PNMT based on the criteria included in the Facility policy. The Monitoring Team noted a concern that the facility policy was in the process of being modified to reflect the revised state policy, which allows for multiple choking events or aspiration pneumonia without requiring an automatic referral to the PNMT. In five of the five individual records reviewed from Sample O.1 (100%), when an individual experienced a change in status that would initiate a referral to the PNMT, there was evidence of an IDT referral to the PNMT within five working days of the ISPA meeting. BSSLC's PNMT RN conducted assessments in response to all changes in status and discussed the results during the PNMT meeting. Based on these discussions, if PNMT involvement was felt to be needed then the IDT was contacted so that a joint meeting would occur to discuss the findings of the assessment, concerns of the PNMT, and how the PNMT could support the IDT by providing a focused or full assessment or by merely discussing the issue and providing guidance to the individual's IDT. As a result, initiation and receipt of the referral occurred simultaneously and well within five working days. Another method in which the PNMT was made aware of changes in status was through	

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		participation by the PNMT lead, and PNMT RN in the morning medical meeting. Information from this meeting was then brought to weekly PNMT meeting for further discussion and shared with the IDT as indicated if not already done so. 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. Participation in this meeting has resulted in improvement in the ability to identify issues occurring throughout the Facility, but as stated in Provision O.1, there remained a lack of analysis of data acquired from the monitoring process as well as data regarding hospitalizations, and frequency of illness. Four of four individuals from sample O.1 who received a feeding tube (not on an emergency basis) since the last review (100%) had been referred to or discussed by the PNMT prior to the placement of the tube. No individuals at BSSLC received an emergency feeding tube placement since the last review. **PNMT Assessment** Nine of nine PNMT assessments/reviews for individuals in Sample O.2 (100%) were initiated at a minimum within five working days of the referral (or sooner as specified in the PNMT policy). BSSLC's RN provides assessment upon return from the hospital in an effort to identify any concerns noted with PNM. Results of the assessment were discussed at the PNMT at the weekly meeting or sooner as indicated. Referrals that were submitted by the IDT outside of a return from hospitalization were discussed at the following PNMT weekly meeting with PNMT attending the IDT as indicated. Nine of nine PNMT assessments in Sample O.2 (100%) were completed in no more than 30 days of the date initiated, or no more than 45 days in extenuating circumstances BSSLC has moved away from the process of providing full comprehensive assessments to all referred individuals to a system that focuses more on areas of assessment based upon discussion of the incident and assessment of the situations surrounding the PNM event. Per interview with the Director of Habilitation Therapies, based on the findings and results of discussion, the PNMT then makes the determination of whether a comprehensive assessment was needed. When a full assessment was not warranted, all relevant assessments (i.e., Nutritional, Habilitation) were reviewed for accuracy and	

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		relevance and included as part of the PNMT discussion and taken into consideration when providing recommendations to the IDT. All of these areas in addition to the PNMT RN assessment were taken into consideration when measuring compliance with this metric. The concern with this process was that there was limited to no evidence/documentation that reviews of the areas that were not assessed were included as part of the consult/review. Based on the PNMT attended on 4/9/13, there was active discussion regarding aspects of the PNM related issues potentially impacting the individual; however, as stated above, there was no clear documentation of these discussions and therefore consistency or reliability of the process could not be evaluated, nor would the Facility be able to show assessment was adequate. Based on review of individuals' records who were referred to the PNMT (Sample O.2), the comprehensiveness of the PNMT assessment components were as follows: • Nine of nine (100%) contained date of referral by the IDT. This information was contained within the ISPA, ISP and/or PNMT assessment • Nine of nine (100%) contained date assessment was initiated. This information was contained within the PNMT assessment, PNMT minutes, Habilitation Therapies Assessments, or PNMT minutes • Nine of nine (100%) contained evidence of review and analysis of the individual's medical history. This information was contained as part of the PNMT RN Assessment. • Nine of nine (100%) identified the individual's current risk rating(s), including the current rationale. This information was contained within the IRRF, and Habilitation Therapy Assessments and/or PNMT evaluation as indicated. • Nine of nine (100%) included updated risk ratings based on the PNMT's assessment and analysis of relevant data. This information was contained within the IRRF, and Habilitation Therapy Assessments and/or PNMT evaluation as indicated. • Zero of nine (0%) contained evidence of discussion of the individual's behaviors related to the provision of PNM supports and services, including problem behaviors and skill acquisition. This information was contained within the Habilitation Assessment but there was no evidence of review of this component when there was a PNMT referral to ensure accuracy. • Nine of nine (100%) contained assessment of current physical status. This information was contained within the PNMT minutes, the PNMT RN Assessment, and the various PNM related assessments (Habilitation, Nutrition, etc.) • Nine of nine (100%) contained assessment of musculoskeletal status as indicated by the PNMT RN Assessment.	

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		• Nine of nine (100%) contained evaluation of motor skills as indicated by the PNMT RN Assessment. • Nine of nine (100%) contained evaluation of skin integrity as indicated by the PNMT RN Assessment. • Nine of nine (100%) contained evaluation of posture and alignment in bed, wheelchair, or alternate positioning, including during bathing and oral hygiene. Three comprehensive Head of Bed (HOB) assessments were provided as part of the PNMT referrals and all other referrals reviewed contained evidence of evaluation of general posture as part of the Habilitation Assessment, and PNMT RN Assessment. • Zero of nine (0%) contained evaluation of current adaptive equipment. This information was contained within the Habilitation Assessment but there was no evidence of review of this component when there was a PNMT referral to ensure accuracy. • Nine of nine (100%) contained nutritional assessment, including but not limited to history of weight and height; intake, nutritional needs, and mealtime/feeding schedule. This information was contained within the Annual Nutritional Assessment, the PNMT RN Assessment as well as consults. • Zero of nine (0%) contained evaluation of potential or actual drug/drug and drug nutrient interactions. This information was contained within the Nutritional Assessment as well, but there was no evidence of review of this component when there was a PNMT referral to investigate impact of medication of the issue at hand. • One of one (100%) identified residual thresholds, if enterally nourished. This was contained within the PNMT RN Assessment and discussed as part of the PNMT meeting • Five of five (100%) contained a tableside oral motor/swallowing assessment, including but not limited to mealtime observation. • Nine of nine (100%) contained respiratory status. This was contained within the PNMT RN Assessment and discussed as part of the PNMT meeting • Zero of nine (100%) contained evidence of review/analysis of lab work. • Zero of nine (0%) contained evidence of review/analysis of medication history over the last year and current medications, such as changes, dosages, administration times, and side effects. This information was contained within the Nutritional Assessment as well, but there was no evidence of review of this component when there was a PNMT referral to investigate impact of medication of the issue at hand. • Nine of nine (100%) contained discussion as to whether existing supports were effective or appropriate. This information was contained within the PNMT RN Assessment as well as in the PNMT minutes.	

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		• Nine of nine (100%) contained oral hygiene status. This information was contained within the Habilitation Assessment but there was no evidence of review of this component when there was a PNMT referral to ensure accuracy. • Nine of nine (100%) contained evidence of observation of the individual's supports at their home and day/work programs. • Nine of nine (100%) contained evidence that the PNMT conducted hands-on assessment. • Nine of nine (100%) identified the potential causes of the individual's physical and nutritional management problems. This information was contained within the Habilitation Assessment as well as part of the PNMT RN Assessment, PNMT Assessment and PNMT minutes. • Nine of nine (100%) identified the physical and nutritional interventions and supports that were clearly linked to the individual's identified problems, including an analysis and rationale for the recommendations. This information was contained within the Habilitation Assessment as well as part of the PNMT RN Assessment, PNMT Assessment and PNMT minutes. • Nine of nine (100%) contained the establishment and/or review of individual-specific clinical baseline data to assist teams in recognizing changes in health status. This information was contained as part of the PNMT Assessment, IRRF, PNMT minutes and ISPA. • Nine of nine (100%) contained measurable outcomes related to baseline clinical indicators, including but not limited to when nursing staff should contact the PNMT. This information was contained within the Habilitation Assessment as well as part of the PNMT Assessment and PNMT minutes. • Seven of nine (77%) contained evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e. revision of the individual's PNMP). o Individual #195 had recommendations to decrease the head of bed on 3/15/13 but the PNMP as of 4/11/13 had not been revised to indicate this revision. o Individual #293's PNMP still contained the strategy to "verbally prompt to chew and swallow food items remaining in mouth". The PNMT recommended this strategy be removed from the PNMP. • Nine of nine (100%) contained recommendations for monitoring, tracking or follow-up by the PNMT. • Nine of nine (100%) contained signatures with dates. Overall, the concern noted was that although assessments or reviews may have been discussed/reviewed at the meetings, there was no documentation/evidence of such discussion or review.	

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		Integration of PNMT Recommendations into IHCPs and/or ISPs For zero of nine individuals (0%) in Sample O.2, all recommendations by the PNMT were addressed/integrated in the ISPA, Action Plans, IRRFs and IHCPs. While 100% of the recommendations were clearly integrated as part of the ISPA and were included as part of the risk action plans primarily in the form of following the PNMP; recommendations were not clearly linked or integrated into the IHCPs. Plans resulting from PNMT recommendations for Sample O.2 included the following components: • In eight of the nine individuals' plans reviewed (89%), the plans addressed the individual's identified PNM needs as presented in the PNMT assessment. • In three of the three individuals (100%) for whom HOBE assessments were conducted, the HOBE recommendations were integrated into individuals' plans. • In nine of the nine individuals' plans reviewed (100%), there were appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan. • In nine of the nine individuals' plans reviewed (100%), there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. • In nine of the nine individuals' plans reviewed (100%), the plans included the specific clinical indicators of health status to be monitored. • In nine the nine individuals' plans reviewed (100%), the plans defined triggers. • In nine of the nine individuals' plans reviewed (100%), the frequency of monitoring was included in the plans. **PNMT Follow-up and Problem Resolution** With regard to plan implementation for Individuals in Sample O.2: • In nine of nine individuals' documentation reviewed (100%), supporting documentation was present to confirm implementation of individuals' action plan within 14 days, or sooner as needed, of the plan's finalization. • In nine of the nine individuals' plans reviewed (100%), documentation was provided to show action plan steps had been completed within established timeframes, or IPNs/monthly reports provide an explanation for any delays and a plan for completing the action steps. **Individuals Discharged from the PNMT** For individuals discharged by the PNMT in Sample O.2: ▪ Five of nine individuals (55%) had an ISPA meeting with the PNMT and IDT to discuss the discharge of the individual from the PNMT to the IDT.	

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		o There was no evidence of a discharge meeting regarding findings from the PNMT for Individual #293 ▪ Nine of nine individuals' (100%) discharge summary/action plan provided objective clinical data to justify the discharge. ▪ Zero of nine individuals' ISPA meeting documentation (0%) provided evidence that any new recommendations were integrated into the IHCP. ▪ Five of nine individuals' ISPA documentation and/or action plan (55%) included criteria for referral back to the PNMT if they differed from the criteria included in the PNMT policy. There was not a clear, consistent process that documented a collaborative discharge summary/action plan which included recommended supports and services, key clinical indicators, individualized triggers, guidelines for monitoring the individual's supports, services and triggers, objective clinical data to justify the discharge, evidence that discharge recommendations were integrated into the IHPC, and criteria for referral back to the PNMT integrated as part of the IHCP.	
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.	**<u>Identification of Individuals Requiring a PNMP</u>** For the 14 individuals in Sample O.1, zero of their annual ISPs (0%) noted that the appropriate disciplines were present to approve and integrate the PNMP in the ISP. All annual ISPs reviewed documented at a minimum an Occupational or Physical Therapist present to discuss the PNMP. The Registered Dietitian was not present at any of the ISPs reviewed and was late in providing their assessment for team review for 13 of 14 (93%) ISP annuals and therefore all disciplines were not available for review and approval. Twelve of 14 PNMPs (85%) were reviewed by the individual's IDT in the annual ISP meeting. The ISPs contained evidence of review, update/revision, and effectiveness, and specified the changes required to the PNMP. During review of medical and physical therapy assessments, the Monitoring Team found one inconsistency. Individual #255 was to be on a ground texture diet; however, the annual medical assessment and a list of current diets indicated the individual was on a chopped diet. The Facility needs to ensure consistency of plans with assessments or a rationale provided in the ISP or ISPAs for decisions about diets. **<u>PNMP Format and Content</u>** A review of individuals' PNMPs from Samples O.1 and O.2 found: • PNMPs for 23 of 23 individuals (100%) were current within the last 12 months.	Noncompliance

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		• PNMPs for 23 of 23 individuals (100%) included a list of all high-risk levels and individual triggers as indicated • In 23 of 23 most current PNMPs (100%), there were large and clear color photographs with instructions. • 23 of 23 PNMPs (100%) listed the adaptive equipment required by the individual. Rationale regarding the need for the adaptive equipment was not present on the PNMP but was available as part of the Habilitation Therapy assessments. • In 13 of 13 PNMPs (100%) for individuals who used a wheelchair as their primary mobility, positioning instructions for the wheelchair, including written and pictorial instructions, were provided. • In 21 of 23 PNMPs (91%), positioning was adequately described per the individuals' assessments. Individuals #253 and #281 only had information regarding the use of the chain to help determine elevation and did not contain the degree of elevation on the PNMP. Only having a description of the chain does not easily transfer should the person move to a new bed. • In 23 of 23 PNMPs (100%), the type of transfer was clearly described, or the individual was described as independent. • In 23 of 23 PNMPs (100%), bathing instructions were provided. • In 23 of 23 (100%)PNMPs, toileting-related instructions were provided, including check and change • In 23 of 23 (100%) of the PNMPs, handling precautions or movement techniques were provided for individuals who were described as requiring assistance with mobility or repositioning. Each of the others was described as independent. • In 23 of 23 PNMPs/dining plans (100%), instructions related to mealtime were outlined, including for those who received enteral nutrition. • 23 of 23 individuals (100%) Dining Plans were current within the last 12 months. • Six individuals (100%) had feeding tubes with no oral intake. Six of six (100%) PNMPs/dining plans indicated the individual was to receive nothing by mouth. • In 23 of 23 PNMPs/dining plans (100%), position for meals or enteral nutrition was provided via photographs, and the pictures were large enough to show sufficient detail. • In 17 of 17 PNMPs/dining plans (100%) for individuals who ate orally, diet orders for food texture were included. • In 17of 17 PNMPs/dining plans for individuals who received liquids orally (100%), the liquid consistency was clearly identified. • In 17 of 17 PNMPs/dining plans for individuals who ate orally (100%), dining equipment was specified in the mealtime instructions section, or it was stated that they did not have any adaptive equipment or used regular equipment, and	

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		the rationale was provided. • In 23 of 23 PNMPs (100%), medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. • In 14 of 23 PNMPs (60%), oral hygiene instructions were included, including general positioning and brushing instructions. Individual #449's PNMP simply stated for staff to assist with Oral care but provided no further instruction. • Twelve of 23 PNMPs (52%) included information related to communication (how individual communicated, how staff should communicate with individual). Missing from the communication section was detailed information on how the person communicated as well as how staff should bridge communication. For example: Individual #312 only stated that the individual communicates using facial expression but provided no additional information **Change in Status Update for Individuals' PNMPs Conducted by the IDT/PNMT** For 12 individuals in sample O.1 and O.2 for whom the IDT identified changes needed to be made to the PNMP, nine ISPA meeting documentations (75%) noted the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status. See above in O.2 for examples of the PNMP not being reviewed or revised. For individuals for whom the PNMP was revised, there was supporting documentation that five of eight individuals' revised PNMPs (63%) had been implemented.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	**Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs** Staff did not engage in safe mealtime practices, as indicated by the following: Per observations conducted by the Monitoring Team, eleven of 22 individuals' (50%) dining plans were implemented as written. Examples of dining plans not implemented include but were not limited to: • Individual #86 was observed gulping liquids, not consistently provided liquids after every 3-5 bites as stated per her PNMP. • Individual #395 was observed in a less than optimal position (leaning back in wheelchair) during enteral nutrition. Based on observations by the Monitoring Team: • Three of 13 individuals' positioning plans (27%) were implemented as written. Implementation of positioning plans was extremely concerning as the plans were implemented minimally and the issues noted may have a significant impact as it relates to the risk of skin breakdown as well as aspiration and pneumonia. Examples of non-implementation included:	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>

Individual #437 was slid down in her chair with no pillow between her knees.
Individual #303 was observed without his chest strap and leaning forward, resulting in increased abdominal compression.
Individual #96 was observed leaning to her left with no side pillows provided for support as stated per her PNMP.

Three of three individuals' transfer plans (100%) were implemented as written.
During three of three observations of medication administration (100%), the nurse followed procedures in the PNMP.

<u>Knowledge of Staff Regarding PNMPs</u>
Staff Interview:
Staff were not knowledgeable of the Individuals' PNMPs. Based upon interviews with ten staff from Fannin, Bowie, and Childress, knowledge of staff has continued to improve but remains lacking especially as it relates to positioning. Following are the numbers of staff who answered correctly and the number asked the question:
<table>
<tr><th></th><th># Asked</th><th># Correct</th><th>% Correct</th></tr>
<tr><td>Positioning:</td><td></td><td></td><td></td></tr>
<tr><td>How do you know the individual is in the correct position in their wheelchair/bed?</td><td>10</td><td>5</td><td>50%</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Mealtimes:</td><td></td><td></td><td></td></tr>
<tr><td>For what reason does the individual have thickened liquids?</td><td>6</td><td>4</td><td>67%</td></tr>
<tr><td>For what reason does the individual eat a modified texture?</td><td>6</td><td>6</td><td>100%</td></tr>
<tr><td>What is the reason for the individual using a specific utensil?</td><td>6</td><td>4</td><td>67%</td></tr>
<tr><td>If the individual receives enteral nutrition, how do you determine if he/she is in the correct position?</td><td>4</td><td>1</td><td>25%</td></tr>
<tr><td>What does the "red dot" stand for?</td><td>6</td><td>6</td><td>100%</td></tr>
</table>
</td><td></td></tr>
<tr><td>O5</td><td>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</td><td><u>NEO Orientation</u>
The PNM related core competencies (i.e., foundational skills) were comprehensive. NEO orientation included the following elements:
▪ Lifting and Transfers;
▪ Positioning (Alternate, wheelchair, and bathing/showering);
▪ Adaptive Equipment;</td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
	nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	▪ PNMP orientation and implementation; ▪ Safe Mealtime strategies; and ▪ Basics of Dysphagia. The above components were included as part of the four following classes: ▪ Lifting People ▪ Nutritional Management ▪ Seating and Positioning ▪ Dysphagia and Swallowing One hundred sixty four of 164 new employees (100%) successfully completed the PNM NEO core competencies (i.e., foundational skills) performance check-offs since the last onsite review. Per BSSLC training records, 164 staff had received and successfully passed all NEO trainings. Staff who had not passed all competency components were not allowed on the floor and were not considered to be a new employee. **<u>PNM Core Competencies for Current Staff</u>** Seven hundred thirty one of 747 current staff that require training (98%) successfully completed the current PNM core competencies (i.e., foundational skills) performance check-offs. Completion rates were as follows: ▪ Lifting People: 97% completion rate ▪ Nutritional Management: 97% completion rate ▪ Seating and Positioning: 97% completion rate ▪ Dysphagia and Swallowing: 99% completion rate Ninety-eight of 98 staff (100%) responsible for training other staff successfully completed competency-based training for PNM core competencies (i.e., foundational skills) prior to training other staff. These staff included those who were responsible for training the following courses: ▪ Lifting People ▪ Nutritional Management ▪ Seating and Positioning ▪ Dysphagia and Swallowing **<u>Annual Refresher Training</u>** Seven hundred thirty one of 747 current staff (98%) that require training have completed annual refresher competency-based training and performance check-offs within the last 12 months. ▪ Lifting People: 97% completion rate ▪ Nutritional Management: 97% completion rate	

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		▪ Seating and Positioning: 97% completion rate ▪ Dysphagia and Swallowing: 99% completion rate **<u>Individual-Specific Training</u>** To determine whether the Facility had a process to determine whether staff had been trained on components of PNMPs for individuals they supported, the Monitoring Team looked at books at one home that showed which staff had been trained on the individuals' PNMPs. Based on that evidence and interview, the Monitoring Team determined the Facility had a process in place. The Monitoring Team then asked the Facility to randomly name a direct support staff who supported individuals in that home. The Monitoring Team then asked for evidence that this staff member had been trained on all components of the PNMP for all individuals in which they were assigned to assist. This staff had completed competency check-offs in all specialized components of the PNMPs (i.e., non-foundational skills) for the individuals supported by that DSP prior to the provision of services. This however was not an accurate representation of the number of staff who had completed individual specific training. During interview, the Habilitation Director stated that staff on third shift had not received this level of training on PNMPs and dining cards specific to the individuals they support. Individuals require staff to be well trained on all areas of the PNMP even if they are on third shift as third shift staff may come in and provide support on other shifts. Additionally, individuals still participate in activities that are likely to provoke PNM difficulties from 10-6 and therefore require staff assistance in mitigating those risks. Examples include intake, positioning in bed, and ambulation. Staff responsible for training other staff did successfully complete competency-based training for the specialized components (i.e., non-foundational skills) of the individuals' PNMPs prior to training other staff on the PNMP/Dining Plan. BSSLC had a process in place in which, as part of the initial training by the therapist, a staff member (PNMP Coordinator) receives the training and then is observed by the therapist once when conducting training before becoming certified. This process was reviewed for a single individual (Individual #318) positioning plan. Based on this review, the process described by BSSLC was fully implemented correctly.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor	**<u>Facility's System for Monitoring of Staff Competency with PNMPs</u>** Monitoring tools included adequate indicators to determine whether or not "staff demonstrates competence in safely and appropriately implementing" mealtime and positioning plans. As stated in previous reports, the monitoring forms contained a	Noncompliance

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	the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	section labeled compliance and noncompliance. Compliance was achieved with a score of 80% or higher. The problem was that each question was weighted equally resulting in staff being allowed to not implement the PNMP and still have a score high enough to be rated as in compliance. Due to this scoring issue, data suggesting high compliance was potentially inaccurate. Monitoring tools did not include adequate instructions. The State Supported Living Center Compliance Monitoring Form did not have guiding questions regarding what the staff conducting the monitoring should be considering and looking for as well as how training should be provided in the occurrence a deficiency was noted. Staff members had completed all the requirements to demonstrate competence in monitoring. PNMP Coordinators (PNMPCs) were primarily responsible for the majority of monitors completed at BSSLC. There was evidence that the PNMPCs: • completed the necessary core training related to PNM • were trained on Individual specific strategies • successfully completed training on the monitoring forms • had been validated by clinicians on completion of monitoring forms Although completion of the core training components would be expected to result in competent monitoring, the Monitoring Team's observations did not correlate with the high frequency of compliance with PNMP implementation reported by BSSLC especially as it related to positioning. Issues with implementation are noted above in Provision O.4. When asked to explain the discrepancy between the differences in the observations made by the Monitoring Team versus results of the Positioning Monitors submitted by BSSLC, the Hab Director stated that the monitors do not look at all the supports listed on the PNMPS, and that staff basically look to see if the person is upright in bed. This approach represented a very lackadaisical approach to monitoring and was not sufficient to ensure appropriate supports. Based on review of monitoring completed between 12/1/12 to 3/1/12, the PNMP monitoring process did not cover all areas that were likely to provoke swallowing difficulties or increase pnm risk, based on the following: • 50 % of the monitoring forms focused on oral intake (meals and snacks) • 14 % of the monitoring forms focused on bathing • 14 % of the monitoring forms focused on medication administration • 14 % of the monitoring forms focused on Oral Care. • 3% of the monitoring forms focused on positioning	

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		• 5% of the monitoring forms focused on lifting/transfers • 57 % occurred during first shift • 43 % occurred during second shift • 0 % occurred during third shift Monitors were not completed across all three shifts and the number of positioning monitors was disproportionate to the rest of the areas that were likely to provoke swallowing difficulties. This was an area the Monitoring Team noted was especially lacking regarding implementation of the prescribed plans of care and therefore would highly benefit from more intense monitoring. **Monitoring for Individuals in Samples** For individuals in Sample O.1, PNM compliance monitoring over the past three months for 13 of 14 individuals (92%), the frequency of monitoring occurred as per the individuals' assessment and/or the individuals' plans/IHCPs. For individuals in Sample O.2, PNM compliance monitoring over the past three months for nine of nine individuals (100%), the frequency of monitoring occurred as per the individuals' PNMT assessment and/or the individuals' plans/IHCPs. Frequency of monitoring primarily defaulted to the risk based monitoring schedule which was as follows: • High Risk: monitored once weekly • Medium Risk: monitored once monthly • Low Risk: monitored once quarterly For the three months prior to the review, 23 of the expected 23 monitoring sessions per policy or the individuals' assessments and/or plans (100%) were completed timely. Monitoring occurred according to the scheduled identified policy and/or as individualized in the assessment and/or plan. Because of the lack of reliability of the monitoring data, the Monitoring Team could not evaluate how well BSSLC was responding to issues identified through the monitoring process. See Provision O.4 regarding lack of positioning implementation and the inconsistency with compliance scores.	
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	**IDT and PNMT Monitoring to Assess Individual's Progress and/or Effectiveness of the Plans** Zero of the 23 individuals' records (0%) contained evidence of indicators integrated as part of the IHCPs to assess the individual's PNM status. The IHCP did not contain criteria for referral to the PNMT, Nursing or other related services (i.e., Habilitation Therapy)	Noncompliance

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	the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	Zero of the 23 individuals' records in samples O.1 and O.2 (0%) contained evidence that the progress and status of individuals with PNM difficulties and the effectiveness of the individuals' plans was monitored based on objective clinical data identified in the individuals' IHCPs/risk action plans, IPNs and data from the PNM related monitoring forms. QDDP monthly reviews only stated that services were provided and provided no information regarding status of the individual or if the individual had any issues related to PNM or if the plan had been revised over the past month. Nineteen of 23 individuals' records (82%) in samples O.1 and O.2 included evidence that the team discussed the need for and developed individualized triggers as appropriate to the clinical needs of the individual. As part of the IRRF, the team identified if there was a need to implement a trigger sheet. A new process that was implemented regarding the trigger sheets was that the trigger sheets were no longer utilized as a permanent method of tracking triggers but as a way to gather data regarding what triggers may occur and therefore need to be added as part of the IHCP. Once these triggers are identified, the trigger sheet will be discontinued and the individualized triggers will transfer over to the IHCP. While the transition makes sense, BSSLC must ensure that all staff remain trained on the identified triggers and there is process in place in which the identification of triggers and sharing of information is well documented. Seventeen of 23 Trigger sheets (73%) were completed correctly. Seventeen of 23 Trigger sheets (73%) were reviewed at a minimum daily by the RN. 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 and Case Manager review of the trigger sheet was inconsistent.	
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	**Evaluation of Individuals who receive Enteral Nutrition** The Facility had a sustainable system to maintain and update a list of individuals who were enterally fed. Included as part of the list was the individual's home, name, type of feeding, date tube was placed, diet, and if the individual received any form of pleasure feeding. Nine of 10 individuals who receive enteral nutrition (90%) were evaluated at a minimum annually as evidenced by review of their IRRF, ISP and Nutritional Assessment.	Noncompliance

#	Provision	Assessment of Status	Compliance
	necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	Zero of 10 individuals (0%) evaluated had an appropriate evaluation to determine the medical necessity of the tube. Medical necessity was identified as part of the Nutritional Assessment, Habilitation Assessment, as well as part of the APEN. The primary issue was that the Nutritional Assessments were either late in being completed or not completed at all and therefore information was unable to be reviewed by the IDT in a timely manner prior to the ISP and IRRF. Another concern noted was that information regarding medically necessity was inconsistent in its locations and not readily present as part of the IRRF. No individuals who received enteral nourishment were admitted since the last review; therefore, the Monitoring Team was unable to review if the medical necessity of the feeding tube was assessed within 30 days. **Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition** One of ten individuals (10%) from Sample O.3 who receive enteral nutrition were appropriately evaluated by the IDT to determine if a plan to return to oral intake was appropriate. Although return to oral intake was included as part of the Habilitation Assessment, there was not a clear determination of whether the individual was a candidate for an oral motor treatment program to improve potential not only for by mouth (PO) intake but for improved saliva control. Also, as stated above, the Nutritional Assessments were consistently late or not completed and therefore there was limited to no discussion regarding current formula and schedule of feedings and determination if there was a possibility for modification to a less restrictive schedule. Examples included: • Individual #53 only mentioned prior oral trials and did not discuss how the person could improve upon their past performances. • Individual #567 was not assessed for the potential to improve oral functioning or the potential to return to oral intake. Zero of the one individual in Sample O.3 (0%) who was identified as potentially benefitting from oral motor treatment or cleared to return to some form of oral intake had a comprehensive plan outlining the treatment or return to PO process. BSSLC did not consistently provide treatments or strategies to help move the individual	

#	Provision	Assessment of Status	Compliance
		along the pathway to oral intake. In many cases, deficiencies were not noted as requiring treatment. Examples included: • Individual #91 was identified as having poor ability to manage secretions but no plan to improve oral musculature was recommended. • Individual #453 was identified by Habilitation Therapy in their 1/16/13 report as someone who would benefit from strategies and exercises to improve control of secretions; however, there was no evidence in the ISP or ISPAs that this was ever initiated or discussed. Plans when developed should include all of the following components: • Staff training required prior to implementation; • Staff roles and responsibilities (e.g., implementation, monitoring); • Time and schedule of interventions; • Specific triggers for when the plan should be stopped; • Milestones for progressing with the plan; • Documentation requirements (method for tracking progress); and • Frequency of subsequent assessments and staff responsible. Zero of the ten individuals' plans to return to oral eating were based on the results of the IDT's discussion (0%) and were integrated in the IHCP, ISP, and/or an ISPA. The IRRF did not provide clinical assessment data to identify an individual's potential to return to oral eating. IRRFs did not provide justification for the medical necessity of the feeding tube. Additionally, any plan the IDT develops should be memorialized in an IHCP that is part of the ISP, and/or documented in an ISPA. No individuals were provided with clear plans to return to oral intake and therefore the Monitoring Team was unable to determine: • Whether plans were implemented in a timely manner • If staff responsible for implementation of these oral intake plans were competent to do so through competency-based training conducted by a licensed clinician with specialized training in PNM. • If plans were monitored as outline in the plan • If plans were modified as needed by the IDT	

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

1. The PNMT discharge process remains vague and non-descriptive resulting in an inconsistent process of information sharing and acceptance by the IDT. BSSLC should clarify and formalize the discharge process. (Provision O.2)

2. The PNMPs while much improved still require more detail as it relates to oral care and communication. (Provision O.3)
3. Pathways to oral intake were not consistently provided by the team. The IDT should ensure that all pathways to oral intake are explored by the IDT and included as part of the ISP, and IRRF.
4. Behavioral Considerations related to PNM as well as review of medications, labs, and adaptive equipment should be part of all PNMT reviews. There should be some type of evidence of their discussion as part of the overall PNMT review. (Provision O.2)
5. All staff should be provided with specialized training as it relates to the PNMP. As of this review, third shift did not consistently receive any specialized training. (Provision O.5)
6. Monitoring should occur throughout all activities as well as across all shifts (Provision O.6)
7. The QDDP, as part of their monthly review, should review data relevant to PNM and comment regarding any PNM related events that have occurred and whether supports remain effective. As of this review, the QDDP monthly review only stated that "Service was provided." (Provision O.7)
8. BSSLC must provide Nutritional Assessments in a timely manner so that they are available for IDT review at the time of the ISP. (Provision O.7)
9. While the transition to a new process for documenting and tracking triggers through the IHCP makes sense, BSSLC must ensure that all staff remain trained on the identified triggers and there is process in place in which the identification of triggers and sharing of information is well documented. (Provision O.7).

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 3/21/13 2. BSSLC Action Plan 3/11/13 3. PNMP Policy (rev 11-14-2011) Record reviews: 4. Sample P.1: Individuals #65, #90, #94, #97, #149, #185, #205, #253, #259, #269, #281, #283, #318 and #449 5. Sample P.2: Individuals #59, #205, 318, #478, and #539 6. Sample P.3: Individuals #68. 260, and #286 7. Lists of individuals: a. Who cannot feed himself or herself and notation of any changes since the last review; b. Who require positioning assistance associated with swallowing activities and notation of any changes since the last review; c. Who have difficulty swallowing and notation of any changes since the last review; d. At high and/or medium risk for aspiration pneumonia and choking; e. With choking incidents since the last compliance review f. Who had a feeding tube inserted since the last compliance review g. Who were admitted to the hospital since the last compliance visit with admitting and discharge date and diagnosis h. Who were diagnosed with pneumonia or a respiratory difficulty since the last compliance review (include date and type) i. With falls in the last 12 months (date, location, type of injury)* j. With chronic respiratory infections k. With chronic dehydration l. With fecal impaction m. With pressure ulcers in the last 12 months (date, location and resolution) n. With fractures in the last year (date, location of fracture, status) o. Who were non-ambulatory or require assisted ambulation p. With wheelchairs for primary mobility q. With wheelchairs for transport r. Who use Assistive Devices for ambulation (type of device) s. With orthotic/braces 8. New PNMT members since last review, including a copy of their curriculum vita; 9. Caseloads of PNMT dedicated and non-dedicated members. 10. List of medical consultants to the PNMT (e.g., medical doctor, nurse practitioner, or physician's assistant and PNMT meeting minutes and attendance sheets for presence and participation of a medical doctor, nurse practitioner or physician assistant, and other IDT members as needed or defined in Facility policy.

	11. PNMT members and PNMT back up curriculum vitas 12. QA reports/matrix since the last compliance review 13. List of referrals to the PNMT since the last compliance visit 14. PNMT RN post hospitalization assessments completed since the last compliance visit. 15. PNMT assessment template 16. PNMT Action Plan template 17. Habilitation Therapy Annual Assessment 18. Habilitation Therapy Update 19. Wheelchair/Adaptive Equipment Maintenance Log (last 6 months) 20. IRRF template 21. IHCP template 22. List of new employees since last compliance visit and their PNM related performance check offs 23. PNM Monitoring Tool template 24. Last three months of PNM monitoring data (including date, activity monitored, time of monitor, person conducting monitor) 25. For Individuals in Sample: a. All ISPs in the last 12 months b. All ISPAs in the last 12 months c. All IRRFs in the last 12 months d. All IRRF Action Plans in the last 12 months e. IHCP/Action Plan f. QDDP Monthly Reviews for the last 6 months g. PBSPs h. Braden Scale forms i. Annual weight graph j. Nutrition tab, including assessments and reviews k. HOBE assessments l. PNMT assessments and any other PNMT documentation other than IPNs in the last 12 months, if not already submitted m. OT/PT assessments in the last 12 months n. SLP assessments, including Communication/AAC in the last 12 months o. 6 months IPNs p. Trigger sheets completed in the last 6 months, including the current one q. PNMPs in the last 12 months, including pictures r. Dining Plans in the last 12 months, including pictures s. Completed PNM-related monitoring sheets in the last three months t. Evidence of effectiveness monitoring completed within the last six months u. APEN in the last 6 months v. Plan for individuals who are returning to oral eating and supporting documentation for implementation of plan (i.e, staff training documentation, staff roles and responsibilities, specific triggers when the plan should be stopped; milestones for progress with the plan, documentation requirements to track progress, and frequency of subsequent assessments and

	staff responsible and monthly progress notes) w. Direct intervention plan and supporting documentation for implementation of the plan (i.e., monthly progress notes) x. Individual notebooks (PNM section) 26. PNMT Process Flow chart (not dated) **People Interviewed:** 1. Kori Kelm Physical Therapist (PT), Habilitation Therapy Director 2. Tracy Searles Physical Therapy Assistant (PTA), 3. Christina Koehn SLP 4. Dr. Karen Hardwick 5. Direct Care Professionals on (2) Childress, (2) Driscoll, and (2) Bowie. (4) Fannin **Meeting Attended/Observations:** 1. QA/QI Meeting 2. PNMT meeting 3. Mealtimes (Bowie, Childress, Fannin, and Driscoll) 4. Daily activities on Driscoll, Fannin, Childress, and Program Services
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section P, dated 3/21/13 and Action Plan dated 3/11/13. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. For Section P in conducting its self-assessment, the Facility: ▪ Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: Settlement Agreement Monitoring Tool for Section P. o This monitoring/audit tool did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. For example: Provision P.1 in the Self-Assessment did not include timeliness of reports due for the annual as well as components of the assessment related to quality. o The monitoring tools did include adequate methodologies, such as observations, record review and staff interview. o The Self-Assessment did not identify the sample(s) sizes and the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). o The Self-Assessment did not state the following staff/positions who were responsible for completing the audit tools: such Facility therapists (i.e., OTs, PTs, and SLPs); therefore there was no evidence of staff responsible for conducting the audits/monitoring had been

	deemed competent in the use of the tools. ▪ The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not consistently measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance in two of the provisions of Section P (Provisions P.1 and P.2). This was inconsistent with the Monitoring Team's findings. The Monitoring Team found Provision P.2 to not be in compliance. • Provision P.1 was found to be in compliance but concern was noted due to assessments not being completed in a timely manner (ten working days prior to ISP) and assessments lacking comparative analysis and discussion of health status over the past year. It is expected that BSDC will take the steps needed to resolve the issue in order to remain in substantial compliance. • Provision P.2 was found to not be in compliance due to lack of integration into the ISP, and lack of monthly review of indirect supports. The Actions plans developed were felt to move BSSLC in the right direction towards compliance; however, BSSLC should continue to review the findings of the Monitor's report and revise the Action Plan as indicated to address all identified concerns.
	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. An area that saw decline was in the timeliness in which assessments were provided. **Provision P.1:** This provision, which had been found in substantial compliance at the last visit, remained in substantial compliance. The Habilitation Assessment addressed the majority of components needed to fully assess an individual with the exception of consistently providing comparative analysis, listing potential side effects related to medications and investigating more ways to improve functional skills. Both of these areas were improving with the newer assessments. However, it should be noted that Habilitation Therapy assessments were not consistently provided in a timely manner. Additionally, there appeared to be a delay in responding to individuals who had experienced changes in status (e.g., falls). The Monitoring Team had expressed in the previous report that it was unclear whether compliance could be retained with current staffing numbers. The lack of full staffing may be having an impact on BSSLC's ability to complete the assessments in a timely manner. The Monitoring Team views these circumstances as meeting the criterion set forth in Section III.D of the Settlement Agreement. In this section, the parties included the following language: "Noncompliance with mere technicalities, or **temporary failure to comply during a period of otherwise sustained compliance**, shall not constitute failure to maintain substantial compliance." (Emphasis added.) As a result, the Facility has maintained the finding of Substantial Compliance with the understanding that for a substantial compliance rating to continue during the next

	review, corrections to the timeliness of the assessments, both annual and in response to changes in status, will be corrected and sustained. For compliance to be retained at the next visit, the Facility must show that this was a temporary decline and must demonstrate the ability to complete assessments and address changes in status in a timely manner. **Provision P.2:** This provision was determined to be not in compliance. Therapy services were not consistently integrated into the ISP. There was little evidence that individual's progress was reviewed and documented based on the action plan in the ISP/ISPA at least monthly. **Provision P.3:** This provision was determined to be not in compliance. Plans were not implemented as written. Individuals were observed without supportive devices. **Provision P.4:** This provision was determined to be not in compliance. Missing from policies/procedures reviewed were evidence of documentation of expectations regarding review of services and monitoring of treatment services. BSSLC had ample frequency of monitoring but there was no evidence that staff or the individual was monitored across all three shifts. Additionally, the reliability of the acquired data is in question due to the large disparity in findings from BSSLC and that of the Monitoring Team.

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	This provision, which had been found in substantial compliance at the last visit, remained in substantial compliance. The Habilitation Assessment addressed the majority of components needed to fully assess an individual with the exception of consistently providing comparative analysis, listing potential side effects related to medications and investigating more ways to improve functional skills. Both of these areas were improving with the newer assessments. However, it should be noted that Habilitation Therapy assessments were not consistently provided in a timely manner and were therefore not available to the IDT for review prior to the ISP annual meeting. Additionally, there appeared to be a delay in responding to individuals who had experienced changes in status (e.g., falls). The Monitoring Team had expressed in the previous report that it was unclear whether compliance could be retained with current staffing numbers. The lack of full staffing may be having an impact on BSSLC's ability to complete the assessments in a timely manner. The Monitoring Team views these circumstances as meeting the criterion set forth in Section III.D of the Settlement Agreement. In this section, the parties included the following language: "Noncompliance with mere technicalities, or **temporary failure to comply during a period of otherwise sustained compliance**, shall not constitute failure to maintain substantial compliance." (Emphasis added.) As a result, the Facility has maintained the finding of Substantial Compliance with the understanding that for a substantial compliance rating to continue during the next review, corrections to the timeliness of the assessments, both annual and in response to changes in status, will be corrected and	Substantial Compliance

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		sustained. For compliance to be retained at the next visit, the Facility must show that this was a temporary decline and must demonstrate the ability to complete assessments and address changes in status in a timely manner. Samples for this section were as follows: Sample P.1 is the same as Sample O.1 that consisted of a non-random sample of 14 individuals who were chosen from a list provided by the facility of individuals they identified as being at a medium or high risk of PNM related issues [i.e., aspiration, choking, falls, fractures, respiratory compromise, weight (over 30 or under 20 BMI), enteral nutrition, GI, osteoporosis], require mealtime assistance and/or are prescribed in a dining plan, were at risk of receiving a feeding tube, and/or who have experienced a change of status in relation to PNM concerns (i.e., admitted to the Facility Infirmary, if applicable, emergency room and/or hospital). Sample P.2 consisted of 5 individuals who receive direct OT/PT services that is chosen based on a review of a list of individuals receiving therapy, including the focus of the therapy. **Timeliness of Assessments** Eleven of 11 admitted individuals since the last review (100%) received an OT/PT screening or assessment within 30 days of admission or readmission. Eleven of 11 individuals (100%) identified with therapy needs received a comprehensive OT/PT assessment within 30 days of identification. Due to BSSLC only providing assessments upon admission, the Monitoring Team included the presence of assessments as meeting and surpassing compliance with this metric. Eight of 14 individuals' OT/PT assessments in sample P.1 (57%) were dated as having been completed at least 10 days prior to the annual ISP. Habilitation Assessments were not consistently completed in a timely manner and therefore were unavailable for review by the IDT prior to the ISP. The lack of having this information available greatly impacts the ability to have a thorough and meaningful discussion by all team members as part of the ISP process. Fourteen of 14 assessments or updates in Sample P.1 (100%) were current within 12 months for individuals who are provided PNM supports and services.	

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		Zero of three individuals (Sample P.3) who experienced falls were appropriately reviewed by the IDT. Individuals who experienced multiple falls did not have evidence of team discussion regarding the situation in which the falls occurred and factors potentially impacting the occurrence. For example: • Individual #60 fell four times in a four month period yet there was no evidence of discussion to address incidents. • Individual #286 fell four times leading up to a fifth fall which resulted in injury before there was evidence of the IDT meeting. • Individual #68 fell five times but the team only met when there were serious injuries. During the meeting on 1/15/12 to discuss a serious fall on 10/14/12, the recommendation was for the tam to reconvene once they had a chance to review video and gather more information. There was no evidence this meeting ever occurred. **<u>OT/PT Assessment</u>** Based on review of the sample of assessments, the comprehensiveness of the OT/PT assessments for samples P.1 and P.2 were as follows: • Eighteen of 18 individuals' OT/PT assessments (100%) were signed and dated by the clinician upon completion of the written report. • Eighteen of 18 assessments (100%) included diagnoses and relevance to functional status. • Eighteen of 18 assessments (100%) 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. • Thirteen of 18 assessments (72%) included a comparative analysis section that clearly analyzed the individuals' level of functional status with previous years or assessments. • Thirteen of 18 individuals' OT/PT assessments (72%) offered a comparative analysis of current functional motor and activities of daily living skills with previous assessments. • Eighteen of 18 assessments (100%) included medical history and relevance to functional status. • Eighteen of 18 assessments (100%) addressed health status over the last year • Five of 18 assessments (27%) listed medications and potential side effects relevant to functional status • Eighteen of 18 assessments (100%) included documentation of how the individual's risk levels impact their performance of functional skills • Eighteen of 18 assessments (100%) included evidence of observations by OTs	

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		and PTs in the individual's natural environments (day program, home, work) • Thirteen of 18 assessments (72%) included discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings • Eight of 18 assessments (44%) included discussion of the expansion of the individual's current abilities. • Ten of 18 assessments (55%) included discussion of the individual's potential to develop new functional skills • Fourteen of 18 assessments (77%) included a functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day • Eighteen of 18 assessments (100%) identified need for direct or indirect OT and/or PT services, and provided recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs. • Eighteen of 18 assessments (100%) included a monitoring schedule. The monitoring schedule primarily listed was the default schedule that is based upon risk. • Eighteen of 18 assessments (100%) included a re-assessment schedule. The reassessment schedule at BSSLC was an updated every year if receiving direct or indirect services and a comprehensive every three years for everyone. • Eighteen of 18 individuals' OT/PT assessments (100%) made a determination about the appropriateness of transition to a more integrated setting. This information was much improved as more detailed requirements were now included as part of the overall determination. • Eighteen of 18 assessments (100%) provided a statement regarding "Factors for Community Placement" that is detailed and lays out the supportive services needed for successful living. • Eighteen of 18 assessments (100%) included evidence that communication and or collaboration was present in the OT/PT assessments as evidenced by dated signature. • Eighteen of 18 assessments (100%) include recommendations for services and supports in the community. This information was present as part of the "Factors for Community Placement" • Eighteen of 18 assessments (100%) recommended ways in which strategies, interventions, and programs should be utilized throughout the day. This information was primarily contained within the PNMP. Ten of 18 updates (55%) (Samples P.1 and P.2) were completed consistent with the established schedule, or the individuals' need. Many assessments were not provided in	

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		a timely manner to allow the IDT time to review prior to the ISP.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	**OT/PT Interventions** For individuals receiving OT/PT supports and services, 18 of 18 plans for Samples P.1 and P.2 (100%) were developed within 30 days of the date of the assessment/update, or sooner as indicated by need. For 11 of 18 individuals in Samples P.1 and P.2 (61%), the ISP/ISPAs addressed each of the recommendations outlined in the current OT/PT assessment. Many times there was lack of integration of the Habilitation Assessment into the ISP as well as lack of an ISPA to discuss finding from an assessment. For example: • There was no evidence of IDT discussion regarding the results of Individual #539's Head of Bed Assessment. • There was no integration of information contained within the Habilitation Assessment into the ISP, including but not limited to Individuals #65 and #97. **Direct OT/PT Interventions** The records of individuals in Sample P.2 were reviewed resulting in the following findings: • Four of five individuals' direct intervention plans (80%) were implemented within 30 days of the plan's creation, or sooner as required by the individuals' health or safety. • For five of five individuals' records (100%) reviewed, the current OT/PT assessment identified the need for direct intervention with rationale. These could be annual assessments or interim assessments completed during the year in response to changes in status or identified needs. • For zero of five individuals' records (0%) reviewed, there were measurable objectives related to functional individual outcomes included in the ISP or ISPA. Measurable outcomes were not included as part of the ISP or ISPA but were clearly included as part of the OT/PT plan of service. • For zero of five individuals' records (0%), whose therapies had been terminated, termination of the intervention was well justified and clearly documented in a timely manner. Clinical justification for the termination of a direct intervention plan was included as part of the discharge/final note. The problem identified was that there was no consistent ISPA meeting upon discharge to discuss final results and recommendations. **Indirect OT/PT Programs**	Noncompliance

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		The implementation of these plans is discussed under Section O4 for PNMPs and in Section S for skill acquisition plans. **<u>Integration of OT/PT Direct Intervention(s) and Indirect OT/PT Program(s) in the ISP</u>** An OT or PT attended the ISP or ISPA meeting, unless adequate justification was provided in the Pre-ISP meeting documentation. Seventeen of 18 ISP annual meetings (94%) had a member from either OT or PT present to represent the disciplines. Eleven of 18 ISPs or ISPAs (61%) integrated the OT/PT interventions. The ISP or ISPA did not consistently describe the supports based on the rationale provided in the therapy assessment. Many ISPs simply stated that the individual had a PNMP and the IDT approved it. Examples included but were not limited to Individuals #90 and #65. In three of three of the ISPs or ISPAs reviewed (100%), skill acquisition programs that had been recommended in the OT/PT assessment were present. The problem noted with this area was that skill acquisition programs continued to be rarely identified as part of the Habilitation Assessment. The Habilitation Assessments continued to focus primarily on supports to mitigate risk or provide support and did not identify potential areas in which skills such as ADLS could be addressed. For 0 of five individuals (0%), the ISP/ISPAs contained measurable objectives related to functional individual outcomes. Measurable outcomes were not included as part of the ISP or ISPA but were clearly included as part of the OT/PT direct plan of service. Five of five individuals receiving direct OT/PT Services (100%) were provided with comprehensive progress notes (IPNs) that contained each of the indicators listed below. Progress notes included the following indicators: • Contained information regarding whether the individual showed progress with the stated goal including clinical data to substantiate progress and/or lack of progress with the therapy goal(s). • Described the benefit of the goal to the individual. Although this indicator was not present as part of every notes entry, it was observed as part of the initial as well as discharge/final note and therefore meets the intent of this indicator. • Reported the consistency of implementation. • Identified recommendations/revisions to the OT/PT intervention plan as indicated related to the individual's progress or lack of progress. • A comprehensive progress note was completed on at least a monthly basis.	

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		For individuals with PNMPs or SAPs, for 0 of 14 individuals (0%), there was evidence that their progress was reviewed and documented based on the action plan in the ISP/ISPA at least monthly. Monthly documentation from the OT and PT and/or QDDP did not include: • Information regarding whether the individual showed progress with the stated goal(s), including clinical data to substantiate progress and/or lack of progress with the therapy goal(s); • A description of the benefit of the program; • Identification of the consistency of implementation; and • Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress. The monthly QDDP note simply stated that service was provided. No more detail regarding the implementation of the services, the effectiveness, or the need to revisit identified concerns was contained within the monthly review.	
P3	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans.	The requirements for this section were discussed in detail with regard to Section O.5. Indirect plans are inclusive of the PNMPs since OT/PT is covered substantially in the PNMP. The Facility must identify which services and supports may need to be provided during the night shift, and therefore require staff to be trained. Clearly, positioning would need to be implemented accurately on night shift for some individuals, and some individuals also will have the potential for swallowing during the night (such as requesting or getting a drink), so PNMPs for those individual would need to be trained. In addition, some individuals will get out of bed, so staff would need to be trained on any ambulation assistance, which is clearly a part of this Section.	Noncompliance
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the	**<u>Monitoring System</u>** The Facility did not implement a system for the adequate monitoring of PNMPs. • See Section O.6 The Facility did not have a comprehensive OT/PT policy. The policy included the following elements: • Description of the role and responsibilities of OT/PT; • Referral process and entrance criteria; • Discharge criteria; • Defines the monitoring process for the status of individuals with identified	Noncompliance

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	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.	occupational and physical therapy needs; • Includes re-evaluation of monitors on an annual basis by therapists and/or assistants; • Requires that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor; • Identifies the frequency of assessments; • Defines how individuals' OT/PT needs will be identified and reviewed; and • Sets forth documentation expectations for individuals receiving direct services Missing from policies/procedures reviewed were elements that: • Define the process for monitoring the condition, availability, and effectiveness of physical supports and adaptive equipment; • Include monitoring of the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; • Identify monitors and their roles and responsibilities; • Define a formal schedule for monitoring to occur; These areas are related to issues noted earlier in Section P regarding lack of monthly review of services. For 14 of 14 individuals (100%), routine maintenance checks were conducted to ensure that positioning devices and other adaptive equipment identified in the PNMP were clean and in proper working condition. Monitoring data logs provided to the Monitoring Team indicated checks of positioning devices and other adaptive equipment were included as part of the risk based PNMP monitoring. The concern mirrors the concern noted in Provision O.6 in that individuals with needs are not being adequately identified due to less than competent monitoring. An example of positioning equipment noted to be broken that was not identified as part of monitoring included but was not limited to: • Individual #160's wheelchair was missing the stops that ensure individual is positioned appropriately in the chair. • Individual #272's buckle was broken on his wheelchair and was using a neck roll, which was not listed on his PNMP, due to a broken headrest. The Monitoring Team was unable to assess if repair of adaptive equipment was completed within 30 days unless justification was provided and in cases where health and safety was impacted, whether the equipment was repaired within 48 hours.	

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		At the time of the review, the adaptive equipment log provided to the Monitoring Team only identified when the equipment was repaired and did not include the repair referral date. Therefore timeliness of repair could not be reviewed.	

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

1. The maintenance log for wheelchair/adaptive equipment repair should include the referral date in addition to the repair date so that BSSLC may track the timeliness in which repairs are provided in response to identified concerns. (Provision P.4)
2. The ISP/ISPAs must do a better job of identifying functional gains resulting from provided therapies. (Provision P.2)
3. ISPAs should be provided when an individual is discharged from therapy to allow for review of status and determination of whether additional interventions are warranted. (Provision P.2)
4. Monthly documentation from the OT and PT and/or QDDP should include:
    - Information regarding whether the individual showed progress with the stated goal(s), including clinical data to substantiate progress and/or lack of progress with the therapy goal(s);
    - A description of the benefit of the program;
    - Identification of the consistency of implementation; and
    - Recommendations/revisions to the indirect intervention and/or program as indicated in reference to the individual's progress or lack of progress. (Provision P.2)
5. Documentation standards and expectations regarding monthly review of indirect OT/OT (PNMP) supports should be included as part of the facility policy. (Provision P.4)
6. Habilitation Assessments must be completed and submitted ten days prior to the annual ISP planning meeting. (Provision P.1)
7. Habilitation Assessments must include comparative analysis regarding health status and status related to PNM supports. (Provision P.1)
8. Habilitation Assessment should include a review of medications relevant to Habilitation Therapies as a consistent part of their assessment. (Provision P.1)
9. A system must be implemented that ensures all staff (all shifts) are monitored for implementation of indirect OT/PT services (PNMPs). (Provision P.3)

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. BSSLC Self-Assessment (3/21/13) 2. BSSLC Action Plan (3/21/12) 3. Presentation Book, April 2013 4. Policy Client Services/Medical Services: Dental III.2.a (undated) 5. Dental radiograph log 6. Dental log of missed dental appointments 7. Dental scheduling spreadsheet (contains appointments, missed appointments, and noncompleted appointments) 8. TIVA log 9. List of individuals who are provided suction toothbrushing 10. List of all dental emergencies that occurred during the reporting period. **People Interviewed:** 1. Mary Anne Brett, MD (Medical Director) 2. Jennifer Pampell, RDA **Meeting Attended/Observations:** 1. None
	Facility Self-Assessment: The Facility's action plan for Q.1, and Q2, was limited in scope and detail, and did not adequately identify requirements for which actions were needed, and lacked steps that would contribute to achieving compliance. Only two actions were listed, one of which was reported to be completed. Review of the Facility's self-assessment, is as follows: The Facility reported that is was in substantial compliance with Provision Q.1, and noncompliance with Provision Q.2, of the Settlement agreement. The self-assessment indicated that the Facility was current with all annual dental evaluations, stating that "all individuals dental examinations were completed within 365 days", and that 100% of the sample was "seen in dental for their annual examination". While the individual may have been in the dental office, the Monitoring Team is aware that many times, the examination and treatments were unable to be completed. In fact, the Monitoring Team was provided data that indicated that 102 individuals were either delinquent with their annual assessment or the assessment could not be completed and needed follow up. The assessment also indicated that 100% of emergency dental care was provided on the same day as requested, and the Monitoring Team review of IPNs indicated that many cases were actually seen on the following day. Also, the self-assessment indicated that all exams and emergency care "are noted in dental progress notes and IPN". As delineated in this report, dental emergency care issues were not documented in the IPN, through resolution of the dental issue. The self-assessment did not address efficiency of the Facility's ability to manage dental database elements, staffing issues, effectiveness of the TIVA program, or dental quality assurance efforts, among many other issues related to dental operations. The Monitoring Team strongly recommends that it develop a more robust,

	and comprehensive method of determining compliance. For example, the Facility should consider identifying all necessary processes, and integrating them into a Gantt chart.
	Summary of Monitor's Assessment: Because of the resignation of the dental director, the dental department had sustained significant delay with moving forward towards substantial compliance with Section Q. The Facility had recently hired a new dental director, who shared with the Monitoring Team her ambition of assisting the Facility towards compliance. At the time of this review, the Facility had made little progress from the previous reporting period, and it is anticipated, that with the support of the new dental director, the Facility will develop many processes to improve dental services. The following is a summary of issues identified by the Monitoring Team: **Provision Q.1:** Following its review for Provision Q.1, the Monitoring Team noted many persistent deficiencies that prevented the provision of necessary oral health care, and agrees with the Facility's self-assessment of noncompliance with Provision Q.1. Compliance will require that the Facility develop a robust mechanism to address dental related database elements; ensure timely and comprehensive annual evaluations; improve on its management of dental emergencies; enhance its suction tooth brush practice; ensure that dental x-rays are obtained per standard of care practice, for special needs dentistry; and provide adequate staffing that will enable completion of necessary dental evaluations, treatments, and dental hygiene. In addition, although not assessed at the time of this review, the Facility must ensure that dental records are maintained and documented according to standard of care practice, and maintain a program that fosters oral health care at the living area. **Provision Q.2:** The Facility had yet to develop and implement necessary policies, procedures, guidelines, and practices to gain substantial compliance for Provision Q.2; hence, the Monitoring Team concurs with the Facility in determining noncompliance. Compliance will require that the Facility develop clinically appropriate process and programs to address the use of TIVA; develop a quality assurance program for dental services; develop and implement a clinically relevant process to help reduce the need for sedation for dental services; identify clinically appropriate practice for pre-treatment oral sedation, general anesthesia, and when necessary, sound physical restraint guidelines. In addition, the Facility must also develop a more robust method of reporting oral health care needs to the IDT, and to ISP meetings.

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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,	To assess Provision Q.1, the Monitoring Team requested policies, procedures, guidelines, integrated progress notes, and dental records. In addition, the Monitoring Team meet with the medical director, newly hired dental director and dental assistant. During the course of this review, the Monitoring Team assessed issues related to dental administration, dental emergencies, suction toothbrushing, dental x-rays, and timeliness of dental services.	Noncompliance

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	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.	Dental Administration The Monitoring Team discussed administrative issues with the medical director, and requested all policies and procedure specific to the provision of oral health care. The only document provided was the Facility's policy for dental services entitled, "Client Services/Medical Services: Dental III.2.a" (undated). In addition, the Monitoring Team discussed with the medical director about staffing issues, and the Facility's progress with developing a mechanism to manage its database elements for dental issues. Dental Scheduling The Facility did not have an effective method of maintaining its dental schedule in real-time. The Facility utilizes a spreadsheet to organize its scheduling of dental issues; hence, it requires significant manpower, and time to track and trend database elements specific to the dental schedule. As a result, the Facility cannot effectively monitor individuals who were current and not current with dental evaluations, treatments, and hygiene. Also, the Facility was unable to efficiently track and trend issues related to appointment failures. According to a spreadsheet provided for review by the Monitoring Team, the Facility reported that 102 individuals were either delinquent with their annual assessment or the assessment could not be completed and needed follow up; hence, out of a total population of 293 individuals, the Facility had completed the annual dental examination 191 out of 293 (65%) of the individuals who reside at the Facility. The Facility could not produce a list of all pending restorative treatments. Summary: The Facility must develop an effective means to manage its dental scheduling, so that all pending, and provided dental treatments, evaluations, emergencies, and dental hygiene can be efficiently tract and trended. Also, the Facility must ensure to maintain a schedule of all missed appointments, and the reason for the missed appointments, so that efficient, and regular trends analysis can be completed. The Facility is significantly behind with providing annual dental evaluations, and must develop a process to ensure timely annual dental treatments. Staffing issues must be assessed by administrations, to ensure that adequate staffing is available for dental operational needs at the Facility. Staff: At the time of this review, the dental office had recently hired a new dental director, following the resignation of the previous dental director. Since the Monitoring Team began its reviews, the Facility has now had four dental directors. The Facility has only one dentist, who also services as the dental director. There are a	

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		total of two hygienists, and one dental assistant, who is also the dental offices clerical support. Summery: The Monitoring Team has significant concern over staffing issues for dental services. The Monitoring Team is aware that for special needs dentistry, each dentist, and hygienist, requires at a minimum, one dental technician, or trained support staff, whenever providing service. Based on review of the significant delay with dental scheduling the Facility must review dental practice standards, the reason for significant delays in completing routine, and emergency dental evaluations, treatments, and dental hygiene, and determine its operational needs for dental services, that will ensure prompt and efficacious oral health evaluation and treatment, for all individuals who reside at the Facility. <u>Dental Policy</u> The Facility did not maintain specific policies, procedures or guidelines to govern dental services. The policy for dental services was a general overview of clinical practice, but did not enable clear guidance of the many important clinical, and dental administrative process for dental services. For example, there was no comprehensive policy, procedure, or guideline for the provision of TIVA services; there was no specific guidance for the standard of care provision of dental x-rays; the policy did not reflect the Facilities actual practice for documenting oral health care issues in the IPNs; and there was no provision regarding the frequency of dental and oral hygiene needs of individuals with special needs. Summary The dental policy did not meet the operational needs of the Facility, and the Facility must develop, and implement, clinically relevant policies, procedures, and guidelines to ensure all clinical, and administrative practices meet standard of care practice, for Individuals with special needs. <u>Dental Emergencies</u> To assess the Facility's process of managing dental emergencies, the Monitoring Team discussed the process with the medical director, reviewed the current policy for dental emergencies, entitled "Client Services/Medical Services: Dental III.2.a (undated), and reviewed the dental records and integrated progress notes related to all dental emergencies that occurred during the reporting period. The current policy for dental emergency continues to state that the dental director will triage dental emergencies with the on-call unit medical clinician. During discussion with the medical director, the practice of the dental director being available 24/7 was still in	

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		place. At the last Monitoring Team review, the Monitoring Team expressed concern that a dentist could not be on-call 24/7, and the policy must be revised, which it had not. The Facility needs to provide some back-up process when the dentist cannot be available. The Facility reported that there were 12 dental emergencies during the reporting period; however, the Monitoring Team identified an additional dental emergency that occurred following the Facility's compilation of the pre-visit document request. The Monitoring Team specifically requested in an on-site document request, and during discussion with the medical director, a list of all dental emergencies that occurred during the reporting period. This demonstrates that the Facility is unable to effectively manage important clinical database elements, as the Facility did not have a mechanism to retrieve a current list of dental emergencies, other then physically going through either a calendar, or the dental records. The Monitoring Team reviewed the first nine sets of integrated progress notes provided by the Facility, regarding dental emergencies (Individuals #170. #321, #18, #316, #243, #51, #462). Of the nine cases, nine out of nine (100%) had an initial assessment documented by the dentist; two out of nine (22%) included an initial IPN documented by the medical practitioner regarding the dental emergency; and one out of nine (11%) documented follow-up through resolution of the dental emergency. Of concern, were four cases (Individuals #51, #462, #170, and #19) that included signs and symptoms of pain and/or bleeding, in which the individual could not be adequately examined, and the plan was to "follow-up". For example, Individual #170 was noted to have oral pain, and was provided narcotic analgesics. The Individual was seen by the dentist on 1/14/13, but the dentist could not examine an extraction site because of behaviors, and continued narcotics for pain management. The Individual was followed up by the dentist on 1/22/13; the dentist documented that the issue had resolved, but was not able to examine the extraction site. Individual #19 was seen 12/4/12 for severe bleeding of the gums, and the dentist reported severe gingivitis and accumulation of plaque at the level of the gums, but no active bleeding. The dentist indicated that the Individual was to follow up at "recall this month." The Individual was seen on 1/4/13; however, the dentist was unable to examine the individual because of "behaviors". The hygienist reported that several unsuccessful attempts had been made to clean the individual's teeth. Also documented was that the individual had an "exophilic mass" that needed to be followed up on. There were no additional IPNs documenting follow-up through resolution of this Individual's oral health issues. On 12/28/12, Individual #51 was noted to have "active bleeding", and reported to be	

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		"difficult to examine because of behaviors". An x-ray demonstrated a dental impaction, and referral was made to an oral surgeon for extraction. There was not follow-up documented in the IPNs. Individual #462 was reported to have facial swelling and a "lacerated area with ragged borders", but because of "behaviors", the dentist could not adequately examine the individual. The only plan documented was to follow-up through resolution; however, there were no IPNs documenting follow-up of this condition. Summary: The Monitoring Team has significant concern over the Facility's emergency dental process. The Facility must develop a clinical process that does not include a single dentist responsible for call 24/7. All dental emergencies must be effectively evaluated, when clinically indicated. For example, if there is active bleeding, a history of significant trauma, known lesions that could potentially be of clinical significance, the Facility must provide that level of care. Based on review of dental emergencies, it appears the Facility does not have adequate resources to provide necessary examination and treatments, for individuals with challenging behavioral issues. The Facility must be able to adequately address such issues. <u>Dental X-RAYs</u> To assess the Facility's ability to provide dental X-rays, per standard of care practice, the Monitoring Team reviewed the Facility's x-ray log, and discussed the issue with the medical director. The medical director informed the Monitoring Team that the Facility did not have a mechanism that enabled a real-time accounting of individuals who were delinquent with their dental x-rays. An excel spreadsheet was developed by review of dental records, which indicated that 102 individuals were delinquent with having dental x-rays completed, per standard of care practice. The x-ray list indicated that in 40 of the 102 cases (40%), the delay was secondary to awaiting TIVA availability. Summary: The Monitoring Team expects the Facility to have an efficient means of identifying individuals who are both current and not current with dental x-rays. Unless contraindicated, dental x-rays must be provided per standard of care practice, which in special needs dentistry is usually annually, and more frequently for dental emergencies. <u>Suction Toothbrushing</u> Suction toothbrushing is effective in helping to reduce aspiration pneumonia for individuals who have swallowing difficulties. The Monitoring Team requested the	

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		Facility's current policy and procedures for suction toothbrushing, a list of all individuals who have been identified as needing suction toothbrushing, individuals who received suction toothbrushing at the time of this review, and a list of all individuals who have been identified as needing suction toothbrushing, but were not provided suction toothbrushing. The Monitoring Team also asked for the procedure for on-going selection of individuals who may develop the need for suction toothbrushing, after their initial assessment. The Facility's policy for suction toothbrushing is a component of the Client Services/Medical Services: Dental III.2.a, policy (undated). The policy was determined by the Monitoring Team to be ineffective because it did not fully delineate the many clinical indications for suction toothbrushing, and it limited referral for suction toothbrushing to the medical staff. Also, there was no mention of a process or program that provides on-going assessment for the need for suction toothbrushing, and follow-up to ensure efficacy. For example, for the selection process for individuals who may need suction toothbrushing, the policy simply indicates, "Medical staff will identify individuals who, because of recurrent respiratory illness, could benefit from tooth brushing with a suction apparatus". There was no formal process that clearly documented efficacy of suction toothbrushing. The Monitoring Team was informed by the medical director that although the "physician" is responsible for suction toothbrushing referral, that other members of the team could refer as well; however, there is no formal process, and associated policies and procedures that delineate a suction tooth brush program, or process. The Medical Director informed the Monitoring Team that all individuals who require suction toothbrushing are provided suction toothbrushing. Summary The Facility needs to develop and implement a specific process to address the oral hygiene needs of all individuals who are at risk for aspiration, and not limited to individuals who have experienced recurrent pneumonia. Also, the program or process must clearly delineate a mechanism to routinely assess individuals for suction toothbrushing, following their initial assessment. The Process must also ensure formal training of staff who provide suction tooth brushing, and a means of assessing efficacy of suction toothbrushing. <u>Oral Hygiene Provided at the Living Areas:</u> During discussion with the medical director and dental technician, the Monitoring Team was informed that oral hygiene is provided by direct care staff, twice per day; and that efficacy was assessed by the dental hygienists. The Monitoring Team did not review the	

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		Facility's documentation of oral hygiene, or quality assurance outcomes for oral hygiene at this review, but will do so at subsequent reviews. Conclusion: The Monitoring Team noted many persistent deficiencies that prevented the provision of necessary oral health care, and agrees with the Facility's self-assessment of non-compliance with Provision Q.1, of the SA. Compliance will require that the Facility develop a robust mechanism to address dental related database elements; ensure timely and comprehensive annual evaluations; improve on its management of dental emergencies; enhance its suction tooth brush practice; ensure that dental x-rays are obtained per standard of care practice for special needs dentistry; and provide adequate staffing that will enable completion of necessary dental evaluations, treatments, and dental hygiene. In addition, although not assessed at the time of this review, the Facility must ensure that dental records are maintained and documented according to standard of care practice, and maintain a program that fosters oral health care at the living area.	
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	To asses Provision Q.2, the Monitoring Team requested policies, procedures, guidelines, TIVA schedule, and reviewed the ISPs of Individuals #39, #88, #223, #222, #258, #318, #305, #252, #431, #461, #61, #75, #34, #25, #460, #444, #481, #415, #89, and #567 . In addition, the Monitoring Team met with the medical director, newly hired dental director and dental assistant to discuss their clinical processes. Specific issues assessed by the Monitoring Team include the Facility's ability to provide total intravenous anesthesia (TIVA), pre-treatment oral sedation, general anesthesia, QA process for dental services, and dental services participation at the ISP. <u>TIVA</u> The Monitoring Team requested policies and procedures for the TIVA program. In addition, the Monitoring Team discussed the TIVA process with the medical director, reviewed a list of all individuals who were known to require TIVA for oral health care evaluations and treatment and a list of individuals who have been provided TIVA during the reporting period. The TIVA list provided to the Monitoring Team reported that 93 individuals require on-going TIVA for their oral health care evaluations, and treatments. During discussion with the Medical Director, the Facility recognized that at least 110 individuals required TIVA. According to the list of who was provided TIVA during the past six months, a total of 25 individuals had been provided TIVA for oral health care evaluations; hence, on average, four individuals a month were provided TIVA in a six month period. Based on the known number of individuals who require TIVA, the Facility should have provided TIVA, at a	Noncompliance

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	medications and dental restraints.	minimum, to nine individuals per month, just to provide annual dental evaluations. The Facility did not maintain additional TIVA services that would enable individuals to be seen for additional TIVA treatments, such as for intensive, and more frequent dental hygiene, and for emergency or restorative needs, outside of the annual examination. For cases that required TIVA outside of their annual examination, they would be put on a waiting list, or take the place of an individual who was scheduled for their annual exam, resulting in delay for the individual with the annual dental examination. It was very clear that the Facility did not provide adequate TIVA services. Summary: The Monitoring Team expects the Facility to develop and implement a process that enables a real-time understanding of all individuals who require TIVA for oral health care evaluation and treatments; adequate TIVA resources so that all individuals who require TIVA are provided TIVA timely, including individuals who require TIVA for restorative care and more frequent intensive dental hygiene. Also, the Facility must ensure that TIVA is provided safely, and that close monitoring for adverse effects to TIVA is completed, and well documented, as a component of a dental quality assurance program. <u>Pre-Treatment Oral Sedation for Dental Services</u> The Medical director informed the Monitoring Team that the Facility does not provide pre-treatment sedation for dental services. As reported in Provision J4, there were two procedures that utilized oral pretreatment sedation during between 8/1/12 and 2/28/13. Summary: The Facility does not provide Pre-Treatment oral sedation for dental services. The Monitoring Team questions the clinical rationale for this practice, as some Individuals, as in the general community, may require the rational administration of pre-treatment oral sedation. For example, many individuals in the community request, from their dentist, mild anxiolytics prior to undergoing dental treatments. <u>General Anesthesia</u> The medical director reported that there were a number of individuals who require treatment for dental services under general anesthesia. This is an important practice that is required when providing oral health treatment to individuals with significant anatomical variances, and that require airway protection. The medical director was unable to provide the Monitoring Team with an absolute number of individuals who required such treatment. The Facility; however, did not have a process in place to enable routine dental services under general anesthesia, but indicated that it would refer such	

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		individuals out to dentists in the community, and is currently working on developing a contract with a community dentist for such purposes. Summary: The Facility must ensure that it maintains a process that enables prompt dental services under general anesthesia, when clinically necessary. <u>Methods to Reduce the Need for Sedation</u> To assess the Facility's ability to enable individuals to receive dental services with the least amount of sedation as possible, the Monitoring Team discussed its process with the medical director, and new director of dental services. The Monitoring Team also requested all documents to demonstrate the Facility's effort to develop and implement programs to help mitigate the use of sedative medications. There was no available policy, procedure or guideline for the Facility's process to reduce the need for sedation. The Monitoring Team was informed by the medical director, that the Facility had not implemented a formal process to develop or implement a program to reduce the use of sedation for dental services. The document request indicated - "there is no specific policy/procedure in place, an interdisciplinary group, lead by psychology is coming together later this month to develop such a procedure and policy". As reported in Provision J4, the Facility reported that there was no consistent method to collect, organize, and analyze information regarding pre-treatment sedation, and that it had put into place a corrective action plan. Refer to Provision J4 for additional detail. Summary: The Facility had yet to develop and implement a formal process to help mitigate the use oral pre-treatment sedation for dental services; however, the Facility had begun the process to address this in a structured manner. The Monitoring Team expects a clinically appropriate program to be developed and implemented, by the next Monitoring Team review period. <u>Dental Participation at the IDT and ISP Meetings</u> To assess the Facility's ability to represent oral health care issues at the annual ISP meeting, the Monitoring Team reviewed the annual ISPs of the sample of ISP used for section L (#39, #88, #223, #222, #258, #318, #305, #252, #431, #461, #61, #75, #34, #25, #460, #444, #481, #415, #89, and #567). Review of the 20 ISPs indicated that zero out of 20 (0%) included a comprehensive review of the individual's oral health care needs. All Individuals must have their oral	

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		health care condition and clinical issues clearly defined within the context of the annual ISP. In addition, there must be a statement on how oral health issues affect the individual's life, the prognosis of all relevant oral health issues, past and pending treatments, clinical prognosis, and all necessary supports and services, including obstacles that may prevent necessary oral health care treatments. The IDT needs to address significant oral health issues, and the ISP should address actions the IDT determines are needed to improve oral health care. <u>Quality Assurance Process for Dental Services:</u> Following discussion with the medical director, the Monitoring Team was informed that the Facility did not develop a program to address quality assurance of dental services. Summary: The Facility needs to develop and implement a robust QA process that ensures that the dental department policies, procedures, and practice standards are adhered to; that the efficacy of oral health practice is assessed; and that adverse outcomes, such as injuries, and pneumonia, are assessed for possible causative factors secondary to recent dental treatments or ineffective treatment. Conclusion: The Facility had yet to develop and implement necessary policies, procedures, guidelines, and practices to gain substantial compliance for Provision Q.2; hence, the Monitoring Team concurs with the Facility in determining noncompliance. Compliance will require that the Facility develop clinically appropriate process and programs to address the use of TIVA; develop a quality assurance program for dental services; develop and implement a clinically relevant process to help reduce the need for sedation for dental services; identify clinically appropriate practice for pre-treatment oral sedation, general anesthesia, and when necessary, sound physical restraint guidelines. In addition, the Facility must also develop a more robust method of reporting oral health care needs to the IDT and integrating oral health care supports into the ISP.	

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

1. Develop and implement a mechanism that enables efficient and efficacious management of dental database elements. (Provision Q.1)
2. Review staffing issues, and ensure appropriate staff to meeting the dental office's operational needs. (Provision Q.1)
3. Develop policies, procedures, and guidelines, as necessary for operational needs. This includes the need to revise the emergency dental policy to reflect necessary on-call coverage. (Provision Q.1)
4. All oral health care issues must be followed up through full resolution, with associated documentation in the IPNs, in language that can be understood by non-dental office staff. (Provision Q.1)
5. Individuals must be provided complete oral evaluations, treatment, and hygiene, when clinically necessary. For example, a complete oral

examination is necessary following acute trauma to the mouth; the annual dental evaluation requires that the entire mouth be completely evaluated; and deep cleaning provided more often then annually. (Provision Q.1)

6. Dental x-rays must be provided per standard of care practice. (Provision Q.1)
7. The Facility must enhance its suction tooth brush program, and ensure that a process is in place that ensures routine assessment of individuals for the needs of suction toothbrushing, and routine assessment of efficacy and safety for the use of suction toothbrushing.
8. Make sure that the Facility maintains a program for oral hygiene at the living areas. (Provision Q.1)
9. Make sure that the Facility documents, and maintains dental records at the level of standard of care practice. (Provision Q.1)
10. The Facility must immediately assess its resources for TIVA, and ensure that all individuals who require TIVA are provided this service, as clinically indicated. (Provision Q.2)
11. Ensue that general anesthesia, and pre-treatment oral sedation are provided to individuals, as clinically indicated. (Provision Q.2)
12. The Facility must implement fully a program to reduce the need for sedation. (Provision Q.2)
13. The dental office must enhance its ability to communicate oral health care needs to the IDT, and to ensure that the oral health care condition and clinical issues are clearly delineated in the ISP, along with necessary supports and services required for the Individual's oral health care needs. (Provision Q.2)
14. The Facility must develop a dental quality assurance program, that ensures all clinical policies, procedures, and guidelines are operational, and that oral health treatment is efficacious, and performed safely. (Provision Q.2)
15. The Facility must improve on the timeliness, and completeness of oral health care services. (Provision Q.2)
16. Maintain a schedule of all missed appointments, and the reason for the missed appointments, so that efficient, and regular trends analysis can be completed. (Provisions Q.1 and Q.2)

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** **Documents Reviewed:** 1. BSSLC Self-assessment 3/21/13, 2. BSSLC Action Plans 3/11/13 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 Record Reviews of Individuals: 4. Sample R.1: Individuals #13, #87, #88, #93, #112, #120, #131, #134, #172, #230, #254, #258, #332, #422, #427, #492, #517, #521, #567, and #574 5. Sample R.2: Individuals #68, #149, #272, #297, and #508 6. Sample R.3: Individuals #144, #160, #255, #321, and #570 7. Sample R.4: Individuals #172, #230, and #521 8. Facility Section R Presentation Book 9. List of current SLPs, caseloads and ratios 10. Copies of each SLP's current license and ASHA certification 11. Continuing education and training completed by the SLPs in the past 12 months 12. Facility list of new admissions since the last review 13. Tracking log of SLP assessments completed since the last review 14. Facility list of individuals with severe language deficits 15. Facility list of individuals with PBSPs and replacement behaviors related to communication 16. PBSP minutes and attendance rosters for the past six months 17. Facility list of individuals with Alternative and Augmentative communication (AAC) devices 18. Facility AAC screening forms 19. Facility AAC-related database reports/spreadsheets 20. Facility list of general common area AAC devices 21. Facility list of individuals receiving direct communication-related intervention plans **People Interviewed:** 1. Kori Kelm Physical Therapist (PT), Habilitation Therapy Director 2. Tracy Searles Physical Therapy Assistant (PTA), 3. Christina Koehn SLP **Meeting Attended/Observations:** 1. Daily activities on Driscoll, Fannin, Childress, and Bowie 2. Mealtimes on Driscoll, Fannin, Bowie and Childress
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section R, dated 3/21/13 and Action Plan dated 3/11/13. In its Self-Assessment, for each sub-section, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating.

	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.2, R.3 and R.4 and in compliance with Provision R.1. This was consistent with the Monitoring Team's findings of noncompliance with Provisions R.2, R.3 and R.4 and substantial compliance in Provision R.1. For Provision R.1, BSSLC stated that data acquired for the time period of August 1, 2012 through January 31, 2013 indicated an overall compliance of 84% which indicated competence of staff in developing and implementing programs, providing staff training and monitoring implementation of programs. The Monitoring Team found that the Speech Staff was trained as evidenced by active certification and licensure by the National and State boards. Staff to Individual ratio was 1:58 which was within an acceptable range for this population. Additionally, a policy/process existed that guided the implementation of speech services. For Section R in conducting its self-assessment, the Facility: ▪ Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The monitoring/audit tools the Facility used to conduct its self-assessment included: Settlement Agreement Monitoring Tool for Section R. o This monitoring/audit tool did not include adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. For example, Provision R.2 in the Self-Assessment did not address the quality of the recommendations included as part of the Communication Assessment. o The monitoring tools did include adequate methodologies, such as observations, record review and staff interview. o The Self-Assessment did not identify the sample(s) sizes and the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population (i.e., n/N for percent sample size). o The Self-Assessment did not state the following staff/positions who were responsible for completing the audit tools: such Facility therapists (i.e., OTs, PTs, and SLPs); therefore there was no evidence that staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools. ▪ The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not consistently measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. 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: BSSLC has shown some improvement with Section R but continues to face roadblocks as communication is given lesser priority than swallowing. Assessments remained one of the stronger aspects of the Communication Section but still lacked the comparative analysis piece that demonstrates improvement or decline of their health as well as communicative status. Training had improved as part of the first and second shift but staff on third shift was not provided with consistent training. **Provision R.1:** This provision was determined to in compliance. BSSLC was at full capacity with regards to Speech Pathologist and had recently opened another position for a Speech Therapy Assistant. All Therapists were board certified and licensed to practice in the state of Texas. All Therapists had evidence of participating in continuing education that was relevant to the field of practice. **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 remained one of the stronger aspects of the Communication Section but still lacked the comparative analysis piece that demonstrates improvement or decline of their health as well as communicative status. Recommendations were at times vague and did not provide clear ideas as to how strategies and supported equipment could be utilized through all programming. **Provision R.3:** This provision was determined to be not in compliance. DCPs were not observed utilizing strategies to engage Individuals in using general area devices. Individuals receiving indirect communication supports did not have their plans reviewed at least quarterly by the QDDP, and individuals were not provided direct speech treatment as per physician's order. Additionally, staff were not provided with consistent training on third shift. **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	Samples for this section are as follows: Sample R.1: Consisted of 20 Individuals identified by the Facility with severe expressive or receptive language disorders with assessments completed in the last 12 months.	Substantial Compliance

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	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.	Sample R.2: Consisted of five Individuals receiving direct speech services. Sample R.3: Consisted of five Individuals with a PBSP and communication deficits. Sample R.4: Consisted of three Individuals from R.1 above with AAC systems **Staffing** The Facility used a reasonable process to determine what an appropriate caseload would be for SLPs at BSSLC. The process used by BSSLC in determining the need for SLPs was conducted around the time of the third compliance visit and included an analysis of SLPs' responsibilities, including consideration of the acuity of individuals' speech and communication needs, and assistance from speech assistants. Such responsibilities included but were not limited to conducting assessments, developing and implementing programs, providing staff training, and monitoring the implementation of programs. When this analysis was conducted, the ratio recommended at that time was approximately 1:65. At the time of this review, the ratio was below the level identified by the facility and was 1:58. The Facility provided an adequate number of speech language pathologists or other professionals (i.e. AT specialists) with specialized training or experience based on the process identified by the BSSLC. As of this review, BSSLC was fully staffed with five SLPs and had recently opened a newly added position for a Speech Pathology Assistant (SPA). The SPA would help provide modeling as well as assist in the development of plans and programs as well as assist with the monitoring process. The current staffing allowed for a caseload of approximately 58 individuals, which is reasonable to conduct the daily activities and responsibilities of the SLP. Per interview with Christina Koehn SLP, at this time, duties related to Communication are being delayed due to the need to get Section O (Physical and Nutritional Supports) developed and implemented. This was considered by the Facility to be a higher priority due to the health and safety implications and therefore they have asked Speech to reprioritize their duties. Once these issues are resolved, the current staffing would be sufficient in meeting all the needs of the individuals. The Monitoring Team was in agreement that the lack of communication services was not a result of a lack of available staff but a result of Facility priority. In fact, one area of improvement had occurred already. At the time of the last compliance visit, therapists continued to primarily pass the development of programs to individuals who lack the expertise needed to write functional and sequential goals. That practice was no longer in place; therapists were developing programs directly.	

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		Qualifications: Five of five positions for SLPs (100%) were filled by licensed SLPs • Five of five SLPs (100%) were licensed to practice in the state of Texas. • Five of five SLPs (100%) had evidence of ASHA certification. **Continuing Education:** 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 the population served. Education included but was not limited to: • 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 **Facility Policy** A local policy/process existed that provided clear operationalized guidelines regarding the delivery of communication supports and services and outlines minimum components of communication supports and services. 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. • Monitoring for the presence of communication adaptive equipment or other AAC	

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		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). • The frequency of monitoring for individuals within the established Master Communication Plan priority levels • The process for identification, training, and validation for monitors. • The process of inter-rater reliability.	
R2	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a screening and assessment process designed to identify individuals who would benefit from the use of alternative or augmentative communication systems, including systems involving behavioral supports or interventions.	**Assessment Plan:** The Facility had a reasonable plan to screen all individuals and, based on priority need, assess individuals who would benefit from the use of alternative or augmentative communication systems. BSSLC provides assessments for all new admissions and has moved away from the process of providing screenings. Individuals at a minimum are provided with a Comprehensive Communication Assessments every three years along with an annual update should the individual be provided with direct or indirect services related to communication. The Facility did define the timeframe for the completion of communication assessments for individuals within their defined priority levels. Per review of BSSLC's Master Communication Plan, a definition of each priority level for individuals with communication needs who would benefit from the use of alternative or augmentative communication systems (AAC) was provided. Communication screenings and assessments for individuals within these priority levels had been completed in the timeframe established by the Facility. Per the BSSLC guidelines, all individuals will have received a comprehensive assessment by December 2013 but per interview, it was expected that this goal would be reached much sooner than the December 2013 deadline. **Assessments Provided** Twenty of 20 individuals in sample R.1 (100%) were provided a communication assessment per policy and/or Master Plan. All individuals in Sample R.1 received assessments annually if the individual was provided with direct or indirect services and at least every three years for all individuals. Eleven of 11 admitted individuals (100%) since the last review received a communication screening or assessment within 30 days of admission or readmission. For 20 of 20 individuals in Sample R.1 (100%), assessments/updates were dated as having been completed at least 10 working days prior to the annual ISP.	Noncompliance

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		Six of eight individuals in Samples R.1 and R.2 (75%) provided direct or indirect communication supports and services were provided an assessment or update current within the last 12 months. Individuals #149 and #297 were not provided with annual SLP assessments as directed by their recommendations and facility policy. **<u>Communication Assessment:</u>** Based on review of the sample of assessments (Samples R.1 and R.2), the comprehensiveness of the communication assessments were as follows: • 25 of 25 individuals' SL assessments (100%) were signed and dated by the clinician upon completion of the written report; • 23 of 25 individuals' SL assessments (92%) were dated as completed at least 10 working days prior to the annual ISP; • Zero of 25 individuals' SL assessments (0%) included diagnoses and relevance of impact on communication; • Twenty five of 25 individuals' SL assessments (100%) included individual preferences, strengths, and needs • Zero of 25 individuals' SL assessments (0%) included medical history and relevance to communication • Zero of 25 individuals' SL assessments (0%) listed medications and discussed side effects relevant to communication; • Zero of 25 individuals' SL assessments (0%) provided documentation of how the individual's communication abilities impacted his/her risk levels; • Twenty five of 25 individuals' SL assessments (100%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day; • Twenty five of 25 individuals' SL assessments (100%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work); • Twenty five of 25 individuals' SL assessments (100%) contained evidence of discussion of the use of a Communication Dictionary, as appropriate, as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who did not communicate verbally; • Thirteen of 25 individuals' SL assessments (52%) included discussion of the expansion of the individuals' current abilities. The SLP assessment did not discuss how an individual's current abilities could be enhanced by direct and/or indirect interventions, including skill acquisition programs; • Thirteen of 25 individuals' SL assessments (52%) provided a discussion of the individuals' potential to develop new communication skills; • Five of the 25 individuals' SL assessments (20%) assessed AAC or Environmental Control (EC) needs, including clear clinical justification; and	

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		rationale as to whether or not the individual would benefit from AAC or EC. The majority of assessments limited exposure to AAC to the assessment itself and if the individual did not initially respond in a positive manner to the devices then the device was no longer in consideration. • Zero of 25 individuals' SL assessments (0%) offered a comparative analysis of health and functional status from the previous year • Twenty five of 25 individuals' SL assessments (100%) gave a comparative analysis of current communication function with previous assessments • Seven of 25 individuals' SL assessments (28%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it. • Twenty five of 25 individuals' SL assessment (100%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff; • Twenty five of 25 individuals' SL assessments (100%) had a reassessment schedule; • Four of the 25 individuals' SL assessments (16%) supplied a monitoring schedule. The SLP assessment did not discuss monitoring results from the previous year and did not recommend the implementation of a monitoring schedule for the upcoming year. • Five of 25 individuals' SL assessments (20%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC or EC devices/systems, as indicated for individuals with identified communication deficits • Twenty one of 25 individuals' SL assessments (84%) made a recommendation about the appropriateness for community transition • Zero of the 25 individuals' SL assessments (0%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. While strategies were provided as part of the Communication Assessment, there was limited evidence outside of those individuals receiving direct treatment regarding how strategies could be implemented throughout the day and integrated into various SAPs. **SLP and Psychology Collaboration:** Based on review of individuals' records (Sample R.3) with Positive Behavior Support Plans (PBSPs) the following was noted: • Two of five communication assessments reviewed (40%) contained evidence of review of the PBSP by the SLP. This was noted in the behavioral considerations section of the SLP assessment. • For four of five individuals (80%) communication strategies identified in the assessment were included in the PBSP.	

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		• For zero of five individuals (0%) communication strategies identified in the assessment were included in the ISP. Based on review of the Positive Behavior Support Committee meeting attendance sheets from 8/13/12 to 2/25/13, participation by a SLP was noted in 21 of the 22 meetings (95%). The SLPs and psychologists continue to improve collaboration on the development and implementation of behavioral supports and direct/indirect SLP interventions for individuals with alternative or augmentative communication systems. Behavior Services and Speech developed a PBSP/Communication Assessment Checklist that was designed to improve consistency between the two documents and assist in identifying areas in which there is cross over between the two disciplines. Three SAPs developed by Speech and Psychology were reviewed and found to be much improved in their consistency as well as the level of detail provided to staff regarding implementation. The three SAPs reviewed were for Individuals #425, #403 and #408. The Monitoring Team looks forward to seeing more SAPs developed in this joint manner.	
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.	**Integration of Communication in the ISP** Based on review of the ISPs for individuals in Sample R.1 and R.2 the following was noted: • In 23 of 25 ISPs reviewed (92%) for individuals with communication needs (programs and goals, Priority 1-3 in Master Plan and/or lists identifying those with communication deficits) an SLP attended the annual ISP planning meeting, or the team provided adequate justification. • Sixteen of 25 ISPs reviewed (64%) included a description of how the individual communicated and how staff should communicate with the individual, including the AAC system if he/she had one. Examples included but were not limited to: o Individual # 521's ISP only describes that the Individual has a device but provides no further information on its use. • Communication Dictionaries for 24 of 25 individuals (96%) were reviewed at least annually by the IDT as evidenced in the ISP and ISPAs. • Zero of 25 ISPs reviewed (0%) included how communication interventions were to be integrated into the individual's daily routine. • One of 25 ISPs reviewed (4%) contained skill acquisition programs to promote functional communication. Strategies were not integrated into existing SAPs and SAPS were not developed to address identified concerns with communication. • Zero of 25 ISPs reviewed (0%) included information regarding the individual's progress on goals/objectives/programs, including direct or indirect	Noncompliance

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		supports/interventions involving the SLP. Per interview and documentation of Communication related SAPs provided by BSSLC, the development of SAPs related to communication is something that has been identified as an area requiring improvement. As of 11/8/12, 20 SAPs related to communication had been developed. This was a significant increase and the Monitoring Team looks forward to further reviewing this component at the next visit. **Development And Implementation Of Functional Individual-Specific Assistive Communication Systems** For five of five individuals in sample R.1 for whom the IDT directed a revision in the communication dictionary (100%), the communication dictionary was revised within 30 days. Observations were conducted in homes with AAC systems in Sample R.4 Findings included the following: • Three of three observations (100%) found AAC devices present in each observed setting and readily available to the individual. • AAC systems for zero of three individuals (0%) were noted to be in use in each observed setting. • AAC systems for three of three individuals (100%) were portable. • AAC systems for three of three individuals (100%) were functional. • For one of three individuals (33%), staff instructions/skill acquisition plans related to the AAC system were available. **General Use AAC Devices:** Observations were completed in six homes and to determine the presence and use of general AAC devices. Findings included the following: • Four of the six homes and other environments observed (66%) had general use AAC devices present in the common areas. General area devices were not noted in Bowie A and Classroom 5. • In four of four homes and other environments (100%), general use AAC devices were operational. • Zero of the 13 general use AAC devices (0%) noted contained clear directives on how staff should use these devices. Directions were vague and did not provide detailed instructions/directions to ensure consistent staff implementation. • Thirteen of 13 general use AAC devices (100%) noted had a clear function within that setting/situation. • Zero of 13 general use AAC devices noted (0%) were used. Observations were provided in which the use of the board/devices would have been appropriate	

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		(for example: mealtimes, washing hands, oral care) but were not prompted by staff or utilized by the individuals. **<u>Direct Communication Interventions</u>** Review of the individuals' records from Sample R.2 showed the following: • Two of five individual's direct intervention plans (40%) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. Individual #297 and #68 were recommended treatment in September 2012 and May 2012 respectively. Neither Individual had been seen as of March 31, 2013. • For five of five individuals' records (100%) reviewed, the current SLP assessment identified the need for direct intervention with rationale. • For zero of five individuals' records (0%) reviewed, there were measurable objectives related to individual functional communication outcomes included in the ISP. • For two of five individuals (40%), information was present regarding whether the individual showed progress with the stated goal. Notes primarily included whether the individual required additional therapy but provided no information regarding level of progress with stated goals. • For zero of five individuals (0%), a description was found of the benefit of the device and/or goal to the individual. There was no evidence that the therapist reported on a monthly basis through the provision of clinical data how the goal would support communication for the individual in their daily activities. • For four of five individuals (80%), a report was found regarding the consistency of implementation. Notes were not available for review for Individual #508 and therefore consistency of implementation was unable to be assessed. • For zero of five individuals (0%), recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress. Progress or lack of progress was not clearly monitored and documented and therefore this metric was unable to be fully reviewed. • For zero records of the one individual reviewed for whom intervention was terminated (0%), termination of the intervention was well justified and clearly documented in a timely manner. There was no evidence that the therapist provided clinical justification for the termination of a direct intervention plan for Individual #149 or of the team discussing the recommendation to terminate the program within 10 working days through an ISPA meeting. • For two of five individuals (40%) progress notes contained the consistency of implementation. • For two of five individuals (40%) progress notes occurred at a minimum	

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		monthly **<u>Indirect Communication Supports:</u>** Programs for individuals in samples R.1 who received indirect communication supports were reviewed and found: Overall there was a lack of indirect communication programs therefore PNMPs which included communication strategies were included as indirect supports. • Twenty of 20 individual's indirect plans (i.e., PNMPs) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. • For two of 20 individuals' records (10%) reviewed, the current SLP assessment identified the need for indirect intervention with rationale. For 3 out of 3 individuals in Sample R.4 (100%), staff instructions were provided for individuals' AAC devices, including written step-by-step instructions and pictures. Zero of 20 individuals (0%) receiving indirect Speech Services (Sample R.1) were provided with comprehensive progress notes that contained each of the indicators listed below. • Quarterly documentation for zero of 20 individuals (0%) contained information regarding whether the individual showed progress with the stated goal(s) or objectives. Review consisted of only stating that the service was provided and offered no information regarding effectiveness of supports in meeting desired outcomes. • Quarterly documentation for zero of 20 individuals (0%) identified the benefit of device and/or goal(s). • Quarterly documentation for zero of 20 individuals (0%) identified consistency of implementation. Since there were limited indirect plans of care (i.e., SAPs for communication), PNMPs were reviewed for their communicative component with regards to these metrics. • Quarterly documentation for zero of 20 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>** Two of six staff interviewed (33%) were knowledgeable of the individual and their communication related programs; direct support professionals had difficulty with the following questions • Stating whether the individual had an AAC system. • Whether there was a communication program.	

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		• Describing the communication program goal. • Described the schedule for implementation of the communication program. • Identifying how communication skills in the program were addressed throughout the day. **<u>Competency-Based Training and Performance Check-offs:</u>** Based on review of the NEO training curriculum, individualized training, BSSLC did develop comprehensive competency based training regarding communication services. • The training materials reviewed did address all the appropriate content areas listed below: o Methods to enhance communication o Implementation of programs o Benefits and use of AAC o Identification of non-verbal means of communication. 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 One hundred sixty four of 164 new employees (100%) had completed NEO core communication competencies for (i.e., foundational skills) and performance check-offs since the last review. **<u>Individual-Specific Competency-Based Training</u>** To assess whether the Facility had a process to determine whether staff had been trained on communication programs for individuals they supported, the Monitoring Team asked BSSLC to randomly name a direct support staff (DSP) who supported individuals in that home. The Monitoring Team checked that DSP's training record. The DSP had completed competency check-offs in all specialized components of their communication programs (i.e., non-foundational skills) prior to the provision of services. This however was not an accurate representation of the number of staff who had completed individual specific training as per interview with the Habilitation Director, it was stated that staff on third shift had not received this level of training. Individuals require staff to be well trained even if they are on third shift as third shift staff may come in and provide support on other shifts. Additionally, individuals still communicate after 10:00 pm and therefore should have staff well trained to assist in this process. Three of three staff (100%) responsible for training other staff successfully completed competency-based training for the specialized components of the individuals'	

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		communication SAPs for Individuals #427 and #492 (i.e., non-foundational skills) prior to training other staff. The Facility did have a process to validate that staff responsible for training other staff are competent to assess other staff's competency. Staff at BSSLC responsible for training others must first be trained by the SLP prior to conducting the training themselves. Additionally, the trained staff must then be observed by the SLP training others before becoming a certified trainer. This process appeared to be working well for BSSLC as no issue was noted with regards to staff being trained in a timely manner.	
R4	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	**Policy and Procedure** A Facility policy and/or procedures existed that describes the monitoring system for communication provision of the ISP for individuals who would benefit from AAC. The Facility policy and/or procedures included the essential components related to monitoring. See Provision R.1 for additional information. **Monitoring of Implementation of Communication Supports** Compliance Monitoring forms for implementation of communication supports the last six months for three individuals from Sample R.4 were reviewed and the following was found: • For zero of three individuals (0%), monitoring of communication supports was outlined in the assessment. • For zero of three individuals (0%) monitoring of their communication supports occurred at the frequency established by Facility policy or ISP. AAC monitoring was conducted that focused on presence and working condition, but this monitoring lacked review of whether the plans/devices remained appropriate. Zero of 20 individuals from sample R.1 (0%) received monthly and/or quarterly monitoring to ensure all communication supports remained effective and functional. See Provision R.3 for additional information.	Noncompliance

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

1. 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)
2. While integration continues to improve 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)
3. 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)

4. All individuals provided with an order to receive direct Speech services should receive such services (Provision R.3)
5. Staff would benefit from increased hands on modeling of the use and integration of devices within normal daily contexts by the PNMPCs and the SLPs. (Provision R.3)
6. A database or other system should be developed to 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)
7. Communication components of the PNMP as well as SAPs should be consistently monitored by the QDDP to ensure appropriateness and functionality. (Provision R.3)
8. The Communication Assessment should contain the following components: clear clinical justification and rationale as to whether or not the individual would benefit from AAC or EC, trials of AAC beyond the assessments phase, comparative analysis of current communication function with previous assessments, and define the manner in which strategies, interventions, and programs should be utilized throughout the day. (Provision R.2)

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, dated 3/21/13 2. BSSLC Action Plan 3/11/13 3. BSSLC April 2013 Presentation notes 4. Documents that were reviewed included the annual ISP, ISP updates, Skill Acquisition Plans (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 Facility Self-Assessment and Facility Action Plan. 5. A sample of 14 individuals was selected for the review of BSSLC's SAPs and ISPs. These 14 individuals included 11 individuals with recent ISPs identified by the Facility, as well as three SAPs that the Facility had identified as reflecting the most recent and "best" work. The specific individuals included in the sample were Individuals #30, #115, #118, #153, #217, #283, #309, #353, #379, #398, #411, #449, #486, and #492. **People Interviewed:** 1. Kim Littleton – Assistant Director of Programs (ADOP) 2. Andrea Miller – Program Services 3. Pam Boehnemann – QDDP Coordinator 4. Terry Hancock, PhD – Chief Psychologist 5. Direct Support Professionals: Approximately 25 staff were interviewed in Program Services, as well as Bowie Springs, Childress Terrace, Driscoll Gardens, and Fannin Villa residences. **Meeting Attended/Observations:** 1. Program Implementation Committee 2. Human Rights Committee 3. Restraint Reduction Committee 4. Observations were conducted in the following areas: Program Services, as well as Bowie Springs, Childress Terrace, Driscoll Gardens, and Fannin Villa residences.
	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. For Section S, in conducting its self-assessment, the Facility: ▪ Did not indicate that it used monitoring/auditing tools. Based on a review of the Facility Self-Assessment, the monitoring/audit templates and instructions/guidelines, a sample of completed

	monitoring/auditing tools, inter-rater reliability data, as well as interviews with staff: o The Self-Assessment identified the sample sizes only in Provision S1. The Self-Assessment for Provision S1 included only the number of individuals/records selected: There was no comparison with the number of individuals/records in the overall population. For the review of Psychology SAPs, the Facility selected four records which represented that majority of such SAPs. This was an adequate sample. For Habilitation SAPs, the Facility selected only five individuals which was too small to be representative of all Habilitation SAPs. o The staff responsible for conducting the audits/monitoring had not been identified. No indication was provided of whether staff completing the audit/monitoring were competent clinically/programmatically competent in the relevant area(s). o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. ▪ Did not use other relevant data sources and/or key indicators/outcome measures. ▪ The Facility consistently did not present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment: o Did not present findings consistently based on specific, measurable indicators. o Consistently did not measure the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with no provisions of Section S. The Monitoring Team found the Facility in compliance with no provisions ▪ The Facility also provided as part of its self-assessment an Action Plan. This plan consisted of only three brief sentences that did not describe actions being taken to achieve compliance, areas of need/improvement, or a set of steps likely to lead to compliance with the requirements of this Section.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at BSSLC from April 7 2013 through April 12 2013. 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 during previous site visits. Based upon available information, examples of continued lack of progress included the following. • Formal task analyses were not completed as part of skill acquisition program development. • The ISP, Personal Focus Assessment, and other assessments 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.

	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.	Historical Perspective In January of 2010, a review of skill acquisition programs (SAPs) at BSSLC indicated that the Facility had provided an adequate number of training programs. Although the SAPs 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 SAPs. During the January 2012 site visit, it was noted that BSSLC had substantially reduced the number of SAPs for each individual and had replaced the SAPs 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 SAPs 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 SAPs. These same conditions were noted in July of 2010. In January 2011, a sample of the "best" SAPs was selected by BSSLC. This sample, which was limited to SAPs that had been written but not yet implemented, reflected modest improvement in SAP content. The improvement was attributed to the incorporation of the Murdoch Center Program Library into the SAP 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 SAPs in addition to the reduction in quantity noted above. During the July 2012 site visit, the Facility reported substantial limitations regarding skill acquisition training and SAPs. Records and staff reports reflected the Facility had not provided adequate assessment in relation to skill acquisition training. In addition, a sample of SAPs reflected substantial limitations involving excessive requirements for successful trials, a lack of precise target definitions, limited details in teaching methodology and data collection, and an inability to identify when shaping and chaining strategies were appropriate. Current Site Visit At the time of the current site visit, BSSLC reported that revisions to both the SAP and ISP process had recently been implemented. In order to capture the most recent changes to the ISP process, it was agreed that a sample of 11 recent ISPs would be used in the review. In addition, a sample of	Noncompliance

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		three SAPs that the Facility had identified as reflecting the most recent and "best" would be included in the review. <u>Use of Assessment Information in Planning Skill Acquisition</u> 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 substantially improved upon the use of assessments in relation to skill acquisition training. Although the integration of individual preferences into the SAP development process had improved, the percentage of SAPs reflecting such integration remained low.	

	01/2010	07/2012	4/2013
Skill acquisition plans are implemented to address needs identified in:	0%	0%	0%
ISP	0%	9%	7%
Adaptive skill or habilitative assessment	0%	9%	7%
Psychological assessment	0%	0%	0%
Skill acquisition plans are chosen in an individualized manner.	0%	0%	7%
Skill acquisition plans are related to the individual's preferences.	0%	0%	29%

Documentation did not reflect that individuals residing at BSSLC at the time of the current site visit were provided with a task analysis as a part of SAP development. Not all teaching procedures require a task analysis. As BSSLC used forward- and backward-chaining procedures in essentially all of the SAPs, a formal task analysis would be an essential assessment. 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.

- Individual #283 was provided an SAP for putting dirty clothes in a hamper prior to bathing. It was stated in the SAP that the basis for the program was the FSA. The FSA includes an item on identifying clothes in need of washing, but does not address the overall goal of the SAP or any of the specific tasks or steps included in the SAP.
- Individual #379 was provided with an SAP to teach selecting the minimum number of dollar bills needed to make a purchase of up to $10 in value. It was stated in the SAP that the basis for the program was an FSA completed in December 2012. A review of that FSA reflected

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		that the individual was rated as being independent in combining coins and currency to make purchases of up to $15. BSSLC had included the FSA as the primary skill assessment instrument despite numerous limitations in the design and utility of the tool. For example, with Individual #283 listed above, the FSA lacked any items that pertained to the specific goals of the SAP. It is possible that by scrutinizing the results of the FSA, areas could have been identified where the FSA provided a broad and valid assessment of a skill in need of strengthening. The selection of skills to be taught, however, should not be driven by the limitations of an assessment instrument. Rather, the unique needs of the individual should guide the selection of an appropriate assessment. Documentation available at the Facility did not reflect an individual-driven assessment process. The development of 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, however, could 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 FSA 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 assessments were used in developing skill acquisitions programs at BSSLC. An example where such an approach would have been beneficial involved Individual #30. The individual was provided an SAP for putting on a pullover shirt. The FSA indicated that the individual required physical prompts to put on pullover clothing. The FSA provided no further information about the difficulties experienced by the individual in putting on pullover clothing or the supports and prompts required to ensure success. At a minimum, a task analysis of this skill would have been appropriate. Unfortunately, no further assessment regarding the skill was provided, and the SAP was developed using only the FSA. Data for the SAP had not been recorded correctly for three consecutive months following SAP implementation, preventing a determination of progress that could indicate whether the assessment did or did not contribute to effective training. Observations and record reviews also indicated weaknesses relating to other assessments. • All individuals included in the sample had been provided with an assessment using either the Preferences and Strengths Inventory (PSI) or the Personal Focus Assessment (PFA). These tools provide 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 preference assessments that vocal, gestural or other non-language-based communication was considered when identifying personal preferences. Furthermore,	

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		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 preference assessments for individuals with limited communication routinely consisted of general, anecdotal statements of undocumented origin that could not be verified or validated. o For Individual #118, it was stated in the PSI that the individual was nonverbal and that information was obtained from "the record book" and reports from staff. o For Individual #398, it was stated that the individual was unable to communicate. For some items, such as favorite color and living options, the PSI included the statement that information was obtained "Through observations"; no other details were provided about how this information was obtained. In response to the question, "Are you able to go out into the community when you want to", the response (provided by a DSP) was that the individual was able to go to the community every Monday to get a dairy snack. Although that activity might be enjoyable for the individual, the response did not address the question. • For the 14 individuals in the sample, information regarding psychological assessments reflected a general lack of meaningful assessment. o None of the 14 individuals in the sample (0%) had been provided an intellectual assessment within the past five years. The most recent intellectual assessment had been completed in 2005, and several of the intellectual assessments were at least 20 years old. o Three of the individuals in the sample (21%) had been provided with a standardized assessment of adaptive skills in the past year. Other than those three assessments, the most recent adaptive skill assessment had been completed in 2005, and several of the adaptive skill assessments were at least 20 years old. o Two of the 14 individuals in the sample (14%) had been provided with a Psychological Evaluation in the previous 12 months. For both of those individuals the most recent intellectual and adaptive assessments were over 20 years old. o None of the most recent ISPs for the 12 individuals in the sample (0%) reflected that the Psychological Evaluation, intellectual assessment, or adaptive skill assessment had been considered in the development of SAPs. • Thirteen of 25 individuals' Speech and Language/Communication assessments (52%) included discussion of the expansion of the individuals' current abilities. The SLP assessment did not discuss how an individual's current abilities could be enhanced by direct and/or indirect interventions, including skill acquisition programs. • One of 25 ISPs reviewed (4%) contained skill acquisition programs to promote functional communication. Strategies were not integrated into existing SAPs and SAPS were not developed to address identified concerns with communication. • Despite obvious need and findings in formal assessments, SAPs did not reflect	

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		accommodation for individual limitations. o For Individual #283, the communication assessment indicated that the individual could not consistently follow verbal, one-step commands. The SAP included verbal directions and prompts. o For Individual #217, a current communication assessment reflected that the individual was unable to recognize the cause-and-effect relationship of pushing a button to produce a specific result. The individual was provided an SAP to learn to push a button to obtain hand-sanitizer. The Communication Assessment did suggest the individual could benefit from training relating to pushing a button to achieve a goal. There was no indication in the ISP, however, that the Communication Assessment had been considered in the decision to develop this SAP. Rather, the agreement between the assessment and the SAP appeared to be a coincidence, and that the SAP reflected a commonly used Self-Administration of Medication program with individuals who lacked the ability to identify prescribed medications.. o Individual #449 was provided with a SAP for using a vending machine. Assessments and the ISP reflected that the individual was blind. The SAP acknowledged the individual's visual impairment by indicating that a sighted guide would be necessary to help the individual locate the vending machine. Despite this, no specific teaching instructions were provided concerning the individual's visual impairment. One area of improvement was noted, but was still limited to a small number of individuals. Three SAPs developed by Speech and Psychology were reviewed and found to be much improved in their consistency as well as the level of detail provided to staff regarding implementation. The three SAPs reviewed were for Individuals #425, #403 and #408. 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 SAPs. These findings supported the information provided by the Facility that 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 some improvement, the 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 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.	

	01/2010	07/2012	4/2013
Plan reflects development based upon a task analysis	0%	9%	7%
Behavioral objective(s)	0%	36%	57%
Operational definitions of target behavior	0%	27%	29%
Description of teaching conditions	0%	27%	31%
Schedule of implementation plans for sufficient trials for learning to occur	0%	0%	0%
Relevant discriminative stimuli	0%	82%	71%
Specific instructions	0%	27%	7%
Opportunity for the target behavior to occur	0%	100%	79%
Specific consequences for correct response	0%	100%***	64%
Specific consequences for incorrect response	0%	9%	64%
Plan for maintenance and generalization that includes assessment and measurement methodology	0%	0%	0%
Documentation methodology	0%	9%	57%

*** 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 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.

It was not evident from a review of the documentation that staff at BSSLC had a clear understanding of task analyses, chaining procedures, and skill acquisition training. Although there were numerous references to task analyses, there was no indication that any actual task analyses had been conducted. Rather, the Facility appeared to be using the term task analysis to refer to the steps in a chaining procedure without recognizing that a task analysis is the process by which those steps are identified.

#	Provision	Assessment of Status	Compliance
		As stated previously, a task analysis is primarily required if a chaining procedure is to be used in teaching a skill. As the majority of SAPs at BSSLC made use of chaining procedures, then the ability to perform a task analysis and develop a chaining methodology was essential. Behavioral objectives: It is essential that efforts to strengthen skills include objectives comprised of observable and measurable elements of the behavior. The SAPs for individuals included in the sample reflected an improvement by the Facility. In almost half the cases (43%); however, 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 #486, the Objective for the SAP was, "When given a single verbal instruction, ""XXXX, rinse your hands,"" XXXX will rinse her hands in 16 out of 20 assessment trials for two consecutive months by 12-31-13". This objective included criteria and a timeframe. There was not, however, an objective and measurable definition of what constituted rinsing behavior either in the objective or the remainder of the SAP. As a result, different trainers might require different behaviors for "rinsing" to be recorded as done. • For Individual #449, who was blind, the objective stated, "When escorted to a vending machine XXXX will complete each step 5 sessions independently to progress to the next step." It was not evident from this statement specifically what behavior the individual was expected to perform. Furthermore, the steps of the SAP did not address the individual's visual impairment or reflect the prompts or accommodations that might be provided for the individual to succeed. As a result, the objective was not measurable. Operational definitions: 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 71% of the skill acquisition programs reviewed, the operational definitions of training targets consisted of general statements such as rinsing, stacking, or complying with a request. Description of teaching conditions: 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, 69% lacked details and failed to ensure that training would be implemented consistently.	

#	Provision	Assessment of Status	Compliance
		Sufficient trials: 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 RSSLC, 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. Relevant discriminative stimuli: 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 SAPs, conditions were described in the SAP that could have served as a discriminative stimulus. For an event actually to serve as a discriminative stimulus, however, an SAP 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 SAPs. Furthermore, the 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 SAP. Specific instructions: 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. In comparison with the previous site visit, the Facility demonstrated a decrease of 20% in relation to providing specific instructions in the SAPs. As a result, for only one of the 14 individuals (7%) included in the sample did the SAP include adequate instructions. One reason for the lack of success in relation to specific instructions was the lack of familiarity with shaping and chaining procedures demonstrated by those writing SAPs at BSSLC. In several SAPs, the teaching process was described as "general shaping". In every such example, however, the SAP included specific steps to be taught in either forward or reverse order. Shaping procedures do not have specific steps, as the teaching relies upon increasingly correct successive approximations of the final skill. If the program author could not accurately identify the procedure he or she was including in the SAP, it was unlikely that the author possessed the expertise necessary to develop adequate training instructions. There were additional indications that SAP authors did not possess sufficient familiarity with behavior chaining procedures. • For Individual #486, the teaching procedure in an SAP for rinsing hands is described as backward chaining. The steps, however, are written so that the individual is required to lather hands multiple times within a single behavior chain. It was unclear whether this was	

#	Provision	Assessment of Status	Compliance
		the procedure intended by the SAP author, or if the instructions failed to accurately describe the training process. • Individual #379 was provided a SAP to select the minimum number of dollar bills required to make a purchase. In the SAP, it was stated that the program used a general shaping procedure. The structure of the program instructions involved specific steps such as included in a chaining procedure. The actual instructions, however, described a process that required the use of basic math to determine the correct number of dollar bills. Although the value of the purchased items was increased in each step, the actual task performed remained unchanged throughout the steps. <u>Documentation methodology</u> In order to determine if a skill acquisition program was successful, there must be a valid and reliable method of measuring and documenting the performance of the person being taught. The Facility achieved substantial progress in this area, increasing the percentage of SAPs that described adequate documentation procedures from nine percent to 57 percent. Despite the progress, however, this reflected that almost half of all SAPs lacked adequate documentation procedures. Despite the improvement in the documentation procedures, the actual recording of training data remained poor. • Three individuals (21%) had training records where prompts were recorded for multiple steps within a single training session. Prompting for success should only be recorded for the final step in each session. • Individual #115 had two data sheets for the same SAP from December 2012. The data on each sheet were different even though the program was only implemented once per day. There were also indications that the Facility was not effectively monitoring data and individual progress. • Four individuals out of 14 (29%) remained on the same step of an SAP for two months or more with no change in the prompting required for success. Two months with no progress is an excessive amount of time without a revision to the SAP. • Two individuals out of 14 (14%) had data reflecting abrupt changes from one step to the next, or from one prompt level to the next, coinciding with the end of the month. Due to the factors relating to SAP documentation, it was not evident that the Facility was able to identify and implement an effective strategy to document skill acquisition. As a result, it was generally not possible for the IDT to determine when an individual was benefiting from teaching and developing functional skills. <u>Plan for maintenance and generalization</u> Skill acquisition programs have the ultimate goal of increasing skills in situations outside of the	

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		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. 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, the assessment information that was available was not used to develop skill acquisition programs tailored to the unique needs of the individual. 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 SAP data reflected undesired responses or a lack of progress from individuals. As indicated previously in Provision S1, BSSLC provided for review three SAPs the Facility believed more closely approximated the expectations of the Settlement Agreement. Outlined below are the general impressions concerning these three SAPs. Individual #309 – SAP for Obtaining Work Materials • <u>Assessment</u> • The ISP did not specifically identify what skills were needed. It stated that the individual completed two tasks and should continue to work at Micro-tech. It was also indicated that a SAP was in place but provided no details. • The ISP also stated the individual was able to follow simple instructions. The Communication assessment reflected that she was able to follow "a series of 2 to 3 very simple, related commands/instructions." The Vocational assessment indicated the ability to follow two-step instructions. • Although a task analysis was discussed in the SAP and the SAP includes training steps, no actual ask analysis was provided in the assessments. • <u>SAP</u> • Objective: In the final step of the SAP, the individual was required to complete the full task independently in 15 of 20 trials for two consecutive months. Requiring an individual to continue a program for two months beyond demonstrated mastery is generally excessive when not part of a maintenance or generalization strategy. In all steps prior to the final step, criterion for progressing to the next step required only that the individual succeed in four out of five trials: there was no two-month requirement in these earlier steps. It was unclear why the SAP used different criteria for the final step. • Source of SAP: The SAP reflected training need was determined by the Vocational	

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		Assessment. The Vocational Assessment does not reflect a need targeted by the SAP. • Training Locations: The SAP reflected that formal training would be conducted at work, but informal training would be conducted at work and home. As the task steps are specific in regard to materials and placement, it would be difficult to replicate/generalize without more specific instructions. The lack of specific instructions could result in errors in teaching. • Teaching Technique: The SAP indicated that general shaping would be used, but specific steps were provided. Shaping does not include specific steps; the procedure described was closer to forward chaining. However, in chaining each step is taught in a sequence including all previous steps. The SAP stated that each step would be taught independently; this was not forward chaining. Even if chaining was used, the training instructions did not provide sufficient detail or specificity to allow a DSP to perform the training correctly. Finally, prompts should be specific to the individual. In the SAP, prompts were generic and lack description. • Consequence – Correct Response: Verbal praise was to be used to reinforce success. There is no indication that verbal praise has reinforcing properties for the individual. In fact, the PSI suggested she prefers to be isolated from others. • Maintenance and Generalization: Specific plans were not provided. Individual #153 – SAP for Placing Laundry in Dryer • <u>Assessment</u> • The Pre-ISP did not include information about laundry. • The ISP indicated the individual displayed tactile defensiveness, but the FSA indicated the individual enjoyed physical contact. This discrepancy was not addressed, but the SAP included prompts that required physical contact. • The ISP indicated that the individual had an SAP for taking care of her clothes, although specifics were not supplied. It was also indicated that she had regressed recently on this SAP, but no specific data or other details were provided. • The FSA indicated that the individual required manipulation on all but one action relating to laundry: Removing clothes from the dryer could be completed with physical prompts. No clear rationale was provided for selecting putting clothes in the dryer as a training target. • Several areas in the ISP indicated the individual frequently holds her hands in front of her face while stationary and in motion. There was not, however, an assessment of this behavior or the impact of the behavior on task completion. • Although the instruction method is listed as forward chaining, there was no task analysis in the assessment materials and the ISP did not reference a task analysis. • <u>SAP</u> • The objective stated the individual would be tasked with "put clothes in the dryer". There is no definition of this behavior. Would one item of clothing constitute success or must the entire laundry basket be emptied into the dryer? Would there always be the same number of clothing items? There needed to be an objective and measureable definition of the behavior.	

#	Provision	Assessment of Status	Compliance
		• Source of SAP: The SAP indication the basis for training selection was the FSA. The FSA reflected many limitations concerning laundry: there was no indication why placing clothes in the dryer was of the highest priority or was considered the most functional. • Special Instructions: The instructions indicated that wet clothing should already be available because the individual did not like to be touched. While it was important to know that the individual did not like to be touched, it was not clear how having wet clothes in the basket would help to avoid physical contact. In addition, this was the only instruction provided about setting up the teaching environment. New trainers would require substantially greater detail. • Teaching Technique: There was a lack of detail in instructions to staff. Chaining can be difficult to implement correctly, and general instructions often lead to teaching errors. • Prompts: The description of prompts was generic. Prompting should be individualized with clear instructions for staff. This was especially relevant considering that the individual was described as tactile defensive. Despite the acknowledgement of this in the SAP, the use of tactile prompts was still included. • Steps: Step One involved opening the dryer door. There was no indication in assessments that she could complete this task without it being broken down into smaller steps. In addition, there was no definition of opening the dryer door. Therefore, one staff might offer reinforcement for simply popping the door from the clasp while a different staff might require the door to be fully opened. Step two did not define or describe how clothes were to be moved from the basket to the dryer. As mentioned previously, did each item of clothing constitute a trial or must the entire basket be emptied? • Maintenance and Generalization: Specific plans were not provided. Individual #492 – SAP for Preparing to Brush Teeth • <u>Assessment</u> • FSA: For the steps included in the SAP, the FSA did support a backward chaining process. It was not clear, however, that the later steps reflected sufficient granularity. In other words, was there evidence that the steps were not too broad? A more specific task analysis would answer this. • The ISP narrative only described the need to have staff assistance in brushing teeth. Although the SAP for brushing teeth was included in the action plans, it was not discussed elsewhere. • The Dental Assessment did not recommend an SAP for brushing teeth. • The PNMP Assessment reflected the need for specific sitting and standing posture during tooth brushing. This was not reflected in the SAP. • The communication assessment reflected that the individual was unable to imitate gestures. While this assessment did not involve brushing teeth, it was something that should be addressed in teaching procedures. • <u>SAP</u>	

#	Provision	Assessment of Status	Compliance
		• Objective: The objective lacked an objective and measureable definition of the targeted skill. In addition, the SAP required only 67% success (20 of 30 trials) for mastery, but specified mastery must be maintained for two months. Two months was rather lengthy for mastery, especially when the criteria were so low. It would be better to increase the criteria and reduce the length of demonstrated mastery. If it was anticipated that the individual would not be able to attain actual mastery (success rate of 80% to 90%), then it might be necessary to select a different skill to teach. • Schedule: It was suggested that the individual would have difficulty learning this skill. Under such circumstances, the opportunities for training should be maximized. The SAP required only one formal session per day. Learning would be enhanced if trials were increased to several per day. • Special Instructions: As indicated previously for this individual, the specific postures included in the PNMP Assessment were not included or addressed in the SAP. In addition, although the trainer was encouraged to assess the willingness of the individual to participate, there were no criteria by which to determine willingness. • Teaching Technique: The SAP used backward chaining. Backward chaining is difficult for many trainers to conceptualize and implement. Therefore, it is important for instructions to be as specific as possible. The instructions provided in the Teaching Technique section, as well as the "task analysis", did not reflect adequate specificity. • Consequences: The consequence for a correct response was derived from the preference assessment and ISP; this was good. • Task Analysis: In backward chaining, the steps should be presented in the order they will be trained. Therefore, the table should begin with step three. This helps the trainer to recognize the appropriate step and teach accordingly. In addition, there should be more detail regarding the behavior to be performed by the individual, as well as the prompts or other actions to be performed by staff. As much as possible, this should be scripted for staff. • Maintenance: The maintenance instruction described delaying reinforcement in order to generalize the behavior. Delaying reinforcement would not maintain the current behavior and could result in inadvertent reinforcement for other, potentially undesired behaviors. It would be appropriate to move from continuous reinforcement (reinforcement for every success) to a ratio schedule of reinforcement. For example, reinforce every second success, then every third, etc. • Generalization: The statement did not reflect a plan. There should be a specific strategy for generalizing the learned behavior to other environments. Based upon a review of the three "best" SAPs, it was not evident that the three SAPs were substantially better than those review in July 2012 or those developed in the past several months but not identified by the Facility as among the best SAPs. In some areas, such as behavioral objectives and incorrect responses, the three SAPs were notably weaker than the remaining SAPs.	

#	Provision	Assessment of Status	Compliance

	7/2012	4/2013 (Best)	4/2013 (Recent)
Plan reflects development based upon a task analysis	9%	0%	9%
Behavioral objective(s)	36%	33%	64%
Operational definitions of target behavior	27%	33%	27%
Description of teaching conditions	27%	33%	30%
Schedule of implementation plans for sufficient trials for learning to occur	0%	0%	0%
Relevant discriminative stimuli	82%	67%	73%
Specific instructions	27%	0%	9%
Opportunity for the target behavior to occur	100%	100%	73%
Specific consequences for correct response	100%***	67%	64%
Specific consequences for incorrect response	9%	33%	73%
Plan for maintenance and generalization that includes assessment and measurement methodology	0%	0%	0%
Documentation methodology	9%	100%	45%

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

If BSSLC is to make progress toward substantial compliance with the Settlement Agreement, it will be necessary to enhance the quality of the SAPs substantially. There were some suggestions of modest improvement. At the same time, however, there were indications that the Facility lacked expertise in relation to essential skill assessment and teaching procedures. Moving forward it will be essential that skill assessment and teaching methods more stringently adhere to principles of learning and evidence-based practices.

<u>Implementation of formal and informal skill acquisition training</u>

In addition to substantial weaknesses relating to skill assessment and SAP 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.

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.

#	Provision	Assessment of Status	Compliance

	Staff Present	Individuals Present	Individuals Functionally Engaged	Percent Functionally Engaged
Program Services A	4	10	5	50%
Program Services C	2	7	1	14%
Program Services D	1	5	1	20%
Program Services D	1	4	3	75%
Program Services D	2	5	2	40%
Driscoll C	1	5	0	0%
Driscoll C	0	3	0	0%
Bowie B	3	5	1	20%
Bowie B	3	2	2	100%
Bowie A	2	7	2	29%
Bowie A	2	3	3	100%
Bowie C	2	3	3	100%
Bowie C	1	7	1	14%
Driscoll C	1	1	0	0%
Driscoll C	0	1	0	0%
Driscoll C	2	8	1	13%
Fannin B	1	1	1	100%
	28	77	26	
Total percentage of individuals functionally engaged				34%
Percentage of locations with 50% or greater functional engagement				29%

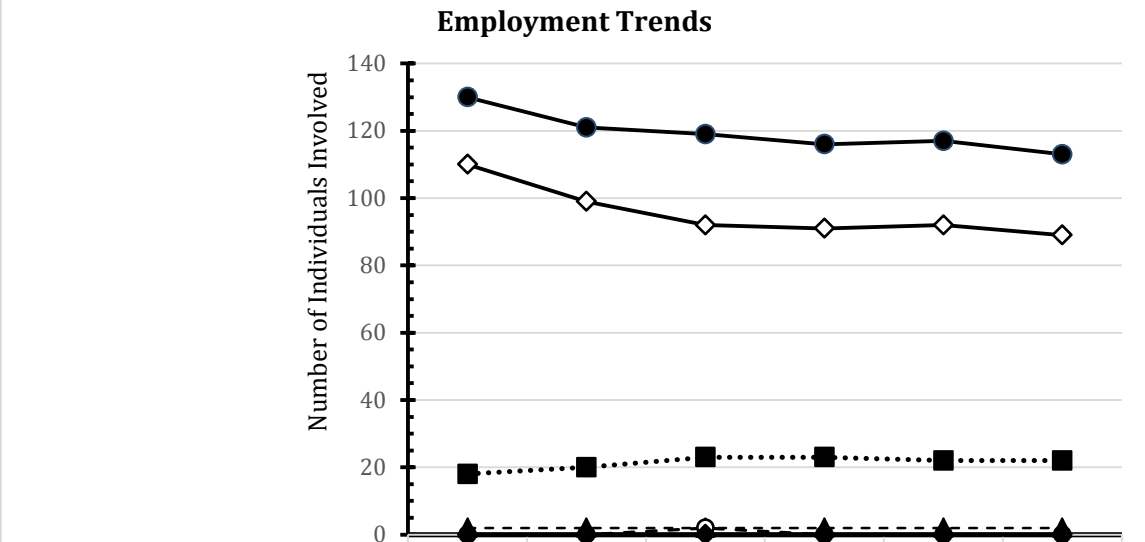
Observations revealed that across all settings only 34% of observed individuals were functionally engaged. Furthermore, only slightly more than one quarter (29%) of all environments observed reflected at least 50% engagement. Specific circumstances noted during observations included the following.

- On 4/10/2013 in the Bowie A dining room, Individual #595 was observed eating large bites rapidly. He consumed at least seven large spoons of food before prompted to slow. Staff did not allow the individual to drink independently or set his cup down per the instructions on his dining card.
- On 4/10/2013 in Driscoll C Classroom 4, three individuals were observed lying on the floor without supervision; all three were engaged in stereotypic behavior. When staff arrived, they were asked about training programs and data collection. The staff replied, "They get snacks about 6:00."
- On 4/9/2013 in Program Services C, leisure materials were present but not in use. When asked about training materials, the staff replied, "They just work with the stuff in front of them."

#	Provision	Assessment of Status	Compliance
		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. • On 4/10/2013 in Program Services D, Training Room One, the staff member demonstrated comprehensive knowledge of the SAPs for all individuals. In addition, the staff member was observed to float amongst the individuals, focusing attention and prompting for participation. . • On 4/10/2013 in the Bowie B dining room, staff demonstrated extensive knowledge of dining plans and individual needs. In addition, staff were consistently observed to enquire about preference, additional portions, and the use of condiments. 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 was infrequently observed to provide individualized attention or use formal prompting. BSSLC must provide the training, monitoring, and supports needed to ensure that individuals are provided with the necessary functional engagement across all settings.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	Based upon a review of assessment practices, it was noted that BSSLC displayed difficulty in ensuring that individuals received complete and comprehensive assessment as part of the ISP process and training program development. Specific issues related to psychological assessments are presented in 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 SAPs, such as assessment findings or documentation that IDT discussions had encompassed skills targeted by the SAPs. • All of the individuals in the sample had a completed Functional Skills Assessment (FSA) included in the permanent record. For only one of the ISPs or SAPs reviewed, however, were there FSA findings discussed in the ISP that corresponded with the specific skills targeted by the SAPs. • None of the SAPs included in the sample presented formal or informal assessment of preferences or reinforcers. • It was not evident that the training steps in the SAPs were individualized or that the task analyses were formulated to reflect individual differences. Because 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	Noncompliance

#	Provision	Assessment of Status	Compliance
		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 the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	Due to the limitations noted in Provisions S1 and S2, it was frequently not possible to determine if training programs addressed pertinent needs of the individual. Without accurate and comprehensive assessment, it was not possible to clearly identify the specific needs of the individual and establish specific teaching goals from which to measure progress. As a result, it was probable that BSSLC did not possess a clear measure of each individual's strengths and needs, and could not develop, monitor or revise training programs with accuracy. As documented in Provision S1 of this report, several observations were conducted of residences and training areas at BSSLC during the current site visit. During these observations, there were isolated instances in which employees were noted to be conducting formal training. In the majority of settings, however, staff had not provided or demonstrated an inability to conduct informal training.	Noncompliance
	(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 minimally. 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. Data regarding training opportunities in other areas of skill development (such as community safety, leisure, or transportation skills) were not provided.	Noncompliance

#	Provision	Assessment of Status	Compliance



	Nov-10	May-11	Nov-11	May-12	Nov-12	Feb-13
Workshops	110	99	92	91	92	89
Supported Employment	0	0	0	0	0	0
Client Worker Program	2	2	2	2	2	2
Enclave Work	18	20	23	23	22	22
Enterprise	0	0	2	0	0	0
Competitive Employment	0	0	0	0	0	0
Total	130	121	119	116	117	113

BSSLC did not provide data reflecting the number of community outings.

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

1. The Facility must act to ensure that SAPs reflect needs identified in the skill assessment process. 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. he 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 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. BSSLC must develop a more diligent and intensive strategy for increasing training and employment in community settings. SAPs that are implemented on campus should include a procedure for formal implementation in the community. SAP 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. Brenham State Supported Living Center (BSSLC) Self-assessment, dated 03/21/2013 2. BSSLC Action Plans, dated 03/11/2013 3. Initiatives/Activities Update since Last Compliance Round Presentation for April 2013 for Settlement Agreement Monitoring Team Visit 4. Section T Presentation Book 5. DADS Policy 018: Most Integrated Setting Practices, 3/30/10 6. Draft of updated DADS Policy 018: Most Integrated Setting, undated 7. DADS Policy 004.1: Individual Support Plan Process, dated 11/20/12 8. BSSLC Policy T.2: Most Integrated Setting Practices Discharges/Transfers, Revision 12/4/12, Implemented 3/27/2013 9. Draft of Job Description for Children's Specialist 10. Since last on-site review, a list of all individuals who have requested community placement, but have not been referred for placement 11. Since last on-site review, a list of all individuals who have been referred for placement 12. 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" 13. Discharge packets for individuals whose discharge since last on-site review may be classified as an "alternate discharge": Individuals #11, #130, #399 and #576 14. ISPs, ISPAs, documentation of community exploration and contact notes for individuals who had a referral rescinded in the last six months: Individuals #173 and #250 15. Since last on-site review, a list of all individuals who have died after moving to community living 16. A current list of all alleged offenders committed to the Facility following court-ordered evaluations 17. For the last twelve months, a list of individuals who were reported to have been assessed for placement 18. Community Placement Report, dated Wednesday, April 10, 2013 19. For the last twelve months, lists of all trainings/educational opportunities provided to individuals, families, and LARs to enable them to make informed choices 20. Annual Report: Obstacles to Community Transition, Brenham State Supported Living Center, Fiscal Year 2012 21. DADS Annual Report: Obstacles to Transition Statewide Summary, issued 2/26/13 22. Since last on-site review, a list of all individuals who have had a Community Living Discharge Plan (CLDP) developed 23. Local Authority (LA) Community Living Options Information Process (CLOIP) Worksheets for Individuals #30, #115, #118, #217, #283, #353, #379, #449, #486 and #492 24. Individual Support Plans (ISPs) and Preferences and Strengths Inventory (PSI) for Individuals #30,

	#115, #118, #217, #286, #283, #353, #379, #449, #486, #492 and #599 25. Completed CLDPs for Individuals #20, #66, #246, #434, #442, #476, #511 and #547 26. Partial CLDPs for Individuals #118, #244, #273, #490 and #492 27. Pre Move Site Reviews for Individuals #20, #66, #246, #434, #442, #476, #511 and #547 28. LA Continuity of Care Pre-Move Site Review Instruments for the Community Living Discharge Plan for Individuals #20, #66, #246, #434, #442, #476, #511 and #547 29. Brenham State Supported Living Center QA/QI Council Meeting, Quarterly Quality Assurance Report, dated February 27, 2013 30. Completed Post Move Monitoring (PMM) checklists for Individuals #20, #66, #181, #242, #246, #434, #442, #476, #511 and #547 **People Interviewed:** 1. Debra Green, Admissions and Placements Coordinator (APC) 2. Andrew Williams, Post-Move Monitor (PMM) 3. Daniel Dickson, Quality Assurance Director 4. Kim Littleton, Assistant Director of Programs **Meeting Attended/Observations:** 1. ISP annual planning meetings for Individuals #286 and #599 2. ISP Preparation Meetings for Individuals #191 and #545
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section T. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. The current Self-Assessment reported on the activities engaged in to conduct the self-assessment, provided the results of the self-assessment, and finally provided a self-rating stating why or why not it believed compliance had been achieved. The Facility often referenced the review of Section T monitoring/auditing tools as the activity engaged in to conduct the self-assessment and as the basis for its self-rating, but did not consistently provide the specific data that would have supported that finding. In order to complete a meaningful self-assessment, the Facility should further develop a set of outcome indicators that it believes would be likely to lead to substantial compliance based on its own experience and on the findings and recommendations in the Monitoring Team's report. This should include the identification of the data needed to measure these indicators. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken or planned to achieve compliance. Once it develops its outcome indicators, the Facility should review these actions to ensure they are focusing on those most likely to support the identified outcomes. For example, for Provisions T1a through T1c, the Facility's only Action Step was to ensure the ISP Guide is followed at all ISP meetings. The evidence that will be used to measure this was not defined, nor the process for measuring it. In any event, the use of the ISP Guide is simply a process, not an outcome. The Facility should define the provision-specific outcomes it hopes to achieve as a result of this Action Step and others as well as how they will be measured.

	For Provision T1, the Facility indicated it was not in full compliance with his provision, but it did report it had achieved some level of compliance for Provisions T1c1, which requires the Facility to specify in the CLDP the actions it needs to take and assistance it should obtain to implement the plan; T1c2 which requires the Facility to specify the SSLC staff responsible for CLDP actions, and the timeframes in which such actions are to be completed; T1c3, which requires the CLDP to be reviewed with the individual, and LAR as appropriate, to facilitate their decision-making; and T1h, the issuance of the Community Placement Report. The Monitoring Team concurred with Facility findings of both substantial compliance and noncompliance for T1c2, T1c3, and T1h, but did not concur for T1c1. **For Provision T2**, the Facility self-rated substantial compliance in Provision T2a due to timely completion of all PMM visits and reports, maintaining adequate documentation and undertaking follow-up in a timely manner. The Monitoring Team could not substantiate compliance, largely due to concerns related to the adequacy of the Facility's efforts to ensure supports were implemented as needed. The Monitoring Team also continues to urge the Facility to develop outcome indicators regarding the IDT review of PMM visits, based not simply on its occurrence, but also on whether it produces the desired results in terms of timely actions that support a successful transition. The Facility did not complete a self-rating in Provision T2b, as it addresses the Monitoring Team's on-site verification of the Facility's PMM processes. No rating was found for this provision, as a PMM visit did not occur during this site visit. **For Provision T3,** no compliance 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 continued impressive effort with the families of children, many of whom had previously expressed opposition to community living, to work toward movement to a more appropriate and integrated setting. Several children had successfully transitioned in the past six months and the Facility had hired a Children's Specialist to support their transition planning. The Monitoring Team again commends the Facility for its initiative in this area. Additional progress was noted in the thoroughness of the implementation of the CLDP and PMM processes, although these did not yet rise to the status of substantial compliance. As noted in Section F, the Facility had chosen to focus training and skill development related to the revised ISP process on four IDTs. It was requested the Monitoring Team similarly focus its review on the work of these teams and provide feedback and some level of technical assistance. It was agreed this focused effort could not result in any finding of substantial compliance at this point due to its limited scope. The findings and recommendations related to ISP development found in this section, particularly as they relate to Provisions T1b1, T1b2 and T1b3, were drawn from a sample from those four teams only, including the two ISP annual meetings held during the site visit and ten other ISPs completed by those teams over the past six months. The Monitoring Team found there was progress in the implementation of the ISP process, but

	significant deficits remained that continued to hamper efforts to develop and implement adequate transition planning. Other specific findings are detailed below: **For Provision T1**, eight individuals had transitioned to community living and there were 14 active referrals. The Monitoring Team did find substantial compliance in several sub provisions, T1c2, T1c3 and T1h. Respectively, these addressed the identification of Facility staff responsible for required CLDP actions, and the timeframes in which such actions are to be completed; review of the CLDP with the individual and LAR to facilitate their decision-making regarding supports and services needed for community living; and, the issuance of the Community Placement Report. 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. The IDT also often 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. The significant improvement in the process noted during the last visit had been sustained and the PMM Checklists continued to be completed in a timely manner. A Program Auditor continued to be 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. Noncompliance hinged largely upon the Facility's lack of adequate assessment and timely action to prevent the failure of a community transition and the gaps in its PMM processes this revealed. **For Provision T3**, no rating is required. **For Provision T4**, the Facility was in substantial compliance. The Facility reported four Alternate Discharges during the past six months and each appeared to have been completed in substantial compliance with CMS discharge planning requirements and DADS policy.

#	Provision	Assessment of Status	Compliance
T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined	<u>Transition Outcomes During Last Six Months:</u> • Community Transitions: The number of community transitions showed a stable or increasing trend.	Noncompliance

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	incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	o There were eight transitions to community living in the last six months. With 293 individuals currently living at BSSLC, this represents approximately three percent of the population. This figure was relatively consistent with the previous two monitoring periods for which six individuals had transitioned during each six month period. o The transition process took more than 180 days for four of the eight (50%) individuals • Referrals for Community Transitions: o The number of community referrals indicated a stable or increasing trend. Ten referrals had been made in the past six months, according to the Community Placement Report. This compared to eleven and six referrals made during the previous two six month periods respectively. o Fourteen individuals were on the active referral list (approximately 5% of the current population at BSSLC). o Five of the individuals had been on the referral list more than 180 days; only one had been on the list for more than one year. • Individuals requesting placement, but were not referred: Of the fifteen individuals who requested placement, but were not referred, eleven (73%) had an LAR who made this decision. • Rescinded Referrals: o There were two rescinded referrals reported since the last review. o Of these, the reasons for the rescinding appeared to be reasonable for neither (0%), in that both had been on the referral list for more than 180 days with little evidence of action taken to facilitate a transition while the referral was active. This assessment was based on a review of documentation provided related to the referral, including the extent of community exploration that had been undertaken and the extent of interactions of Facility staff with the LARs to facilitate maintaining the referral. For one of the two individuals (#173) the IDT did document additional barriers in the ISPA related to rescinding, but this action did not occur until more than two years after the initial referral date. o An adequate review was conducted to determine if changes in the referral and transition planning processes were needed at the Facility for neither (0%) of the rescinded referrals. • Returns from Community Placement o Two individuals had returned from a community placement o This number of individuals who returned to the SSLC after a failed community placement indicated an increasing trend over the previous two monitoring site visits. o For those who returned to the Facility after a failed community	

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		placement, the Facility did not provide documentation that reflected an adequate review had been conducted to determine if changes in the referral and transition planning processes at the facility should be made. An appropriate corrective action plan was developed to address certain elements of one of these situations, but not all of the pertinent issues were identified or addressed. See Provision T2a for additional detail. • Deaths Following Community Placement o One individual who moved since 7/1/09 passed away since the last onsite review. The death did not occur within the 90-day post move monitoring period. • Other Adverse Outcomes o Over the past six months, of the eight individuals who transitioned, two (25%) experienced one or more untoward events since placement. Of these, there was documentation provided of an adequate review conducted for none (0%) of the cases to determine if changes in the referral and transition planning processes at the facility should be made. <u>Actions Taken to Encourage and Assist Individuals to Move to the Most Integrated Setting:</u> During this past six months, BSSLC had taken some steps that were intended 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. A Transition Specialist funded by the State's Money Follows the Person grant had begun work, and a Children's Specialist had been hired. Much of the work of these positions will be to encourage and assist individuals to move to the most integrated setting. The Monitoring Team was particularly impressed by the Facility's endeavors to assist several children to transition. Many of the families of these children had been very reluctant to consider transition; the Facility is to be commended for working closely with these families and the children themselves to create successful opportunities for community living. <u>Conclusion:</u> There was progress in this area, but the provision was found to be not yet in compliance. As detailed in the rest of this Section T and in Section F above, outcomes in the areas of assessment and planning for protections, services and supports (see Provisions F1c, F1d, F1e, F2a1 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	<u>Policies and Procedures related to transition and discharge processes</u>:	Noncompliance

#	Provision	Assessment of Status	Compliance
	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:	At parties' meetings in July 2012, the parties agreed that the Monitors would rate Provision T1b as just the development of an adequate policy. The subsections T1b1 through T1b3 would be considered stand-alone provisions that require implementation independent of Provision T1b or any of the other cells under Provision T1b. The Facility reported that it had made no changes to transition and discharge policies. There was a pending revision of DADS Policy 018, particularly related to the requirements for the CLDP and PMM, which is expected to also require modifications to local policies. As the State and Facility had not yet finalized an adequate policy related to transition and discharge processes, the Facility remained out of compliance with this provision.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	<u>Protections, services, and supports:</u> DADS, DOJ, and the Monitors agreed that substantial compliance would be found for this portion of this provision item if substantial compliance was found for three provision items of section F: F1d, F2a1, and F2a3. As noted above in Section F of this report, substantial compliance was not found for Provisions F1d, F2a1, and F2a3. 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. Therefore, substantial compliance was not found for Provision T1b1. <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 • 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 As described further in Provision T1g below, the Facility was not confident of its current process for collecting these data. The status of aggregation and analyses of these data are further discussed in Provision T1g.	Noncompliance

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		Of the twelve ISPs reviewed, the Monitoring Team found that nine should have had obstacles defined (the other three individuals were referred for transition to the community). Of these nine ISPs, none (0%) included an adequate list of obstacles to referral and obstacles to transition. This included the two annual ISP meetings observed. Plans to address obstacles at the individual level were also not adequate. Of the nine ISPs for non-referred individuals, none (0%) included an action plan to address/overcome obstacles identified that was adequate (i.e., individualized, measurable, and comprehensively addressed the obstacles). <u>Preferences of Individuals and LARs</u> Of the nine ISPs for which a referral had not been made, none (0%) included an adequate description of the individual's preference and how that preference was determined by the IDT (e.g., communication style, responsiveness to educational activities). For the most part the documentation indicated the individual's preference was unknown. In none of two annual ISP meetings observed (0%) was the individual's preference for where to live adequately described. Preferences of LARs and families for living arrangement were typically 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 lend itself to a comfortable discussion of community living opportunities, as described in Provision F1e.	
	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: <u>An Individualized Plan For Each Individual</u>: The Facility did not yet succeed in developing individualized plans for community education and awareness. There was little progress observed in the sample of nine recent ISPs reviewed for which a referral had not been made, as well as in the two new-format ISP process meetings attended. 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 none of the nine (0%) ISPs for which a referral had not been made was there an individualized plan for increasing awareness of community living options that took into account the learning needs of the individual. The Monitoring Team also found that in the two new format ISPs observed there was minimal discussion regarding a plan for community awareness and	Noncompliance

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		education. For example, for Individual #599, it was noted that the individual had attended one CLOIP tour this past year, with no discernible response noted, but there was no Action Plan discussed for the upcoming year. An Annual Provider Fair: The Facility had held its semiannual provider fair on January 5, 2013. The Facility continued to complete a survey of the participants in the fairs and use these data to vary its approaches to this activity. Regular SSLC Meeting With Local LAs: The APC reported BSSLC staff continued to have joint Interagency Planning Meetings with local LAs and staff at RSSLC to coordinate admissions and discharges. Education About Community Options: 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: BSSLC was not yet collecting data regarding the development and 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. • 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 nine CLOIP Worksheets for recent ISPs. For these individuals, five of nine (55%) were allowed by the LAR to participate in the CLOIP. For two of the five (40%) 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 remaining three reviewed, the LA Service Coordinator documented the individual did not seem to comprehend or attend to the material presented. 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. Tours Of Community Providers: There did not yet appear to be a consistent, formalized process in place at the Facility to fashion these provider tours as a part of an individualized community living awareness and education plan, although there was some progress noted as described below. Specific findings regarding community tours included: • Opportunities to go on a tour available to all (except those individuals and/or	

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		their LARs who state that they do not want to participate in tours): In the past six months, the documentation provided by the Facility listed a total of 46 names of those who had participated in CLOIP community tours. This did not reflect that 46 individuals had the opportunity to make such visits, as several individuals had multiple visits. 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 293 individuals residing at the Facility to obtain enough experience about community living to form an opinion or participate in informed decision-making. • 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. The APC's office had made arrangements for individuals who were expected to be moving out of the Brenham area to participate in CLOIP tours offered by Contract LAs in the preferred areas. This was a commendable practice that should be continued. Overall, however, there was not a consistent or formalized process described for choosing tour sites based on individual preferences and needs. • 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. 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. The Facility did not provide any description of a formalized process to ensure this assessment. Opportunities Are Provided To Visit Friends Who Live In The Community: BSSLC indicated there had been some opportunities for individuals living at the Facility to visit with friends who had moved to the community. These included one individual who was reported to make a monthly visit to the new home of a friend who had moved and visits by the young ladies living at the Cottages to former housemates who had transitioned. Education Provided In Various Venues: The Facility did hold bimonthly self-advocacy meetings for adults and youth. A review of the minutes for the past six months did not reflect education about community living options.	

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		A Plan For Staff To Learn More About Community Options: 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 48 staff participating in such activities, including tours and visits. Staff also had the opportunity to attend the Provider Fairs and the Facility documented 56 staff who took advantage of this. The Facility also offered its Bi-Annual In-Service Training on Community Living Options on January 9, 2013 and 31 staff attended. Individuals And Families Who Are Reluctant Have Opportunities To Learn About Success Stories: Two individuals who had moved to the community were in attendance at the January Provider Fair to share their stories. The Monitoring Team commends this practice. The APC also reported her department intends to develop a newsletter that will highlight success stories. She also planned to engage LARs for permission to share successful transitions experienced by individuals, and hoped to be able to provide such an opportunity at the upcoming Parents' Association meeting. Conclusion: This provision was found to be not in compliance. The Monitoring Team commends the efforts and progress 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. The Facility should also consider how it can address each of the criteria in this provision to create a comprehensive coordinated plan for community living education and awareness.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to	Percentage of Individuals Assessed as Required: The Facility provided a list of 247 individuals entitled "Assessed for Placement Since 3/12/2012. The process in use at the Facility to assess individuals for community living remained inadequate to qualify as an assessment for community placement. State and local policies require that each SSLC team member must include in his/her assessment/evaluation a recommendation regarding the individual's appropriateness for transition to a more integrated setting, and delineation of the supports the individual	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	would need. 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. Issues that affected the adequacy of the assessment included: • The Facility often did not have an adequate basis for determining the preferences of individuals for living arrangements as described in Provisions T1b2 and F1c. Plans to educate individuals as to community living options were not well-thought out, individualized or sufficient in scope in most instances. • As described in Provision T1b1, the IDTs continued to lack proficiency in identifying 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. • For the twelve ISPs reviewed, there were a total of 114 assessments provided. Of the 114 total assessments that were reviewed, 53 (46.5%) included a determination of whether the individual could be served in a less restrictive setting. • Of the 114 total assessments reviewed, 26 (22.8%) included recommendations for how the individual's needs could be met in a more integrated setting. • In 12 of the 12 (100%) written ISPs reviewed, a statement of the opinion and recommendation of the IDT's professional members was included, and a statement regarding the overall decision of the entire IDT, inclusive of the individual and LAR, was also included. • In none of the 12 (0%) written ISPs reviewed, and during none of the two (0%) annual ISP meetings observed, did a thorough discussion of living options occur (i.e., consideration of different types of community living settings, locations, preferences, safety needs, etc.) <u>Conclusion:</u> This provision was found to be not in compliance.	
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	<u>CLDP Policy and Process</u>: The APC was responsible for coordination of the CLDP process, in collaboration with the individual's IDT. DADS had issued a revision to the CLDP format (Form SSLC 018E, March 2013) which the Facility had begun using with the two most recent referrals. The revised format was condensed and closer to the original CLDP format used previously. The Monitoring Team concurred with the APC that the CLDP had grown cumbersome	Noncompliance

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	coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	and somewhat convoluted and that provider direct care staff did not appear to find it useful. One approach DADS and the Facility might also consider is providing more of a succinct narrative summary at the beginning of any format finally chosen, so that direct care staff can envision the big picture and have a better understanding of what all the sections of information that follow are about and why they need to refer to them. <u>Timeliness of Development and Implementation of CLDP:</u> The CLDP was to be initiated at the time of referral and was to be updated on an ongoing basis as circumstances required. • Four of the four (100%) CLDPs for referrals made during this past six months were initiated within 10 calendar days of referral. • Eight of the eight (100%) completed CLDPs included adequate documentation to show that they were updated throughout the transition planning process. • One of five (20%) CLDPs in progress included adequate documentation to show that they were being updated throughout the transition planning process. The Monitoring Team also reviewed an updated Community Placement Report, updated on April 10, 2013. • Five of the 14 (36%) current referrals had exceeded the 180 days allowed in the current policy and pending revision. • Four of the eight (50%) transitions that had occurred also exceeded 180 days. 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. DADS policy also acknowledges this and provides an avenue to apply for and receive a waiver when needed. It appeared, however, that there was sometimes a delay in initiating community exploration following the initial referral meeting or in sustaining that activity at a reasonable pace. For example, as described in Provision T1a, for both of the rescinded referrals that occurred during the past six months, the individuals had been on the referral list for more than 180 days with little evidence of action taken to facilitate a transition while their referral was active. In addition, the Monitoring Team reviewed five CLDPs in process to evaluate whether the Facility was compliant with its policy to document transition activity on an ongoing basis. Only one of five (20%) CLDPs in progress did not evidence unexplained delays in meeting to select providers for pre-selection visits, scheduling pre-selection visits and/or reviewing the outcomes of pre-selection visits. The Facility should ensure that timeliness of actions related to referrals and community placements is included as a measure 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	

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		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. Development of CLDP in coordination with the LA: A review of completed CLDPs indicated that eight of the eight (100%) CLDPs included documentation to show that the Facility worked collaboratively with the 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. Conclusion: Provision T1c was 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. There were a number of instances in which placements did not occur within the 180-day requirement, which was sometimes related to a lack of timely action and follow-up by the IDT after a referral was made. The new staff in the APC office, particularly the Transition Specialist position should contribute to a timelier outcome for most individuals in the future. It would also be helpful for the APC to institute and monitor a tracking list to ensure follow-up with IDTs to ensure timely actions.	
	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.	Identification of Pre and Post Move Supports: In none of the eight CLDPs reviewed (0%) was there identified a comprehensive set of pre and post move supports in, measurable/observable terms, to be implemented. This finding was based on an evaluation of presence or absence of each of the following criteria: • The list was comprehensive and inclusive, demonstrated by: o Sufficient attention was paid to the individual's past history, and recent and current behavioral and psychiatric problems. o All safety, medical, healthcare, risk, and supervision needs were addressed. o What was important to the individual was captured in the list of Pre and Post Move supports. o The list of supports thoroughly addressed the individual's need/desire for employment. o Positive reinforcement, incentives, and/or other motivating components to an individual's success were included in the list of Pre and Post Move supports. o There were Pre and Post Move supports for the teaching, maintenance, and participation in specific skills, such as in the areas of personal	Noncompliance

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		hygiene, domestic, community, communication, and social skills. o There were Pre and Post Move supports for the provider's implementation of supports. That is, the important components of the BSP, PNMP, dining plan, medical procedures, and communication programming that would be required for community provider staff to do every day. o Topics included in training had a corresponding Pre and Post Move support for implementation. • The wording of every Pre and Post Move support was in appropriate, measurable, and observable terms. • Every Pre and Post Move support included an adequate description of what the Post Move Monitor should look for when doing PMM (i.e., evidence): a criterion, and at what level/frequency/amount the support should occur. For none of eight CLDPs (0%) reviewed was there sufficient descriptions or adequately defined criteria. There was 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 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. • Any important support identified in the assessments or during the CLDP meetings that was not included in the list of Pre and Post Move supports had a rationale as to why it was not included. <u>Coordination of CLDP with provider staff:</u> A review of completed CLDPs indicated provider staff were typically very involved throughout the CLDP process. In eight of eight (100%), there was documentation of training of provider staff, visits by the individual to the provider sites and the individual's responses and provider staff attendance at the CLDP.	
	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> Responsible staff by name were provided for all Pre and Post Move supports. • Eight of eight (100%) of completed CLDPs identified all Facility staff and other staff by name and/or title for each Pre and Post Move support. <u>Completion timeframes for needed actions identified</u>:	Substantial Compliance

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		• Eight of eight (100%) of completed CLDPs identified specific timeframes/specific dates for completion and/or implementation for each Pre and Post Move support. Conclusion: This provision was found to be in substantial compliance.	
	3. Be reviewed with the individual and, as appropriate, the LAR, to facilitate their decision-making regarding the supports and services to be provided at the new setting.	Evidence of individual/LAR participation: Based on review of eight CLDPs, eight (100%) included documentation that the plans had been reviewed with the individual and/or the LAR as evidenced by signatures on the CLDP and narratives descriptions throughout the ongoing updates to the plan. Conclusion: This provision was found to be in substantial compliance.	Substantial 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.	Timeliness of Assessments: The APC had implemented a Pre-CLDP meeting to review assessments and make assignments for any updates or revisions that needed to be made to an individual's current assessments. This was a positive practice that should be continued. The final assessments were then reviewed as a part of the CLDP meeting. These processes in themselves appeared to be adequate for purposes of ensuring that assessments were available and current within 45 days prior to the individual leaving the Facility. BSSLC continued to need to continue its attention on whether these assessments were adequately prepared. Adequacy and Comprehensiveness of Assessments: 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. 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. As described in Provision T1c1 above, in a review of five completed CLDPs, the Monitoring Team found that the assessments did not consistently address the services and supports needed for each an individual to make a successful transition, nor how the individual's preferences could be accommodated and supported in a community setting. In addition, few of the assessments reviewed placed any emphasis on recommendations and strategies for community integration and how the individual could be supported to take advantage of the new opportunities community living might offer. In addition, the Monitoring Team completed a focused review of eight Nursing Discharge	Noncompliance

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		Summaries and accompanying discharge packets for the individuals transitioned in to the community since the last compliance visit to evaluate the assessment process. Findings included the following: • A current nursing assessment was conducted for six of eight (75%) of the individuals prior to discharge/transferring to the community. • Six of eight (75%) assessments showed comprehensive assessments for clinical risk indicators were completed for each specific health item contained on the Nursing Discharge Summaries up to 45 days prior to discharge. • Two of eight (25 %) individuals' health status in relation to each significant identified health clinical indicators was thoroughly summarized such that the receiving agency could understand their present health status in order to respond to their health care needs. • Three of eight (38%) individuals' Discharged Packets contained Integrated Risk Rating Assessments or Integrated Risk Rating Forms (IRRFs) updated within 45 days prior to discharge. • One of eight (13%) individuals' Discharged Packets contained Active Risk Plan or Integrated Health Care Plans (IHCPs) updated at least 45 days prior to discharge. • Six of eight (75%) of the summaries completed included the required, "Special Instructions: for Medication techniques (likes/dislikes, crushed, etc.), triggers/signs/symptoms of illness/behaviors (how I communicate when I don't feel well or what makes me angry, etc.,), and special techniques to have them be cooperative. Other pertinent information (i.e.: special behaviors and what they mean, how I communicate, signs and symptoms of pain, etc.)." <u>Conclusion:</u> This provision was found to be not in compliance. Facility action must address the adequacy of assessment practices before compliance can be achieved under this provision.	
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	<u>LA Continuity of Care Process:</u> The Monitoring Team reviewed documentation for eight individuals who had transitioned to the community in the last six months and found each of the LA Continuity of Care Pre-Move Site Review Instruments was completed within the required timeframe and included the required DADS QRS report as an attachment. One of the instruments, for Individual #511, indicated there was an environmental concern that required follow-up, but it was not clear that follow-up was completed by either the LA or the Facility. <u>Pre-Move Site Visit Completed by Facility:</u> 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	Noncompliance

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	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.	Team was not able to observe the process but rather relied upon documentation to assess compliance. The Monitoring Team reviewed the Pre-Move Site Review documentation completed for eight individuals who had transitioned in the past six months. For the eight CLDPs reviewed for individuals who were placed, a Pre-Move Site Review was conducted by the Facility for eight (100%). • Of these, eight (100%) were completed on a timely basis. • Eight of eight (100%) appeared to have included a visit to each service provision site. • Of these, five (63%) fully indicated that all of the essential supports were in place prior to the individual's move or described a specific plan. For the remaining three, the Pre-Move Site Reviews sometimes identified a due date without a specific plan provided or indicated a support would be available for observation at a later date, but did not provide evidence the observation was confirmed. In one instance, for Individual #511, the Pre-Move Site Review documented environmental concerns in addition to that identified by the LA, but there was no follow-up documented any of these were addressed and resolved. Conclusion: This provision was found to be not in compliance.	
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 included: • A QA Auditor was assigned to monitor Section T. The process used the State Standardized Tools and Guidelines for Section T- Most Integrated Setting Living Options, CLDP, and PMM. A quarterly report was generated from data collected from observations and document reviews. Record audits were to be completed monthly by the APC and the Program Compliance Monitor. • The APC continued to track the provision of the 45-Day assessments by the various disciplines. • The APC had instituted a Pre-CLDP meeting held ten days prior to the CLDP meeting to review and reconcile information and recommendations in assessments. This practice is commended. 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	Noncompliance

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		supports were in place. A Program Auditor continued to be assigned to accompany the Post-Move Monitor on PMM visits to monitor the accuracy of the findings. In addition, the Facility had implemented a Corrective Action Plan (CAP) to address issues that had emerged as the result of a failed transition. Trends and Improvement Actions: It was reported the current process only displayed the aggregate data without any accompanying analysis at this point. The QA Director further indicated the Facility was examining whether the use of the Section T Monitoring Tool was meeting their needs for useful data. The APC also noted that the Section T tools were in the process of being updated. Conclusion: This provision was found to be not in compliance. The Facility continued to implement some actions toward developing quality assurance processes in the development and implementation of the CLDP, but the process was still evolving.	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and	Facility Annual Obstacles Report: The Facility provided an updated Annual Report: Obstacles to Community Transition, Brenham State Supported Living Center, Fiscal Year 2012 for review. BSSLC self-identified issues related to the reliability of the obstacle data collection and reporting systems currently in place. The current process clearly did not accurately capture the obstacles. For example, only 26 obstacles to transition in 2012 had been entered into the database from which this report was drawn. The Facility noted it was taking action to ensure that it will remain in compliance with the statewide policy regarding obstacle data collection, reporting and analysis and had developed an action plan to ensure compliance. The Action Plan to improve data integrity regarding obstacles included the following steps: • The APC will provide training for all IDT members twice annually regarding identification of obstacles. • Data collection forms will be revised to capture specific reasons of what individual's reluctance and LAR's reluctance for alternate placement to be entered into a Center database to track and trend the data • The APC will compile the data for trending and analysis on a quarterly basis. The APC will present the Obstacle Trend Reports to QA/01 on a quarterly basis to develop corrective action plans as identified. The Quality Assurance division will monitor the tracking	Noncompliance

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	feasible, DADS will seek assistance from other agencies or the legislature.	and trending of the obstacles on a quarterly basis and will monitor corrective actions plans implemented. Additional Action Plans were devised to reduce individual and LAR reluctance for alternate placement, to ensure successful placements and reduce the numbers of rescinded referrals. Having accurate and meaningful data as a result of the first Action Plan will allow the Facility to develop more focused Action Plans in the future. <u>DADS Annual Obstacles Report:</u> DADS had also issued an Annual Report: Obstacles to Transition Statewide Summary. It included data as of 8/31/12 from all 13 Facilities. The report was issued to the Monitors and DOJ on 2/26/13, six months after the data collection period ended. The following summarizes some positive aspects of the report: • The statewide report listed the 13 obstacle areas used in FY12. DADS indicated it would continue working with the Facilities in relation to the annual reporting of obstacles to transition. Such technical assistance is needed given the continuing problems with data collection discussed below. • There was some effort to separate a review of obstacles to referral from a review of obstacles to transition once an individual was referred. • DADS included a list of 12 initiatives it was continuing to support. In general, these efforts were in the early stages of implementation and/or were ongoing activities related to Section T as well as other sections of the Settlement Agreement (e.g., revisions to the ISP process). • The report included attachments with each of the Facilities' annual reports. The following concerns were noted with regard to the report: • <u>Definitions</u>: Section T.1.b.1 of the Settlement Agreement required that the Facility "identify the major obstacles to individuals' movement to the most integrated setting consistent with the individual's needs and preferences at least annually." The State's report, however, defined obstacles "as issues, barriers, or impediments that delay an individual from moving to a service delivery setting of his/her choice. These include any supports not currently available to meet the needs and preferences of the individual in the alternate setting." This definition does not seem to adequately capture those issues, barriers or impediments that could prevent an individual from making a choice of a more integrated setting, including a lack of awareness on the part of the individual or LAR or LAR reluctance. These are frequently identified obstacles to individuals' movement to the most integrated setting, and the data in the report reflect that this is so. • <u>Referrals</u>: As indicated on page 3, if a team did not refer an individual for	

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		transition, then an obstacle to a referral should be identified. However, generally, the numbers of obstacles to referrals were much lower than they should have been given the limited numbers of referrals at each of the Facilities. o It appeared Facilities had interpreted Table 4 differently. In some instances, data were provided for the list of obstacles for all individuals for whom they had data, regardless of whether the individual's preference was to transition to the community. In other instances, it appeared these data were for the subgroup of individuals who had expressed an interest in transition, but their guardians were reluctant to consider it. Both sets of information were important, but the reports certainly should have included the data on obstacles to referral for all individuals the Facilities supported. • Transitions: Surprisingly, adequate methodologies were not in place to collect data on obstacles to transition. As a result, the validity of the data provided in the report was questionable. • Data: It was concerning that valid and complete data were not available. In addition, the plans included in the Facility reports often did not describe specific actions that would be taken to make improvements with the data. For example, for many of the SSLCs, the plan to improve data collection involved retraining QDDPs and IDTs, as well as using a new data system. This was presented in general terms, and it was unclear if it was based on an analysis to determine the underlying causes for teams not properly identifying obstacles to referral and/or transition. • Assessment: The Facility-specific reports generally did not provide the "comprehensive assessment" the Settlement Agreement required. They merely stated the data with little to no analysis of the data. Beyond some minimal descriptions of often vague actions the Facilities would take, the reports offered no recommendations to DADS with regard to issues that went beyond the capacity of the Facilities to address, and for which DADS' intervention was needed. • DADS initiatives: DADS included a list of initiatives; however, these initiatives did not address many of the obstacles that the Facilities had identified. For example, according to the 2012 Annual Obstacle Report Data spreadsheet, 112 individuals were not referred due to "Behavioral health/psychiatric needs requiring continuous monitoring/intervention," and 100 individuals faced a "Lack of supports for people with significant challenging behaviors." Similarly, 54 individuals were not referred due to "medical issues requiring 24-hour nursing interventions/services," and 92 individuals faced a "Lack of availability of specialized medical supports." Even without full data, it was clear that these two areas required attention. However, beyond general statement about	

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		maximizing use of available funding and "Engaging local authorities and private providers in joint discussions on how to enhance provider capacity to meet the characteristics of those individuals transitioning from the SSLCs to community placement settings," the report provided no indication of the specific steps, if any, the State was taking "to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs…" • Assistance: In addition, 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.	
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	The Facility did provide an accurate Community Placement Report for six months ending on 4/10/2013 that included the following information as further detailed in T1a: • Number and names of individuals placed in the community • Number and names of individuals on active referral list • Number and names of those who would have been referred by the IDT, but were not due solely to LAR preference Conclusion: This provision was found to be in substantial compliance. The report was made in a timely fashion. As a stand-alone document, it still did not fairly represent the relatively large number of individuals who were not referred due to LAR choice, but the Facility did collect this information and provided it to the Monitoring Team for review. One other possible error regarding a referral was pointed out to the APC for follow-up, but this was not significant enough to effect compliance in this provision.	Substantial Compliance

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	generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.		
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.	Policies and Procedures related to Post-Move Monitoring: The Facility reported there had been no changes or additions to policies related to Post-Move Monitoring, but a revision of the PMM Checklist was expected to be issued in the near future. Staffing: There were additional staff positions devoted to transition since the previous monitoring visit. These included a Transition Specialist funded through the state's Money Follows the Person project and a Children's Specialist. Review of PMM Checklists: The Monitoring Team reviewed PMM Checklists for ten individuals who had moved to the community for 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. For ten individuals, 23 reviews should have been completed since the previous review. Of the 23 required visits, 23 (100%) were conducted and 23 (100%) were completed on time. • Locations visited: For the 23 PMM visits conducted, 22 (96%) included visits to all sites at which the individual lived and worked/day activity (e.g., day program, employment, public school). In the instance in which a site was not visited, the monitoring visit took place during the winter break for a school age individual. While it was obviously not feasible to visit the school at that time, the Post-Move Monitor should have completed some sort of follow-up either before or after the break. This was not evidenced in the documents provided for review. • Use of Standard Assessment Tool: Twenty-three (100%) of the PMM visits were documented in the proper format, in line with Appendix C of the Settlement Agreement. The Post-Move Monitor also gathered documentation of the completion of supports and maintained these materials in a file.	Noncompliance

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		Assessment of Presence of Supports Called for in CLDP: The Monitoring Team found in its review of the PMM process that there was one return from community placement, for Individual #242, in which adequate assessment of supports was not present and in which assertive action should have been taken, but was not. The description of this series of events below should be considered illustrative of remaining deficits in both the Facility's assessment of support in this subsection as well as its efforts to ensure supports are implemented as assessed in the subsection below. Individual #242 returned from community placement on 10/29/13, eleven days following the 45 Day PMM visit. There were significant issues identified surrounding and during this PMM visit that did not receive adequate attention and or action by the Facility. On the day before the 45 Day visit, the provider sent an email in response to the Post Move Monitor's request for documentation related to logs and reports he would want to review. In the email, the provider indicated significant behavioral issues had emerged and the individual had had medication changes made by a psychiatrist. The behavioral issues, such as constant attempts at mouthing of objects, trying constantly to get into the rooms of housemates, and "tearing up stores," were described as requiring additional staff, including having a staff person with the individual at all times, and preventing community outings for the entire home. At the 45 Day visit on 10/18/13 at 5:00 PM, the Post-Move Monitor documented staff had apprised him of physical and self-injurious behaviors and there was concern expressed by these staff that the other individuals in the house were not receiving the assistance they needed as a result. The Post-Move Monitor also had viewed an incident report dated 10/10/13 that confirmed these behaviors. Despite these written and verbal reports, the Post-Move Monitor documented the individual "seems to be content" in the new environment and "did not display any type behaviors" that would indicate discontent. The aforementioned email to the Post-Move Monitor of 10/17/12 also noted the individual had lost five pounds between the transition date of 9/6/12 and 9/27/12. During the 45 Day visit on 10/18/12, the Post Move Monitor documented that staff reported the individual was eating less than half of each meal. There was no evidence the Post Move Monitor or the Facility considered the potential seriousness of this issue, especially in context of the behavioral issues and medication changes. On 10/22/13, the APC received an email from the provider, with multiple incident reports attached, that indicated significant self-injurious, aggressive and destructive behaviors, along with sleep disturbances, irritability and weight loss. There was no documentation provided of any action taken by the Facility on that date. On 10/23/13, a call was received from the provider that the behaviors were increasing. On that same date, the IDT was convened to review the 45-Day PMM Checklist and provided with this	

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		information. The team made several recommendations, including that the BSSLC Psychologist should consult with the provider Psychologist and that other team members could be available to provide on-site consultation if needed. The Post-Move Monitor indicated to the IDT that this did not appear to be necessary. Per the Monitoring Team interview with the APC and the Post-Move Monitor, this statement to the IDT was based on an assurance they received from the provider that their staff could handle the situation. The emails from the provider and other documentation did not reflect any expression of this confidence, however. No further action by BSSLC staff was documented until the individual returned to the Facility on 10/29/13. The re-admission exams by the Facility physician and nursing staff documented the individual had lost 11 pounds, had signs of malnourishment, multiple bruises as well as an abrasion and healing scars that were most likely secondary to self-injurious behaviors. The Facility did implement a Corrective Action Plan as a result of this event, which the Monitoring Team commended as far as it went. The CAP focused on strategies for ensuring that providers notify the Facility of issues and concerns on a timely basis. The APC also reported that, while it was not part of the CAP, the Facility would be calling immediate IDT meetings when the Post-Move Monitor identified problems related to transitions. Again, this was an appropriate response. Overall, however, it was not clear from the sequence of events documented that the Post-Move Monitor or the Facility adequately identified or assessed the severity of the situation, such that action would be triggered. There appeared to have been several steps along the way in which the alarm bells should have sounded and been addressed, regardless of a provider's verbal assurances. The Monitoring Team recommends that additional training be provided to the Post-Move Monitor in terms of making such assessments. Given that a Program Auditor accompanies the Post-Move Monitor on these visits, it may be prudent to include that staff person in the training as well. In most other cases, there was improvement noted. The PMM Checklists for six of ten individuals (60%) indicated that post move monitoring appeared to have been conducted in a thorough manner. The PMM Checklists reviewed appeared to include a verification that each support was in place and being implemented. If there were supports that were not in place as required, the Post-Move Monitor often took actions and maintained a record of emails and phone logs that documented follow-up and loop closure. There were some instances in which the documentation did not clearly indicate the Post-Move Monitor obtained sufficient information or verification. For example: • For Individual #242, during the 7 Day visit, the Post-Move Monitor documented precautions related to a providing a safe environment that would protect the individual related to PICA behaviors at the home, but not at the day program.	

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		This was of particular concern because the HCS case manager did note potential risks in this regard at the day program the day following the 7–day visit, indicating a lack of knowledge on the part of the day program staff about this critical support and/or the procedures for implementation. • For Individuals #246 and #547, the Post Move Monitor did not document staff interviews regarding safe dining needs at the day program. <u>Facility's Efforts to Ensure Supports are Implemented:</u> Overall, there was improvement noted in this area. As described above, however, the Monitoring Team found the Facility failed to take assertive action on a continuing basis to ensure supports were implemented for Individual #242. This was the most concerning example, particularly given the negative outcomes for the individual. Another example in which the Facility should have completed additional or timelier follow-up was for Individual #20, a school-aged individual. The 90-Day PMM visit took place during the winter break, such that the Post-Move Monitor was not able to check supports being provided there. There was no evidence provided that the Post-Move Monitor had completed any follow-up with the school since the 45-Day visit or after the 90-Day to ensure supports were implemented as needed. <u>ISPA meetings after each PMM visit</u>: The Facility's Policy T.2: Most Integrated Setting Practices Discharges/Transfers addressed special concerns that arise after the move, but did not specifically address IDT review after each PMM visit or the expectations for such a review, including required timeframes. The Facility should review the policy to clarify expectations about IDT responsibilities to review outcomes of PMM visits. <u>Conclusion:</u> This provision was found to be not in compliance. The Monitoring Team again commends the Facility for its efforts to implement the PMM process in a rigorous manner; however, continuing deficits remain as described above.	
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	<u>Observation of Post-Move Monitoring Visit:</u> this provision was not rated as any PMM visits occurred during the site visit.	Not Rated

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	accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.		
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the 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;	<u>Number and Categories of Alternate Discharges:</u> The Facility reported four alternate discharges had occurred since the last on-site review, all of which involved a transition to another SSLC. <u>Compliance with CMS-required Discharge Planning Procedures:</u> At the time of the discharge, the Facility is required to develop a final summary of the individual's developmental, behavioral, social, health and nutritional status. Based on a review of the discharge summaries completed: • Four of four (100%) contained the categories consistent with the Centers for Medicare and Medicaid Services (CMS) requirements. Each included a summary of the individual's developmental, behavioral, social, health, and nutritional statuses. • Four of four (100%) summaries appeared to "accurately describe the individual, including his/her strengths, needs, required services, social relationships and preferences" as required by the CMS guidelines [42 Code of Federal Regulations (CFR) §483.440(b)(5)(i), and W203]. In addition, the discharge plans did appear to meet the CMS requirement [42 CFR §483.440(b)(5)(ii), and W205] to provide a discharge plan "sufficient to allow the	Substantial Compliance

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	(d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement." Each of the requirements of the CMS-required discharge planning process and an assessment of the Facility's compliance is discussed below: • If an individual is either transferred or discharged, the Facility has documentation in the individual's record that the individual was transferred or discharged for good cause. Based on the information provided, in four of four records reviewed (100%), good cause was identified in the discharge summaries. In each case, the individual's family/LAR had requested the transfer in order to have the individual living in closer proximity. • The Facility provided a reasonable time to prepare the individual and his or her parents or guardian for the transfer or discharge (except in emergencies.) Based on the information provided, for four of four individuals (100%), reasonable time was given to prepare. While the summaries did not document the precise timeframes, they adequately documented that families and individuals were involved in the process and had sufficient time to make visits to prospective facilities in order to familiarize themselves with the options. • The Facility provides a post-discharge plan of care that will assist the individual to adjust to the new living environment. The Facility tended not to use the Referrals and/or Necessary Services Required in New Environment section to capture most of this information, but rather incorporated it throughout the Summary of Individual's Developmental, Behavioral, Social, Health and Nutritional Status section. The Referrals and/or Necessary Services Required in New Environment section was used primarily to address other issues such as dental needs. Overall, the IDTs for four of the four individuals (100%) appeared to have adequately described the key supports that the individual would need in the new setting. <u>Conclusion:</u> This provision was found to be in substantial compliance.	

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

1. Further develop a set of outcome indicators that would be likely to lead to substantial compliance based on the Facility's own experiences and needs as well as on the findings and recommendations in the Monitoring Team's report. This should include the identification of the data needed to measure these indicators. (Self-Assessment)
2. Define the provision-specific outcomes that will be achieved as a result of each Action Step as well as how they will be measured. (Self-Assessment)
3. Develop a process to collect data regarding the development and implementation of ISP Action Plans for community awareness and education in order to ensure these receive sufficient priority by IDTs. (Provision T1b2)
4. 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)

5. DADS and the Facility should consider providing a succinct narrative summary at the beginning of the CLDP to make it more user- friendly and effective for provider staff. (Provision T1c)
6. 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. (Provision T1c)
7. The format the State provides Facilities for their Facility-specific obstacle reports should include data for the list of obstacles to referral for all individuals at the Facility, as well as the subgroup of individuals who have expressed an interest in transition, but their guardians are reluctant to consider it. (Section T1g)
8. The State should define the process Facilities use to collect data on obstacles to transition. (Section T1g)
9. The Facility should expand the analysis of the data included in its Facility-specific report, include specific action plans to address the findings from the analysis, and whenever issues identified are outside of the scope of the Facility to correct, the Facility should include recommendations for DADS' intervention. (Section T1g)
10. The State should conduct and include in the report an analysis on a systemic level of the data the Facilities provide, and provide a description of the specific steps, if any, the State had or planned to take "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…" (Section T1g)
11. In the obstacles report, the State 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). (Section T1g)
12. Provide additional training to the Post-Move Monitor and Program Auditor in assessing the implementation of supports and the overall status of individuals post-move. (Provision T2a)
13. The Facility should revise Policy T.2: Most Integrated Setting Practices Discharges/Transfers to clarify expectations about IDT review after each PMM visit. (Provision T2a)

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Brenham State Supported Living Center (BSSLC) Self-assessment 3/21/2013 2. BSSLC Action Plans 3/11/2013 3. Initiatives/Activities Update since Last Compliance Round, Presentation for April 2013 for Settlement Agreement Monitoring Team Visit 4. DADS Policy 019: Guardianship, effective 3/7/2012 5. DADS Policy 057: Self-Advocacy, effective 5/30/12 6. BSSLC Draft Policy: Client Services-Guardianship, un-numbered, dated 12/4/12 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 April 8, 2013 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 5/07/10 11. Rights Assessment, Form 6614, dated September 2011 12. Annual ISPs and Completed Rights Assessments for Individuals #30, #115, #217, #283, #353, #379, #449, #486 and #492 13. Guardianship Committee minutes, August 2012-February 2013 14. Self-Advocacy Minutes, July 2012-February 2013 **People Interviewed:** 1. Cheryl Powell, Human Rights Officer (HRO) 2. Linda Lothringer, DADSs Settlement Agreement Coordinator 3. Natalie Montalvo, Facility Director **Meeting Attended/Observations:** 1. ISP annual planning meetings for Individuals #286 and #599 2. Human Rights Committee (Review of Annual Rights Assessments) for Individuals #93, #94, #474 and #527
	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 previous reports of the Monitoring Team, it has been recommended the Facility 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. The current Self-Assessment indicated that such a system was still in draft, with no data to review; therefore, this recommendation is continued. The Facility's self-rating indicated it was not in compliance with Provisions U1 and U2 due to the lack of a tool to assist teams to determine an individual's capacities to provide informed consent. Action Plans for Section U were minimally detailed. The single Action Plan for Provision U1 was to

	"Continue current activities." For Provision U2, the two Action Steps were "Revise Local Policies" and "Continue current activities to obtain advocates and guardians." The definition of desired outcomes and performance measures as recommended above should assist the Facility to develop more meaningful and focused Action Plans in the future.
	Summary of Monitor's Assessment: This Section was not yet in compliance. A summary of noted progress included the implementation of a Guardianship Committee, as required by DADS policy. The Facility continued to provide support for self-advocacy for both children and adults and made use of formal choice-making materials as a part of these activities. The Facility also continued to develop its commendable capacity to provide advocates for individuals as an alternative to guardianship, with some 34 individuals currently having an advocate assigned. Specific findings for each provision are as follows: **Provision U1:** This provision was found to be not yet in compliance. There was no statewide or local policy that addressed either a 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, nor was there any evidence that IDTs were yet making any concerted effort to address capacity for decision-making or strategies to enhance these capacities. It was reported DADS hoped to promulgate an assessment process in the near future. The Facility did maintain a prioritized list of individuals lacking an LAR, which was updated on an ongoing basis based on referrals from the IDTs. Not all individuals without guardians had yet been assigned a priority level. **Provision U2:** This provision was found to be not in compliance. It was reported no guardians had been obtained during the past six months, but 34 individuals did have advocates assigned through a robust Advocacy program, including five advocates newly assigned since August 2012. The Facility had initiated its Guardianship Committee, as called for in the DADS Policy, although it continued to work towards having consistent membership. The Facility continued to need to ensure it has an appropriate methodology in place to determine the actual need for guardianship.

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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	<u>Policies And Procedures Related To Functional Capacity To Give Consent And/Nor Need For LAR:</u> No new DADS policies had been issued related to this provision. DADS Policy 019: Guardianship, effective 3/7/2012, addressed the development and maintenance of a prioritized guardianship list as required. The Monitoring Team has expressed concern in previous reports that the 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's IDTs	Noncompliance

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	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.	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 needed to be provided as to how, and how often, a need for guardianship should be periodically reviewed. The HRO reported that a statewide policy was pending on this topic in the near future. She anticipated the policy would prescribe the tools and or processes to be used by IDTs to assess decisional capacity. DADS Settlement Agreement Coordinator made inquiries about the status of a standardized capacity tool and/or process during the site visit. She reported DADS did hope to issue guidance in the near future, possibly based on procedures being tested at another SSLC and using an expanded Rights Assessment document (Form 6614). Maintenance of Prioritized List: The Facility maintained a list of forty-four individuals who did not have current guardians, organized by area of residence. This list was entitled Prioritized List and included certain other information regarding rights restrictions for each individual. The Monitoring Team reviewed the Prioritized List for timeliness of updates to the list and the prioritization process: • Timeliness of Updating Process: The SA requires the prioritized list to be updated semiannually. The HRO reported the list was updated each Monday. The Monitoring Team reviewed a list dated April 8, 2013, which included prioritization decisions made up until the March 22, 2013 Guardianship Committee meeting. • Prioritization Criteria: The Facility stated it continued to use the same prioritization criteria as previously reported. The list provided indicated the priority level for some, but not all, individuals was assigned. A review of the list provided for review indicated 24 of the 44 (55%) individuals were not yet assigned a priority. The HRO indicated this was an evolving process as IDTs made referrals. Assessment of Functional Capacity to Render a Decision: The Facility did not yet routinely use standardized or valid instruments and/or processes to assess functional capacity, so the decision to place someone on the prioritized list continued to be 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 5/07/10, but this process was not predicated on any objective criteria. While the Facility indicated it did not have a standardized tool to use in this process, it also noted it relied to some extent on the Functional Skills Assessment (FSA) to provide some rationale for IDT decisions in	

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		the area of capacity to provide informed consent. There was no clear process for how the FSA was to be used. The Monitoring Team reviewed the ISPs, including the Rights Assessments and FSAs, for a sample of individuals from four focus IDTs that had been identified by the Facility as those with the most experience in the new ISP process. For none of the nine reviewed (0%), did the IDT conclude the individual was able to give, or participate in giving, 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 one of nine (11%) instances the IDT made some attempt to provide a rationale for the determinations, but this was not based on any valid formal assessment process. In none of the nine Rights Assessments (0%) did the IDT document any strategies to improve the individuals' skills or abilities to participate in decision-making. This finding was borne out in observations made by the Monitoring Team of the ISP meetings held during the site visit. For zero of two individuals (0%) did the IDT undertake any discussion regarding decision-making capacity or strategies to enhance participation in decision-making as they pertained to the ability to provide informed consent. The Monitoring Team also observed the review of the Rights Assessments for four individuals at a meeting of the facility's Human Rights Committee (HRC) and found for none of the four (0%) did the HRC members address the informed consent restrictions in a substantive manner. The HRC should address the informed consent restrictions in the same manner as other restrictions, including requiring rationale for any restrictions and the plans to reduce the need for them. <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. In order to achieve compliance, DADS and the Facility will need to prescribe an assessment process and/or tool rooted in evidence-based principles of decisional capacity and, further ensure the IDTs receive sufficient training and oversight to ensure they implement the process thoughtfully and carefully.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the	<u>Policies And Procedures Related To Obtaining Lars For Individuals In Need:</u> DADS Policy 019: Guardianship, effective 3/7/2012, provided guidance and protocol as to obtaining LARs for individuals who may need one. The Facility reported there had been no changes to the statewide policy. BSSLC had drafted a localized version of DADS Policy 019, dated 12/4/12, which was not yet considered final pending statewide	Noncompliance

#	Provision	Assessment of Status	Compliance
	Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	revisions related to the functional capacity assessment. DADS had also issued Policy 057: Self-Advocacy, effective 05/30/12. A local policy was also in draft. Facility Efforts to Obtain LARs: The Facility reported no new LARs had been obtained during past six months for individuals living at BSSLC, but the Guardianship Committee minutes indicated five individuals had been assigned advocates to assist with decision-making as described below. Guardianship Committee: The HRO served as the BSSLC Guardianship Coordinator as required by the statewide policy. The Facility had established a Guardianship Committee. The first monthly meeting was held in August 2012. Membership appeared to be relatively consistent with both statewide and local policy requirements, but the HRO reported sustaining that membership continued to be a challenge. The minutes reflected little to no participation by a community member unrelated to an individual living at BSSLC or by the designated representative of individuals living at the Facility. 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. In addition, the Facility was to make monthly progress notes regarding the status of individuals referred to the Guardianship Committee. These data were reflected in the ongoing minutes, providing follow-up information from one meeting to the next through resolution. The Monitoring Team attended the Committee meeting held during this compliance visit. The membership was well represented, including the representative of individuals living at BSSLC, with good participation. State Policy also calls for the Guardianship Coordinator to organize 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 HRO reported this had not yet been implemented. Advocacy Program: BSSLC continued to have an active Advocacy Program as described in the previous report, although the statewide policy had not yet been issued. This appeared to be a thriving program. Of the 44 individuals living at BSSLC without a current guardian, 34 had been provided with an assigned Advocate. Advocates were matched with individuals through the Guardianship Committee in what appeared to be a thoughtful process as	

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		reflected in the meeting minutes and the observation of a committee meeting during the on-site visit. For example, the Monitoring Team noted the committee took a creative approach for certain individuals who had an LAR who was not able to routinely visit or participate in ISP meetings by matching them with a co-advocate who could assist the LAR. This process was reported to have been very successful in its early implementation. While advocates did not have authority to provide consent in those situations that required a written authorization, the Facility Director reported she routinely consulted assigned advocates in those circumstances before signing the consent forms. Recruitment and training of advocates continued to be completed by the Volunteer Services Department. The HRO indicated the Facility was considering organizing an Advocates Association in order to provide ongoing support and information to them as a group. Self-Advocacy Program: As required by Policy 057, the HRO was responsible for providing support for the Self-Advocacy Committee. The Monitoring Team reviewed the minutes of Self-Advocacy meetings held since the last monitoring visit and attended the Adult Self-Advocacy meeting held during the site visit. The Facility also provided a separate Self-Advocacy group for the children residing at BSSLC, which remained active. The Monitoring Team reviewed the minutes of the Self-Advocacy meetings for both children and adults and noted the Facility continued 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 minutes did not provide sufficient detail, however, to reflect how the officers were involved in and supported in their specific roles, as described in policy, on an ongoing basis. At the meeting observed during the visit, the president of the group was assisted to lead part of the meeting. Individuals were encouraged to respond to questions and to participate actively. The Monitoring Team would also encourage DADS and the Facility to consider how to implement a broader vision of self-advocacy that may be incorporated into the everyday lives and program of active treatment for of individuals. For example, regular self-governance meetings could be implemented at all homes, structured to meet the developmental needs of the individuals living there. Classes might be offered to teach individuals meeting participation and leadership skills, which could also be designed to support meaningful involvement in ISP meetings. Statewide policy requires the Self-Advocacy Coordinator to conduct an annual self-advocacy in-service for residents of the State Center, their LARs/family members, and State Center staff, with the involvement of the Self Advocacy Group. When implemented, this would be an opportunity to disseminate such a broader vision.	

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		Conclusion: This Provision was found to be not yet in compliance. The Facility continued to make progress in its efforts to obtain appropriate decision-making assistance for individuals, but did not have an appropriate methodology in place to determine the actual need for guardianship as the foundation for seeking such assistance, as described in Provision U1 above. 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. Determine outcome and/or performance measures to assess progress for self-assessment (Facility Self-Assessment)
2. Implement an assessment process and/or tool for determining the ability to provide informed consent rooted in evidence-based principles of decisional capacity and provide IDTs with sufficient training and oversight to ensure they implement the process thoughtfully and carefully. (Provision U1)
3. The Facility HRC should address the review of informed consent restrictions in the same manner as other restrictions, including requiring rationale for any restrictions and the plans to reduce the need for them. (Provision U1)
4. Develop plans for implementation of the annual Self-Advocacy and Guardianship in-services as required in state policies. (Provision U2)

The following are offered as additional suggestions to the Facility:

1. DADS and the Facility should consider how to implement a broader vision of self-advocacy that may be incorporated into the everyday lives and program of active treatment for of individuals. For example, regular self-governance meetings could be implemented at all homes, structured to meet the developmental needs of the individuals living there. Classes might be offered to teach individuals meeting participation and leadership skills, which could also be designed to support meaningful involvement in ISP meetings.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. BSSLC Self-Assessment 3/21/13 2. BSSLC Action Plan 3/11/13 3. BSSLC Presentation Book for Section V 4. DADS Policy 020.1 Recordkeeping Practices 3/05/10 5. BSSLC Policy V.1 General Records Keeping Practices 12/17/12 6. BSSLC Policy V.2 Filing and Thinning of the Unified Record 12/17/12 7. BSSLC Policy V.3 Monitoring of the Unified Records 12/17/12 8. BSSLC Policy A.1 Policy & Procedures Guidelines 2/1/12 9. DADS Policy 001.1 Use of Restraint 4/10/12 and related training materials 10. BSSLC Policy C.1 Restraint 12/31/12 11. DADS Policy 021.2 – Protection From Harm – Abuse, Neglect, and Exploitation 12/4/12 12. DADS Policy 02.4 Incident Management 11/20/12 13. DADS State Supported Living Center Procedure: Injury Audits (undated) 14. Draft BSSLC Policy D.1 Protection from Harm-Abuse, Neglect, and Exploitation 12/4/12 15. Draft BSSLC Policy DD.1 Incident Management 11/20/12 16. BSSLC Policy D.2: Maintaining and Providing ANE Resource Guide 1/25/12 17. BSSLC Policy D.3: Participating in and Completing Incident Management UIR Committee 1/25/12 18. DADS Policy 003.1 Quality Assurance 1/26/12 19. DADS SSLC Nursing Quality Assurance Audit Process 3/21/13 20. BSSLC Policy E.1 Quality Assurance Process 1/1/13 21. BSSLC Policy E.2 Quality Assurance/Quality Improvement Council – scheduled for implementation 4/21/13 22. BSSLC Policy E.3 – Developing, Implementing, & Tracking Corrective Action Plans 5/24/12 23. BSSLC Policy T.2: Most Integrated Setting Practices Discharges/Transfers, Revision 12/4/12, Implemented 3/27/2013 24. List of all new and revised State and Facility policies implemented since the last compliance visit 25. Training curriculum relevant to the Unified Record, including: a. Observing and Reporting in MH and MR Facilities 7/18/03 and Training Guidelines rev 10/21/2005 b. OBS0100 Observing and Reporting 6/18/03 26. QA Internal Audit Tool Guidelines & Settlement Agreement Section V Monitoring Tool Guidelines, November 2012 27. Section V: Recordkeeping and General Plan Implementation Guidelines (April 2011) 28. Individual Notebook Record Order and Guidelines for Filing and Thinning (Revised 10/28/10) 29. Active Record Order & Maintenance Guidelines (rev. 10/28/10) 30. Active Record Audit forms for Individual Notebook V6.1, Chart I V6.2, and Chart II V6.2 11/17/11 31. Internal Audit notes (undated)

	32. Interobserver agreement database for February and March 2013 33. Unified Record for Individuals #140, #170, #370, #425, #468, and #496 34. Audits of Active Records and Individual Notebooks from February and March 2013 35. Database of corrective actions required from audit of Individual Notebook and Active Record for Individual #370 36. Section V Quarterly Reports for 11/1/2012-1/31/2013 37. Assessment Filing—tables and graphs of assessments filed later than 10 working days prior to annual ISP meeting each month in January, February, and March 2013 38. Problematic Tracking System for Interview Tool rev. 5/16/12 with responses for Individuals #76, #114, #481, and #532 39. Table: Observations of Compliance Using the Active Record at Monthly Meetings (undated) completed for February and March 2013, and Observation Notes for each meeting 40. BSSLC Master Table of Contents of Policy and Procedure (undated) 41. Policy-Procedure Review Committee Meeting Minutes 4/10/13 42. Policy and Procedure Checklist **People Interviewed:** 1. Unified Records Coordinators (URCs) Deborah Borah and Joyce Carnagey, Olivia Najera CARE/CWS, and Daniel Dickson, Director of Quality Assurance (QA) regarding records 2. Daniel Dickson, regarding policy development and implementation 3. QDDP Coordinator Pam Boehnemann and QDDPs Shanitra Dennis, Phil Carnegey, and Tamara Fitzhugh **Meeting Attended/Observations:** 1. ISP Annual Planning Meeting for Individual #599 2. ISP Preparation Meeting for Individual #191 3. QA/QI Council 4/10/13 4. Cottage C and F, Childress B, C, and D, and Fannin A homes 5. Policy Committee 4/10/13
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section V. In its Self-Assessment, for each provision, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating. In conducting its self-assessment, the Facility used auditing tools to assess compliance with Provisions V1, V3, and V4. These included the Active Record audits and Individual Notebook audits, and, for a smaller sample, the Section V monitoring tool, as well as the V4 Interview Tool. These monitoring tools included adequate indicators to assess and report compliance with Appendix D requirements for the Active Record and Individual Notebook as well as to check presence of the other required components of the Unified Record (which was not reported in the Self-Assessment). The Facility reported sample sizes for these audits, which met requirements of Provision V3 and provided a representative sample. The Facility did have written guidelines for the monitoring tools. The audits were completed by Unified Records Coordinators who were experienced in carrying them out.

	The Facility also provided other relevant data, including results of spot checks for corrective actions, data from V4 Meeting Observations Tracking (although it was unclear how compliance percentage data were determined), and percent of facility procedures current and updated per local requirements. Data were provided in a clear and meaningful manner. The Facility assessed all provisions as not in compliance, which is consistent with the findings of the Monitoring Team. Nevertheless, the data assessed provide a good basis for identifying areas of systemic improvement needed. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. Actions were specific and appeared appropriate to move the Facility toward compliance. It would be useful for the Facility to identify actions to complete needed policy development and revision and to ensure implementation of policies, as well as to expand the tracking system for utilization of records to consider activities the Facility currently has put into place in addition to the interview tool.
	Summary of Monitor's Assessment: Progress continued in all provisions of the Section. Records were generally in order, a robust audit system was in place, and there was evidence that records were being used in making decisions. However, records still were not consistently accurate and complete, the corrective action process for addressing issues identified in the audit had not yet limited recurrence of similar errors, and records were not always referred to when making decisions. To achieve substantial compliance regarding Provisions V1, V3, and V4, the Facility must ensure additional improvement in filing documents in the record timely, in complying with the requirements of Appendix D, and in using information from the record, including data, to make decisions. These should all be achievable in a short time, but this will require that areas for systemic improvements be identified and acted on. Regarding Provision V2, policies continued to be developed and revised, both for recordkeeping and for other requirements of the Settlement Agreement. It will also be important to ensure training on policies is done as needed. Finally, it would be wise to develop some process to assess whether policies are being implemented accurately.

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V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the	<u>Policies Governing Recordkeeping</u> Recordkeeping was governed by BSSLC policies V.1 General Record Keeping Practices and V.2 Filing and Thinning of the Unified Record. In addition, policy V.3 Monitoring of the Unified Record provided the requirements and general procedures for auditing records. These policies had been revised since the last compliance visit. The policies were comprehensive and localized to the Facility, with clear statements of responsibility	Noncompliance

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	guidelines in Appendix D.	for various aspects of recordkeeping. The policies were generally consistent with DADS policy, but variations existed. For example, the Facility had developed, and policy described, an Inactive Record for documents that had been thinned and would be retained at Central Records for two years that contained aspects of both the Master Record and Overflow Folder defined in DADS Policy 020.1. The variations were operational in nature and substantially complied with DADS policy. <u>The Facility Maintains a Unified Record</u> 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 had developed 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; this table of contents mirrors the active record and uses the same tabs, which should improve ease of finding records when needed. When documents are purged from the Active Record, they are to be sent to Central Records to be placed 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. The Central Records staff reported that the inactive records for six individuals had been converted to the new table of contents. In addition, assessments and some other information were copied to a shared drive that was not considered part of the unified record but allowed information to be easily accessible to members of the PST. The Individual Notebook accompanies the individual wherever the person goes for supports and services provided by the Facility. Six of six records reviewed (100%) included an Active Record, Individual Notebook or equivalent, Inactive Record, and Master Record. 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 had been revised; replacement in the binders was planned to occur shortly after the compliance visit. <u>Staffing</u> The Facility had staff assigned to oversee the Unified Record. These staff included two URCs and a coordinator for CARE/CWS; these staff report to the Director of Quality Assurance. <u>Training of Staff on Documentation</u> The Facility provided training through new employee orientation to staff who document	

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		in the Unified Record. The Facility provided the curriculum and training guides used. Review of those curricula indicated the training covered all requirements of Appendix D and included exercises that provided opportunities to practice observation and recording. The materials did not include competency tests. However, the Facility reported that required job-specific on the job training included: • Employee writes a progress/observation note according to "SCOTT" Reporting Criteria and Guidelines for Written Records and supervisor checks for competency using Reported Criteria and Guidelines for Written Records Checklist and gives feedback(.) • Employee locates consumer charts and reviews notes as part of determining baseline behaviors(.) • Employee locates consumer reporting forms(.) In response to a request for a list of training on issues relevant to records provided since the last compliance visit to staff responsible for oversight of the Unified Record, the Facility responded that this was not available. It is important for these staff to receive regular updates and refresher training on issues relevant to recordkeeping. <u>Accuracy, Completeness, and Timeliness of Records</u> 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 #170, #425, and #468. Individual #468 was selected by computer randomization out of the admissions since the last compliance visit. Individual #425 was selected by computer randomization from among the individuals the Facility had selected randomly for audit in April. The Monitoring Team did not use selection criteria for Individual #170. For all three individuals, the Monitoring Team determined the Active Record, Individual Notebook, Master Record, and Inactive Record were all available and in good condition. The Monitoring Team used the Facility's Active Record Audit checklist to record whether documents in the Active Record and Individual Notebook were current and in order; this form, which the Facility used for record audits, had a list of documents and, for each, places to mark whether the document was current and whether it was in order. Each could be marked Yes, No, or N/A. The Monitoring Team used the Section V monitoring tool (titled Settlement Agreement Cross Referenced with ICF-MR Standards, Section V) to rate whether the requirements of Appendix D were met. The Monitoring Team referred to the guidelines provided by the Facility for the Individual Notebook and Active Record and the guidelines for the monitoring tool. Review of Active Records showed the percent of required documents present and	

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		current was 91% for Individual #170, 78% for Individual #425, and 56% for Individual #468. Review of Individual Notebooks found percent of records present and current was 95% for Individual #170, 81% for Individual #425, and 50% for Individual #468. Improvement is needed in order to ensure records are consistently available for decision-making. Data from Facility random audits for November 2012 through January 2013 indicated compliance with at least 80% of audited items on the internal audits of the Individual Notebook and Active Records each month. The range of data on compliance was consistent with the range found by the Monitoring Team. Reviews of records for the visit as a whole did not identify significant issues related to missing documents. Some issues were found, including: • As reported in Provision M3, occasionally, the entries on the Integrated Progress Notes (IPNs) did not include the time they were documented. • Review of nursing documentation found problems with illegibility of the individuals' names and demographic information printed on the records by the use of an addressograph card/machine. Documentation errors were not consistently corrected according to standards of practice. Two of three records (67%) were substantially consistent with the requirements of Appendix D; 95% of Appendix D items checked by the Monitoring Team were compliant for Individual #170, 78% for Individual #425, and 67% for Individual #468. One item was found not to be compliant in all records and reflected a need for the Facility to revise the record; there was no initial legend for Skill Acquisition Program/Specific Program Objective data sheets, but initials were used in documentation for many of these. For Individual #468, the number of missing documents would have made it difficult to use the records effectively in making decisions on treatments and interventions. Nevertheless, these findings show improvement in meeting the requirements of Appendix D. For example, corrections of errors were done correctly, there were only a few gaps in documents (mostly lines at bottoms of pages), and the notes were legible. The Master Record was reviewed for each of the three individuals. In all cases, all required documents appeared to be present, and the documents were filed neatly and were easily accessible. <u>Accessibility and Security of Records</u> The Monitoring Team checked the accessibility and security of records for Individuals #140, #170, #470, #425, #468, and #496. Individual Notebooks or equivalent were available for each individual so staff could get information and could record data. For	

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		four of these individuals, staff were asked to provide the Individual Notebook; four of four staff (100%) were able to find it immediately. The Monitoring Team did not observe any Individual Notebooks visible to people who did not need them. The Monitoring Team checked the accessibility and security of the Active Records. These charts were kept on a rack in an area accessible only to staff. The records were all present (except for one that was appropriately checked out). However, the Active Record for Individual #460 was unavailable when requested for review regarding documentation of restraint, as reported in Provision C4. The Facility reported it could not locate the chart and provided no information by the end of the review. The Facility had an effective process for checkout/check-in of Active Records. Five of six (83%) active records for individuals were present in the residence. For the one record not present, one (100%) was signed out. 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. <u>Use of Share Drive</u> The Facility had a process and consistent format for filing and accessing specified documents in a Share Drive. 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 an interview, QDDPs were able to access assessments due for an upcoming annual ISP meeting. However, the process to access the assessments was cumbersome, requiring several steps to navigate to each specific assessment. <u>Conclusion</u> Although, as reported below in Provision V3, the Facility had a robust audit system, this had not resulted in improvement in presence of current documents adequate to reach compliance with this provision. Nevertheless, improvement in meeting requirements of Appendix D, along with records being generally accessible and secure, is promising.	
V2	Except as otherwise specified in this Agreement, commencing within six	<u>Facility Process to Develop and Revise Policies</u> A Facility process existed and was followed to develop and revise policies, protocols, and	Noncompliance

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	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.	procedures; this process required periodic review and revision as needed. BSSLC Policy A.1 Policy & Procedures Guidelines governed the process. 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 policy manual had been 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. Not all policies had yet migrated to the new table of contents. The table of contents continued to be updated as policies were revised. However, per interview with the Director of Quality Assurance, although updates were to occur after every committee meeting approving a new or revised policy, this did not always occur. The Policy and Procedure Checklist did include updating the Table of Contents as a step. The Policy and Procedure Checklist identified a policy and included a standard set of actions to be taken when a policy is developed or revised. It also included a place to add other actions needed for a specific policy. This checklist could be valuable in ensuring all needed actions are taken. The Monitoring Team did not review checklists for recently developed or revised policies but did note above that the Table of Contents was not consistently updated as required by the checklist. <u>Training on Policies</u> The Monitoring Team continues to note that the responsibility for training staff was assigned to department heads and suggests that a centralized process be developed to determine training needed on policies and to track training to ensure all relevant staff receive consistent training. Although the policy did not establish such a process, documentation provided by the Facility regarding training of policies I.1, I.2, and I.3 (At-Risk Individuals), 012.3/P.1 (Physical Nutritional Management Team Referral Criteria), and N.12 (Medication Variances) demonstrated that training plans for some policies included identification of staff needing training and tracking of who has received training. For example, for N.12, signed Training Rosters for the months of January 2013 and February 2013 validated that 98% of the nursing staff responsible for administering medications had received training provided by the Clinical Pharmacist on the Medication Variances, N.12, Policy, according records provided. Nurses that had not received the training were noted to be on extended leave. Training on the Policy was included in the	

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		New Nurse Orientation and at the annual nursing competency-based refresher training. As observed in the Policy Committee meeting, this Committee determines training needed for a given policy, who is to develop and provide the training, categories of staff to receive training, how training will be documented and tracked, and timelines. It would be useful to include also determination of who is to certify staff have been trained (to competency, if the Committee identifies such a need) and/or to monitor to ensure accurate implementation is occurring. The Facility should consider whether to formalize this process in Policy A.1. The Facility did not have a process in place to track training identified as needed and to report status. Nevertheless, for the policies noted in the paragraph above, the Facility provided training rosters with participant signatures; for the At-Risk Individuals and PNMT Referral policies, the Facility provided a table by discipline of the percent of staff who had completed training or needed training. These documents demonstrate the Facility had, for some policies, tracked training. As noted above, the Facility should consider formalizing this process so it is implemented as needed, and so documentation of training is retained in an efficient manner. The Facility should develop a standardized system to train staff, and ensure staff have the necessary knowledge and skills to implement new or revised policies. To accomplish this, the Facility should define in policy or procedure the process that will be used to ensure this occurs. In developing such a policy, the following should be considered: • It should incorporate mechanisms already in place, such as an email/correspondence being sent to the departments impacted by the policy. • It should identify whether a process to ensure knowledge or competence needs to be established for the specific policy, whether staff in specific job categories need to document knowledge of the policy by signing off, and the list of job categories to which training should be provided. • In addition, for each policy approved, consideration should be given to defining who will be responsible for certifying that staff who need to be trained have successfully completed the training, what level of training is needed (e.g., classroom training, review of materials, competency demonstration, etc.), and what documentation will be necessary to confirm that such training has occurred. It would seem that sometimes this responsibility would be with the Competency Training Department, but often others would have responsibility. • Timeframes also would need to be determined for when training needed to be completed. It would be important to define, for example, which policy revisions need immediate training, and which could be incorporated into annual or	

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		refresher training (e.g., ISP annual refresher training). <u>Policies to Implement Part II of the Settlement Agreement Have Been Developed or Revised</u> Per interview with the Director of QA, policy revisions typically are initiated in one of two ways. One way is that each discipline reviews policies at least every six months and determine if any need revision. A second way is that when a state policy is revised developed, it is sent to QA and the discipline; these review and determine whether they need to revise local policy, and if so, set up a date. An example of the second situation was observed during the Policy Committee meeting. Although Policy P.1 regarding PNMT had already gone through the committee, it returned because DADS PNM policy included criteria for referral. The Facility policy was revised; the Policy Committee determined the training that will be needed and the process to disseminate the revision. Both DADS and the Facility had continued developing and revising policies. New and revised DADS policies included the following: • DADS Policy 021.2 – Protection From Harm – Abuse, Neglect, and Exploitation 12/4/12 • DADS Policy 02.4 Incident Management 11/20/12 • DADS State Supported Living Center Procedure: Injury Audits (undated) • DADS Policy 003.1 Quality Assurance 1/26/12 • DADS Policy 010.2 Nursing Services, Policy, Effective 9/20/12, Replaces: 010.1 • DADS SSLC Nursing Quality Assurance Audit Process 3/21/13 • DADS Policy 004.1 Individual Support Plan Process 11/20/12 • DADS Policy 006.3 At Risk Individuals 12/7/12 • DADS Policy 012.3 Physical Nutritional Management 3/4/12 Newly developed or revised BSSLC policies included: • BSSLC Policy C.1 Restraint (12/31/12) • BSSLC Policy D.2: Maintaining and Providing ANE Resource Guide 1/25/12 • BSSLC Policy D.3: Participating in and Completing Incident Management UIR Committee 1/25/12 • BSSLC Policy E.1 Quality Assurance Process 1/1/13 • BSSLC Policy E.2 Quality Assurance/Quality Improvement Council – scheduled for implementation 4/21/13 • BSSLC Policy F.1 Individual Support Plan Process 9/26/12 • BSSLC Policy H.1 Minimum Common elements of Clinical Care 10/29/12 • BSSLC Policy I.1 At-Risk Assessment Review 10/29/12 • BSSLC Policy M.1 Completing and Routing Fall Evaluation Form 11/7/12 • BSSLC Policy T.2: Most Integrated Setting Practices Discharges/Transfers,	

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		Revision 12/4/12, Implemented 3/27/2013 • BSSLC Policy V.1 General Records Keeping Practices 12/17/12 • BSSLC Policy V.2 Filing and Thinning of the Unified Record 12/17/12 • BSSLC Policy V.3 Monitoring of the Unified Records 12/17/12 • BSSLC Policy W.4 Ensuring Sufficient Staff Coverage 9/26/12 • Since the last compliance review, July 2012, the Facility had operationalized the State's Medication Variance Policy, 053, i.e., Pharmacy Services and Safe Medication Practices: Medication Variances, N.12, Implementation Date: 12/31/12. In addition, the Facility continued to develop and revise procedures. Although it would be difficult to identify all such revisions, some examples include the following procedural guidelines: • Procedural Guidelines for Botox Injections, dated 8/3/12 • Procedural Guidelines for PCP on call (no date) • Procedural Guidelines for Psychiatrist on call (no date) • Procedural Guidelines for the Morning Medical Debriefing Meeting (no date) • BSSLC State Supported Living Center Guidelines (Nursing), Revised: 8/15/12 • BSSLC Pharmacy Services and Safe Medication Practices: Medication Variance Policy, N.12, Implemented: 12/31/12. • BSSLC Nursing Care: Completing/Routing Fall Evaluation Form, Date of Implementation: 12/20/12. • BSSLC Pressure Ulcer Management Guidelines, Revised: 12/6/12 • BSSLC Algorithms developed for: Exposure involving blood, tissue, or body fluids that are potentially infectious; Abuse and Neglect Allegations; and Reported Sexual Incidents. <u>Areas in Which Efforts Are Needed</u> Although much progress had been made in development and implementation of policies needed to address requirement of the Settlement Agreement, there were still areas that needed further development. In some cases, this involved the need to develop and revise policies; in other cases, this involved the need to ensure policies were implemented accurately. • Regarding implementation of the newly revised restraint policy, four Individuals were subjected to the regular use of restraints that were determined by the Monitoring Team to be protective mechanical restraint for self-injurious behavior (PMR-SIB). The Monitoring Team reviewed records for these four (Sample C.5). Of these, none (0%) followed state policy regarding the use, management, and review of PMR-SIB. The Facility erroneously classified restraint of these four Individuals as medical restraint. Consequently, in	

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		documenting these restraints they applied incorrect provisions of the State policy on restraint and used incorrect State required forms in doing so. • As reported in Provision L1, the Monitoring Team discussed the Facility's policies, procedures, and guidelines, with the medical director, who informed the Monitoring Team that the State Central Office was developing a new policy for health care; however, at the time of this review, the draft policy was still being developed. Subsequently, the Facility has discontinued work on its previous policy, entitled Physician Procedures, and Best Practice Guidelines, and will incorporate the State Policy into a comprehensive local policy for health care, once the State Policy has been completed, and approved for implementation. • The Facility did not maintain specific policies, procedures or guidelines to govern dental services. The policy for dental services was a general overview of clinical practice, but did not enable clear guidance of the many important clinical, and dental administrative process for dental services. • The Facility reported that it had made no changes to transition and discharge policies. DADS and BSSLC had not yet finalized an adequate policy related to transition and discharge processes. There was a pending revision of DADS Policy 018, particularly related to the requirements for the CLDP and PMM, which is expected to also require modifications to local policies. • There were facility policies that adequately supported most of the requirements of State policy for quality assurance. The Facility had revised its Quality Assurance Process policy (1/1/13) and its Quality Assurance/Quality Improvement Council policy (scheduled for implementation 4/21/13) to reflect current expectations and requirements of both the Settlement Agreement and the new State QA policy which was issued in January. The Facility also updated its QA Plan (8/25/12). The QA Plan contained many of the written procedures and administrative requirements necessary to implement the QA policies. One key exception was the lack of reference in any of these documents addressing the requirement of the development of outcome measures and process indicators/measures (key indicators for evaluation). The Facility needs to review its QA policies to ensure each and every State requirement is included. DADS and the Facility need to continue to develop and revise policies to ensure all that are needed to implement Part II of the Settlement Agreement are in place and are being implemented accurately.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three	<u>Audit Policy and Process</u> The Facility had a process in place to audit records, in which the URCs were each assigned to audit six records per month selected through computer randomization; a	Noncompliance

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	years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	random list was generated of three individuals from each of the four living units. The Facility had recently implemented a rule that no individual will be audited twice within a six-month period; the computer randomization process does not pull those individuals. The URCs audit the Individual Notebook and each chart of the Active Record. For each of the audited records, the URCs used the Active Record Audit tool that identifies whether current documents are in the record and whether they are filed in the correct order and location. 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 current ("Yes"), absent/not current ("No"), or not required for this individual ("N/A"). There was a column with the same headings to check whether the document was in order. There was also a column for comments, where the URCs could state the reason a "No" was checked or make other comments such as a need to thin/purge outdated documents. The Facility had revised the form to gray out the cells for N/A for documents that required a "Yes" or "No" response, "Yes" or "No" for documents that were no longer applicable (or were no longer to be included in the Active Record) for all individuals, and "No" for two documents that were either present or considered "N/A." Graying out these cells has the potential to improve interobserver agreement as it clarifies which documents may or may not be N/A and eliminates other cells that should not be used. However, some of the selections seemed odd. • The Reiss Screen could only be marked N/A. The Monitoring Team was informed this document would no longer be part of the Active Record. It seems that this document could be important for decision-making about the need for comprehensive psychiatric assessment and may be used when there is a possible change in mental health status, so it is unclear why it would not be included in the Active Record. • Suicide Risk Assessment could only be marked N/A. Although this is not applicable to most individuals, it could be crucial in some cases. There was no indication that this had been replaced by documentation in a different place, although that is certainly a possibility. In addition to these audits for current and in-order documents, the URCs select four records to use the Settlement Agreement Cross-referenced with ICF/MR Standards (the Section V monitoring tool). The Facility had developed guidelines for scoring both the internal audit and the Section V monitoring tool. At least five randomly selected records were audited each month since the last	

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		compliance visit. Prior to the compliance visit, the Monitoring Team requested the last 10 audits conducted. The Facility provided the completed audit forms for 12 audits conducted in February 2013. During the compliance visit, the Facility provided the completed audit forms for 12 audits conducted in March 2013 and a schedule of 12 visits assigned by computer for April 2013. In addition, the quarterly report for Section V listed 10 audits for November 2012 and 12 audits each for December 2012 and January 2013. Completed audit forms covered the Active Record and the Individual Notebook. According to the URCs, there are no other components of the Unified Record other than the Master Record and Inactive Record. <u>Interobserver Agreement/Interrater Reliability</u> The Facility had a process for evaluating interobserver agreement on audit findings for each audited component of the Unified Record. From the six audits assigned to each URC, one individual was selected for audit using the Interview tool and as an inter-rater audit between the URCs; thus, interobserver agreement was assessed for 17% of audits. Per interview with the URCs, interobserver agreement audits were done independently on the same day with no discussion. Discussion from findings of interobserver agreement checks had led to revisions in written guidelines and to the graying-out of cells that should not be marked, as described below and in Provision V1. To improve consistency of auditing and interobserver agreement, the Active Record Audit tool had grayed out cells for ratings that should not be made. For example, documents that were required for all records had the cells for N/A grayed out. This was an excellent idea. However, some of the grayed cells seemed odd or inappropriate. For example, the rating of No was grayed out for Pharmacy Annual Evaluation, and the cells for Yes and No were grayed out for Safety Plan for Crisis Intervention. The Facility should review and revise which cells were grayed out. The Facility had a database for tracking interobserver agreement. Audit data were entered for each individual by entering the rating for each item on the Active Record and Individual Notebook; the ratings by each auditor were entered separately, and agreement was determined for each item (separately for "current" and "in order") and calculated for the audit tool. For six reliability audits conducted in February and March 2013, database printout showed interobserver agreement on presence of current documents ranged from 82% to 95%, with all six (100%) documenting agreement greater than an 80% threshold. Interobserver agreement on documents being in order ranged from 77% to 94%, with five (83%) documenting greater than the 80% threshold. For one individual, an	

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		Individual Notebook was not available for auditing at the time. These data indicate acceptable agreement. As a check to determine whether the definitions and guidelines provided adequate information to permit another rater to agree, the Monitoring Team selected one record (for Individual #425) by computer randomization from among those selected by the Facility for an audit in April. No training was provided other than the guidelines and an undated document entitled Internal Audit notes that was shared by the URCs and appeared to be a set of instructions developed as a result of interobserver agreement audits. The Monitoring Team audited this record on the same day with no opportunities for the charts to be updated or revised. Agreement on presence of current documents was 78%; agreement on whether documents were in order was 74%. Although somewhat lower agreement was found, agreement approached an acceptable level. An interobserver agreement check was done for one of the four Section V monitoring tools conducted in February 2013. Out of 29 items, the URCs agreed on 26 (90%). As a check, the Monitoring Team and URC also completed this tool for Individual #425 (although the Monitoring Team could not rate two items—one about whether access to electronic records was protected, and one about the interview tool used to assess whether the records are being used to make decisions. The Monitoring Team and URC were in agreement on 23 of 27 items (85%), an acceptable level of agreement. Based on these reviews, the Monitoring Team concludes that the level of interobserver agreement indicates that definitions and audit practices are adequate to provide data that may be valid and useful for making decisions about recordkeeping. A second audit process continued in place. The Facility had long had a process in which Program Compliance Auditors do monthly chart audits of active records per month. Program Auditors had a number of program review responsibilities, including monitoring active treatment, doing mealtime observations, and competency checks on a rotating schedule of topics. The Chart Audit Tool used by the Program Auditors differed from the one used by the URCs; it covered many of the items on the form used by the URCs as well as additional items related to the appropriateness of content (such as whether the action plan steps match Skill Acquisition Programs and whether Monthly Reviews address all Action Steps). The audits by URCs and by Program Auditors 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 Program Auditor selects one record from each URC and does the active record audit and the Settlement Agreement Cross-referenced reviews as well as the Monthly Chart Audit Questions, and does a reliability check. There may be 2	

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		weeks in between the URC and PCM audits, which is a problem because the corrective action notices have been sent out before PCM audits and some corrections have been made, thus potentially lowering the interobserver agreement found (because the records would have been added to, and because this could change whether some documents would be considered current). This additional audit could be quite valuable, and it would be more useful if the Facility would ensure these occur on the same day (or, at least, close together in time), and if items relevant to recordkeeping were included in the trending and corrective action processes for audits. <u>Corrective Actions</u> The Facility had a process to take corrective actions for specific deficiencies identified in audit of an individual record, to ensure corrective actions were completed, and to track deficiencies to determine trends that require systemic action. 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. 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 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. The URCs reported that they continued to do follow-up checks until all required corrections were made and to send these notifications as needed. Although this process had the potential to put the responsibility of documenting corrections on the people responsible for making those corrections, in practice, the URCs did the follow up checks on the basis of due date regardless of whether the responsible person documented that a correction had been made. 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	

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		process to confirm that corrections, such as re-training, that do not result in a change in the record itself, are made. Nevertheless, the Records staff reported having done training on the Observation Notes primarily completed by Direct Support Professionals (DSPs) when they found widespread problems. The Unit Director and Supervisor were to train staff at the home, but there was no process to determine whether there are DSPs still needing training, nor was there evaluation of the effect of the training on improving Observation Note documentation. The Monitoring Team selected the record of Individual #370 through computer randomization from the February 2013 audits. One URC and Monitoring Team member checked to determine if all documented corrections to the Active Record and Individual Notebook had actually been made. For the Individual Notebook, all corrections had been made and remained in place. For the Active Record, some corrections had been made, but there were now some missing documents that had been present at the time of the audit. Furthermore, observation notes that had not been kept current were being documented at the time the original follow-up check was done but were now not consistently kept current. It appeared that the process of follow-up accurately tracked whether corrections had been made, that most but not all corrections had been made, but that additional problems occurred later. The corrective action process may have been effective at getting most corrections made but did not ensure continuing compliance. <u>Review of Trends and Use of Audit Information for Systemic Improvement</u> Findings of audits were included in the Facility's regular QA process for evaluating status and making decisions about corrective and improvement actions. The Facility provided trend data that could be used to review and assess status of the Unified Record. For each item on the Settlement Agreement Cross-Referenced with ICF-MR Standards form, the findings were aggregated monthly. Graphs were provided quarterly to the QA/QI Council of the percent compliant on each item on the Section V Monitoring Tool as rated by the URCs during the quarter, and a table was provided of the compliance percentages found for each record and aggregated by living unit. In addition, data were provided on checks for whether corrections had been made for issues identified in the audits. Data were provided for the quarter, but there was no comparison to prior quarters to show whether there were any trends; the Facility should identify what data should be provided for a 12-month period to facilitate identification of trends and identification of areas for corrective or improvement actions. Per interview with Records staff, they had picked out some items they thought needed attention, and had presented a graph of those to the QA/QI Council. As yet, however, audit data had not led to identification of and action on systemic issues. Because recordkeeping/Section V was not on the schedule for presentation and discussion at the QA/QI Council meeting held during the compliance visit, the Monitoring Team could not assess how that Council evaluated, discussed, and	

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		made decisions from the data provided. Conclusion: The audit system did include random audits of five or more records and did have a process to monitor all deficiencies identified in each review to ensure that adequate corrective action is taken. It did not yet have processes that effectively limited reoccurence, either for individual or systemic deficiencies identified. As a result, although the audit system itself identifies the issues needing correction, additional action is needed to limit reoccurrence and to achieve substantial compliance with this provision.	
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.	Records are Accessible to Staff, Clinicians, and Others As reported in Provision V1, the Active Records and Individual Notebooks were accessible. In addition, the Share Drive makes assessments and other documents easily available to clinicians, QDDPs, and management staff. Documents are Filed in the Record Timely and Accurately Data from Facility random audits for November 2012 through January 2013 indicated 80% of audited documents on the internal audits of the Individual Notebook and Active Records each month were current. The range of data on compliance was consistent with the range found by the Monitoring Team. Review of Active Records for three individuals showed the percent of required documents present and current was 91% for Individual #170, 78% for Individual #425, and 56% for Individual #468. Review of Individual Notebooks found percent of records present and current was 95% for Individual #170, 81% for Individual #425, and 50% for Individual #468. Improvement is needed in order to ensure records are consistently available for decision-making. Annual assessments were not filed in the Unified Record or Share Drive in compliance with Facility policy. According to the Assessment Tracking Database, many assessments were not completed at least ten working days prior to the ISP annual meeting. As reported in Provision F1c, in a sample of 12 ISPs reviewed, only one (8.3%) had all assessments included and completed on a timely basis, at least ten working days prior to the ISP annual meeting. This sample included the two ISP annual meetings observed during this site visit The Monitoring Team also requested the assessments available on the shared drive for a sample of individuals with ISP annual meeting scheduled within ten working days of the date of our request. The number of available assessments ranged from four to ten. Only one of four (25%) had a current Medical Assessment, none of four (0%) had a	Noncompliance

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		Psychological Assessment or Update and none of the four (0%) included a PSI. The most consistently available assessments included Habilitation Therapies, Communication, Nursing and Dental, although even each of these were present for only three of the four (75%) individuals. For example, during an interview, QDDPs were able to access assessments due for an annual ISP meeting to occur within 10 days for Individual #195 (one of the individuals in the sample for Provision F1c). Six of 10 assessments that were identified at a pre-ISP meeting as required (60%) had been completed and posted to the Share Drive at least 10 days prior to the ISP meeting. During review of the Active Record for Individual #468, who had been admitted several months prior, the Monitoring Team determined that six of eight assessments that are required for all newly admitted individuals (75%) had been done within 30 days of admission; the assessments for audiology and nutrition were not present in the Active Record. Furthermore, as reported in Provision R2, all individuals admitted since the last compliance visit received a communication screening or assessment within 30 days. <u>Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure)</u> Data were not always documented timely and accurately. For example, as reported in Provision K12, PBSP data books were reviewed in 16 locations, with one PBSP selected by chance from within the PBSP data book. None of the 16 reviewed PBSP data sheets was recorded up to the current shift at the time of the review. <u>Staff Surveyed/interviewed Indicate the Unified Record is Used</u> The Facility had a process to survey staff regarding use of the Unified Record. As part of the records audit process, each URC selected one individual per month and emailed the statewide form titled Interview Tool for Use of the Record to the IDT member from each clinical discipline listed on the S: Drive Population Report, which lists all disciplines that serve each individual. Each discipline is to fill out responses to the questions and return by email; reminders were sent to any discipline that did not respond in two weeks. URCs summarized the responses. URCs enter information onto the Problematic Tracking System for Interview Tool that includes the 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 percent of responses to each question that are positive, and feedback. The URCs can make recommendations to address the negative responses and feedback.	

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		Data on participation (that is, completed interviews returned) and positive responses to the questions on the interview tool were provided in the quarterly report to the QA/QI Council for the months of January, February, and March 2013. Bar graphs showed the percent of participation to range from just greater than 80% in February to approximately 75% in January, and the percent of responses rated as positive to range from approximately 83% in February to approximately 95% in January. Review of completed Problematic Tracking System for Interview Tools for Individuals #76, #114, #481, and #532 revealed: • Participation was 11% (one of nine disciplines) for Individual #114, 56% (five of nine) for Individual #481, 75% (six of eight) for Individual #76, and 88% (seven of eight) for Individual #532. The Facility should implement a process of follow up to ensure a high level of participation. This may need to be an in-person interview. • Percent of items rated positive was 85% for Individual #76, 88% for Individual #532, and 100% for Individuals #114 (with only one discipline responding) and #481. • At least some feedback was provided for four of four interviews (100%). Six of seven feedback statements were recommendations for electronic records. • One recommendation provided a system improvement, which was related to checkout procedures. It stated signs will be placed on record carts reminding staff to follow the checkout procedure. At prior visits, the Monitoring Team interviewed QDDPs, the Director of Habilitation Services, and the Medical Director using the questions on the interview tool. 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. This was consistent with the data provided on the Problematic Tracking System and was not repeated at this compliance visit. <u>Observation at meetings, including ISP meetings, indicates the unified record is used and data are reported rather than only clinical impressions</u> The Facility had a process to observe meetings and assess whether the unified record is used during meetings and data are reported. The URCs listed the names of individuals, the type of meeting observed, the number of people present, the charts that were brought, the number of documents used, and the percent of compliance. No information was provided to the Monitoring Team about how compliance percentage is determined, how the data are tracked and trended, or whether there have been any improvement or corrective actions resulting from these data. Nevertheless, the process appeared useful, and the feedback from the process would be useful for the meeting leaders and others to	

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		get. For six of six meetings (100%), there was evidence that information from records were used to make decisions. The Monitoring Team observed an annual ISP planning meeting for Individual #599 and an ISP Preparation Meeting for Individual #191. The Active Record was present at both meetings. The Active Record was not referred to at the meeting for Individual #599. Although the Active Record also was not referred to during the meeting for Individual #191, a document was provided that did include information from the Active Record and summaries of information on programming and health. In neither meeting was there an example in which impressions were presented that conflicted with information in the record. The Facility's process to survey staff for use of the record found that staff described how the record was used in meetings. The question about how the record is used in meetings was rated positive for all responses. Conclusion: Progress continued in using information in records to make decisions on care, treatment, and training. Information is regularly used at meetings, and an observation process is in place to monitor that. Records are accessible. However, problems with timeliness of assessments and documentation will need to be corrected to make the information in records fully useful for IDT decision-making.	

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

1. Provide or arrange for periodic training for staff responsible for oversight of the Unified Record. (Provision V1)
2. Develop a process to determine training needed on policies and to track training to ensure all relevant staff receive consistent training. (Provision V2)
3. Review grayed out items on the audit forms to ensure they are appropriate. (Provision V3)
4. 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)
5. Consider revising the audit process by Program Auditors to be closer in time to the audits done by URCs, and to integrate the information from the audits into the trending and corrective action processes from random record audits. (Provision V3)
6. Implement changes in processes or take other actions to limit reoccurrence of deficiencies in recordkeeping and evaluate the effectiveness of those changes. Improve monitoring by those management and supervisory staff responsible for documentation to ensure issues found not to meet requirements are corrected quickly, and emphasize that the audits provide them with information that should guide them in acting to ensure improvements in documentation occur. (Provisions V1 and V3)
7. The QA/QI Council should review and revise, as needed, what data from audits should be provided for a 12 month period to facilitate identification of trends; the Facility should take identify areas for systemic improvement in recordkeeping and initiate actions. (Provision V3)
8. Implement a process of follow up to ensure a high level of participation in the interviews about use of information from the records. This may need to be an in-person interview. (Provision V4)

List of Acronyms

Brenham State Supported Living Center

April 8-12, 2013 Compliance Visit

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
ART	Administrative Review Team
AS	Action Step(s)
AT	Assistive Technology
BAIP	Behavior Assessment and Intervention Program
BAP	Behavioral Assessment Program
BCBA	Board Certified Behavior Analyst
BIR	Behavioral Incident Report
BMC	Behavior Management Committee
BMD	Bone Mineral Density
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
CME	Continuing Medical Education
CMS	Centers for Medicare and Medicaid Services
CEU	Continuing Education Unit
CNE	Chief Nurse Executive
COP	ICF/MR Condition of Participation
CPE	Comprehensive Psychiatric Evaluation
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/DSP	Direct Care Professional/Direct Support 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	Direct Support Professional, 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
MRP	Medication Response Profile
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
OHCP	Oral Health Care Plan
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
PMTP	Psychiatric Medication Treatment Plan
PNA	Psychiatric Nursing Assistant
PNM	Physical and Nutritional Management
PNMC/PNMPC	Physical and Nutritional Management Coordinator/ Physical and Nutritional Management Plan Coordinator
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team

PO	By mouth, oral intake
POC	Plan of Correction
POI	Plan of Improvement
PRC	Polypharmacy Review Committee
PRN	Pro Re Nata (as needed)
PSA	Prostate Specific Antigen
PSP	Personal Support Plan; Psychiatric 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
RRC	Restraint Reduction Committee
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