United States v. State of Texas

Monitoring Team Report

Brenham State Supported Living Center
April 7-11, 2014

Date of Report: May 31, 2014
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Introduction

Background

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

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

In order to conduct reviews of each of the areas of the Settlement Agreement and Healthcare Guidelines, each Monitor has engaged an expert team. These teams generally include consultants with expertise in psychiatry and medical care, nursing, psychology, habilitation, protection from harm, individual planning, physical and nutritional supports, occupational and physical therapy, communication, placement of individuals in the most integrated setting, consent, and recordkeeping.

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

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

Methodology

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

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

(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review, while other requests were for documents to be available when the Monitors arrived. The Monitoring Team made additional requests for documents while on site. In selecting samples, a random sampling methodology was used at times, while in other instances a targeted sample was selected based on certain risk factors of individuals served by the facility. In other instances, particularly when the facility recently had implemented a new policy, the sampling was weighted toward reviewing the newer documents to allow the Monitoring Team the ability to better comment on the new procedures.

(c) **Observations** – While on site, the Monitoring Team conducted a number of observations of individuals served and staff. Such observations are described in further detail throughout the report. However, the following are examples of the types of activities that the Monitoring Team observed: individuals in their homes and day/vocational settings, mealtimes, medication passes, Personal Support Team (PST) meetings, discipline meetings, incident management meetings, and shift change.

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

Organization of Report

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

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

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

Substantial Compliance Ratings and Progress

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

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

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

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

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

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

Executive Summary

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, especially Tammy Nicewarner, Susan Fletcher, and Wendy Ashorn. They ensured the documents requested were available before, during, and after the visit. They coordinated arrangements for all the meetings and observations. Too many other staff to mention assisted in numerous ways.

Second, the Monitoring Team found management, clinical and direct care professionals eager to learn and to improve upon what they did each day to support the individuals at the Facility. Many positive interactions occurred between staff and Monitoring Team members during the weeklong onsite tour. All Monitoring Team members had numerous opportunities to provide observations, comments, feedback, and suggestions to managers and clinicians. It is hoped that some of these ideas and suggestions, as well as those in this report, will assist the Facility in meeting the many requirements of the Settlement Agreement.

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

Given the number of issues identified during the baseline review, it was expected that the change processes would take time. During this review, it was clear that the staff at the Facility had taken a number of steps to address identified issues and to comply with the Settlement Agreement. In a number of areas, progress had been made. In other areas, the foundation had been laid for change. In some areas, concerted efforts need to be made over the next six months to make the necessary improvements. The following report provides brief highlights of areas in which the Facility is doing well or had made significant improvements and other areas in which improvements are needed.

General Comments

Population. Population of the Facility at the beginning of the compliance visit was 291 individuals.

Facility Self-Assessment. Brenham State Supported Living Center (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. If the Facility intends to use its Self-Assessment to conclude whether it is in substantial compliance, it must identify and factor in all of the criteria upon which compliance is to be based. It may choose to prioritize only certain components in its Action Plan, but it should be aware that the prioritized activity might not be sufficient in achieving substantial compliance.

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. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcomes and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities.

Specific Findings

In June 2013, the parties agreed that some modifications to monitoring could be made under specific circumstances. These include the following: 1) sections or subsections for which smaller samples are drawn, or for which only status updates are obtained due to limited or no progress; 2) no monitoring of certain subsections due to little to no progress for provisions that do not directly impact the health and safety of individuals; and 3) no monitoring of certain subsections due to substantial compliance findings for more than three reviews. For each review for which modified monitoring is requested, the State submits a proposal for the Monitor and DOJ's review, comment, and approval. This report reflects the results of a modified review. Where appropriate, this is indicated in the text for the specific subsections for which modified monitoring was conducted.

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

Restraints

For the most part the Facility maintained the improvements noted in the last report by the Monitoring Team with respect to compliance with the use of crisis intervention restraint. The Facility was still struggling with compliance related issues associated with the use of medical restraint. The Facility had formed a Medical Restraint Performance Evaluation Team (PET) to address the issues related to compliance requirements associated with the use of medical restraint. The Facility has continued to limit the use of crisis intervention restraint.

- Positive Practices and Improvements Made
  - The Facility is to be commended for its continued downward trend in the use of crisis intervention restraint. The Facility used crisis intervention an average of four times a month. The Facility rarely used chemical restraint for crisis intervention, only twice since the last review.
  - Crisis intervention restraint was only used if the individual posed an immediate and serious risk of harm to him/herself or others and 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 maintained its comprehensive and thorough system for the review of crisis intervention 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 reviewed 100% of restraints.
- Improvements Needed
  - Restraint reviews conducted by the Unit IDT and the IMRT were not always well documented and sufficient 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.

Abuse, Neglect and Incident Management

Since the last review the Facility had appointed a new Incident Management Coordinator (IMC) and had additional staff turnover among investigators. This may have attributed to the quality of Facility-only investigations. Late reporting of incidents, and the failure to begin implementation of under-reporting audits required in Provision D.2.i remained problematic.

- Positive Practices and Improvements Made
  - The Facility updated its policies on Abuse/Neglect and Incident Management since the last review.
  - Alleged perpetrators were consistently removed from direct contact with individuals immediately following the Facility being informed of an allegation.

- Allegations of abuse/neglect were appropriately referred to law enforcement.
- Based on responses to questions about reporting abuse and neglect, 10 direct support professionals provided satisfactory answers with 90% accuracy when asked to describe the reporting procedures for abuse, neglect, and/or exploitation.
- Investigations commenced within 24 hours of the incident being reported and were generally completed within 10 days. In most cases those that were not had an approved Extension request.
- The scope of the tracking and trending of incidents and injuries, and the analysis of these data, was comprehensive and these data were used to initiate corrective actions.
- The staff training requirements associated with this section of the Settlement Agreement were up-to-date.

- Improvements Needed
  - The Facility had not demonstrated consistent reporting of allegations and serious incidents within the timeframes required by policy and by the Settlement Agreement.
  - The Facility had taken no action to implement its under-reporting audit policy.
  - Facility-only investigations were both incomplete and not thorough. They did not always provide a clear basis for the investigation conclusion and almost always did not consider all available evidence.
  - The Facility continued to make improvements in the processes associated with the conduct of its review of DFPS investigations. Nevertheless, the Monitoring Team in its review of investigations identified investigation issues that were not identified by the Facility review process.

<u>Quality Assurance</u>
While the Facility had improved practices from those observed at the last review, most elements of the QA process need to be implemented consistently over time to demonstrate effectiveness.

- Positive Practices and Improvements Made
  - There were facility policies that adequately supported the state policy for quality assurance including a specific policy on developing, implementing, and tracking corrective action plans.
  - The QA plan narrative at the Facility was complete and adequate.
  - The Facility processes for initiating, implementing, and tracking Corrective Action Plans (CAPs) had become more organized than that observed during the last review. Much improvement in the CAP process was noted during this review. The origin of each CAP was clear and it was evident that CAPs resulted from review and analysis of data, primarily at benchmark meetings, and later presented to and approved by the QAQI Council. Additionally, the CAPs all articulated a problem statement that the CAP was intended to correct and from which measurement of progress and eventually a determination of effectiveness could be made. Further refinement is needed.
- Improvements Needed.

- Discipline policies which contain QA components should be reviewed for content by the Facility QA department to ensure consistency in purpose with the overall QA plan for the Facility.
- The QA plan matrix did not include all self-monitoring tools and self-monitoring procedures.
- There was not a complete and adequate data list/inventory at the Facility although it had improved from that noted in the last report by the Monitoring Team. Much progress had occurred since the last review but full and complete implementation of data collection, review, and analysis (including inter-rater reliability) had not as yet been achieved.

Integrated Protections, Services, Treatments and Supports

The Facility demonstrated sustained and even further improvement in the facilitation of the ISP process. Overall, the Monitoring Team found the Facility's model for facilitating the development of the ISP had contributed to sustaining the progress noted during the previous monitoring visit, as well as furthering that progress in some instances. To ensure the workload was manageable, the Facility had recently added a fourth Lead QIDP position. The Facility had continued to devote considerable thought and resources to its integrated planning processes over the past six months and continued progress was evident. The Monitoring Team had ongoing concerns that there was a fairly pervasive lack of vigilance and sense of urgency about responding to the needs of individuals. Sometimes those needs are not being adequately identified; sometimes they have been identified, but follow-up has been delayed, insufficient or even absent. This was also reflected in some continuing inadequacy of assessments for ISPs and ongoing assessment of status.

- Positive Practices and Improvements Made
  - There were examples in which individuals were prepared for and supported in meaningful participation in ISP planning meetings.
  - The Facility had implemented a new process for Skill Acquisition Plans. Based on a small, Facility-selected, sample, progress was noted.
- Improvements Needed
  - Programs and recommendations were not consistently implemented as needed, and sometimes not at all.
  - IDTs often failed to conduct timely or comprehensive assessments of sufficient quality to reliably identify the individual's strengths, preferences and needs.
  - ISPs still did not consistently specify individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain identified outcomes related to each preference and meet identified needs, nor did barriers to living in the most integrated setting always lead to goals, objectives, or service strategies.

Integrated Clinical Services

The Monitoring Team noted continuing progress in integrated planning and implementation of clinical services.

- Positive Practices and Improvements Made
  - The Medical Morning Debriefing continued to provide an excellent venue for integrated discussion and identification of issues needing collaborative planning; participation was clearly integrated, and disciplines used this as an opportunity to provide education and information to other disciplines.
  - There were numerous interdisciplinary committees and workgroups.
  - Documentation of review and acceptance of recommendations was routinely found on consultation forms and in Integrated Progress Notes.
  - The Facility had continued its process of auditing a sample of consultations monthly.
- Improvements Needed
  - Although there were examples of excellent integrated planning for the needs of individuals, there were also examples in which opportunities for integrated planning were missed; the Facility needs to continue to help staff identify inconsistencies among assessments and related services, to improve the consideration of how risks in one area of functioning and health may affect other areas and the services needed, ensure assessments are timely so the information from one discipline can be considered by others when planning supports and services, and remind clinicians that they need to communicate with other disciplines when they identify changes in an individual's status.

<u>Minimum Common Elements of Clinical Care</u>
Recent compliance reports had noted continuing progress on meeting the requirements of Section H. Progress was not as evident at this review. The status of timeliness and comprehensiveness of assessments continued to improve for some disciplines, but this remained variable. There were some initiatives occurring in the use of clinical indicators of health status, but there was also less clarity about how these would be used in making decisions on treatments and interventions.

- Positive Practices and Improvements Made
  - The Facility had implemented a tracking and follow-up process to ensure the timeliness of annual assessments; Monitoring Team findings of timeliness for samples of assessments were relatively consistent with Facility tracking data.
  - Both psychiatric and medical diagnoses were consistent with the appropriate diagnostic standards. Psychiatric diagnoses made recently were justified and clinically fit corresponding assessments.
- Improvements Needed
  - Assessments for the annual ISP were not routinely completed on a timely basis.
  - Comprehensiveness of assessments improved for specific disciplines; similar improvement needs to continue to occur across all disciplines.

- Assessments in response to identified change of status occurred, but there were instances in which either signs of change of status did not result in identification of such change, or in which assessment was delayed.
- Medical diagnoses did not consistently clinically fit corresponding assessments; in some cases, observable signs did not lead to appropriate assessment.
- There were continuing improvements in timely implementation of treatments and interventions but also examples in which treatments and interventions were not provided timely or were not clinically appropriate based upon assessments and diagnoses. There were examples of timely modification of treatments and interventions in response to clinical indicators, and examples in which that did not occur.
- There was no evidence that the use of clinical indicators for chronic conditions had expanded. The Facility had begun carrying out audits for chronic conditions, starting with hypertension and diabetes. These were too recent to determine how they were being used for review of systemic status of health care or to improve individual care. Similarly, the Facility had developed a catalog of clinical indicators that should lead to further evaluation and possibly determination of a change of status, as well as "alarm indicators" that should lead to immediate assessment, but it was not yet clear how this catalog was being used.

<u>At-Risk Individuals</u>

The BSSLC processes to demonstrate compliance with this section of the SA had not improved from that reported in the last review and in fact had experienced significant regression in many areas. The Facility had made only marginal improvements in fully implementing its At-Risk Individuals policy to guide the risk assessment process.

- Positive Practices and Improvements Made
  - The Monitoring Team noted, from meetings observed, improvement in the IDT process and ISP meeting content. Having written policy and procedural direction, and additional staff training, appeared to have contributed to the improvements observed by the Monitoring Team.
- Improvements Needed
  - Improvement was noted in the processes used to identify a change in status. The resulting IDT meetings did not always result in timely plans with sufficient specification of details.
  - Although the Monitoring Team observed IDT participation and discussion during the risk discussion at the ISP meetings it attended, further improvements are needed. This is especially true in the consistent use of clinical data in discussions making determinations of risk and in developing IHCPs.

<u>Psychiatric Care and Services</u>

The Lead Psychiatrist had left shortly before the compliance visit, bringing psychiatric staffing to two FTEs. Progress had continued in several areas including Comprehensive Psychiatric Evaluations (CPEs), combined assessment and case formulation, and monitoring medication treatments for their efficacy.

- Positive Practices and Improvements Made
    - There was significant progress in psychiatric evaluations, in particular around the need to justify the psychiatric diagnoses. Additional short paragraphs were now in place next to the diagnosis that provided such justifications. When those paragraphs were present, a large majority of the evaluations were good and some were exemplary.
    - In the area of combined behavioral assessment and case formulation the work processes were strong.
    - The Facility had a good process in place for combined assessment and case formulation.
    - Increased focus was noted to reductions in polypharmacy that was not clinically necessary.
- Improvements Needed
    - Further progress was needed to complete evaluations for individuals who did not have one and to resolve Not Otherwise Specified (NOS) diagnoses.
    - There needed to be more evidence of non-pharmacological supports for individuals with Behavior Support Plans for Psychiatric Symptoms (BSPPSs).
    - The Facility did not yet have programs in place to reduce the need for medical restraint.
    - Reiss Screening remained strong but the required CPEs were not yet in place.
    - Improvements were needed for IDT determinations of which treatments (medication, behavioral interventions or other) were needed, and there needed to be better delineation of non-pharmacological supports when medication treatments were chosen.

<u>Psychological services</u>

Although many Provisions continued to lack substantial compliance, progress had been achieved in several areas. Despite the numerous areas of improvement, the Facility also continued to demonstrate limitations or a lack of progress in several areas. Even though substantial limitations were noted in some areas, it was evident that the Facility had invested considerable time and resources toward improving behavioral services. Some areas of noted weaknesses, such as the BSPPSs, were recently implemented. It was therefore not surprising that various challenges were experienced in the implementation process.

- Positive Practices and Improvements Made
    - The Facility continued to address the need for BCBAs through recruitment and education.
    - A well-qualified Director of Behavior Services continued to be employed by the Facility.
    - A robust and evidence-based peer review process was in place.
    - Formal behavior intervention plans were sophisticated and comprehensive.
    - Staff instructions for behavior intervention plans were written in accessible language.
- Improvements Needed
    - Not all behavior intervention plans were developed by a BCBA.

- Data collection and treatment monitoring reflected weaknesses that included the use of rating scales not intended for use with people with intellectual and developmental disabilities, infrequent use of indications on graphs of changes in interventions, and lack of documentation of treatment integrity and reliability on data graphs and progress notes.
- Behavior Support Plans for Psychiatric Symptoms (BSPPSs) did not reflect adequate assessment of pertinent behavioral and environmental factors, and frequently did not offer strategies for strengthening coping skills or developing adaptive behaviors.
- Counseling plans lacked an evidence-based approach to intervention.

Medical Care

The Facility has made little progress in areas of direct medical care, developing a medical quality assurance process, substantially implementing its medical care policy, or enhancing its medical audit and mortality review process.

- Positive Practices and Improvements Made
  - The Facility had continued to ensure a robust and meaningful morning medical meeting that helps to ensure dissemination of clinical information among the various clinical departments at the Facility.
  - The medical care policy is comprehensive.
- Improvements Needed
  - Follow up to acute medical conditions was not consistently carried through to resolution.
  - Regular assessment for pain was not always done when indicated.
  - There needs to be improvement in documenting all necessary supports and services on the IRRF and ISP.
  - The Facility must ensure development of Community Living Discharge Plans and a post move monitoring process that effectively addresses all significant medical and dental issues.
  - The mortality review process must be significantly revised to ensure that medical providers conduct a comprehensive case review of all deaths, and that meaningful recommendations are provided for each death, derived by a root cause analysis that assesses a historical review of all supports and services, including medical care. The Facility must conduct 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.
  - The Facility must develop and implement a medical quality assurance process including an internal process to assess medical providers' clinical performance.

Nursing Care

Based on the Monitoring Team's review, Provisions M.2, M.4, and M.6 continued to be found in substantial compliance. Provisions M.1, M.3, and M.5 were not found in substantial compliance. However, Provision M.1 was found to be very close to substantial compliance with all of the multiple requirements.

- Positive Practices and Improvements Made
  - If the Hospital Liaison Activities, Infection Control Program, and Emergency Response System were standalone requirements they would be considered in substantial compliance.
  - Significant progress was found in the Skin Integrity Management System and substantial compliance should be achieved in the near future if the positive practices are maintained.
  - Staffing appeared to be sufficient to meet individuals' nursing care needs. There were no reports over that last six months where the established staffing ratios were not met.
  - The Quality Assurance Processes appeared to be solidly in place for the Nursing Department auditors and the inter-rater reliability processes completed by the QA Nurse.
  - The Nursing Department continued to maintain a robust competency based educational program that tracked all required training and ensured the training was completed.
  - There was evidence through interviews with nursing administration and management staff, as well as review of individuals' records, that demonstrated the required nursing policies, procedures, processes, and protocols were implemented and being followed sufficiently to meet individuals' health care needs.
  - The Facility continued to show sustained progress in all aspects of medication administration practices according to current generally accepted standards of practice. The Facility had a robust system for identifying, reporting, tracking and analyzing medication variances, as well as for taking corrective actions to mitigate medication variances.
- Improvements Needed
  - While improvement was found in Assessments and Documentation of Acute Changes there remained the need for continuous improvement in assessing and documenting acute illnesses/events that do not require the initiation of Acute Care Plans. The Nursing Department needs to ensure that these events follow the respective nursing protocols and are documented through to resolution.
  - Significant progress was found in the individualization, quality, and content of the Acute Care Plans since the guidelines for developing Acute Care Plans was recently revised. However, there were two active Corrective Action Plans that need to be closed and all nursing care monitoring tools and nursing protocol audits need to achieve and maintain at least 90% or greater compliance scores.
  - There needs to be continued improvement in the Integrated Risk Rating Form and Integrated Health Plan Processes to ensure that all pertinent nursing related assessments are included in the clinical data to assist with determining risk conditions, and that plans are developed for each risk condition that sufficiently meet individuals' health care needs.

- The Facility continued to refine and implement the revised ISP, Integrated Risk Rating Form, and Integrated Health Care Plan Processes. However, these processes were continuing to evolve, but had not matured sufficiently to demonstrate substantial compliance. There needs to be continued improvement in the Integrated Risk Rating Form and Integrated Health Care Plan Processes to ensure that all pertinent nursing related assessments are included in the clinical data to assist with determining risk conditions, and that plans are developed for each risk condition that sufficiently meet individuals' health care needs.

Pharmacy Services and Safe Medication Practices

The Facility has maintained substantial compliance in Sections N.1, through N.8, for three consecutive compliance visits. This compliance review demonstrated that the Facility not only maintained clinically effective processes, but also continued to enhance its processes to further improve services to individuals served by the Facility. The Monitoring Team compliments the Facility Director for supporting the Facility to move forward to compliance with Provision N, as well as the entire pharmacy and other staff involved in developing, implementing, and maintaining processes not only to meet the requirements of the Settlement Agreement, but also to enhance pharmacy services and improve clinical outcomes.

- Positive Practices and Improvements Made
  - All new medication orders reviewed demonstrated that the pharmacists documented review for clinical appropriateness, allergies, interactions, appropriate dose and necessary clinical diagnostics.
  - The Facility continues to produce exceptional QDRRs that should be considered as exemplary models.
  - Metabolic syndrome, polypharmacy, anticholinergic use, stat chemical restraint, and benzodiazepine usage were addressed when completing Quarterly Drug Regimen Reviews (QDRRs). Regularly scheduled systems review of benzodiazepine, anticholinergic, and polypharmacy usage is conducted through relevant committee structure.
  - Medical providers review and appropriately follow-up on pharmacy recommendations.
  - The Facility maintained an Adverse Drug Reaction (ADR) reporting process and added a severity scale for evaluating ADRs. There was robust staff training on the ADR process, and staff other then pharmacists reported ADRs.
  - Drug Utilization Evaluations (DUEs) provided clinically relevant information, and provided medical providers and pharmacists with information to enhance clinical practice.
  - The Facility maintained a medication variance process that promptly addressed all reported medication variances, and tracked and trended variances of prescribing, documenting, dispensing, administering, and storage of medication; nursing, pharmacy and medical leadership participated in the medication variance process.

Physical and Nutritional Management

Overall, while improvement continued to be noted in some areas, others showed a marked decline. BSSLC was able to maintain a fully functional PNMT but concerns were noted regarding the decreased interventions of the PNMT and

involvement with guiding the IDT in their greater role in PNM care. Lack of guidance has resulted in lack of thorough and timely assessment

- Positive Practices and Improvements Made
  - BSSLC had a Physical and Nutritional Management Team (PNMT) that included all the relevant professionals.
  - The risk process continued to improve in its ability to identify those individuals who are at increased risk.
  - A formal process did exist that would ensure pulled staff members responsible for implementing individual specific plans for individuals with physical or nutritional management problems received individualized specific training prior to working with the individuals. Additionally, new staff as well as current staff was provided with initial comprehensive and annual refresher courses.
  - Return to oral intake was included as part of the Habilitation Assessment and there was a clear determination of whether the individual was a candidate for an oral motor treatment program to improve potential for by mouth (PO) intake.
- 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 meeting. There were many instances in which proper assessment was delayed with lack of temporary modifications implemented to mitigate risk until completion.
  - PNMPs were now lacking detail how staff can improve communication with the individual as well as strategies to mitigate risk during intake.
  - PNMPs were not consistently readily available to staff.
  - Staff were not consistently observed implementing the PNMP. Strategies during mealtime were not consistently implemented, nor were strategies to ensure correct positioning (although there had been improvement in positioning).
  - There were concerns with reliability of the monitoring process.
  - PNMPs were not being comprehensively reviewed by the individual's IDT during the annual ISP meeting or as part of the monthly QDDP review. It should be noted that a new process had just been implemented in which the Physical and Nutritional Management Plan Coordinator (PNMPC) will share monitoring information with the QIDP so that it can be integrated into the monthly review.

<u>Physical and Occupational Therapy</u>

Overall, there continued to be improvement with the Occupational Therapy (OT) and Physical Therapy (PT) services provided at BSSLC. Assessments continued to show some improvement and did a respectable job in providing a comprehensive review of the individual. Concerns focused on BSSLCs ability to adequately monitor the implementation of services and the integration process between Habilitation Therapies and the integration into the ISP and collaboration post assessment with the rest of the IDT.

- Positive Practices and Improvements Made
    - The Habilitation Assessment addressed the majority of components needed to fully assess an individual. Areas regarding comparative analysis, listing potential side effects related to medications and investigating more ways to improve functional skills were slightly below the 90% threshold but still represented a comprehensive process.
    - A formal process did exist that would ensure pulled staff members responsible for implementing individual specific plans for individuals with physical or nutritional management problems received individualized specific training prior to working with the individuals. Additionally, new staff as well as current staff was provided with initial comprehensive and annual refresher courses.
    - 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.
- Improvements Needed
    - Therapy services were not consistently integrated into the ISP. There was little evidence that individual's progress was reviewed and at least monthly.
    - While policies and procedures for monthly monitoring of OT/PT services were revised and represented a more complex process, concerns remained over the accuracy of data acquired through the PNM monitoring process due to staff error and a faulty method of scoring which may result in inflated scores of compliance. Another concern was that the Facility did not consistently use the data to pinpoint areas of concern on a systemic basis; therefore, the need for training or development of an action plan would be difficult to determine.

<u>Dental Services</u>

The Monitoring Team recognizes that the Facility had experienced many challenges in maintaining a dental director. The Facility had recently hired a new dental director who had not officially started his duties as dental director at the time of this compliance review. The Facility had not made progress towards compliance with the settlement agreement.

- Improvements Needed
    - The Facility must immediately enhance dental services by developing strategies to ensure efficient tracking and trending of dental database elements, such as scheduling issues, and treatments that had been provided and pending.
    - The Facility must enhance oral hygiene programs at the living area, ensure timely provision of all dental services, and better track and trend restorative treatments.

- The dental office must ensure the development of IPNs that clearly document all dental issues, treatments provided and that are pending, follow-up plans for dental services, and specific monitoring and reporting parameters for dental issues.
- The Facility should develop and implement an effective mechanism to track and trend dental services.
- Programs to help reduce the need for dental sedation must be implemented more broadly.
- There is a need to ensure close monitoring following total intravenous anesthesia (TIVA), and to ensure appropriate communication of issues associated with the provision of TIVA.

Communication

BSSLC continued to show improvement with Section R. Assessments continued to improve, especially post October 2013 when a revision was implemented. Strategies to improve communication for those who were identified as needing service were consistently identified; however, implementation and monitoring of the identified needed services were still lacking with minimal to no use of AAC as part of a 24-hour communication system/program.

- Positive Practices and Improvements Made
  - BSSLC was at full capacity with regards to Speech Pathologists and had recently filled a 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. Assessments remained one of the stronger aspects of the Communication Section. All areas of the assessments found lacking before October 2013 were addressed with the latest revision and showed presence of 100% of the areas for 100% of the sample.
- Improvements Needed
  - Direct Care Professionals (DCPs) were not observed utilizing strategies to engage Individuals in using general area devices. Staff responsible for implementing plans did not appear to be knowledgeable of the plans.
  - Individuals receiving indirect communication supports did not have their plans reviewed at least quarterly by the QIDP.
  - BSSLC had a monitoring process to address the presence and working condition of the AAC devices but were not consistently monitoring whether or not each device was effective and/or meaningful to the individual.

Habilitation, Training, Education, and Skill Acquisition Programs

The Facility had recently implemented a new skill acquisition program (SAP) process and format, and requested feedback.. The parties had agreed to reduced monitoring for Provisions S.2 and S3.a, and no monitoring of Provision S3.b. Because of the request to focus on the new skill acquisition plans, Provisions S.1, S.2, and S.3.a were reviewed only in the context of a sample

of three SAPs selected by the Facility. No review was conducted of Provision S.3.b. The primary request of the Facility was that the three SAPs be reviewed to determine if the new format and development process was appropriate.

- Positive Practices and Improvements Made
    - The new SAP format and procedures were a substantial improvement over previous efforts.
        - The new SAPs were much more integrated with the assessment and ISP process. Information from each pertinent assessment was clearly presented on the SAP cover page, as well as how that assessment was used in selecting and developing the training methodology.
        - The SAPs reflected a coherent approach to teaching that was based in behavior analytic principles. SAPs reviewed during previous site visits had reflected some sound teaching strategies. The SAPs reviewed during the current site visit, however, were the first to reflect an integrated methodology that was evidence-based.
        - The new SAPs also emphasized an approach to teaching that was practical for the staff and addressed skills that were likely to lead to greater independence.

- Improvements Needed
    - As was evident in the past, the new SAPs did not include an adequate number of trials, in most cases including one trial per day or less. In addition, although the new SAPs also included good examples of maintenance and generalization targets, it would have been beneficial to include at least general information about how maintenance and generalization would have be measured and tracked.

<u>Most Integrated Setting</u>

The Monitoring Team continued to find noncompliance overall for this Section. More work remained to ensure transitions were effectively planned and successfully implemented. A summary of noted progress included the continued 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. The Monitoring Team again commends the Facility for its initiative in this area. The Monitoring Team found there was continued progress in the implementation of the ISP process as it related to this Section, but significant deficits remained that continued to hamper efforts to develop and implement adequate transition planning.

The parties had agreed to no monitoring or reduced monitoring of several provisions of this Section because of a history of compliance or because the Facility indicated it had made little progress. For those, findings of substantial compliance or noncompliance found in the last report were continued.

- Positive Practices and Improvements Made

- The Monitoring Team again commends the Facility for its efforts to work with families toward movement of children to more integrated settings.
- While the pace of transitions had slowed as compared to the previous two monitoring periods, many of the current referrals were close to transition dates being finalized.
- PMM Checklists continued to be completed in a timely and generally attentive manner.

- Improvements Needed
  - The Facility to continue to need to work toward development of an individualized education/awareness strategy for each individual that takes into account his or her specific learning needs.
  - Continuing deficits in assessments translated to instances in which the IDT failed to identify in each individual's ISP the protections, services, and supports that needed to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs, or the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences and the strategies intended to overcome such obstacles. In turn, these deficits continued to be apparent in Community Living Discharge Plans (CLDPs) that did not adequately reflect the protections, services and supports an individual would need to make a successful transition to community living.
  - Deficits in the adequate identification of needed supports, services and protections in the CLDP continued to hamper the implementation of a post-move monitoring process that would serve to promote a safe and successful transition.
  - For an alternate discharge that occurred during the compliance period, the post-discharge plan of care was not sufficient to allow the receiving facility to provide all the services and supports needed by the individual.

<u>Consent</u>

This Section was not yet in compliance. A new Human Rights Officer had been in the position for only two months. A summary of noted progress included the Facility's renewed emphasis on self-advocacy and pending promulgation of Facility policies related to this Section, including Guardianship, Advocacy and Self-Advocacy. It was also reported that two new social work positions had been allocated to the Facility and these staff would be responsible for activities to ensure individuals with current guardians did not experience any lapses due to expiring guardianship papers or the need for a successor guardian.

- Positive Practices and Improvements Made
- The Facility reported it had been working with some QIDPs toward enhancing the ability of IDTs to complete a thoughtful examination of capacity to provide informed consent; while significant progress was not yet noted in this regard, this effort could be seen as a first step in preparing IDTs for an effective capacity assessment.
- Improvements Needed

- The Facility did maintain a list of individuals without a guardian, but not all individuals on the list had yet been assigned a priority.
- DADS 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. Facility IDTs continued to rely almost solely on their own subjective assessment of capacity, with no objective standardized criteria or process.
- The Facility's Guardianship Committee continued to meet as called for in the DADS Policy, but the minutes did not reflect significant ongoing actions and deliberations. The Facility was to make monthly progress notes regarding the status of individuals referred to the Guardianship Committee. These data were not adequately reflected in the ongoing minutes and provided little follow-up information from one meeting to the next.

Recordkeeping and General Plan Implementation

The Facility maintained a Unified Record with all required components.

- Positive Practices and Improvements Made
  - Records were generally accessible. The chart checkout procedure had been revised; all charts that were not present were correctly checked out.
  - Records were generally in order, and documents were, for the most part, present and current.
  - Both DADS and BSSLC had developed numerous policies, and the process is ongoing.
  - The audit system did include random audits of more than five records (with 12 per month done routinely).
  - Observation of ISP and IDT meetings found that the active record was consistently present, and information from the record was used to make decisions.
- Improvements Needed
  - Improvement continued to be needed in meeting requirements of Appendix D.
  - The Facility establish a clear set of procedures to ensure training on policies meets the needs for implementation of those policies, and can be tracked to ensure all staff who need training receive it.
  - There was a process to monitor all deficiencies identified in each review to identify corrective actions that need to be taken; however, this process only checked whether corrections were completed by due date and did not follow through to correction of all deficiencies nor address those corrections that required action to limit reoccurrence when the records themselves could not be corrected.
  - Although most documents were present and current in the active record, and therefore available for use in decision-making, assessments were not consistently completed and posted in time for IDT review prior to the annual ISP planning meeting.

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 (3/18/14) 2. BSSLC Action Plan (3/18/14) 3. DADS Policy 001.1 Use of Restraint (4/10/12) 4. BSSLC Policy C.2 Restraint for Behavioral Crisis 11/2/13 5. BSSLC Policy C.3 Medical Dental Restraint 11/2/13 6. List of crisis intervention restraints 10/12/13 to 2/17/14 7. List of medical restraint, including TIVA, since the last review (3/4/14) 8. List of Individuals with a Crisis Intervention Plan (undated) 9. Sample C.1: ten crisis intervention restraint records listed by the Facility in response to the Documents Request. This represented 10 of the 20 (50%) crisis intervention restraints reported by the Facility and included restraint of Individuals #248 (2x), #390, #533, #490, #173, #112 (2x), #259, and #360. One of these 10 restraints occurred off campus. 10. Sample C.2: ten medical restraint records listed by the Facility in response to the Documents Request. This represented ten of the 36 (28%) medical restraints reported by the Facility and included restraint of Individuals #118, # #445, #140, #595, #258, # 217, #486, #417, #472, and #473 11. Sample C.3: a subsample of Sample C.1 records associated with the one use of crisis intervention restraint which occurred off-campus (Individual #248) 12. Sample C.4: records associated with the two uses of crisis intervention chemical restraint (Individuals #248 and #112) 13. Sample C.5: records associated with four Individuals with abdominal binders (Individuals #29, #14, #474, and #35) 14. Medical Restraint Performance Evaluation Team (PET) minutes 12/12/13, 2/6/14, and 2/20/14 15. Staff training records for staff serving as restraint monitors for restraints in Sample C.1 16. DADS report "Percent of All Employees Completing Courses of Training Programs" 9/5/13 17. Minutes of Restraint Reduction Committee 11/21/13, 12/19/13, 1/30/14 and 2/27/14 18. BSSLC Restraint Trend Report 3/31/14 **People Interviewed:** 1. Terry Blackmon, PhD, BCBA, Chief Psychologist 2. Donna Bradley-Schrick, BCBA, Assistant Director of Behavioral Services 3. Kelcie Mauer, Psychology Associate 4. Ten Direct Care Professionals **Meeting Attended/Observations:** 1. QA/QI Council meeting 4/9/14 2. Restraint Reduction Committee meeting 4/10/14 3. Behavior Support Committee 4/8/14

	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: • Used a monitoring/auditing tool in assessing compliance for the use of crisis intervention restraint. The tool used was developed by the Chief Psychologist and was in most cases administered by the Chief Psychologist who is a Board Certified Behavior Analyst (BCBA). This tool included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. The tool was used for every crisis intervention restraint (a 100% sample) and included review of documentation, staff interviews, and video review when applicable. • The monitoring tool had standard instructions/guidelines. • Inter-rater reliability was occurring with another BCBA in the Behavioral Services Department conducting an independent review of a subset of the crisis intervention restraints using the same monitoring tool. Additionally the QA department had recently begun conducting inter-rater reliability monitoring. In neither case was inter-rater reliability data presented separately in the Facility self-assessment. • Recently began using a monitoring/auditing tool for assessing compliance with Settlement Agreement requirements associated with use of medical restraint. • The Facility presented data in a meaningful and 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. • Distinguished data collected by the staff in the Behavioral Services Department versus QA staff conducting the inter-rater reliability review. The Facility rated itself as being in compliance with the following provisions of Section C: Provisions C.1, C.2, C.3, C.6, C.7.a, C.7.b, C.7.e, C.7.f, and C.7.g. This was not consistent with the Monitoring Team's findings. The Monitoring Team did not find substantial compliance with Provision C.6 because of issues associated with the use of medical restraint. Additionally the Monitoring Team did not rate Provision C.7 because the Facility had no Individual meeting the review criteria for this Provision 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 completed or in process. For Provisions previously determined to be in compliance by the Monitoring Team, the Action Plan described a series of action steps necessary for maintenance of compliance. Areas in need of improvement primarily related to medical restraint practices and nursing requirements associated with restraint use. The action steps described in the Action Plan included assigned staff responsibilities, projected completion dates, and a set of steps intended to lead to compliance with the requirements of this Section. 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. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcome and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities.
	Summary of Monitor's Assessment: For the most part the Facility maintained the improvements noted in the last report by the Monitoring Team with respect to compliance with the use of crisis intervention restraint. The Facility was still struggling with compliance related issues associated with the use of medical restraint. The Facility had formed a Medical Restraint Performance Evaluation Team (PET) to address the issues related to compliance requirements associated with the use of medical restraint. The Facility has continued to limit the use of crisis intervention restraint. In FY12 crisis intervention restraint was used an average of 20 times a month. In FY13 this decreased to six times a month. In the seven months of FY14 crisis intervention restraint this decreased to four times a month. The Facility rarely used chemical restraint for crisis intervention, only twice since the last review. The Facility is to be commended for its continued downward trend in the use of crisis intervention restraint. The Facility maintained its comprehensive and thorough system for the review of crisis intervention 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 reviewed 100% of restraints. Reviews conducted by the Unit IDT and the IMRT were not always well documented and sufficient 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. With respect to crisis intervention restraint the documentation reviewed by the Monitoring Team showed substantial compliance in most areas. This was not the case with documentation associated with medical restraint. The Facility had initiated a Performance Evaluation Team to address this and had designated the Assistant Director of Behavioral Services to lead this effort. Crisis intervention restraint was only used if the individual posed an immediate and serious risk of harm to him/herself or others and 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.

#	Provision	Assessment of Status	Compliance

<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>The Facility had revised its restraint policies since the last review to provide a separate policy for restraint for behavioral crises and for medical/dental restraint. This was done to minimize misunderstandings on the different policy and procedural requirements associated with each. Facility leadership felt that separate policies would provide clearer direction to various facility staff responsible for restraint administration and review. The Facility identified this as an issue at the last review by the Monitoring Team and had in fact presented the Monitoring Team with these policy drafts at that time.
The Facility continued to minimize use of crisis intervention restraint. Data presented in the Facility Restraint Trend Report (3/31/14) showed that in FY12 the Facility averaged 20 restraints per month. This decreased to six restraints per month in FY13. For the first seven months of FY14 this decreased further to an average of four restraints per month. This is especially commendable because the Facility has had admissions of Individuals with very challenging behavior.

For comparison purposes, data was provided to the Monitoring Team by the Facility for the past two six month periods showing:

<table>
<tr><th>Type of Restraint</th><th>4/1/13 to 9/30/13</th><th>10/1/13 to 3/31/14</th></tr>
<tr><td>Crisis Intervention (physical holds)</td><td>27</td><td>22</td></tr>
<tr><td>Crisis Intervention (chemical restraint)</td><td>4</td><td>2</td></tr>
<tr><td>Crisis Intervention (mechanical restraint)</td><td>1</td><td>0</td></tr>
<tr><td>TOTAL Crisis Intervention Restraints</td><td>32</td><td>24</td></tr>
<tr><td>TOTAL Individuals represented in above total</td><td>12</td><td>12</td></tr>
<tr><td>Of the above individuals, those restrained pursuant to a Crisis Intervention Plan</td><td>5</td><td>2</td></tr>
<tr><td>Medical restraints/medical procedures
Medical restraints/dental procedures</td><td>15
25</td><td>5
40</td></tr>
<tr><td>TOTAL individuals restrained for medical/dental reasons</td><td>36</td><td>41</td></tr>
</table>
Note: The Monitoring Team, in interviewing Facility staff and reviewing additional data prepared by the Facility was presented apparently conflicting data some of which had a reasonable explanation. For example, data entered into the computerized data base was sometimes different than data maintained by Facility staff. The Facility was able to cross reference, by Individual restraint, between the conflicting data sources and eventually produce a list believed to be accurate. This was particularly the case with medical restraints although the problem was also present to a lesser degree with crisis intervention restraints. In the Restraint Reduction Committee meeting observed by the Monitoring Team, data was presented that ostensibly represented 78 instances of medical restraint. This number was much larger than data presumably reconciled for the</td><td>Substantial Compliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Monitoring Team earlier in the week. Additionally, when reviewing records of Individuals with abdominal binders (from a list provided by the Facility) one Individual should not have been on the list as use of the abdominal binder was discontinued over a year ago. As noted in the last report by the Monitoring Team the Facility needs to ensure the accuracy and consistency of data provided to the Monitoring Team. <u>Prone Restraint</u> Based on Facility policy review, prone restraint was prohibited. Based on review of other documentation (trend reports, Restraint Reduction Committee minutes, investigation reports, and lists of restraints) prone restraint was not identified. A sample, referred to as Sample C.1, was selected (a list of restraints in Sample C.1 is provided in the Documents Reviewed Section above). Based on a review of the restraint records for individuals in Sample C.1 involving 10 Individuals, none showed use of prone restraint. Based on questions with 10 direct support professionals, 10 (100%) were aware of the prohibition on prone restraint. Most of these 10 staff had been involved in restraint application since the last review by the Monitoring Team. <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; and 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: • In 10 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. • Based on the review of 10 restraints, involving eight individuals, 10 (100%) were approved restraints.	

#	Provision	Assessment of Status	Compliance
		In 10 of these records (100%), there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. The Facility did not have any instance of restraint use considered to be physical mechanical restraint to prevent self-injurious behavior (PMR-SIB). The Monitoring Team reviewed four Individuals who used abdominal binders related to G/J tube placement (Sample C.5 described in documents reviewed above). In each case the Individual's recent ISP Addendums explained the purpose of the abdominal binder being a medical support and not a restraint. This was validated in the physician order for the abdominal binder. Based on this review this Provision was in substantial compliance.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The parties agreed the Monitoring Team would conduct reduced monitoring for this subsection, because previous reviews showed substantial compliance. The restraint records involving the eight individuals in Sample C.1 were reviewed. In each case the individual was released as soon as the individual was no longer a danger to him/herself. Based on this review this Provision was in substantial compliance.	Substantial 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	Some Facility policies related to restraint are discussed above with regard to Provision C.1 of the Settlement Agreement. Review of the Facility's training curriculum 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. Twenty different direct care staff were involved in the restraint applications associated with Sample C.1. The training transcripts of these 20 staff was reviewed by the Monitoring Team which found 100% compliance with all restraint related required training. This included: • RES0105 Restraint Prevention and Rules. • RES0110 Applying Restraint Devices • PMAB 320, 400, and 700 • CPR0100 • Abuse/neglect ABU0100 In order to evaluate staff knowledge in the area of restraint, 10 Direct Care Professionals	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	supervision of any individual in restraint.	were asked a series of questions. The 10 staff were selected by the Facility from a list of staff provided by the Monitoring Team. This list included all staff who had been involved in restraint application since the last review and included both am and pm staff. Each response was evaluated by one member of the Monitoring Team, a psychologist from the Facility's Behavioral Services department, and the Facility's Quality Assurance Director. Consequently, for each question, responses were subjected to 30 evaluations (ten staff times three raters). Based on responses to questions, the 10 direct support professionals provided satisfactory responses to the following questions as follows: • "When is the only time we should restrain an Individual?" Thirty of 30 responses were evaluated as satisfactory (100%). • "What other things should we have done before we restrain?" Twenty-four of 30 responses were evaluated as satisfactory (80%). • "Verbal redirection can be asking the individual when they are upset if they would like to do another activity. Tell me one other kind of verbal redirection you can use?'" Thirty of 30 responses were evaluated as satisfactory (100%). • "Tell me two kinds of restraint we can use here?" Twenty-six of 30 were evaluated as satisfactory (87%). • "What level of supervision should happen when an Individual is in restraint?" Thirty of 30 responses were evaluated as satisfactory (100%). • Is it ever ok to restrain a person face down (prone)? Thirty of 30 responses were evaluated as satisfactory (100%). Overall 170 of 180 responses were evaluated as satisfactory (94%). Note: these six questions are the same questions used when the Facility conducts random competency checks with staff. 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. Based on this review this Provision was in substantial 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	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 the eight Positive Behavior Support Plans associated with the Individuals in Sample C.1, 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	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	use of programmatic restraint). In addition, Facility policy did not allow for the use of non-medical restraint for reasons other than crisis intervention. The Facility did not maintain a "Do Not Restrain" list but did use a "Considerations For Implementing Restraint" form to document physician review of physical, medical, and any related conditions that may indicate a need to restrict or modify restraint use. This completed and signed form was in place for all 10 (100%) crisis intervention restraints reviewed pursuant to Sample C.1. Not all forms contained complete information in that some Individuals had conditions listed on the Active Problem List section of the Annual Medical Summary that should have been considered when contemplating restraint instructions but were not. For example, the Active Problem List for Individual #390 reported a non-union hip joint and a history of recurrent osteomyelitis after bone fractures but the considerations form reported there were no medical conditions to consider. Similarly, the Active Problem List for Individual #173 reported a seizure disorder and scoliosis but the considerations form reported there were no medical conditions to consider. It is important that medical conditions that could potentially effect restraint use be considered by the physician and be recorded on the considerations form in the section labeled "List the medical conditions/factors below:" This does not necessarily mean restraint modifications will be recommended by the physician but will serve to document that all relevant medical conditions have been considered. The Facility did not present to the Monitoring Team any evidence related to any specific mechanism to review and document IDT consideration of any non-medical factors that might suggest a need for restraint application restrictions. Presumably this occurred in the Individuals ISP discussion; however there was no documentation to validate this. Nevertheless, in 10 of 10 restraint records reviewed (100%), there was no evidence that the restraint used was in contradiction to the individual's ISP, PBSP, or Crisis Intervention Plan. In reviewing 10 ISPs for individuals for whom restraint had been used for the completion of medical or dental work: • Ten (100%) showed that there had been appropriate authorization (i.e., Human Rights Committee (HRC) approval and adequate consent); • None (0%) included appropriately developed treatments or strategies to minimize or eliminate the need for restraint; and • None (0%) of the treatments or strategies developed to minimize or eliminate the need for restraint were implemented as scheduled. Examples where this was not the case included all restraints in Sample C.3. Based on this review this Provision was not in substantial compliance primarily because of issues related to use of medical restraint. The Facility had formed a Medical Restraint Performance Evaluation Team (PET) to address these, and other, issues related to compliance requirements associated with the use of medical restraint. The Assistant	

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		Director of Behavioral services has been designated to lead this effort. At the time of this review this group had met three times since December, 2013. Additionally, the Facility needs to improve its practices with respect to use of the considerations form completed by physicians and develop a mechanism to document IDT considerations of non-medical factors which may need to be considered in the context of restraint application for each Individual.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face- to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	Review of Facility training documentation showed that there was an adequate training curriculum for restraint monitors on the application and assessment of restraint and this training was competency based. Based on review of training records, seven staff at the Facility who performed the duties of a restraint monitor for Sample C.1 all (100%) successfully completed the training to allow them to conduct face-to-face assessment of individuals in crisis intervention restraint. Based on a review of 10 restraint records (Sample C.1), a face-to-face assessment was conducted: • In nine (90%) by an adequately trained staff member. No restraint monitor was present for restraint on Individual #360. • In nine (90%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. No restraint monitor was present for restraint on Individual #360. • In nine (90%), the documentation showed that an assessment was completed of the application of the restraint. No restraint monitor was present for restraint on Individual #360. • In nine (90%), the documentation showed that an assessment was completed of the consequences of the restraint. No restraint monitor was present for restraint on Individual #360. There were no instances where a physician had ordered alternative monitoring schedule. Sample C.1 consisted of 10 restraints, nine of which occurred at the Facility, of which two were chemical restraint, and one restraint which occurred at the school operated by the local school district but on the campus of the Facility. Data associated with nursing monitoring of these three restraint situations is presented below. Based on a review of nine restraint records for restraints that occurred at the Facility (Sample C.1), there was documentation that a licensed health care professional: • Conducted monitoring at least every 15 minutes from the initiation of the restraint in seven of nine (78%) restraints, as required by DADS Policy Number 001.1, Use of Restraint. Records that did not contain documentation of this included:	Noncompliance

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		o Individual #360: On 10/21/13 at 1:45 p.m., Individual #360 was physically restrained. The Crisis Intervention Restraint Checklist contained documentation that the licensed health care professional was notified of the physical restraint at 5:00 p.m. After the notification, there was documentation that the nurse initiated monitoring. o Individual #490: On 1/18/14 at 6:56 p.m., Individual #490 was physically restrained. The Crisis Intervention Restraint Checklist contained documentation that the licensed health care professional was not notified of the physical restraint. Consequently, there was no monitoring completed by the licensed health care professional. • Monitored and documented vital signs in three of nine (33%). Records that did not contain documentation of this, per policy, included: o Individual #259: On 11/27/13 at 11:26 a.m., Individual #259 was physically restrained. The Crisis Intervention Restraint Checklist did not contain documentation that the licensed health care professional monitored Individual #468's vital signs every 15 minutes, as required by policy. For this example and others, even if vital signs monitoring was refused by Individual #259, the licensed health care professional should have completed and documented objective observations of respiratory and cardiac/circulatory status. o Individual #490: On 1/18/14 at 6:56 p.m., Individual #490 was physically restrained. The Crisis Intervention Restraint Checklist contained documentation that the licensed health care professional was not notified of the physical restraint. Consequently, there were no vital signs monitoring completed by the licensed health care professional. o Individual #360: On 10/21/13 at 1:45 p.m., Individual #360 was physically restrained. The Crisis Intervention Restraint Checklist documented the licensed health care professional was not notified of the physical restraint until 5:00 p.m. The checklist did not contain documentation that the licensed health care professional monitored Individual #360's respiration, pulse, and blood pressure every 15 minutes, as required by policy. o Individual #533: On 1/24/14 at 6:21 p.m., Individual #533 was physically restrained. The Crisis Intervention Restraint Checklist did not contain documentation that the licensed health care professional monitored Individual #533's initial vital signs upon notification of the physical restraint due to being in restraint (a physical arm hold). Objective observations of respiratory, pulse, and blood pressure status should have been completed and documented. However, after the initial physical restraint application, the licensed health care professional completed the required vital sign monitoring every 15 minutes.	

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		o Individual #173: On 1/3/14 at 12:01 p.m., Individual #173 was physically restrained. The Crisis Intervention Restraint Checklist did not contain documentation that the licensed health care professional monitored Individual #173's respiration, pulse, and blood pressure every 15 minutes, as required by policy. o Individual #248: On 1/8/14 at 7:54 p.m., Individual 248 was physically restrained. The Crisis Intervention Restraint Checklist documented that the baseline monitoring of vital signs was refused by Individual #248. Even if the baseline monitoring of vital signs was refused Individual #248, the licensed health care professional should have completed and documented objective observations of respiratory and cardiac/circulatory status. Thereafter, the vital signs were monitored every 15 minutes per policy. • Monitored and documented mental status in five of nine (56%). Records that did not contain documentation of this, per policy, included: o Individual #259: On 11/27/13 at 11:26 a.m., Individual #259 was physically restrained. The Crisis Intervention Restraint Checklist did not contain documentation that the licensed health care professional monitored Individual #468's mental status every 15 minutes, as required by policy. Even if mental status monitoring was refused by Individual #259, the licensed health care professional should have completed and documented objective observations of mental status. o Individual #360: On 10/21/13 at 1:45 p.m., was physically restrained. The Crisis Intervention Restraint Checklist documented the licensed health care professional was not notified of the physical restraint until 5:00 p.m. Upon notification of the physical restraint, the licensed health care professional inconsistently completed the required mental status monitoring. o Individual #490: On 1/18/14 at 6:56 p.m., Individual #490 was physically restrained. The Crisis Intervention Restraint Checklist contained documentation that the licensed health care professional was not notified of the physical restraint. Consequently, there was no mental status monitoring completed by the licensed health care professional. o Individual #533: On 1/24/14 at 6:21 p.m., Individual #533 was physically restrained. The Crisis Intervention Restraint Checklist contained documentation by the licensed health care professional, stated on one of 15 minute mental status monitoring, "no change." The licensed health care professional should have described the mental health status as opposed to stating, "no change." • Monitored and documented whether restraint-related injuries occurred for physical restraint episodes. In 10 of 10 (100%) instances of restraints the Crisis	

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		Intervention Restraint Checklists for Injury were documented. There were no injuries reported as a result of the restraint episode. Based on documentation provided by the Facility, one restraint had occurred off the grounds of the Facility in the last six months. For this restraint (Sample C.3) a licensed health care professional: • Conducted monitoring within 30 minutes of the individual's return to the Facility in one out of one (100%). • Monitored and documented vital signs in one (100%). • Monitored and documented mental status in one (100%). Sample C.2 was selected from the list of individuals who had medical restraint in the last six months. It represents 28% of the individuals for whom medical restraint was used. (Sample C.2 is defined above in the Documents Reviewed section.) For these individuals, the physicians' orders were reviewed, as well as documentation of monitoring. • In two of 10 (20%), the physician specified the schedule of monitoring required or specified facility policy regarding this was followed; and • In none of 10 (0%), the physician specified the type of monitoring required. • In five of 10 of the medical restraints (50%), appropriate monitoring was completed either as required by the facility policy, or as the physician prescribed. Based on this review this Provision was not in compliance primarily because of issues associated with medical restraint. The Facility had formed a Medical Restraint Performance Evaluation Team (PET) to address these, and other, issues related to compliance requirements associated with the use of medical restraint. At the time of this review this group had met three times since December, 2013.	
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	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 nine (90%), information about what happened before, including what was happening prior to the change in the behavior that led to the use of restraint. The exception was restraint of Individual #490. In this case there was insufficient detail with respect to activities and behavior prior to use of restraint; • In 10 (100%), the actions taken by staff prior to the use of restraint to permit adequate review per Provision C.8. • In 10 (100%), the specific reasons for the use of the restraint	Noncompliance

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	minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	• 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; • In 10 (100%) observations of the Individual and actions taken by staff while the Individual was in restraint; • 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 ten records (Sample C.1), restraint debriefing forms that contained data consistent with that reported on the Restraint Checklist had been completed for ten (100%). A sample of 10 Individuals subject to medical restraint was reviewed (Sample C.2), and in two (20%), was there evidence that the monitoring had been completed as required by the primary care provider's order. Primary care provider orders specifying the type and schedule for monitoring were either missing or did not include both the type and schedule of monitoring required. Sample C.4 included the two instances of use of a chemical restraint for crisis intervention. In these two instances, 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 this Provision was not in substantial compliance because of issues associated with medical restraint monitoring. The Facility had formed a Medical Restraint Performance Evaluation Team (PET) to address these, and other, issues related to compliance requirements associated with the use of medical restraint. At the time of this review this group had met three times since December, 2013. Based on this review this Provision was not in substantial compliance.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day		

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	period, the individual's treatment team shall:		
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	During this review period the Facility did not have any Individuals who met the requirement for review under this Provision. Therefore this Provision did not receive a compliance rating.	Not Rated
	(b) review possibly contributing environmental conditions;	During this review period the Facility did not have any Individuals who met the requirement for review under this Provision. Therefore this Provision did not receive a compliance rating.	Not Rated
	(c) review or perform structural assessments of the behavior provoking restraints;	During this review period the Facility did not have any Individuals who met the requirement for review under this Provision. Therefore this Provision did not receive a compliance rating.	Not Rated
	(d) review or perform functional assessments of the behavior provoking restraints;	During this review period the Facility did not have any Individuals who met the requirement for review under this Provision. Therefore this Provision did not receive a compliance rating.	Not Rated
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;	During this review period the Facility did not have any Individuals who met the requirement for review under this Provision. Therefore this Provision did not receive a compliance rating.	Not Rated

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	(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	During this review period the Facility did not have any Individuals who met the requirement for review under this Provision. Therefore this Provision did not receive a compliance rating.	Not Rated
	(g) as necessary, assess and revise the PBSP.	During this review period the Facility did not have any Individuals who met the requirement for review under this Provision. Therefore this Provision did not receive a compliance rating.	Not Rated
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	The BSSLC-established process for reviewing each episode of restraint starts with a Face-to-Face Assessment/Debriefing (FFAD) with the first section completed by the restraint monitor immediately after the restraint episode and the second section completed by a psychologist after interviewing staff and the Individual involved in the restraint. The restraint episode is to be reviewed in the unit morning meeting within three days of occurrence but in practice it is usually reviewed 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. Similarly the restraint episode is to be reviewed in the Facility IMRT meeting within three days of occurrence but in practice it is usually also reviewed the next business day after the restraint episode with whatever information has been prepared by the time of the meeting, Because these review meetings occur so quickly it is often the case that insufficient data and other information is available at the time of the review to facilitate a meaningful review which addresses the requirements of this Provision. Policy requires that the restraint episode is to be reviewed by the Individual's IDT within one working day of occurrence if the Individual does not have a Crisis Intervention Plan, or in accordance with the schedule established in an Individual's Crisis Intervention Plan (but no less often than quarterly). If a restraint was recorded by the Facility's 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 Restraint Checklist (RC) and FFAD was accurate, and if not, corrected. Video review of a restraint episode cannot always occur within the three day review requirement. Consequently, this part of the review process was considered supplementary to the primary restraint review processes in place at the Facility. Restraint procedures were also reviewed at the monthly Restraint Reduction committee, typically focusing on restraint procedures associated with policy implementation issues,	Noncompliance

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		for example, the use of PMR-SIB, and the use of medical restraint, including TIVA. Additionally, the Quality Assurance/Quality Improvement Council included a review of SA Section C data on its agenda in each monthly meeting with a more extensive presentation and analysis quarterly. These meetings would typically not include discussion of an individual episode of restraint but did ensure a broader base of general review of restraint data and restraint practices at the Facility. The files produced pursuant to Sample C.1 were to include documentation associated with this Facility-specific restraint review process. Documentation related to 10 incidents of non-medical restraint was reviewed (Sample C.1), including the Restraint Checklist, the Face-to-Face Assessment and Debriefing Form, the Unit Team meeting and IMRT meeting minutes, and ISP addenda. This documentation showed that: • In eight (80%), the review by the Unit IDT occurred within one business day of the restraint episode and this review is documented by signature on the Restraint Checklist and substantiated in IDT minutes. The exceptions were restraint of Individuals #490 and #390. • In 10 (100%), the review by the unit IMRT occurred within three business days of the restraint episode and this review is documented by signature on the Restraint Checklist and substantiated in unit IMRT meeting minutes. • In nine (90%), the review by the Facility IMRT occurred within three business days of the restraint episode and this review is documented by signature on the Restraint Checklist and substantiated in Facility IMRT meeting minutes. The exception was restraint of Individual #490. It is customary for a BCBA to be present at the Facility IMRT review to facilitate discussion. • 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 two (20%), the reviews conducted by the Unit IDT, the Unit IMRT, and the Facility IMRT were sufficient in scope and depth to determine if the application of restraint was justified; if the restraint was applied correctly; and to determine if factors existed that, if modified, might prevent future use of restraint with the individual, including adequate review of alternative interventions that were either attempted and were unsuccessful or were not attempted because of the emergency nature of the behavior that resulted in restraint. This was the case for restraint of Individuals #360,\ and #248 (2/19/14). The primary deficiency in these reviews was the absence of sufficient information recorded in unit meeting and/or IMRT meeting minutes to reflect discussion regarding important SA requirements, including: 1) determining if factors existed that, if modified, might prevent future use of restraint with the individual, and 2) adequate review of alternative interventions that were either attempted and were unsuccessful or were not attempted because of the emergency nature of the behavior that resulted in restraint. In most cases	

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		some information was presented in meeting minutes but not enough to address all elements required by the SA. Through interview the Facility reported it was satisfied with the quality of these restraint reviews but was struggling with properly documenting the substantive discussion that reportedly occurs during these reviews. No restraints occurred during the week of this review so the Monitoring Team was unable to observe a restraint review at either a unit of Facility IMRT meeting. The Facility should consider routinely conducting a "day three" restraint review at both the Unit and Facility IMRT meetings when presumably sufficient data is available to facilitate a substantive review. The IDT review of each restraint often occurs before, or the same day as the unit and Facility review. These reviews often do not include complete and accurate information regarding the restraint episode. For example, all staff with knowledge regarding activities and events occurring in the environment leading up to the behavior that resulted in restraint may not have been interviewed. Video review (where applicable) may not have been reviewed. Sample C.4 included the two instances of use of chemical restraint. For these two chemical restraints, 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; that there was review 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. Based on this review this Provision was not in substantial compliance because of the absence of sufficient information 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. As reported in the last report by the Monitoring Team Facility staff reported this to be primarily a documentation issue and indicated future restraint review would be sure to document the substance of the restraint review, including the above Settlement Agreement requirement, in the minutes of both Unit IDT meetings and the unit and Facility IMRT meeting. During this review Facility staff acknowledged this remains an issue needing improvement.	

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 (3/18/14) 2. BSSLC Action Plan (3/18/14) 3. Section D Presentation Book (undated) 4. DADS Policy 021.2 – Protection From Harm – Abuse, Neglect, and Exploitation (12/4/12) 5. DADS Policy 02.4 Incident Management (11/20/12) 6. DADS State Supported Living Center Procedure: Injury Audits (undated) 7. BSSLC Policy D.1 Protection from Harm-Abuse, Neglect, and Exploitation (11/5/13) 8. BSSLC Policy DD.1 Incident Management (11/5/13) 9. BSSLC Policy DD.2 Injury Reporting Semi-Annual Under Reporting Audits (8/24/13) 10. BSSLC Policy D.5: Prohibition Against Retaliatory Action (5/15/13) 11. BSSLC Policy D.7: Placing & Monitoring Alleged Perpetrators On Non Direct Care (NDC) Status (8/3/13) 12. Abuse/Neglect/Exploitation Competency Exam updated 10/16/13 13. List of Department of Family and Protective Services (DFPS) cases 9/1/13 to 3/11/14 14. List of Office of Inspector General (OIG) cases 9/1/13 to 3/11/14 15. List of serious injuries 9/1/13 to 3/11/14 16. List of other serious incidents 9/1/13 to 3/11/14 17. List of witnessed injuries 9/1/13 to 3/24/14 18. List of discovered injuries 9/1/13 to 3/24/14 19. Sample D.1 which included a random sample of 14 DFPS investigations of abuse, neglect, and/or exploitation, as well as the corresponding Facility investigation reports. This sample was selected from the document the Facility submitted listing the allegations/investigations completed since the last review. The sample was 50% of reported investigations initiated and completed since the last review, and included DFPS investigations 43013511, 43036320, 43026114, 43000143, 42984743, 42962768, 42962236, 42954549, 42939090, 42932147, 42921495, 42915348, 42899408, and 42913250. Review of this sample included review of personnel and programmatic recommendations made as a result of UIR Committee and IMRT recommendations. Five of these 14 cases were also investigated by OIG. 20. Sample D.2 which included a sample of five Facility-only investigation reports selected from the document the Facility provided listing investigations completed since the last review. The sample was 20% of reported investigations initiated and completed since the last visit and included UIR's 053, 014, 031, 024, and 059. Review of this sample included review unit and IMRT meeting minutes and of personnel and programmatic recommendations made as a result of UIR Committee and IMRT recommendations. 21. Sample D.3: ISPs for Individuals 360, #259, #112, #173, #248, #490, #533, and #390. These are the eight Individuals that were part of Sample C.1

	22. Sample D.4: Other UIRs: 02, 03, 04, 015, 019, 023, 045, 043, 042, and 030 23. BSSLC Investigator UIR Tracking Log 4/8/14 24. Non-serious Injury Investigation (NSI) for Individuals #8, #133, and #400 25. List of the ten most injured individuals 9/1/13 to 3/11/14 26. List of peers who caused the most injuries 9/1/13 to 3/11/14 27. BSSLC Unusual Incident Trend Report 3/31/14 28. BSSLC Abuse, Neglect, Exploitation Trend Report 3/31/14 29. BSSLC Injury Trend Report 3/31/14 30. Minutes of Self-Advocacy group 1/29/14 and 2/22/14 31. 2013 Program Review Preliminary Report from the Office of the Independent Ombudsman (site visit 11/5/13) 32. DADS report MHMR0102 Percent of All Employees Completing Course of Training 3/7/14 33. 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. Daniel Dickson, Quality Assurance (QA) Director 4. D'eandra Polk, Incident Management Coordinator (IMC) 5. Susan Aguilar, Independent Ombudsman **Meetings Attended/Observations**: 1. Incident Management Review Team (IMRT) Meeting 4/8/14 2. Quality Assurance Quality Improvement (QAQI) Council meeting 4/9/14 3. Unusual Incident Report (UIR) Committee 4/8/14
	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 had not been using any monitoring tool for Section D. The Incident Management Coordinator (IMC) reported she reviewed policies to ensure they cover the requirements of the SA. The IMC reported she conducted a 100% review of all investigation documentation. There was not any formal external validation of these reviews by the QA department, but the QA Director (who supervises the IMC) also reviewed 100% of investigations. ▪ 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 did not consistently present data in a meaningful and useful way. Specifically, the

	Facility's Self-Assessment: o Where appropriate, presented findings based on specific, measurable indicators. For example, it compared the number of investigations completed within the required timeframe with the total number of investigations. Where self-assessments reported compliance rates at less than 100% there was no additional data presented to show areas of strength, weakness, or the status of progress. o For the most part 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 because the QA Department did not independently conduct any self-assessment activity for Section D. ▪ The Facility rated itself as being in compliance with 21 of 22 Provisions of Section D, the exception being Provision D.2.i which addresses injury audits to detect underreporting of significant injuries. This was not consistent with the Monitoring Team's findings. The Monitoring Team found the Facility in compliance with 17 Provisions. Four Provisions rated as in compliance by the Facility self-assessment were determined to be noncompliant by the Monitoring Team. These were: 1. Provision D.2.a, which addresses timely reporting requirements. 2. Provision D.3.f, which addresses investigation report content. 3. Provision D.3.g, which addresses Facility review of investigation reports. 4. Provision D.3.h which addresses the requirement for a written report subsequent to Facility review of investigation reports. 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. 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. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcome and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities.
	Summary of Monitor's Assessment: Since the last review the Facility had appointed a new Incident Management Coordinator (IMC) and had additional staff turnover among investigators. This may have attributed to the quality of Facility-only investigations. Late reporting of incidents, and the failure to begin implementation of under-reporting audits required in Provision D.2.i remained problematic.

	The Facility updated its policies on Abuse/Neglect and Incident Management since the last review. The Facility also had a new Incident Management Coordinator. Seventeen of 22 Provisions in Section D were in substantial compliance. Those that were not, however, were very important as they address timely reporting of incidents and conducting adequate investigations. The Facility had not demonstrated consistent reporting of allegations and serious incidents within the timeframes required by policy and by the Settlement Agreement. Additionally, the Facility had taken no action to implement its under-reporting audit policy (Provision D.2.i). Facility-only investigations were both incomplete and not thorough. Facility investigation reports did not always provide a clear basis for the investigation conclusion and almost always did not consider all available evidence. The Facility continued to make improvements in the processes associated with the conduct of its review of DFPS investigations. Nevertheless, the Monitoring Team in its review of investigations identified investigation issues that were not identified by the Facility review process. Alleged perpetrators were consistently removed from direct contact with individuals immediately following the Facility being informed of an allegation. Allegations of abuse/neglect were appropriately referred to law enforcement. Based on responses to questions about reporting abuse and neglect, 10 direct support professionals provided satisfactory answers with 90% accuracy when asked to describe the reporting procedures for abuse, neglect, and/or exploitation. Investigations commenced within 24 hours of the incident being reported and were generally completed within 10 days. In most cases those that were not had an approved Extension request. Recommendations coming from the Facility's investigation review process were tracked and recorded in a database until satisfactory evidence was provided to the IMC and reviewed by the Facility's UIR Committee and Incident Management Review Team. The scope of the tracking and trending of incidents and injuries, and the analysis of these data, was comprehensive and these data were used to initiate corrective actions. The staff training requirements associated with this section of the Settlement Agreement were up-to-date. Investigation files were well organized.

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>D1</td><td>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.</td><td>The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.
Note: Frequent instances of late reporting of incidents and allegations are reported in Provision D.2.a. While policy clearly describes reporting requirements, the problems noted in Provision D.2.a suggest a need for more vigilant administrative oversight of policy related training and administrative implementation practices.</td><td>Substantial Compliance</td></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>Although in the paragraphs that follow, the Monitoring Team has provided some figures with regard to allegations and incidents, it is essential to note that reviewing pure numbers provides very little meaningful information. For each of these categories, the Facility would need to conduct analyses to determine causes, and to review carefully whether adequate action had been taken to prevent recurrence for incidents that were preventable. Determining the reasons or potential reasons for increases or decreases in numbers also is essential. Although the ultimate goal is to reduce the overall numbers of preventable incidents, care needs to be taken to ensure that the result of such efforts is not the underreporting of incidents. For an incident management system to work properly, full reporting of incidents is paramount, so that they can be reviewed and appropriate actions taken. The Facility's progress in analyzing data collected, and addressing issues identified, is discussed in further detail with regard to Section D.4 of the Settlement Agreement.
According to data the Facility provided in a report prepared for the Monitoring Team, the number of Individuals involved in abuse/neglect/exploitation allegations for the past two six-month periods were:
<table>
<tr><td></td><td>4/1/13 to 9/30/13</td><td>10/1/13 to 3/31/14</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td>Total abuse allegations</td><td>40</td><td>36</td></tr>
<tr><td>Physical</td><td>33</td><td>27</td></tr>
<tr><td>Verbal/Emotional</td><td>7</td><td>9</td></tr>
<tr><td>Total Abuse Confirmations</td><td>6</td><td>0</td></tr>
<tr><td>Physical</td><td>5</td><td>0</td></tr>
</table></td><td>Noncompliance</td></tr>
</table>

#	Provision	Assessment of Status	Compliance

Verbal/Emotional	1	0
Total Abuse Inconclusive	2	0
Physical	2	0
Verbal/Emotional	0	0
Total Neglect Allegations	23	20
Neglect Confirmations	3	5
Neglect Inconclusive	2	1
Total Exploitation Allegations	1	0
Exploitation Confirmations	0	0
Exploitation Inconclusive	0	0

The Facility attributed the decrease in the number of allegations, and commensurate decrease in confirmed findings to its proactive and aggressive efforts in promoting staff awareness and improved staff training, especially in New Employee Orientation. Abuse and Neglect training provided in New Employee Orientation was being conducted by QA/Incident Management staff rather than instructors from the training department. The Facility also reported it had taken steps to ensure staff with personal relationships outside the Facility were not assigned to the same work location.

According to data the Facility provided in a report prepared for the Monitoring Team, the numbers of other unusual incidents for the past two six month periods were:

	4/1/13 to 9/30/13	10/1/13 to 3/31/14
Deaths	5	4
Serious Injuries	31	22
Sexual Incidents	3	1
Suicide Threat (credible)	4	1
Unauthorized Departure	1	0
Choking	1	0
Other	2	0

Based on the Monitoring Team's review of DADS revised policies, including Policy 021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section V: Notification Responsibilities for Abuse, Neglect, and Exploitation; and Policy 002.4 on Incident Management, dated 11/10/12: Section V.A: Notification to Director, the policies were consistent with the Settlement Agreement requirements.

According to the Facility policy Protection from Harm-Abuse, Neglect, and Exploitation (D.1), and Incident Management (DD.1), staff were required to report suspected abuse, neglect, and exploitation within one hour by calling the DFPS 1-800 number. This was consistent with the Settlement Agreement requirements.

With regard to unusual/serious incidents, the Facility policy entitled Protection from Harm-Abuse, Neglect, and Exploitation (D.1), and Incident Management (DD.1) required

#	Provision	Assessment of Status	Compliance
		staff to report unusual/serious incidents within one hour of discovery to the Facility Director/designee. This policy was consistent with the Settlement Agreement requirements. In order to evaluate staff knowledge in the area of abuse and neglect reporting, 10 Direct Care Professionals were asked six questions. These questions were taken from the competency exam used by the Facility when conducting random competency checks of staff. The 10 staff were selected by the Facility from a list of staff provided by the Monitoring Team. This list included all staff who had been involved in restraint application since the last review and included both am and pm staff.. Each response was evaluated by one member of the Monitoring Team, the Facility's Incident Management Coordinator, and the Facility's Quality Assurance Director. Consequently, for each question, responses were subjected to 30 evaluations (ten staff times' three raters). Based on responses to questions, the 10 direct support professionals provided satisfactory responses to the following questions as noted: "Who do you report abuse or neglect to?" Twenty-seven of 30 responses were evaluated as satisfactory (90%). "Describe two signs or symptoms of neglect." Nineteen of 30 responses were evaluated as satisfactory (63%). "Describe two signs of abuse." Nineteen of 30 responses were evaluated as satisfactory (63%). "If a staff tells you that they witnessed abuse or neglect do you have to report it?" Thirty of 30 responses were evaluated as satisfactory (100%). "Describe two other types of serious incidents (other than ANE) that must be reported?" Eighteen of 30 responses were evaluated as satisfactory (60%). "When do serious incidents have to be reported?" Twenty of 30 responses were evaluated as satisfactory (67%). The above data suggests staff is not retaining information learned in formal training classes and may contribute to the problem the Facility identified in its self-assessment (and confirmed by the Monitoring Team) of late reporting described below. Based on a review of the 14 investigation reports included in Sample D.1: ▪ Six DFPS investigation reports identified a date and/or time of the alleged incident. Two (33%) of these six included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by DADS/Facility policy. This was a decrease from the compliance rate of 40% noted by the Monitoring Team in its last review. For eight investigations the DFPS investigation report did not include a date and/or time of the alleged incident from which a determination of timely reporting could be made. In summary, 10 of 14 (71%) included evidence that allegations of abuse, neglect, and/or exploitation were reported within the timeframes required by Facility policy or the date and time of the alleged incident was not known and the Monitoring Team could not determine if the incident was reported within one	

#	Provision	Assessment of Status	Compliance
		hour of occurrence or discovery. This was a decrease from the compliance rate of 80% noted by the Monitoring Team in its last review. The four allegations that were not reported timely were UIRs 066, 044, 034, and 021. The Facility review process did not identify the late reporting. Consequently, no follow-up to prevent reoccurrence occurred. ▪ Fourteen (100%) included evidence that allegations of abuse, neglect, and/or exploitation were reported to the appropriate party as required by DADS/Facility policy. Separate from the Monitoring Team review of Sample D.1 the Facility reported that it had identified, through the normal course of DFPS investigation reviews, six instances of untimely reporting. In each case appropriate administrative follow-up occurred. Based on a review of five investigation reports included in Sample D.2: ▪ Three (60%) showed evidence that unusual/serious incidents were reported within the timeframes required by DADS/Facility policy. This was a decrease from the compliance rate of 86% noted in the last report by the Monitoring Team. UIRs 053 and 031 were not reported within the required timeframes. The Facility review process did not identify the late reporting. Consequently, no follow-up to prevent reoccurrence occurred. ▪ Five (100%) included evidence that unusual/serious incidents were reported to the appropriate party as required by DADS/Facility policy. Considering both DFPS reportable incidents and Facility investigation reportable incidents, 13 of 19 (68%) met the requirement of being reported within one hour of occurrence or (in some cases) discovery. Additionally, as reported in Provision D.2.i the Facility had not as yet implemented its policy for under-reporting audits (Policy DD.2). Implementation of this policy could detect yet undiscovered instances of under reporting significant injuries. 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 19 investigation reports included in Samples D.1 and D.2, all 19 (100%) contained a copy of the report utilizing the required standardized format and were completed fully. Based on this review the Monitoring Team determined this Provision was not in compliance. Late reporting of allegations of abuse and neglect remained a problem at the Facility, as reporting was not timely for 68% of sampled allegations for which date and time of incident were known. This was an increase from the rate of 60% noted in the last review by the Monitoring Team	
	(b) Mechanisms to ensure that,	The parties agreed the Monitoring Team would not monitor this provision, because the	Substantial

#	Provision	Assessment of Status	Compliance
	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.	Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. The smaller sample has been used to confirm whether or not substantial compliance continues. The Monitoring Team reviewed the training transcript of each staff person identified as an alleged perpetrator in Sample D.1. All were found to have met the training requirements. Additionally, DADS report MHMR0102 Percent of All Employees Completing Course of Training was reviewed which found training completion rates of 99% for abuse/neglect training (Course ABUO100) and 99% for unusual incident training (Course UNU0100). As reported in Provision D.2.a staff knowledge of abuse/neglect reporting responsibilities was variable. This may suggest the effectiveness of the training should be further probed by the Facility through quality assurance monitoring. Based on this review the Monitoring Team determined this Provision was in compliance.	Substantial Compliance
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. Note: The Monitoring Team reviewed the documentation associated with the requirements of this Provision for each staff person identified as an alleged perpetrator in Sample D.1. All were found to have met the requirements.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.		
	(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.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. The smaller sample has been used to confirm whether or not substantial compliance continues. The Monitoring Team review of Sample D.3 (described in the Documents Reviewed above) confirmed that there was 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 eight individuals' ISPs (Sample D.3), all eight (100%) individuals, and/or their LAR and/or other significantly involved individuals 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. The Monitoring Team reviewed minutes of the two meetings of the self-advocacy group which had been held since the last review. Both included discussion of rights and/or abuse/neglect and/or how to report a problem. The Monitoring Team noted three instances where different parent/guardians reported allegations. This suggests that the Facility had undertaken sufficient educational activities so that parent/guardians understand abuse/neglect and reporting procedures. Finally, in the review conducted by the Office of the Independent Ombudsman on 11/5/13, which consisted of interviews with Individuals living at the Facility, 75% of respondents reported that if they had a rights concern or complaint they would know what to do, and 100% reported they were comfortable speaking up for themselves. This suggests that the Facility had undertaken sufficient educational activities so that Individuals understand abuse/neglect and reporting procedures. Based on this review the Monitoring Team determined this Provision was in compliance.	Substantial Compliance
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. In its last report the Monitoring Team noted that the Facility reported it had an ongoing surveillance process that ensured the presence of posters is maintained. At the time of that review this process was informal and the Facility was unable to provide any documentation to validate its existence. The Monitoring Team suggested that the Facility should formalize this process and include it (and reports) in its regular QA program. This had not as yet occurred.	Substantial Compliance
	(g) Procedures for referring, as	The parties agreed the Monitoring Team would not monitor this provision, because the	Substantial

#	Provision	Assessment of Status	Compliance
	appropriate, allegations of abuse and/or neglect to law enforcement.	Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. Based on a review of investigation records (Samples D.1 and D.2), 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
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The Facility policy (DD.2) defined sufficient procedures to audit whether significant injuries are reported for investigation. This policy had an effective date of 8/24/13. This policy had not as yet been implemented. At the time of the review by the Monitoring Team no audits pursuant to this policy had been done. The Action Plan submitted by the Facility with the Self-assessment included steps to implement this policy. The Monitoring Team looks forward to assessing compliance at its next review. Based on this review this Provision is not in compliance.	Noncompliance
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. Since the last review the Facility has a new Incident Management Coordinator who has	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	met all the training requirements and was not within the direct line of supervision of alleged perpetrators. Additionally the investigations staff experienced quite a bit of turnover and at the time of this review new investigators had been hired and were in training.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. 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. Additionally, the Facility continued to make office space available to DFPS which is accessible 24/7.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. As noted in its previous reports the Monitoring Team remains concerned that no action had been taken regarding an important provision of State and Facility policy regarding testimonial evidence. According to State and Facility policy, steps are to be taken to preserve physical evidence and should prioritize the collection of evidence that is most at risk of contamination. The State and Facility policy further states that "in most cases the highest priority will be to identify interviewees and physically separate them until they have been interviewed." The Monitoring Team found no evidence that would suggest that component of the Facility and DADS policy (separation of witnesses until they are interviewed) was being followed. In reviewing Sample D.1 (DFPS investigations) there was no indication that collateral witnesses had been physically separated pending interview. As a practical matter this would be difficult since DFPS usually does not conduct interviews of collateral witnesses or alleged perpetrators (APs) until days after an allegation is reported. The Facility and DADS should review its policy with respect to testimonial evidence. It would be helpful if DADS provided guidance to the Facility as to how this policy should be implemented, or	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		change the policy such that it establishes requirements that can be reasonably administered**.** The Facility was unaware of any action in this regard. As noted in the last report by the Monitoring Team to its credit the Facility had taken some steps to address the issue of protection of testimonial evidence. 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 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. Additionally, The Facility convenes a quarterly meeting with DFPS and OIG to discuss, among other things, any issues which may affect compliance with this Provision.	
	(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 Facility policies Protection from Harm-Abuse, Neglect, and Exploitation (D.1), and Incident Management (DD.1) 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) 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 Sample D.1 DFPS investigations: Fourteen out of 14 (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: • 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,	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		• 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. The Facility had no Class I allegations since the last review. In some cases the time delay in beginning staff interviews was extraordinary and could have affected the accuracy of testimonial evidence. For example, in reviewing Sample D.1 the Monitoring Team determined that the first staff interview did not occur until at least six days after the allegation was reported in four investigations. Twelve of 14 (86%) were completed within 10 calendar days of the incident, including sign-off by the supervisor; for the two that were not completed within 10 days, one 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. For the other (42962768) no written extension request was provided to the Monitoring Team. In summary, 13 of 14 (93%) investigations were completed within 10 days or had an acceptable approved extension request. Fourteen (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 seven of the investigations (50%), 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. As noted in the last report by the Monitoring Team, it may be helpful to the Facility 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: Five out of five (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. As previously reported the Facility had modified the UIR template to describe commencement timeframes and work activity.	

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		In reviewing Sample D.2 the Monitoring Team determined that four out of five (80%) Facility investigations were completed within 10 calendar days of the incident (or had an approved extension request), including sign-off by the supervisor. The exception was UIR 031. The signatures of the IMC and IMC supervisor for this investigation were not dated so the Monitoring Team could not validate completion of the investigation within 10 calendar days. The Monitoring Team expanded its sample for testing this SA requirement by reviewing 10 additional Facility-only investigations to determine if investigations were completed within 10 days. This consisted of Sample D.4 (10 UIRs). In reviewing Sample D.4 the Monitoring Team determined all 10 facility investigations had been completed within 10 calendar days of the incident being reported. All 10 were signed and dated by the IMC and the IMC supervisor. In summary, the Monitoring Team reviewed 15 facility-only investigations (Samples D.2 and D.4) and determined that 14 of 15 (93%) met the 10 day completion requirement. Five (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. In three (60%) of the investigations reviewed, the UIR included entries in the "Recommendations for Current/Future Actions" section of the UIR template. This was the case for UIRs 031, 024, and 059. In each the recommendations were generally adequate to address the findings of the investigation. UIRs 014 and 053 (both serious discovered injuries) did not include entries in the "Recommendations for Current/Future Actions" section of the UIR template. In each case a thorough investigation should have identified some issues requiring additional follow-up such as reassessing each Individual's Level of Supervision, unit administrative practices regarding staff assignments and accountability for the supervision of Individuals, or medical assessments/reassessments related to whatever risks may have been connected to the events leading to the injury. Based on this review the Monitoring Team determined this Provision was in substantial compliance.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and	Based on the Monitoring Teams' review of DADS revised Policy 021.2 on Protection from Harm – Abuse, Neglect, and Exploitation, dated 12/4/12: Section VII.B, the policy was consistent with the Settlement Agreement requirements. The Facility policy and procedures were consistent with the DADS policy with regard to the content of the investigation reports. Investigation files maintained by the Facility were well organized. Each file contained 24 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. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations:	Noncompliance

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	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.	• In 13 of 14 investigations reviewed (93%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. Investigation 42962768 did not. This was an unconfirmed allegation of physical abuse related to injuries suffered by an Individual. The Facility's injury report notes the location of the injury as the chest. The investigation report notes the location of the injury as the upper to middle part of the back and concludes that the injuries were most likely self-inflicted scratches. This may be a plausible explanation if the injuries were to the chest. It is a less plausible explanation if the injuries were to the middle to upper back. This discrepancy in injury location should have been identified by the investigator and reconciled. Additionally, this discrepancy was not discovered by the Facility in its review of the investigation report. • The report utilized a standardized format that set forth explicitly and separately: o In 14 (100%), each unusual/serious incident or allegations of wrongdoing; o In 14 (100%), the name(s) of all witnesses; o In 14 (100%), the name(s) of all alleged victims and perpetrators; o In 14 (100%), the names of all persons interviewed during the investigation; o In 14 (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 14 (100%), all documents reviewed during the investigation; o In 14 (80%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency. o In 14 (100%), the investigator's findings; and o In 14 (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 none of five investigations reviewed (0%), were the contents of the investigation report sufficient to provide a clear basis for its conclusion. All five investigations were for discovered serious injuries. In each investigation the UIR identified multiple staff in the "Staff Involved" section of the UIR template. In no case did the UIR indicate that all staff involved were interviewed, or that written staff statements were obtained, or that any rationale was provided as to why some staff involved were interviewed and others were not. For example, for UIR 053 17 staff were identified as involved and only five were selected for interview by the investigator. For UIR 014 eight staff were identified as involved and only	

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		one was selected for interview by the investigator. These UIRs provided no rationale as to why some staff were selected to be interviewed and others were not. Interviews documented in each UIR did not record the specific date, and in some cases time period, for which the interviewee was describing a recollection of events. In reviewing the account of these interviews the Monitoring Team could not determine if the interviewee was reporting events from today, yesterday, two days ago, or further back in time. All five investigations were of serious discovered injuries. In only one investigation did the investigator determine the last date/time the Individual was observed without the injury or without signs of pain or discomfort that might have been related to the injury. Establishing such a timeline is helpful in focusing all elements of the investigation, including staff who should be interviewed, environmental conditions/hazards, activity going on in the environment, behavior of other Individuals, changes in medication or medical conditions, etc. None of the investigations probed in detail issues related to Level of Supervision and staff who had (or should have had) supervisory accountability for the Individual who suffered the injury. In one investigation (UIR 031) in the "Analysis of Findings/Causes/Issues" section of the UIR template it was reported that "abuse nor neglect was suspected as a result of this investigation…" It was unclear whether this was meant to convey that neither abuse nor neglect was suspected or abuse or neglect was suspected. In either case investigation review should have identified this as language needing clarification. One of the primary reasons for investigations of serious injuries is to rule out abuse or neglect and statements regarding this should not be left open to interpretation. • The report utilized a standardized format that set forth explicitly and separately: o In five (100%), each unusual/serious incident or allegations of wrongdoing; o In five (100%), the name(s) of all staff involved however they were not separately identified as witnesses versus other staff on duty; o In five (100%), the name(s) of all alleged victims and perpetrators; o In five (100%), the names of all persons interviewed during the investigation; o In none (0%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made. As reported above in no case could the Monitoring Team determine, from reading the investigation report, if the interviewee was reporting events from today, yesterday, two days ago, or further back in time; o In five (100%), all documents reviewed during the investigation; o In five (100%), all sources of evidence considered, including previous investigations of unusual/serious incidents involving the alleged	

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		victim(s) and perpetrator(s) known to the investigating agency; o In five (100%), the investigator's findings; and o In five (100%), the investigator's reasons for his/her conclusions. Based on this review the Monitoring Team determined this Provision was not in compliance because of issues associated with Facility investigations.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	The Facility policy and procedures required 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 Facility policy did require that any further inquiries or deficiencies be addressed promptly. DFPS Investigations The following summarizes the results of the review of DFPS investigations: ▪ The DFPS investigations in Sample D.1 did meet at least 90% compliance with the requirements of Section D.3.e (excluding timeliness requirements) and D.3.f; ▪ Twelve of 14 (86%) were reviewed by the Incident Management Coordinator and/or the Facility Director within five working days of receipt of the completed investigation as required by policy. Those that were not were investigations 42962236 and 42921495. ▪ The Facility Director/Incident Management Coordinator did accept at least ninety-four percent of the investigations over the six months prior to the onsite review. • For one of the DFPS investigation files (Sample D.1) the Monitoring Team noted problems with regard to Provision D.3.f. This problem was not discovered by the Facility in its review of the investigation report and as a result was not returned to DFPS for reconsideration and/or clarification. This was the case for investigation 42962768. The Facility had a thorough process for reviewing DFPS investigation reports, including a UIR Committee, which met twice a week. This committee also reviewed every facility investigation. The Committee consisted of the Facility Director, Assistant Director of Programs, the Incident Management Coordinator, the Quality Assurance Director, and the Independent Ombudsman. The Monitoring Team observed one meeting and was impressed with the thoroughness of review and discussion. From a review of meeting minutes it was clear that in most cases these reviews detected issues associated with the investigation under review; however, as reported in Provision D.3.f this was not always the case (DFPS investigation 42962768). Facility review of DFPS investigations by the UIR Committee resulted in two being returned to DFPS for reconsideration because DFPS did not consider all available evidence in its investigation. In one instance DFPS completed a methodological review, including consideration of the additional evidence. This did not result in a change in the findings. The other was reviewed by the UIR	Noncompliance

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		Committee during the week of the visit by the Monitoring Team and a determination was made to return it to DFPS to consider additional evidence. Facility Investigations The following summarizes the results of the review of Facility investigations: ▪ Five of five (100%) were reviewed by the Incident Management Coordinator within five working days of receipt of the completed investigation. ▪ In five of five investigation files reviewed (100%), there was evidence that the supervisor had conducted a review of the investigation report to determine whether or not the investigation was thorough and complete and that the report was accurate, complete, and coherent. ▪ As reported in Provision D.3.f the Monitoring Team identified many issues with Facility investigations that were not detected by the IMC, or, if detected were not addressed. Similarly, Facility investigations are reviewed by the Facility UIR Committee which apparently also did not detect these issues, or, if detected did not see that they were addressed. Based on this review the Monitoring Team determined this Provision was not in compliance. Two of 14 (14%) DFPS investigations (Sample D.1) reviewed were not reviewed by the Facility within timeframes established by State and Facility policy. Review of Facility investigations was insufficient to identify and correct apparent issues with investigatory methodology.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. Because the sample of Facility investigations (Sample D.2) was only five all five were considered in assessing compliance with this provision. The sample has been used to confirm whether or not substantial compliance continues. The metric used by the Monitoring Team for this provision is whether or not Facility-only investigations met the requirements of Provision D.3.f. The Facility-only investigations did not met the requirements outlined in Provision D.3.f. therefore based on this review the Monitoring Team determined this Provision was not in compliance. Previous reviews had shown compliance.	Noncompliance
	(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	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands. During this review the Facility provided the Monitoring Team with direct evidence of employee disciplinary action and programmatic actions for each investigation in Sample D.1 which demonstrated continued compliance with this Provision. Additionally, the Facility reported that at the conclusion of each investigation the investigation recommendations are discussed the appropriate Unit IMRT meeting and the IMC attends these meetings to facilitate discussion.	Substantial Compliance

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	outcomes.		
	(j) Require that records of the results of every investigation shall be maintained in a manner that permits investigators and other appropriate personnel to easily access every investigation involving a particular staff member or individual.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
D4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation.	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample) for this subsection, because previous reviews showed substantial compliance. The smaller sample has been used to confirm whether or not substantial compliance continues. As noted in previous reports by the Monitoring Team for all categories of unusual incident categories and investigations, the Facility had a system that allowed tracking and trending by: • 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. As noted in previous reports by the Monitoring Team, the Facility's trend analyses: • Were conducted at least quarterly; • Addressed the minimum data elements; • Used appropriate trend analysis procedures; • Provided a narrative description/explanation of the results and conclusions; and • Did**,** as appropriate, contain recommendations for corrective actions. As noted in previous reports by the Monitoring Team in reviewing Trend Reports, IMRT minutes, QA/QI Council minutes, and minutes of the Executive Safety Committee, when a negative pattern or trend was identified and an action plan was needed, action plans were developed. Data on incidents and injuries was presented to each monthly meeting of the QAQI Council (rather than quarterly) providing that group information to permit it to more closely monitor abuse, neglect, and injury trends and determine trends which may suggest a need for corrective action planning. As appropriate, action plans were	Substantial Compliance

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		developed both for specific situations and at a systemic level. QAQI Council minutes showed that action plans were implemented and tracked to completion and addressed the effectiveness of previous action plans. Based on this review the Monitoring Team determined this Provision was in substantial compliance.	
D5	Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at 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.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

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 3/18/14 2. BSSLC Action Plan 3/18/14 3. Section E Presentation Book (undated) 4. DADS Policy 003.2 Quality Assurance 5/22/13 5. BSSLC Policy E.1 Quality Assurance Process 6/1/13 6. BSSLC Policy E.2 Quality Assurance/Quality Improvement Council 6/1/13 7. BSSLC Policy E.3 – Developing, Implementing, & Tracking Corrective Action Plans 6/1/13 8. BSSLC Quality Assurance Plan (including QA matrix) 1/31/14 9. Data List Inventory 1/31/14 10. Quality Assurance/Quality Improvement (QA/QI) Council meeting minutes for all meetings since the last review 11. Monthly Benchmark meeting minutes for all meetings since the last review 12. Section Lead Meeting Notes for all meetings since the last review 13. Corrective Action Plans and related tracking data initiated since the last review. 14. QA/QI meeting agenda and meeting handouts 4/9/14 15. Minutes of Statewide QA Committee since the last review 16. Facility Trend Reports 3/31/14 17. Monitoring tools used by the Facility **People Interviewed:** 1. Daniel Dickson, QA Director 2. Natalie Montalvo, Facility Director **Meetings Attended/Observations**: 1. QA/QI Council meeting 4/9/14
	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 related administrative systems, reviewed QA processes established since the last review, and reviewed the Corrective Action Plan (CAP) tracking system. The Facility QA Department did not use any specific monitoring tools in assessing compliance with Section E. The Facility did not always present data in a meaningful/useful way. For example, the Facility's Self-Assessment did not provide sufficient detail to determine the status of QA implementation by departments

	and disciplines. Additionally, the Facility's inter-rater reliability process was not fully implemented. For example, the self-assessment reported a compliance rating of 25% in this regard. While improved since the last review, the Facility was still in the developmental stages of implementing important components of a comprehensive QA program and different departments/disciplines were at different stages of QA implementation. In the future, 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. The Monitoring Team established substantial compliance for Provision E.3 which addresses dissemination of Corrective Action Plans. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. Action steps were for the most part general and were not targeted at specific actions for specific departments and disciplines at the Facility. For example one action step was to develop and implement internal and external monitoring systems for the remaining sections of the SA that require monitoring. This action step (which is very broad and all encompassing) had a projected completion date of 12/30/13 and a completion status noted as "in process." The action steps associated with this desired outcome should be much more detailed and targeted if it is to achieve success. The Facility believes the set of action steps presented in the Action Plan will likely lead to compliance with the requirements of this Section. All steps in the Action Plan are noted to be completed by 4/30/14 implying the Facility intends to have a fully compliant QA system by 4/30/14. As reported by the Monitoring Team in this section of this report administrative actions necessary to achieve full compliance make this desired outcome highly unlikely. 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. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcome and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities.
	Summary of Monitor's Assessment: While the Facility had improved practices from those observed at the last review, most elements of the QA process need to be implemented consistently over time to demonstrate effectiveness. There were facility policies that adequately supported the state policy for quality assurance including a specific policy on developing, implementing, and tracking corrective action plans. Discipline policies which contain QA components should be reviewed for content by the Facility QA department to ensure consistency in purpose with the overall QA plan for the Facility.

	The QA plan narrative at the Facility was complete and adequate. The QA plan matrix did not include all self-monitoring tools and self-monitoring procedures. The Facility had in use key indicators and had drafted an additional 87 key indicators, anticipating most would be in use by the next review by the Monitoring Team. It will be important that as the Facility continues to develop key indicators and build its monitoring and data collection to measure activity associated with each key indicator, that it carefully assess and determine whether each key indicator is measuring a process or an outcome. The Facility processes for initiating, implementing, and tracking Corrective Action Plans (CAPs) had become more organized than that observed during the last review. Much improvement in the CAP process was noted during this review. The origin of each CAP was clear and it was evident that CAPs resulted from review and analysis of data, primarily at benchmark meetings, and later presented to and approved by the QAQI Council. Additionally, the CAPs all articulated a problem statement that the CAP was intended to correct and from which measurement of progress and eventually a determination of effectiveness could be made. Further refinement is needed. The Facility characterized this as a "work in progress." It appeared to the Monitoring Team that a basic administrative structure for the CAP process was now in place and with continued maturation should lead to improved SA compliance in future reviews. There was not a complete and adequate data list/inventory at the Facility although it had improved from that noted in the last report by the Monitoring Team. Much progress had occurred since the last review but full and complete implementation of data collection, review, and analysis (including inter-rater reliability) had not as yet been achieved. Monthly "benchmark meetings" between the QA Department, Section/discipline leads, and the SA Coordinator had occurred. Additionally, the Facility convened a monthly meeting of Settlement Agreement (SA) Section Leads to further assess progress towards SA compliance and facilitate coordinated communication and planning. The Facility had an Executive Safety Committee that met regularly to review specified QA data and make recommendations. The role of this committee should be added to the QA Plan.

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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	DADS Policy 003.2 Quality Assurance 5/22/13 adequately addressed all five of the provision items in section E of the Settlement Agreement. 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.	Noncompliance

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	receiving services and supports.	• 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. <u>Facility QA policies and practices</u> There were facility policies that appeared to adequately support the state policy for quality assurance. These consisted of a policy addressing the QA process, a policy addressing QA Quality Improvement, and a policy addressing the development, implementation, and tracking of corrective action plans. Through interview it was determined that some other Facility policies, discipline specific, also contained QA requirements specific to that discipline. The Facility produced a list of 18 discipline specific policies (that covered 13 SA sections) that addressed QA. Some included specific QA procedures specific to that particular discipline a while others made reference to participating in the Facility QA process. If the Facility has not already done so, the Monitoring Team suggests the Facility consider having the Facility QA department review these policies for content. It is important that discipline specific policies, where appropriate, include QA requirements and it is important these requirements be reviewed by the QA department to ensure consistency in purpose with the overall QA plan for the Facility. There was not a complete and adequate data list/inventory at the Facility. The Facility QA Data List Inventory updated in January, 2014 included 220 data sources. In its last report the Monitoring Team noted that the Facility was collecting QA data from 165 sources. The list was not organized by SA section so the Monitoring Team could not validate that QA related data was being collected that was relevant to all sections of the SA. The organization of QA related data around common clinical topics was appropriate and can provide support for assessing progress in integrating clinical services. Nevertheless, it is important that QA related data be cross-referenced to SA topics to ensure relevant data is collected and analyzed with respect to each section of the SA as a	

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		good practice for purposes of administrative oversight in the context of achieving SA compliance. Through interview the Facility reported that no QA related data was being collected for Sections G (Integrated Clinical Services) and Q (Dental Services). The Facility reported it was in the process of developing a Medical Quality Improvement Plan which would include data related to both Section G and Q of the SA. The Monitoring Team looks forward to reviewing this plan at its next review. The data inventory was maintained by the QA Director and was regularly reviewed. The QA plan narrative at the Facility, reviewed and updated 1/31/14, appeared adequate and addressed a description of the purpose of the QA program; the organizational structure of the QA process (including individual roles and responsibilities); provisions for a data list/inventory; a QA matrix; provisions for the development of key indicators; a description of how data are summarized and analyzed; requirements for inter-rater reliability; a description of the role of other clinical and operational departments in the QA process; provisions for special workgroups and Program Evaluation Teams; a description of the role of monthly benchmark meetings; a description of QA staff responsibilities; a requirement for a QA report; a description of the responsibilities of the QAQI Council; and a description of the Corrective Action planning process. Through interview the Monitoring Team learned of an Executive Safety Committee that meets regularly to review specified QA data and make recommendations. The role of this committee should be added to the QA Plan. The QA plan matrix showed the data to be submitted to the QA department; these data are then intended to be included in QA reports and presented to the QA/QI Council. Data requirements related to monitoring Sections H (Minimum Common Elements of Clinical Care), G (Integrated Clinical Services), S (Habilitation, Training, Education, and Skill Acquisition Programs), and Q (Dental Services) of the SA had not as yet been incorporated into the QA Plan Matrix, even though in some instances at least some data were being collected. From review of QA/QI monthly reports and data provided by the QA Director, the Facility had 14 key indicators currently in use. These covered the following topics: 1. Regulatory Trends – standard trend report produced monthly 2. ANE Trending – standard trend report produced monthly • # of allegations Neglect	

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		• # of confirmed cases of ANE • # of Unusual Incidents • # of Unusual Incidents resulting in injury 3. Unusual Incidents – standard trend report produced monthly • # of Unusual Incidents • # of Unusual Incidents resulting in injury • # of deaths 4. Client to client aggression – QA manually tabulates data and presents in graphical display • # of persons injured as a result of peer aggression • # of peer to peer aggression without injury 5. Injuries – standard trend report produced monthly • # of discovered injuries 6. Slip, Trips & Falls – QA manually tabulates data and presents in graphical display • # of falls resulting in injury • # of falls without injury 7. Restraints – standard trend report produced monthly • # of restraints • # of crisis intervention restraints • # of persons who required 4 or more restraints in a rolling 30 day period • # of persons who required 4 or more restraints in a rolling 30 day period with IDT review within 3 business days	

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		• # of chemical restraints • # of Dental restraints • # of Medical restraints 8. Pneumonia – Avatar data entry; beginning to aggregate and present graphical display • # of persons at high risk for aspiration • # of persons at high risk for respiratory compromise • # of persons diagnosed with pneumonia • # of persons diagnosed with aspiration pneumonia • # of persons diagnosed with pneumonia that are fed orally • # of persons diagnosed with pneumonia that are enterally fed 9. Skin Integrity – Database issues with tracking and trending • Skin Integrity database--no reports currently available 10. Medication Variances – Avatar entry; continuing to produce local database graphical reports • Medication Variances Report (this will be completed quarterly) 11. Immunizations – Avatar data entry beginning to aggregate and present graphical display • # of persons current on immunizations 12. Infection Control – Avatar data entry; beginning to aggregate and present graphical display • Infection Control Database reports 13. Hospitalization Trending - Avatar data entry; beginning to aggregate and present graphical display	

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		14. Re-evaluation for Enteral Feeding –beginning to aggregate and present data • # of persons with enteral nutrition • # of persons who have returned to oral presentation The Facility suggested these 14 key indicators addressed at least some elements of 15 sections of the SA and represented a good start to what was described as a work in progress. In a table prepared for the Monitoring Team most of the 14 key indicators were noted to be applicable to more than one SA section. For example, key indicator #7 (restraints) was listed as applicable to Sections C (restraints), D (ANE/Incident Management), F (Integrated Protections, Services, Treatments, and Supports), I (At-Risk Individuals), J (Psychiatric Care and Services), K (Psychological Care and Services), and Q (Dental Services). The Facility needs to be judicious in deciding the relevance of a particular key indicator to a particular SA section. From the above example regarding key indicator #7 this key indicator would likely be a primary key indicator for some sections of the SA and a secondary key indicator for others. For some sections of the SA this was the only key indicator noted, at this time, for a SA section. In many cases the current key indicator(s) for a SA section or a clinical practice area did not comprehensively address the substance of the Provision (s) and required further development. As the Facility further develops key indicators, as described below, relevance to SA sections should be closely examined. The Facility also had a draft of 87 additional key indicators. These were organized around six topical areas: 1. Safety and Freedom from Harm 2. Physical, Mental, and Behavioral Health and Well-being 3. Preventive Care and Disease and Disease Management 4. Person Centered Planning/Protection of and Respect for Individual Rights/Satisfaction 5. Meaningful Engagement and Community Inclusion 6. Access to Services The Facility reported it expects to have most of these implemented by the time of the next review by the Monitoring Team. It will be important that as the Facility continues to develop key indicators and build its monitoring and data collection to measure activity associated with each key indicator that it carefully assess and determine whether each key indicator is measuring a process or an outcome. It will also be important as the Facility moves forward that data associated with key indicators include analysis related to the specific requirements for Provision E1--trends	

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		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, as necessary and appropriate to each key indicator. It was not clear if the Facility's data system had achieved a level of maturity such that multiple variables could be examined from many different data points. The Monitoring Team looks forward to assessing progress in the development of key indicator definition and data at the next review. The QA Plan Matrix did not include self-monitoring tools and self-monitoring procedures for all sections of the SA. For example, as reported by the Facility, sections H (Minimum Common Elements of Clinical Care), G (Integrated Clinical Services), and Q (Dental Services) had no formal systematic monitoring process yet incorporated into the QA Plan Matrix. Consequently, 16 of 19 (84%) of SA sections were subject to regular monitoring and data collection. Data listed on the QA Plan matrix that was to be collected by QA staff members was very limited, primarily related to nursing data. The primary role of QA with respect to the implementation of the QA plan matrix appeared to be to produce data related to inter-rater reliability monitoring that would be incorporated into the monthly reports to the QAQI Council. It was unclear to the Monitoring Team if all data listed in the data inventory was in one way or another incorporated into the QA plan matrix. The QA Plan Matrix identified 62 data items that were expected to be routinely reported to the QA Department. This was an increase from the 43 noted in the last report by the Monitoring Team. From review of QA/QI monthly reports and interview with the QA Director the Monitoring Team determined that of the 62 items in the QA plan matrix, 41 (66%) were submitted/collected/received by the QA department for the last two reporting periods for each item (e.g., monthly, quarterly). Of the 62 items in the QA plan matrix, 41 (66%) were documented to show review or analysis by the QA department and/or the department section leaders for the last two reporting periods for each item (e.g., monthly, quarterly). At the time of the review, of the 79 components of the QA plan narrative (17 components) and QA plan matrix (62 components), the Facility had implemented 58 (73%). During the last review by the Monitoring Team it was noted that the Facility had recently initiated "benchmark meetings" between the QA Department, Section/discipline leads, and the SA Coordinator. The Facility intention was that a monthly benchmark meeting be held for each section of the SA (19 meetings/month). The purpose of these monthly	

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		meetings, as articulated in the QA Plan narrative, was to review monitoring data and determine what recommendations, if any, should be presented to the QA/QI Council. All 19 Sections of the SA (not including Section E) included a monthly benchmark meeting each month since the last review by the Monitoring Team. Minutes of these meeting were kept and reviewed by the Monitoring Team, demonstrating good review and discussion of SA requirements and compliance related progress. Consistent implementation of monthly benchmark meetings was apparent to the Monitoring Team. Additionally, the Facility convened a monthly meeting of SA Section Leads to further assess progress towards SA compliance and facilitate coordinated communication and planning. Minutes of these meetings for each month since the last review were reviewed by the Monitoring Team. The meetings appeared to serve their intended purpose. Of the 16 self-monitoring tools for the SA, the content of 16 (100%) appeared to be appropriate and the QA Director reported 16 (100%) were reviewed within the past six months, and five were revised as appropriate (Sections C, O, P, R, and V). Sections H (Minimum Common Elements of Clinical Care), G (Integrated Clinical Services) and Q (Dental Services), did not have formal self- monitoring tools. Therefore, 16 of 19 (84%) of SA sections had monitoring tools that had been recently reviewed and revised as appropriate by the QA Director. The Facility reported all 16 self-monitoring tools had adequate formal instructions and guidelines for the user and in each instance (except for section K) these instructions were written. Those tools reviewed by the Monitoring Team confirmed this. From review of QA/QI monthly reports and interview with the QA Director the Monitoring Team determined that since the last onsite review, of the self-monitoring tools for the 19 sections of the SA (one is not expected for Section E), 16 (84%) were implemented as per the QA plan (e.g., number, schedule, person responsible, inter-rater reliability). Those that did not (Sections G, Q, and H) had not as yet implemented monitoring tools. From review of QA/QI monthly reports, benchmark meeting minutes, and interview with the QA Director the Monitoring Team determined that since the last onsite review, of the 19 sections of the SA, there was documentation that the implementation and results (including outcomes) of self-monitoring were reviewed with the department staff at least once each quarter for 16 (84%) of the 19 sections. Those that did not (Sections G, Q, and H) have not as yet implemented monitoring tools. Based on this review this Provision was not in compliance. While the Facility had improved practices from that observed at the last review there are still many elements of	

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		the QA process that need to be implemented and/or implemented consistently over time.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	All data in the QA plan matrix should be summarized, graphed, and analyzed by discipline department with oversight and assistance as needed by the QA department. Data from the QA plan matrix for 16 of the 19 (84%) sections of the SA (not section E) were summarized, graphed showing trends over time, and analyzed 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 appropriate to the indicator being measured. This was not the case for sections G, H, and Q. Not all data measured performance and/or performance related trends; some counted events, such as the number of hospitalizations. Most relevant data was trended longitudinally. Not all Sections of the SA had been monitored longer than six months (16 of 19 had–84%) and as reported in Provision E.1 some aspects of the QA plan, primarily related to key indicators, were not yet fully defined and implemented. Therefore, not all monitored elements of some of the sections of the SA had been used long enough to permit assessment of trends. As reported in Provision E.1, since the last review by the Monitoring Team, a meeting occurred between discipline/department staff and QA staff at least twice for 19 of the 19 (100%) sections of the SA. These meetings (referred to as benchmark meetings): • Included a review of the data listing inventory and matrix, • Included discussion of data and apparent outcomes, • Included a review of the conduct of the self-monitoring tools, • Included discussion of the need to create corrective action plans as appropriate, • Included a review of previous corrective action plans. Data were generally available during these meetings to facilitate department/discipline review and analysis with QA staff; however, as noted above, the Facility reported that monitoring tools were not in use for three of the 19 (16%) sections of the SA. As a result in some areas there was not sufficient data available to permit meaningful review and analysis. Since the last review by the Monitoring Team, the Facility had initiated five Corrective Action Plans (CAPs). In its last review the Monitoring Team articulated many issues with the CAP development process at the Facility. This was not unexpected as the Facility had just begun using a CAP process. Much improvement was noted during this review. The	Noncompliance

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		origin of each CAP was clear and it was evident that CAPs resulted from review and analysis of data, primarily at benchmark meetings, and later presented to and approved by the QA/QI Council. Additionally, the CAPs all articulated a problem statement that the CAP was intended to correct and from which measurement of progress and an eventual determination of effectiveness could be made. Examples included, "Reiss screenings and referrals not being completed in a timely manner", and "Assessments are not consistently addressing all elements of assessment." Since the last onsite review, a facility QA report (for dissemination at the Facility and for presentation to the QA/QI Council) was created for six of six months (100%). Of the 19 sections of the SA, 16 (84%) appeared in a QA report at least once in each quarter since the last onsite review. As reported by the Facility, Sections G, H, and Q did not appear in the QA report as there was not an adequate monitoring process for these sections. Of the 16 sections of the SA that were presented at the QA/QI Council: • All contained self-monitoring data. • All reported key indicator data although as reported in Provision E.1 in many cases the current key indicator(s) did not comprehensively address the substance of the Provision (s) and required further development. • All contained narrative analysis, although in some cases what was labeled as "analysis" was more of an explanation of the data rather than an analysis of how one might interpret the data. There was an adequate description of the QA/QI Council in the QA plan narrative and in a separate QA/QI Council policy or procedure document. Since the last onsite review, the QA/QI Council met at least once each month. Agendas were structured so that each Section of the SA was reviewed at least once every three months except for those three sections that have not as yet implemented self-monitoring tools. Minutes from all QA/QI Council meetings since the last review indicated that the agenda included relevant and appropriate topics, Minutes from all QA/QI Council meetings since the last review indicated that there was appropriate attendance/representation from all departments. Minutes from all QA/QI Council meetings since the last review documented that (a) data	

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		from the QA plan matrix were presented, (b) for the most part the data presented were trended over time, (c) comments, interpretation, and/or analysis of data were presented. As reported in Provision E.1 some Monitoring Tools had not yet been implemented. In each QA/QI Council meeting recommendations and corrective action plans were reviewed and/or acted upon when appropriate to do so, and were based on the data presented. During a QA/QI Council meeting observed by the Monitoring Team, there was participation of attendees other than the presenter for six of the six (100%) reports/data presented during the meeting. This participation was limited. This meeting appeared to consist primarily of a presentation of information by a SA section lead with the QA/QI Council listening attentively as an audience. There was limited discussion and virtually no discussion that led to decision-making. The QA Director, in interview, assured the Monitoring Team that this meeting was atypical and most meetings are much more substantive in content. The Monitoring Team looks forward to observing such a meeting in the future. The Facility processes for initiating, implementing, and tracking CAPs had become more organized than that observed during the last review. It appeared to the Monitoring Team that a basic administrative structure for the CAP process was now in place and with continued maturation should lead to improved SA compliance in future reviews. The Facility had a specific policy on developing, implementing, and tracking corrective action plans. It did not include specific criteria for the development of a CAP such as when monitoring data showed performance indicators were not at, or had dropped below, a pre-determined threshold (for example, 85%). The QA Director reported that this was intentional as Facility leadership wanted time for various disciplines to become accustomed to the QA process. He also reported such threshold decision points would likely be developed in the future. Of the five CAPs reviewed by the Monitoring Team, five (100%) appeared to appropriately address the specific problem for which they were created. These five CAPs addressed: 1. UTI documentation 2. Seizure record documentation 3. Timely implementation of behavior plans 4. Quality of assessments 5. Updating data books and the active record The Facility had two additional CAPs initiated during the week of the review by the	

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		Monitoring Team. These addressed: 1. TIVA as restraint 2. Mealtime management In reviewing the five CAPs that had been in place the Monitoring Team found the following: • Five (100%) included the actions to be taken to remedy and/or prevent the reoccurrence. • Five (100%) included the anticipated outcome of each action step. • Five (100%) included the person(s) responsible. • Five (100%) included the time frame in which each action step must occur. Based on this review this Provision was not in substantial compliance. Much progress had occurred since the last review but full and complete implementation of data collection, review, and analysis (including inter-rater reliability) had not as yet been achieved. Additionally, the process for the development of CAPs was much improved from that observed by the Monitoring Team at its last review but still is best characterized (as noted by the QA Director) as a "work in progress."	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	In reviewing the seven CAPs that the Facility had in process (including the two initiated during the week of the review) the Monitoring Team determined that: (a) Seven(100 %) included documentation about how the CAP was disseminated (b) Seven (100 %) included documentation of when each CAP was disseminated, and (c) Seven (100 %) included documentation of to whom it was disseminated, including specific person(s) responsible. Based on this review the Monitoring Team determined this Provision was in compliance.	Substantial Compliance
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	From interview the Monitoring Team determined none of the CAPs at the Facility were implemented fully (meaning that all steps of the CAP were implemented and there was complete implementation of the stated action steps) or timely (meaning that due dates in the CAP were met or a reasonable explanation was provided for delays). Monitoring of CAPs, usually consisting of discussion of status, occurred at the Monthly Benchmark meetings described in Provision E.1, and at QA/QI Council meetings. For example, the status of CAP implementation was presented at the QA/QI Council meeting observed by the Monitoring Team but the Monitoring Team did not observe any qualitative discussion directed at progress or lack of progress in either implementing a CAP or assessing its effectiveness. The Facility process for reviewing CAPs also did not	Noncompliance

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		include a data driven methodology to determine whether or not the desired outcome of remedying or reducing the problems originally identified occurred as a result of CAP implementation. Some improvements in monitoring CAP implementation from that observed at the last review were noted by the Monitoring Team. For example, for the most part, information on the tracking log was presented more clearly. The facility QA Director maintained summary information/data (the CAP Tracking Log) regarding CAPs and their status that was updated within the month prior to the onsite review and did present this information to QA/QI Council at least quarterly. As with other components of the CAP process, the QA Director reported that moving towards compliance with this Provision remained a "work in progress." 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 process for reviewing CAPs did not include a data driven methodology to determine whether or not the desired outcome of remedying or reducing the problems originally identified occurred as a result of CAP implementation. This is a necessary step in order to assess the effectiveness of a CAP. The status of CAP implementation was presented at the QA/QI Council meeting observed by the Monitoring Team but the Monitoring Team did not observe any qualitative discussion directed at the effectiveness of the CAP and/or whether or not modification should be considered. Benchmark meetings, described in Provision E.1, were described as a forum for reviewing the effectiveness of CAPs and determining the need for modification. CAPs are a standard item on the Benchmark meeting minute's template. In reviewing the most recent set of Benchmark meeting minutes (February, 2014) the Monitoring Team did not find any review and/or discussion related to the effectiveness of a CAP. As with other components of the CAP process, the QA Director reported that moving towards compliance with this Provision remained a "work in progress." Based on this review the Monitoring Team determined this Provision was not in compliance.	Noncompliance

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 3/18/2014 2. BSSLC Action Plans, updated: 03/18/2014 3. Brenham State Supported Living Center Presentation for April 2014 Settlement Agreement Monitoring Team Visit, Section F 4. Section F Presentation Book materials 5. DADS Policy 018.2: Most Integrated Setting, dated 10/18/2013 6. DADS Policy 004.2: Individual Support Plan Process, dated 11/21/2013 7. DADS Policy 017: Habilitation, Training, Education, and Skill Acquisition Programs, effective, 8/01/2013 8. BSSLC Policy F.1: Individual Support Plan (ISP) Process, implementation date 11/9/2013 9. BSSLC Policy F.2: ISP Process Monitoring Data Collection Process implementation dated 02/15/2014 10. Assessment Completion, 1/1/2014-2/28/2014 11. Overall Attendance of Required Disciplines, dated Tuesday, March 11, 2014 12. Individual Support Plans (ISPs), including ISP Preparation documents and related assessments, for Individuals #53, #62, #102, #141, #189, #255, #379, #481 and #490 13. Assessments for on-site annual ISP planning meetings for Individuals #123, #547 and #599 14. Completed ISPs and Skill Acquisition Plans (SAPs) for on-site annual planning meetings for Individuals #123 and #599 15. Thirty-Day ISPs for Individuals #265, #464 and #584 16. Sample of Monthly Reviews for Individuals #53, #62, #102, #141, #189, #255, #379, #481 and #490 17. Facility selected example s of new-format Monthly Reviews for Individuals #270, #473, #548 and #597 18. Alphabetical list of ISP dates, the date on which the ISP document was completed , the date ISP was filed and the date of the previous ISP, dated 3/18/2014 19. Brenham State Supported Living Center QA/QI Council Meeting, Quarterly Quality Assurance Report, dated February 26, 2014 20. Section F Monitoring Tool **People Interviewed:** 1. Pam Boehnemann, QIDP (Qualified Intellectual Disability Professional) Coordinator 2. Kim Littleton, Assistant Director of Programs (ADOP) 3. Susie Johnson, Director of Residential Programs 4. Stacey Saunders, QIDP Compliance Monitor 5. Daniel Dickson, Quality Assurance (QA)Director 6. Crystal Chavez, QA Compliance Monitor for Section T 7. Phillip Carnagey Lead QIDP 8. Martha Ratcliff, Lead QIDP

	9. Leesa Donoho, Lead QIDP **Meeting Attended/Observations:** 1. ISP annual planning meetings for Individuals #123, #547 and #599 2. ISP Preparation Meetings for Individuals #545 3. Lead QIDP Meeting 4. Section F Strategy Team meeting
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section F. In its Self-Assessment, for each provision, the Facility 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. In order to improve its Self-Assessment for use in achieving compliance, the Facility should continue to review the criteria by which it assesses that compliance. The current self-assessment did not always fully address the noncompliant findings from the Monitoring Team. For example, the Facility reported the activity engaged in for the self-assessment of Provision F1a was to review the attendance information from the ISP Process Monitoring database to ensure that that a QIDP was in attendance of the meeting and that a Lead Qualified Intellectual Disability Professional (QIDP) was the facilitator . Based upon the results of the self-assessment, the Facility then concluded the provision was in substantial compliance. However, attendance and facilitation of the meeting is only one criterion by which the Monitoring Team assesses compliance for this provision. In addition, the Monitoring Team reviews indicators related to the quality of the facilitation as it relates to team participation in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports. If the Facility intends to use its Self-Assessment to conclude whether it is in substantial compliance, it must identify and factor in all of the criteria upon which compliance is to be based. It may choose to prioritize only certain components in its Action Plan, but it should be aware that the prioritized activity may not be sufficient in achieving substantial compliance. 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. Most of the activities engaged in to complete the Self-Assessment remained subjective, so the Monitoring Team continues to suggest 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. Working with the Section Lead, the QA Director had begun the process of developing potential indicators and data sources. The Facility also provided for each Section of the Settlement Agreement provisions an Action Plan listing actions to be taken to move forward toward compliance. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcomes and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be

	measured. Overall, a comprehensive strategic plan that identifies all requirements and the measurable indicators for each not only would allow the Facility to better prioritize its activities, but would also allow it to better monitor its overall progress toward substantial compliance. At least, the Facility should determine the priorities for action for the next six months, complete an analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities. Sections of the Self-Assessment could reference the specific Action Steps that would be implemented to address the reasons for noncompliance, which could tie the Self-Assessment and Action Plans together. The Facility may want to consider how it could further the integration of these two documents, such that staff could visualize the results of the self-assessment, the specific action plan to address any identified deficiencies and the measurable outcome intended to be achieved. This would also allow the Facility to appropriately update or modify its Action Steps based on an evaluation of outcome data. BSSLC indicates it had achieved substantial compliance in Provision F1a, but as described above, the Monitoring Team did not concur. The Facility indicated it remained in noncompliance with the remaining provisions and the Monitoring Team concurred with that assessment.
	Summary of Monitor's Assessment: The assessment which follows represents a compilation and synthesis of the interdisciplinary findings of the Monitoring Team. Positive findings included sustained and even further improvement in the facilitation of the ISP process, particularly as observed in one of the on-site ISP annual planning meetings attended by the Monitoring Team. Overall, the Monitoring Team found the Facility's model for facilitating the development of the ISP had contributed to sustaining the progress noted during the previous monitoring visit, as well as furthering that progress in some instances. It appeared the model allowed the Facility to maintain a tremendous degree of consistency in the facilitation process and the ISPs themselves. The Facility had continued to devote considerable thought and resources to its integrated planning processes over the past six months and continued progress was evident. The Monitoring Team commended these efforts. Overall, however, the Monitoring Team had ongoing concerns that there was a fairly pervasive lack of vigilance and sense of urgency about responding to the needs of individuals, some with the potential of significant harm. Sometimes those needs are not being adequately identified; sometimes they have been identified, but follow-up has been delayed, insufficient or even absent. This was also reflected in some continuing inadequacy of assessments for ISPs and ongoing assessment of status. Programs and recommendations were not consistently implemented as needed, and sometimes not at all. There was also a lack of routine monitoring that would have helped to identify when modifications or additional follow-up might be needed. Additional specific findings as to each provision are as follows: **Provision F1:** This provision was in noncompliance. Some continued improvements in integrated planning were observed, particularly in ISP related meetings observed by the Monitoring Team. Overall, however, documentation reviewed for the six month period indicated the Facility was still meeting with limited success specific to the requirements of this section of the SA. The IDTs often failed to conduct timely or comprehensive assessments of sufficient quality to reliably identify the individual's strengths,

	preferences and needs. **Provision F2:** This provision remained in noncompliance. The Monitoring Team found there were some examples of improved integration observed in planning meetings and record reviews. Overall, however, the ISPs reviewed lacked many of the requirements 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. Review by the Monitoring Team of skill acquisition plans (SAPs), as it informed these findings, was limited as the parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample the Facility selected) for this subsection. This was because the Facility had recently implemented a new process and requested feedback on the newest SAPs, recognizing that previous SAPs needed improvement. While progress was noted in the review of a Facility-selected sample of three recent SAPs, this was too small a sample to make any assessment of compliance; therefore the Facility was still considered to be in noncompliance for all provisions related SAP development and implementation. This is reflected in Section F provisions that rely in part on that assessment.

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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 Intellectual Disabilities Professional (QIDP) was the one person assigned to each individual to facilitate the work of each IDT. Beginning November 1, 2013, the Facility initiated a plan to use three Lead QIDPs as the facilitators for all ISP and ISP Preparation meetings. The assigned QIDP co-facilitated and scribed, but the Lead QIDP was responsible for developing the final ISP. This was designed to focus more QIDP effort on program implementation and monitoring. Overall, the Monitoring Team found the Facility's model for facilitating the development of the ISP had contributed to sustaining the progress noted during the previous monitoring visit, as well as furthering that progress in some instances. It appeared the model allowed the Facility to maintain a tremendous degree of consistency in the facilitation process and the ISPs themselves. At the time of the previous monitoring visit, the Monitoring Team had expressed some concern as to whether the workload was manageable for three Lead QIDPs and encouraged the Facility to monitor that aspect. The Facility had kept a watchful eye on the workload issue and, based on its own findings, had recently added a fourth Lead	Noncompliance

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		QIDP position. <u>Staffing of QIDP Department</u> The supervision of the QIDP Department was being provided by the Residential Services Director as of March 2014. The Facility reported that it had 19 QIDP positions, including four Lead QIDPs. The Facility was using the Q Construction Facilitation curriculum for training in this area but was not evaluating competence at this time. Based on the list provided, only the QIDP Coordinator and three Lead QIDPs had been deemed fully competent in facilitation. All individuals had an assigned QIDP. The QIDP/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. Staffing also included a QIDP Coordinator and a QIDP Educator. The Facility continued to re-organize certain aspects of its workflows and responsibilities to ensure QIDPs had sufficient time and opportunity to facilitate the team process and monitor implementation and progress. Two additional positions had been added to support the work of the QIDP. One was an administrative position to handle data entry and tracking of various work products related to the ISP, and the other was a QIDP Compliance Monitor. The duties of the latter position were still being defined but included monitoring of timeliness of assessments and the quality of Monthly Reviews. Overall, outcomes in the facilitation and development of ISPs were improving. The Monitoring Team found the Facility's model for facilitating the development of the ISP had contributed to sustaining the progress noted during the previous monitoring visit, as well as furthering that progress in some instances. It appeared this model allowed the Facility to maintain a tremendous degree of consistency in the facilitation process and the ISPs themselves. Remaining deficiencies that continued to need improvement included: • For none of the nine plans reviewed (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 nine (0%) ISPs reviewed (0%) did the facilitation process result in an adequate discussion of the most integrated setting. See Provision F1e. • The assigned QIDP also remained responsible for monitoring and revising treatments, services, and supports. The Monitoring Team found in its review of the sample that there was progress noted over previous visits, but the QIDPs 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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		Conclusion: This provision was found to be not in compliance, but continued progress was noted.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	Composition and Participation of IDT: BSSLC Policy F.1: Individual Support Plan (ISP) Process and DADS Policy 004.2: 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. BSSLC provided a document entitled Overall Attendance of Required Disciplines, dated Tuesday, March 11, 2014 and found it showed an overall required attendance rate of 73% for the date range of 11/1/2013 through 2/28/2014. This included Individual participation at 66%, LAR participation at 53% and Direct Support Professional (DSP) participation at 89%. The Monitoring Team reviewed a sample of signature sheets for nine sample ISPs held during the past six months as an alternative measure. This review revealed actual attendance based on the IDT members identified as being required participants at the ISP Preparation meeting was 62% (63 0f 102 required participants were present.) A direct support professional (DSP) was in attendance at five of nine (56%) ISP annual planning meetings. The Individual participated in five of nine (56%) as well. Both of these were below the rates documented in the Facility's tracking data. It was noted the Registered Nurse participated in 100% of the ISP annual planning meetings, and the Primary Care Physician participated in eight of nine (89%), but a Vocational Services representative was present at only one of six (17%) annual ISP meetings in which their presence was required. The Facility continued to need to work on ensuring required IDT members participate. Extent of Individual participation in ISP: In addition to actual meeting participation by individuals, meaningful participation appeared to be improving as observed at on-site annual ISP meetings. For example, for Individual #123, the individual had clearly been prepared for the meeting and was supported to participate throughout. The individual's strengths were repeatedly referred to throughout the process, resulting in a very positive tone to the entire process. Even much of the IRRF discussion was couched in everyday language that made sense to the individual. Conclusion: This provision was found to be not in compliance.	Noncompliance
F1c	Conduct comprehensive	Policy:	Noncompliance

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	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.	DADS Policy #004.2 defined "assessment" as "A formal document that identifies an individual's current level of functioning, preferences, strengths, needs, and recommendations to achieve his or her goals, promote independence, and overcome obstacles to community integration. The assessment is used to identify strengths and needs to support the individual in the development of training, participation, and service objectives listed in the "Action Plans" section of the ISP." For annual ISP planning meetings, the expectations remained that the Preferences and Strengths Inventory (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. The IDT was to identify the assessments that were required for the annual ISP meeting at the ISP Preparation meeting, also held approximately 90 days prior to the ISP meeting. The policy requires in Section III.C that these assessments be completed and placed in the share drive for IDT review no later than 10 working days before the annual ISP meeting to permit the entire interdisciplinary team (IDT) to review them. The assessments were to be used by the QIDP to develop an ISP Guide no later than five days prior to the ISP annual meeting. For a new admission, Facility policy requires that the assessments be completed and posted at least five working days prior to the initial ISP meeting. <u>Extent to which assessments are conducted routinely:</u> Assessments for the ISP were still not routinely completed on a timely basis, as evidenced by the Facility's own self-assessment and by other findings of the Monitoring Team, but there was improvement noted. In the current ISP procedure, the IDT was to identify the assessments that were required for the annual ISP meeting at the ISP Preparation meeting. Each of the sample ISPs clearly defined the assessments that were to be completed. Findings included: • The Facility had implemented a tracking and follow-up process to ensure the timeliness of assessments. According to a document entitled Assessment Completion, 1/1/2014-2/28/2014, of 810 assessments due between the dates of 1/1/2014 and 2/28/2014, 426 (52.6%) were completed by the due date. • In a sample of nine recent ISPs reviewed, none (0%) had all assessments included and completed on a timely basis prior to the ISP annual meeting. • Overall for this sample, the rate of timeliness was 45% based on the requirements listed in the ISP Preparation meeting documentation. • As described in Provision F2d below, the Monitoring Team found assessments were still not always being updated in response to significant changes, particularly as they related to protection from harm. In January, 2014, the Facility began to use a new ISP Process Monitoring database to	

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		track assessment completion dates. Weekly reports are now being sent to Department Heads regarding delinquent and due assessments. Daily email reminders are sent to IDT members when assessments have not been posted at 14 days and nine days prior to the ISP meeting. The Monitoring Team looks forward to seeing improvement in timeliness as a result at the next monitoring visit. During an interview, the Monitoring Team requested the assessments available on the shared drive for Individual #538, whose ISP annual meeting was scheduled within ten working days. The QIDP provided the Assessments/Reports Needed for the Annual ISP Meeting sheet that identified which assessments were required and accessed the assessments. Eight of 10 (80%) assessments determined to be needed for the annual ISP meeting had been completed and posted on the Share Drive; in addition, the Habilitation Therapy assessment or update was posted timely but had not been listed as required. <u>Extent to which to which assessments are of sufficient quality to reliably identify the individual's strengths, preferences and needs/ assessments are conducted in response to significant changes:</u> Progress was noted in certain discipline specific assessment processes and outcomes throughout this report. Examples included findings of substantial compliance in Provisions M2, P1, and R2. The Monitoring Team commends the Facility for these efforts, particularly as this has been an area of weakness overall. However, despite these strides, noncompliance continued to be found in the following provisions related to the quality of assessments: J6, K5, L1, M5, O2, R2, S2, T1b1, T1b3, T1d. and U1. These findings, taken together, demonstrated assessments were still not routinely of sufficient quality overall to reliably identify the individual's strengths, preferences and needs. Examples included: • As reported in Provisions L1 and T1d, assessments prepared for Individuals #118 and #303 did not adequately address significant issues that could impact a safe transition to community living. • As reported in Provision U1, the Facility did not routinely use standardized or valid instruments, methodologies and/or processes to assess functional decisional capacity. • As reported in Provision K5, based upon the documentation provided during the current site visit, it was evident that the Facility possessed the tools and resources to conduct comprehensive assessments of behavior. This was most evident in the assessments completed as part of the BAIPs. The application of these tools and resources, however, was not equally distributed across all individuals. In particular, individuals for whom a mental illness was diagnosed and psychotropic medications were prescribed often were provided	

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		assessments that did not address environmental issues or the role of learned behavior in the expression of mental illness. If individuals living at the Facility are to be provided adequate services and supports, the Facility must ensure that comprehensive behavior assessment is provided to all individuals as a part of the intervention development process. At the time of the site visit, however, the Facility had not achieved substantial compliance. Conclusion: This provision was found to be not in compliance. Assessments were not completed routinely in a timely manner nor were they of adequate quality to reliably identify the individual's strengths, preferences and needs.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	Extent to which assessment results are used to develop ISPs: Current assessment practices at BSSLC, in terms of timeliness, accuracy and thoroughness, did not provide assessment results that could adequately be used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual. As described in Provision F1c, assessments required to develop an appropriate ISP meeting were frequently not done in time for QIDPs 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 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. There were some examples of improvement, however: • For three ISPs observed, the Monitoring Team found there was continued 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. • As reported in Provision S1, based upon the documentation provided by BSSLC of a very small (three) facility-selected sample, the use of assessments in the development of SAPs appeared to be substantially better in the latest iteration of the SAP development process. • In addition, the Facility had recently undertaken an initiative to ensure the implementation of ISP-related assessment recommendations. The QIDP Recommendation Log documents all recommendations from the ISP Preparation meeting, the ISP and ISPA meetings. These are monitored on an ongoing basis by the QIDP Coordinator's office. This was another modification to the process and should result in improvement Conclusion: This provision was found to be not in compliance.	Noncompliance
F1e	Develop each ISP in accordance	Adequacy of process to develop each ISP in accordance with ADA and Olmstead decision	Noncompliance

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	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).	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 ISPs reviewed the Monitoring Team found the required determination was still not being consistently provided. • Of the nine ISPs reviewed, for none (0%) did all of the assessments include the applicable statement/recommendation. Of the 49 total discipline assessments that were available to review, 35 (71%) included a determination of whether the individual could be served in a more integrated setting. • For the most part, those that provided a determination used a template statement indicating that the professional opinion was based on the current services and support being provided at the Facility and did not take into account that any different services might be needed in the community. Only four of 49 discipline assessments were found to have an individualized and substantive statement about the individual's needs in community living. • Nine of nine ISPs (100%) included an independent recommendation from the professionals on the team to the individual and LAR that the individual could be served in a more integrated setting, but only two (22%) resulted in a referral. • Of the nine ISPs reviewed none (0%) adequately identified the protections, services and supports that would be needed by the individual in the most integrated setting. • 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 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 obstacles. In summary, the Facility was not yet effectively identifying or addressing obstacles. None of seven (0%) of the recently completed ISPs reviewed that did not result in a referral evidenced proficiency in identification and addressing of obstacles to referral. The Monitoring Team observed some progress in the observed ISP annual meetings in the effectiveness with which IDTs addressed the concerns of the LARs and offered information to LARs about the potential benefits of community living. For example, as	

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		reported in Provision T1b1, for Individual #547, there was a well- managed Living Options discussion with a reluctant LAR. The Lead QIDP and QIDP had engaged the LAR in at least one conversation about community awareness and living options prior to the meeting, which resulted in a living options discussion at the meeting that was respectful and non-threatening in nature. While the LAR and another family member were very clear about their continued opposition to community transition, the discussion was open and comfortable. The IDT was able to express its opinion about what they considered an appropriate most integrated setting for the individual without discomfort on anyone's part. The LAR was not put on the defensive and agreed to allow the individual to participate in CLOIP tours on a quarterly basis. The Lead QIDP closed the discussion with an acknowledgement that he and the QIDP would have continuing discussions with the LAR over time. This was a very positive outcome. Still, the IDT needed to continue to improve upon its processes as evidenced by these additional findings: • The IDT unfortunately did not have any discussion about what the individual's needs might be in a more integrated setting. This was a missed opportunity to address some of the concerns of the reluctant family members. For example, a sister was concerned that individuals with similar disabilities were not well supervised in the community. This would have been an opportunity to discuss the level of supervision the family thought would be needed. As long as the family understood this was not leading to any foreseeable movement, this type of discussion could be held in a non-threatening way. It also would give the IDT an opportunity to talk about some of the likely advantages for the individual, such as smaller settings, proximity to an aging parent who cannot travel as much as in the past, a quieter and calmer environment, etc. • The Monitoring Team would have also liked to see the IDT provide more definition about the purpose, structure and desired outcome for the individual. There was a discussion about how often the individual should attend tours; there was no rationale stated as to why the IDT chose a quarterly schedule. As noted in the preceding bullet, there was no discussion as to what types of community living options might best fit the individual's needs which would relate to setting up appropriate tours, nor was there any discussion as to what the IDT hoped to glean from the tours, or how and when they would be evaluated. Each of these components is important part of a community awareness plan. As it relates to this provision, there was little overall progress demonstrated in the ability of the IDTs to identify 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. This may be attributed in part to a sequence that did not ask the team to actually determine the most integrated appropriate	

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		setting until after the individual's services and supports had been identified. This tended to perpetuate the tendency of the teams to focus primarily on the supports and services currently being provided at the Facility. While such an array may include many essential services and supports, it does not take into adequate consideration the varied needs that may be needed for successful transition and community living. The IDT must identify the supports, services and protections that would be needed in that setting even if the IDT ultimately chooses not to make a referral. The process of identifying the needed supports and services is integral to determining whether a setting would be appropriate, and also serves to assist the individual and LAR to visualize how community living could be safely supported. The identification of needed services and supports is also pre-requisite to assisting the team to identify and address potential obstacles to movement. In addition, the Monitoring Team was concerned by the report that, even for individuals who the IDT determined would be referred for community living during the ISP annual meeting, the Facility practice was to defer the identification of required services and supports until an ISPA meeting was scheduled within 14 days. Unfortunately, attendance at the Living Options meeting was not consistently as rich as that at the annual planning meeting, such that fewer IDT members were available to contribute to the discussion. This further diluted the effectiveness of the ISP as the Facility's process for assessing individuals for community living, as well as deprived individuals who were referred of full IDT participation in the identification of community living needs and development of appropriate supports and services. If the IDT members have reached a general consensus that the individual could be served in a community setting, it is incumbent upon them under the SA and Olmstead to address what would be needed to facilitate that, regardless of whether a referral is made. Engaging the IDT, including the individual and family/LAR in a discussion of both obstacles and opportunities is an essential component of an ISP developed in accordance with the ADA and Olmstead. <u>Conclusion</u>: This provision was found to be not in compliance. To move in the direction of substantial compliance, the Facility should focus its efforts over the next six months on the following: Additional policy guidance and training should be provided to 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, including supports and potential obstacles in terms of their availability . 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, or living in closer proximity to family. Having accomplished that, the determination of whether or not a referral will be made can be completed in which individual and/or LAR	

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		preference would take final precedence.	
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner 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;	This provision of the Settlement Agreement addresses a number of specific requirements, including identification and use of individuals' preferences and strengths, prioritization of needs and explanation for any need or barrier not addressed, and identification of supports needed to encourage community integration. Each of these is addressed separately below. <u>Identification and Use of Individuals' Preferences and Strengths:</u> DADS Policy 004.2 describes the PSI as an on-going integrative assessment process that provides a written record of the resident's preferences, strengths, goals, programs, and supports provided at the State Supported Living Center and as the cornerstone of the Facility's person-centered processes. In previous reports, the Monitoring Team had found that there were significant deficiencies as to the extent to which ISP builds on the individual's preferences and strengths and prioritized needs. The ISP process relied, and continues to rely, heavily on the Preferences and Strengths Inventory (PSI) process to identify preferences and strengths, a process that did not involve formal assessment of preferences or reinforcers, but relied largely on anecdotal information. The Facility should consider procedures and tools that may provide more accurate and useful information; examples include a variety of person-centered planning processes as well as data-based preference assessments. In the current ISP process, the IDT began with a discussion of preferences and strengths. It was not yet evident the Facility was proficient in completing this assessment, as evidenced by the outcomes. Examples included: • Preferences continued to be focused on favorite foods and environmental likes and dislikes. The IDTs should expand their approach to include an examination of where and how an individual would like to live, what kind of work and/or avocation is meaningful to the individual, preferences related to social	Noncompliance

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		interactions beyond the basics of enjoying staff interaction and/or personal space, and how individuals relax and/or spend spare time. If these preferences are not known or cannot be discerned, this should indicate to the IDTs a need to implement Action Plans to help the person discover them. • At the ISP Preparation Meeting for Individual #545, a SAP under discussion called for teaching the individual how to turn on the television. Watching television was described as one of the individual's preferences, it having been observed the individual would come out when the TV was turned on, but would watch whatever was on. There was no indication that the IDT had made any attempts to discern what specific programs the individual might be interested in. • For Individual #102, whose ISP was reviewed as a part of the sample for this section, the review of preferences included items such as puzzles, big wooden blocks, legos, pegs and large plastic balls. It is important for IDTs to consider how individuals developed such preferences. In many instances, these developed because this type of activity was what was offered over long periods of time rather than some inherent pleasure. The IDT should at least question what other more functional, age appropriate activities could be introduced over time, rather than just accepting these as personal preferences instead of learned behavior. Observations of ISP annual planning meetings on-site indicated the IDTs were making progress in their efforts to incorporate preferences and strengths, however. For example, the Monitoring Team attended the ISP annual planning meeting for Individual #547 and found the ISP developed at that meeting clearly integrated the individual's preferences, needs and strengths. For example, this was observed with the plan for integration of the acquisition of sign language across all SAPs and SSOs. In one particularly well-integrated approach, the communication strategy was integrated with fostering the individual's friendship with another individual. In addition to the use of the signs, it also included dining out in the community with the friend, which promoted community integration and fostered relationships; and the use of picture symbols for ordering the meal, which in turn promoted communication development and independent living skills. This had not yet been consistently implemented. In the review of nine ISPs, 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 for these nine, but were seldom reflected in any substantive manner in the assessments developed for the annual ISP and/or integrated throughout the narrative and/or discussion of the ISP.	

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		Prioritization of Needs and Explanation for Any Need or Barrier Not Addressed: The Monitoring Team found that one of the nine (11%) completed plans reviewed included a list or discussion of prioritized needs in which the IDT clearly indicated whether any needs were to be prioritized for implementation and provided an appropriate justification for any need or barrier not addressed. IDTs were required to identify barriers to living in the most integrated setting, but 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 seven (0%) recent ISPs reviewed for which a referral had not been made evidenced proficiency in this regard, but some improvement was noted. Because the ISPs did not clearly list needs or barriers, prioritization could not be done, and there was no way to determine whether all needs and barriers were addressed. Extent to which ISP encourages community participation: Three of the nine ISPs (33%) reviewed included specific skill acquisition action plans for implementation in the community. Each called for individuals to engage in exchange of money for purchases in the community, and none were designed to occur more than once per week. It was not clear these SAPs effectively promoted actual community participation. For example: • One, for Individual #189, was individualized to address specific preferences and called for the individual to purchase a DVD at Wal-Mart two times per month. Monthly Reviews indicated no data had been collected on this SAP in October, November and December 2013. The January Monthly Review was not provided. • The Monthly Reviews for Individual #62 indicated no community outings had been documented in December 2013 or January 2014, but the notation regarding the SAP to count dollars needed to make a purchase in the community provided some implementation data. As recommended in Provision T1b2, the Facility's IDTs should develop an individualized community participation strategy for each individual that takes in to account their specific learning needs, preferences, and strengths. These plans could include, and integrate, purposeful community integration activities; community tours; self-advocacy; community work, job exploration, and volunteer activities; developing and/or maintaining relationships with people living and working in the community; and other approaches the Facility might explore and create. All of these provide opportunities for increasing awareness of community living and should be considered in developing an integrated and individualized strategy for each individual.	

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		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 on developing a comprehensive and functional plan for community integration and awareness will be required. Conclusion: This provision was found to be not in compliance.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	Extent to which ISP specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to attain identified outcomes related to each preference: As described in Provision F2a4 ISP programs were still not adequately individualized to the individual's needs; however, there was progress observed in a small, Facility selected sample of SAPs in this regard. Findings included: • Each SAP included on the cover page a detailed presentation of which assessments were used in determining the need for the SAP, as well as the date of each assessment and, where needed, a succinct presentation of the findings. • Each of the three SAPs clearly reflected a process that emphasized identifying and supporting the unique needs and preferences of the individual. Although only two of the three SAPs were rated successful for the use of individualization • One of the three reviewed SAPs (33%) reflected an adequate behavioral objective • Two of the three SAPs (67%) included adequate instructions for staff. For the nine ISPs reviewed, it appeared the ISPs being developed still 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 still 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, but some progress was noted in this sample compared to previous reviews. Examples included: • Emphasis on skill acquisition was improving, but four of seven (57%) ISPs had only one or two SAPs. • Individual #62, who had been referred for transition at the time of the ISP	Noncompliance

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		annual meeting, had only one SAP, which was for selecting the correct dollar amount for making purchases in the community. While it was positive this individual had a SAP for community implementation, there was no evidence the IDT considered other skills that would benefit the individual in community living. Other than the Action Plan for the referral and the single SAP, the remaining Action Plans were limited to the following: to be provided with activities she enjoys, a psychiatric support plan, to be provided with staff support for tooth-brushing, a continued SAMS program to count pills at medication time and for TIVA to be scheduled. The individual was also school aged and there was no reference to or incorporation of the IEP in the ISP. • There was progress reflected in the ISPs developed at the annual planning meetings held during this monitoring visit. The most impressive of these, in terms of a providing full complement of individualized goals or objectives and/or strategies to address the array of supports and services the individual required, was for Individual #547, who was provided with a rich array of skill acquisition plans which also integrated communication strategies. See Provision F2a3. <u>Adequacy of processes for identification of and plans to overcome barriers</u>: 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 seven (0%) recent ISPs reviewed in which a referral was not made evidenced proficiency in this regard. Also see Provision F1e above. <u>Conclusion</u>: This provision was found to be not in compliance.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	<u>Extent to which ISP integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions:</u> 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	Noncompliance

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		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; • Evidence 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 did find evidence that integration was improving. • As reported in Provision J8, the Facility was found to be in substantial compliance in integrating pharmacological treatments with behavioral and other interventions, through combined assessment and case formulation. Processes that enhanced integrated care were also evident at ISP meetings that were attended by a large portion of the IDT. During the visit the Monitoring Team attended the ISP meeting for Individual # 599. During that meeting and in particular during the IRRF discussion there was good sharing of information between clinicians. • The Monitoring Team attended the ISP annual planning meeting for Individual #547 and was impressed with progress observed in the development of integrated planning for skill acquisition. For example, this was observed with the plan for integration of the acquisition of sign language across all SAPs and SSOs. In one particularly well-integrated approach, the communication strategy was integrated with fostering the individual's friendship with another individual. In addition to the use of the signs, it also included dining out in the community with the friend, which promoted community integration and fostered relationships; and the use of picture symbols for ordering the meal, which in turn promoted communication development and independent living skills.	

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		• The Monitoring Team also observed two additional ISPs and two ISP preparation meetings during the on-site visit. There was some progress noted in these meetings as well, particularly as it related to the development of integrated SAPs. • As reported in Provision S1, each of the three facility-selected SAPs clearly reflected a process that emphasized identifying and supporting the unique needs and preferences of the individual, although only two of the three SAPs were rated successful for the use of individualization. • As reported in Provision R3, a review of individuals' records with Positive Behavior Support Plans/ Behavior Assessment and Intervention Plans indicated communication assessments contained evidence of review of the PBSP/BAIP by the SLP, and communication strategies identified in the assessment were included in the PBSP/BAIP. 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, additional improvement was still needed. 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 the annual ISP planning meeting attended for Individual #123, the IDT missed some opportunities to define integrated and coordinated approaches to skill acquisition that would support the individual's personal goal of independent living. For example, the relationship goal could have incorporated leisure planning for activities with friends and family as well as extended the use of telephone to calling to obtain information about preferred activities in the community. Similarly, money management training could have been integrated with the individual's program to follow a baking recipe, in which the individual could have made a grocery list from the recipe, shopped for the ingredients, paid for the ingredients and obtained the correct change and then mixed and baked the food item. It was noted that Program Development staff indicated this was latter strategy was the sort they intended to implement, even though this was not specifically described at the annual planning meeting. A review of the completed SAP for following the recipe did not include any of these. • None of the nine (0%) plans reviewed for this section integrated all of the protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. • As reported in Provision O2, for only four of 11 individuals (36%) in Sample O.1 and O.2, were all recommendations by the PNMT addressed/integrated in the ISPA, Action Plans, IRRFs and IHCPs.	

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		• As reported in Provision R3, only one of 13 ISPs reviewed (8%) contained skill acquisition programs to promote functional communication. Strategies were not integrated into existing SAPs and SAPs were not consistently developed. • Also as reported in Provision R3, two of 13 ISPs reviewed (15%) included how communication interventions were to be integrated into the individual's daily routine. Recommendations were consistently present as part of the Communication assessment but integration of these recommendations was lacking. Conclusion: This provision was found to be not in compliance. Overall, progress had been made, but 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: The Monitoring Team could not confirm the Facility consistently identified adequate methods for implementation. Examples included: • Findings in Provision S1 related to the consistent identification of methods for implementation was limited, as reported in the Summary of Monitors' Assessment above, and insufficient to support a finding of substantial compliance. • As reported in Provision O2, in one of 11 individuals' plans reviewed (9%), the plans included the specific clinical indicators of health status to be monitored. In one of 11 individuals' plans reviewed (9%), the plan defined triggers and in one of 11 individuals' plans reviewed (9%), the frequency of monitoring was included in the plans. Adequacy of identification of time frames in action plans: For four of the nine ISPs reviewed (44%) did action plans in the ISP include adequate timeframes for completion. There was progress noted in this area from previous monitoring periods. This review indicated timeframes were more often individualized according to need and activity, with less reliance on a standard (i.e. one year) completion date across the board. There were other indications that timeframes were still not adequately identified. For example, as reported in Provision O2, in only two of the 11 individuals' plans reviewed (18%), were there established timeframes for the completion of action steps that adequately reflected the clinical urgency. Adequacy of identification of persons responsible in action plans: The ISPs typically indicated by position who would be responsible for program	Noncompliance

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		implementation, documentation and data review. This did not yet 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 F2f which indicated that ISPs, including the completed Action Plans, were not consistently being put into place on a timely manner by those identified as responsible for ensuring plan development. Conclusion: This provision was found to be not in compliance.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	Adequacy of interventions, strategies and supports that are practical and functional at the Facility and in community settings: 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 nine plans (0%) reviewed effectively addressed the individual's full array of needs for services and supports in a manner that was practical and functional across settings. There was some progress noted. As reported in Provision S3(a), it was suggested that a SAP would be practical and functional if it a) could be implemented in locations where the individual was likely to live and work, and b) was likely to strengthen the basic set of skills the individual would need to succeed. In order to obtain a measure of practical and functional qualities of the SAPs in the current Facility-selected sample, three SAPs were rated on five questions. Based on the findings, it appeared that the three SAPs were substantially more functional and practical than SAPs reviewed during previous site visits. Conclusion: This provision was found to be not in compliance.	Noncompliance
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the	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: The Monitoring Team found the Facility did not yet consistently identify 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. Examples of deficits in identifying 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 included:	Noncompliance

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	data collection, and the person(s) responsible for the data review.	• As reported in Provision S1, for a small, Facility-selected sample of SAPs, none of the three SAPs (0%) called for more than a single trial per day. It has been repeatedly demonstrated in research regarding learning that the development of skills requires repetition • As reported in Provision K4, seven of 15 records (47%) did not include adequate criteria for assessing the success or failure of the intervention plan. In some cases, this was due to the absence of the necessary criteria. In other circumstances, however, criteria were included, but were vague or subjective, such as relying upon the judgment of the treating psychiatrist. • Also as reported in Provision K4, eight of 15 records (53%) reflected inadequate data collection procedures and eleven of 15 records (73%) did not include data collection procedures for the training of replacement behavior. <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 nine of the nine ISPs reviewed (100%), the Action Plans defined the person(s) responsible for data collection. Similarly, for nine of the nine ISPs reviewed (100%), the Action Plans also clearly defined the person(s) responsible for data review. This did not appear to be sufficient to achieve the outcomes of ensuring program review was accomplished as required, however, as evidenced by the findings described in Provision F2d below. <u>Conclusion</u>: 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.	<u>Adequacy of coordination of goals, objectives, anticipated outcomes, services, supports, and treatments in the ISP:</u> 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. For example, as reported in Provision R2, SLPs and psychologists continued 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 continued to use a PBSP/Communication Assessment Checklist that was designed to improve consistency between the two documents and assist in identifying areas in which there is crossover between the two disciplines. In addition, a SLP was noted to have participated in 92% of the Positive Behavior Support Committee meetings from 1/1/2014 to 3/31/2014.	Noncompliance

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		The Monitoring Team commends the Facility for these initiatives to promote staff coordination in the development and monitoring of supports and services. Overall, coordination of goals, objectives, anticipated outcomes, services, supports, and treatments in the ISP continued to be lacking, as described throughout this Section F and in other sections of this report. For example, as reported in Provision T1b2, the Facility should have, but did not create comprehensive coordinated plans for community living education and awareness for individuals. Such 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. <u>Conclusion</u>: This provision was found to be not in compliance.	
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	<u>Extent to which ISP is accessible and comprehensible to staff:</u> The ISP appeared to be accessible to staff. • A copy of the ISP was filed in each individual's All About Me book (Individual Notebook). • As reported in Provision K11, the Facility was in substantial compliance in ensuring that PBSPs are written so that they can be understood and implemented by direct care staff. • As reported in Provision M3, the Monitoring Team interviewed DSPs for two individuals. The DSPs were able to quickly locate and show individuals' All About Me Books, Communication Notebooks, and Training Notebooks. The DSPs without hesitation were able to find the DSP Instruction Sheets and to explain their care responsibilities for these individuals. Overall, however, observations and review of program data indicated that the ISP did not appear to be consistently comprehensible to the staff responsible for implementing it, as there were still 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, per observations conducted by the Monitoring Team, 16 of 23 individuals' (70%) dining plans were implemented as written. This represented a seven percent decrease in implementation. Twenty of 28 individuals' positioning plans (72%) were implemented as written, but this represented an improvement. • As reported in Provision R3, three of seven staff interviewed (43%) were knowledgeable of the individuals and their communication related programs	Noncompliance

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		• As reported in Provision S1, observations revealed that across all settings 64% of observed individuals were functionally engaged. • Conclusion: This provision was found to be not in compliance, although progress was noted.	
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate.	Monthly review of progress: The assigned QIDP was required to make an overall monthly review and evaluation of progress for each individual. The ISP Preparation 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 Facility reported that there were significant concerns about the implementation of monthly reviews of progress by the QIDP. The Monitoring Team confirmed this finding. Overall, the Monitoring Team found that QIDP Monthly Reviews were not consistently completed in a way that provided for meaningful evaluation of progress, program revision or to support future plan development. QIDP Monthly Reviews for the past three months for nine individuals with recent ISPs were reviewed. The Monitoring Team observed there continued to be progress in the actual timely completion of the monthly reviews but there was little progress noted in the substance of the recent monthly notes; 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. Most of the monthly reviews provided little actual progress evaluation or led to any program modification. The Facility was aware of this concern and was taking corrective action. It was in the process of implementing improvements to the QIDP Monthly Review process. Components of this plan included: • A revised Monthly Review format had been devised that required specific information to be entered from various sources including the Interdisciplinary Progress Notes (IPNs), the Observation Notes, Community Outing logs, status of referrals, and summaries of information regarding restraints, incident, falls and other significant events, and SAP progress. Monthly Reviews were to represent all data and information on a three month rolling cycle to ensure that progress and regression could be easily visualized and acted upon. This Monthly Review also introduced a SAP graphing element that would represent the data across an entire year. While this process was still evolving, it had the potential to be a significant improvement in the current processes. The Monitoring Team reviewed samples and provided several suggestions for further enhancing the documentation of follow-up actions.	Noncompliance

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		• A Monthly Review Tracking system, in which all Monthly Reviews were to be turned into the QIDP Coordinator's office as they were completed. These were entered into the tracking system and a report was to be issued weekly to the Lead QIDPs to allow them to monitor and follow-up on workflow and completion. • The QIDP Compliance Monitor was to complete a random sample of the revised Monthly Reviews for quality monitoring. Those that did not meet quality criteria would be returned for correction and/or amplification. Exemplary documents would also be recognized as examples that could be disseminated as it was intended the results of the quality review would support ongoing training efforts. The Monitoring Team also found evidence that the Facility did not ensure the other responsible interdisciplinary team member(s) for each program or support included in the ISP assessed the progress and efficacy of the related interventions and/or take action as a result of a lack of progress. • As reported in Provision O7, five of 11 individuals' records in Samples O.1 and O.2 (45%) 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. • As reported in Provision K4, none of 15 records reviewed for individuals with either a Behavior Support Plan for Psychiatric Symptoms (BSPPS) or a Behavior Assessment and Intervention Plan (BAIP) (0%) reflected a review of monthly progress notes by a BCBA. • As documented in Provision P2, for four of 13 individuals with PNMPs (31%), 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 QIDP did not include detail regarding the implementation of the services, the effectiveness, or the need to revisit identified concerns was contained within the monthly review. 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. Examples included: • As documented in the previous two monitoring report, Individual #286 had been identified as at high risk for falls and fractures. The Monitoring Team had	

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		raised concerns about the IDT's vigilance in addressing these risks. On 10/11/13, after the Monitoring Team last raised these concerns, the IDT met and determined a set of actions it would take as a falls prevention plan. These included a DEXA scan, a pending referral to ophthalmology, the use of a gait belt, a referral for the development of a SAP to increase his awareness of the environment and an IDT agreement to meet anytime the individual fell. • The DEXA scan was completed on 3/12/14, although the IDT had made earlier attempts to obtain it in September and February. There was no documentation of any attempts were made between the 10/11/13 meeting and 2/12/14, however. • The individual was referred to the ophthalmologist on 11/07/13 and seen on 11/20/13. There was no documentation indicating why the referral was delayed for almost one month after the IDT determined at the falls prevention ISPA meeting on 10/11/13 that it was needed. • The falls prevention ISPA on 10/11/13 stated the IDT believed the individual needed to be more aware of the environment and would send a referral to the SAP department to develop a SAP in this area. At an ISPA meeting held on 2/4/14 to discuss transfer to another residence as a possible falls protection strategy, the Habilitation Therapist especially noted that the individual was not aware of the environment "below chin level." The Monitoring Team was unable to find any evidence in the record that either the Program Development Unit or Habilitation Therapies had developed any training or therapy to address this. Upon request of the Monitoring Team for this documentation, the Facility provided a referral to Habilitation Therapy that was not submitted until 1/7/14, more than three months later. In response, an assessment by a Habilitation Therapist was dated January 27, 2014; there was no evidence the IDT had met to discuss the findings and any additional actions that might be needed as a result. • The Monitoring Team identified seven falls documented in the record since the last monitoring visit in October 2013, while the Facility's document request only listed three in that period. The falls occurred on 11/21/13, 12/1/13, 12/7/13, 1/8/13, 1/14/14, 1/30/14, and 3/7/14. Although the IDT had committed to meet each time the individual had a fall, only two ISPAs to address the falls that occurred were found in the record. o One was held on 1/9/14 and addressed a fall that occurred on 1/8/14. It did not reference the falls that occurred on 11/21/13, 12/1/13, 12/7/13, so it was not clear the IDT was aware of these at that time. The IDT indicated only that the fall on 1/8/13 was an accident and no changes were needed to the falls prevention plan. The IDT did not address any follow-up on the other components of the plan. o On 2/13/13, the IDT met again to address falls that occurred on	

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		11/21/13, 12/7/13, and 1/30/14, but did not reference a fall that occurred on 1/14/14 or acknowledge that a fall had occurred on 12/1/13. The IDT again noted the individual had no awareness of environment below eye level, but the only recommendation was to obtain tennis shoes rather than loafers. o There was no ISPA in the record for the fall that occurred on 3/7/14. • The Monitoring Team attended the ISP Preparation Meeting for Individual #545. There were behavioral health concerns that had not been adequately addressed for some months: o It was agreed the IDT would meet in another ISPA meeting to address psychiatric and behavioral concerns. The Individual had had significant decompensation of psychiatric symptoms of Obsessive-Compulsive Disorder and related behavioral manifestations since Abilify had been discontinued due to metabolic disorder. More recently, additional medication changes had been made. It was not clear, however, whether current behavioral supports were sufficient to address the behaviors that were being observed and whether there was currently sufficient coordination between psychiatry and behavioral health/psychology. The individual had a Behavior Support Plan for Psychiatric Symptoms (BSPPS) in place, but did not have a BAIP. The psychiatrist asked the behavioral health specialist on two occasions about behavioral supports that could be implemented; the behavioral health specialist indicated that because these symptoms were biological in nature, there was no BAIP but that there were prevention strategies built in to the PSP. The Monitoring Team was concerned that there appeared to be no methodology for monitoring the implementation of these strategies or their effectiveness. The Behavioral Health Specialist did agree that the individual's compulsive behaviors needed to be more discretely defined so that prevention strategies could also be more specific. Again, there was no methodology for testing or evaluating these prevention strategies. o The IDT discussed IRRF ratings to ascertain if any might need to be modified. The Monitoring Team noted that the current Behavioral Health rating was low, and the IDT failed to consider that it might need to be changed given the current circumstances. The Monitoring Team recommended this be considered at the ISPA to be scheduled. • Individual #490 returned to the Facility approximately in August 2013, approximately 30 days after transitioning to community living. The individual, who had a history of mouthing which had been identified but not otherwise addressed in the pre-placement Behavioral Assessment and Intervention Plan	

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		(BAIP), had swallowed a battery and been hospitalized for its removal just prior to returning to the Facility. Upon return, the individual also was observed by staff to ingest a paper clip. Despite these events, the IDT did not act assertively to put adequate protection from harm provisions in place. The BAIP in the record was dated April 2013 and had not been updated to address this significant behavioral and protection from harm need. The PNMP, dated September 4, 2013, did not reference pica behavior. Upon request by the Monitoring Team, a more current BAIP was located, but it was not available in the individual's record and did not address pica behavior. The most recent Integrated Risk Rating Form (IRRF) was from January 2013 and had not been updated since the individual returned from the community. On 12/30/13, the record indicated the individual put a hanger in her mouth and it had to be removed by staff. An ISPA held on 12/31/13 indicated the individual had stated a suicidal intent and attempted to swallow a penny. The IDT met to discuss the suicide statement and physical aggression to staff, but did not address the attempt to swallow the object as an ongoing behavior. The Monitoring Team was also very concerned to note the ISP Preparation materials for this individual noted neither psychiatry nor psychological assessments were required for this individual, stating that the individual "does not need services." Neither of these assessments were in fact provided with the ISP packet for this individual, which called into question whether the Facility was adequately assessing and addressing this individual's significant behavioral health needs. See also Provision T1c1 for discussion of the negative impact of this in the IDT's evaluation of barriers to community transition. • As reported in Provision O2, individuals who were expected (per policy) to be referred to the PNMT for assessment were not consistently provided with such assessment. For example, Individuals #318, #191 and #68 all had multiple pneumonias over the past 12 months but were not assessed by the PNMT. Individuals who experienced PNM related hospitalizations were not consistently provided with comprehensive review or assessment that addressed all the needed components. <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	<u>Extent and adequacy of competency-based training for staff:</u> The Facility continued to make progress toward competency-based training for staff responsible for implementation of ISPs. Examples included: • Provision O5 was found to be in substantial compliance. BSSLC provided comprehensive PNM related trainings as part of new employee orientation as well as part of annual refreshers and intermittent training based on changes in	Noncompliance

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	completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	plans of care. All training that needed to be competency based was provided as such. Additionally, BSSLC had formalized the process for ensuring staff were trained prior to working with new individuals on different homes. • Provision P3 was also in substantial compliance. • Overall, however, the Monitoring Team found it could not yet adequately verify staff were adequately provided with competency-based training. For example, as reported in Provision F1a, the QIDPs were the staff responsible for ensuring members of the team participated in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports. Based on the list provided, only the QIDP Coordinator and three Lead QIDPs had been deemed fully competent in facilitation. The Facility was not currently using the Q Construction Facilitation or other curriculum for training the remaining QIDPs in this area and was not evaluating their competence at this time. It was reported the state was currently in the process of revising the training materials. Overall outcomes in the facilitation and development of ISPs were improving, but deficiencies remained in facilitating the adequate assessment of individuals, and the development, monitoring, and revision of adequate treatments, supports, and services as well as in the adequate discussion of the most integrated setting. • As reported in Section K, Provision K12 requires the Facility to 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. The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress; therefore the noncompliance finding from the last review stands. • This finding was also influenced by observing outcomes of the lack of active treatment and engagement and lack of fluency with which staff were able to discuss the strategies, supports and interventions included in an individual's ISP without referring to the record, as described in Provision F2c above. Substantial compliance in competency-based training must be supported by the actual observed competence of the staff trained; otherwise, the training protocol cannot be considered to be effective. <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 ISP for each individual within	<u>Extent to which ISPs are developed within 30 days of admission:</u> The Facility reported 12 admissions during this six month period. The Monitoring Team reviewed the ISP and assessments for a sample of three of these. The ISP annual planning meeting was held for each of these within 30 days of admission. Many assessments were not consistently completed on a timely basis for this sample, however,	Noncompliance

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	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.	calling into question whether the IDT had all the information it needed to develop an appropriate and comprehensive plan. For example, for Individual #464, the following assessments were not completed until well after the ISP meeting was held: Nursing, Medical, Psychiatry, Vocational, Water Safety and Dental. In addition, no Psychological or Behavioral Assessment was provided. <u>Extent to which ISPs are revised annually and as needed:</u> The Facility reported that for the period January 1, 2013-February28,2014 only two ISP Annual Meetings had occurred more than 365 days after the previous annual meeting. 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 3/18/2014. The list indicated six ISPs had occurred more than 365 days after the previous annual meeting. Most were completed within one week of the required timeframe, but one was more than six months late. From the list the Monitoring Team was not able to fully determine the Facility's status as it pertained to implementation of the ISPs once the annual meeting was held. The list indicated that a new process for collecting data on timely filing and implementation of the annual ISP began in January 2014. Data were only available for 26 of 288 individuals. Another document provided in response to the document request indicated the total number of ISPs filed more than 30 days late for the period November 2013 through January 2014 was 38, however. The Monitoring Team also noted that of the three new admissions described above, only one (33%) appeared to have been implemented on a timely basis as reflected by presence of the completed SAPs and data sheets requested for review. The Monitoring Team found the IDTs did not consistently make revisions to ISPs as needed, as evidenced by findings and examples in Provision F2d. In addition, as reported in Provision O2, in two of 11 individuals' documentation reviewed (18%), supporting documentation was present to confirm implementation of individuals' action plan within 14 days, or sooner as needed, of the plan's finalization. In two of 11 individuals' plans reviewed (18%), 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. <u>Conclusion:</u> This provision was found to be not in compliance.	
F2g	Commencing within six months of the Effective Date hereof and with	The Facility was had developed or was developing several new quality assurance processes designed to identify and remediate problems to ensure that the ISPs are	Noncompliance

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	full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	developed and implemented consistent with the provisions of this section. These appeared to hold promise for quality management. They included: • An ISPA Tracking system was in development and scheduled to be implemented by May 1. This was intended to ensure that all ISPA meetings were tracked and the minutes available within three working days as required by facility policy. The QIDP Coordinator's Office was to be responsible for the tracking log and reporting of any delinquencies to the appropriate Lead QIDP. • A Monthly Review tracking system as described in Provision F2d. • An Assessment Tracking Log as described in Provision F1c,. • An Attendance Tracking database, which took into account the ISP Preparation attendance requirements. The Monitoring Team reviewed the Brenham State Supported Living Center QA/QI Council Meeting, Quarterly Quality Assurance Report, dated February 26, 2014 and interviewed both the Quality Assurance Director and Section F QA Compliance Monitor 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: • The Facility continued to implement the Section F Monitoring. No changes had been made to the tool. • Each month the Lead QIDPs, the QIDP Educator and the QIDP Coordinator completed a tool for an ISP completed 60 days prior. The QA Auditor then completed an inter-rater audit for two of these, per the interview with the QA Director. • At the time of the last monitoring visit, the Facility had recently implemented a Corrective Action Plan (CAP) that addressed the QIDP monitoring of the competency-based implementation of ISP. In this process, the Facility had developed an observation form to judge competency to be used by the QIDPs, who had also been trained on the tool and protocol. This process had been implemented August 1, 2013, but the Facility found it was not effective and it was discontinued. • The Facility had developed Draft QA Process/Outcome Indicators as of 01/31/2014, including a number of indicators pertaining to this section. The Monitoring Team commends the Facility for this initiative overall, as it should support Facility-specific plans for improvement. <u>Conclusion:</u> This provision was found to be not in compliance. The Facility was continuing to develop its quality assurance processes.	

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 3/18/14 2. BSSLC Action Plans 3/18/14 3. Presentation Book for Section G 4. Provision Action Information for Section G 5. BSSLC Policy H.1 Minimum Common elements of Clinical Care Ensuring Integration of Clinical Care 11/30/12 6. BSSLC Policy L.1 Medical Care 11/2/13 7. Morning Medical Debriefing minutes of 10/1/13, 11/1/13, 12/2/03, 1/2/14, 3/17/14, 3/18/14, 3/19/14, 3/20/14, 4/7/14, 4/8/14, 4/9/14, 4/10/14, and 4/11/14 8. BSSLC Procedural Guidelines for On-Campus and Off-Campus Consultations 2/28/13 9. Consultation Report blank form 10. Consultation Audits reports of October 2013, November 2013, December 2013, January 2014 and February 2014 11. Sample of medical consultation reports for Individuals #24, #93, #95, #96, #141, #230, #384, #415, #517, and #579, and Modified Barium Swallow Studies (MBSS) for Individuals #19, #35, #380, #465, and #566 **People Interviewed:** 1. Mary Ann Brett, MD, Director of Medical Services, and Penny Foerster, RN **Meetings Attended/Observations:** 1. Medical Morning Meeting 4/8/14 and 4/9/14 2. ISP annual planning meetings for Individuals #123, #547 and #599 3. Meetings attended by Monitoring Team members noted in several report Sections
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section G. 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 G, in conducting its self-assessment, the Facility: ▪ Did not use monitoring/auditing tools, although the assessment of consultations involved a review of 10 components that should be present, and the Provision Action Information reported the Facility had audited 20 samples per month for that information. There was no indication of who reviewed the consultations and gathered that information. The criteria required appropriate and valuable action that met the requirements of this provision. ▪ Used other relevant data sources and/or key indicators/outcome measures: o Attendance of clinicians at ISP meetings

	○ Evidence of integration of discussion and planning among disciplines at Medical Morning Meetings (although the criteria for rating this were not provided, and there was no evidence of inter-rater agreement measurement to assess reliability of the ratings) ▪ The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self Assessment: ○ Presented findings consistently based on specific, measurable indicators. For example, the ratings of consultations were reported by criterion, rather than by a global measure. ○ Did not consistently measure the quality as well as presence of items. For the consultations, criteria included "clear synopsis" and "pertinent medical history," both of which are measures of quality, but there was no evidence of inter-rater agreement measurement to assess reliability of the ratings. On the other hand, attendance of clinicians at ISP meetings was reported, but not participation by those clinicians during those meetings. ○ Did not distinguish data collected by the QA Department versus the program/discipline. ▪ The Facility rated itself as being in compliance with neither provision of Section G. This was not consistent with the Monitoring Team's findings. The Monitoring Team agreed with a finding of noncompliance for Provision G1 but found the Facility in substantial compliance with Provision G2 (a continuation of a finding of compliance in the last compliance report. 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 Complete or In Process ▪ The Facility data only identified one area of need/improvement—"additional auditing and consistency within the database to ensure the facility's ability to measure integrated clinical services." No actions were related to this need. ▪ The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. Because there was no focus on actual participation integrated planning, within the ISP planning meeting or as part of the many other times integrated planning is needed (other than the Medical Morning Meeting), any improvement will result from activities other than those reported in the Action Plan. Other areas the Facility might address include collaborative case formulation, involvement of multiple disciplines to address a specific area of need of an individual (such as a medical condition like diabetes or reduction of problematic behavior with needs for psychiatric, behavioral, and communication therapy involvement), and collaborative development of facility-wide systems to assess health status and address means to improve.
	Summary of Monitor's Assessment: The Monitoring Team noted continuing progress in integrated planning and implementation of clinical services. The Medical Morning Debriefing continued to provide an excellent venue for integrated discussion and identification of issues needing collaborative planning; participation was clearly integrated, and disciplines used this as an opportunity to provide education and information to other disciplines.

	There were numerous interdisciplinary committees and workgroups. Although there were examples of excellent integrated planning for the needs of individuals, there were also examples in which opportunities for integrated planning were missed. To achieve substantial compliance, the Facility needs to continue to help staff identify inconsistencies among assessments and related services, to improve the consideration of how risks in one area of functioning and health may affect other areas and the services needed, ensure assessments are timely so the information from one discipline can be considered by others when planning supports and services, and remind clinicians that they need to communicate with other disciplines when they identify changes in an individual's status. Documentation of review and acceptance of recommendations was routinely found on consultation forms and in IPNs, and observations of Clinical Morning Report meetings documented examples of follow up with IDTs. In the sample of consultations reviewed by the Monitoring Team, there were no referrals to the IDT; however, a process was in place that provided information on consultations to the morning unit meetings. The Facility audit of a sample of consultations provided data consistent with the findings of the Monitoring Team.

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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 Monitoring Team noted continuing progress in integrated planning and implementation of clinical services. <u>Policy</u> BSSLC Policy H.1 Minimum Common elements of Clinical Care: Ensuring Integration of Clinical Care continued to be the guiding policy relevant to this provision. This had not been revised since the last compliance visit. In response to a request for any policy guiding integrated clinical services, the Facility did not provide Policy H.1 but instead provided Policy L.1 Medical Care; while this policy states that "PCPs play an integrated role in the management of nutritional, physical, psychiatric, and psychological needs of the individual" it does not reference any specific integrative actions required of the PCP other than sharing consultation recommendations with the IDT and attending meetings, and it does not address integrative actions required of other clinicians. <u>Medical Morning Meetings</u> BSSLC continued its excellent Medical Morning Meetings (also referred to as the Morning Medical Debriefing). Although these meetings have evolved from a medical report, and medical issues are addressed as a central focus of these meetings, they are actually integrated meetings that extend to all clinical disciplines and provide an excellent opportunity for education and planning across disciplines.	Noncompliance

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		The Medical Morning Meeting is chaired by the medical director and conducted five days per week. It is an integrated, multidisciplinary meeting that consists of medical providers, unit nursing staff, and representatives from various departments, including habilitation services, behavioral services, residential services, psychiatry, dietary services, quality assurance, dental, and pharmacy services. The purpose of the meeting is to report, and discuss clinical issues to ensure continuity of care and to enhance clinical management of individuals. There was a standard agenda and format for the meeting. This included the following standard topics: • On-Call Physician Report • On-Call Psychiatrist Report • On-Call Psychologist Report • Individuals in a Hospital • Individuals Sent to ER • Review Follow Up Items • Pre ISP & ISP Meetings Today • Missed Appointments • Additional Notes Review of numerous meeting minutes indicated a documented summary of the events discussed at the meeting, action plans developed for clinically relevant issues discussed during the meeting, discussion of systemic issues such as reporting adverse drug reactions and procedures for post-hospitalization medication orders and meetings, and follow up to action plans (primarily to report completion). The Monitoring Team attended the April 8 and April 9, 2014 meetings, and was impressed at the comprehensiveness and efficiency of the meeting. The meetings followed the structured agenda. They demonstrated good communication and integration among the disciplines. The meetings enabled all members to gain greater insight into the clinical management of individuals reviewed during the meeting; technical terms were explained so that all clinicians would understand. These were not merely meetings to report but instead used the reports to prompt integrated discussion, review, and planning. The only recommendation the Facility might consider is standardizing and clarifying the documentation of action plans, as they were not clearly specified in a consistent manner; this would help to ensure follow-up is timely and is reported at the meeting and documented in the minutes. Overall, the Monitoring Team commends the Facility on this excellent process. <u>Integrated Committees and Workgroups</u> The Facility had several committees and workgroups that brought together numerous disciplines for interdisciplinary reviews of individuals and systemic issues, including,	

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		among others, the following: • The Psychotropic Medication Oversight Committee (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 psychiatry, medicine, nursing, psychology, and quality assurance. The Facility provided comprehensive data, and data analysis, of psychotropic polypharmacy usage. In addition to reviewing system issues related to general and psychotropic polypharmacy, the Facility also conducts polypharmacy reviews, during which time the psychiatrist, nurse, pharmacist, and other members of the IDT meet to discuss individuals' prescribed polypharmacy, and develop clinical strategies to help reduce the polypharmacy burden. The Facility-level review augmented reviews of polypharmacy that took place at the level of the IDT, where polypharmacy was reviewed in many venues, including psychiatric treatment reviews (PTRs). • Much of the clinical process for creating and monitoring the treatment program for individuals supported by psychiatry took place at PTRs, which were regularly attended by IDT members including behavioral services, psychiatry, nursing, and QIDPs, by Primary Care Providers (PCPs) when their schedules allowed, and sometimes by family members/guardians (via telephone). • The Physical and Nutritional Management Team (PNMT) was composed of a Registered Nurse (RN), Physical Therapist (PT), Speech Language Pathologist (SLP), Occupational Therapist (OT), Registered Dietitian (RD) and Physician (MD) as standing core members. Additionally, a Senior Direct Support Professional (DSP-IV) continued to be present at many of the meetings. The Facility PNMT had a sustainable system fully implemented for resolution of systemic issues/concerns. • The Skin Care Committee was comprised of interdisciplinary team members. Core membership included: Skin Integrity Nurse, Chair, CNE, NOO, Medical Director or designee, RN Case Manager Supervisor, Habilitation Therapy Representative, PNMT Nurse, QA Nurse, Nurse Managers, Psychology Representative, Qualified Intellectual Disability Professional (QIDP) Representative, Direct Support Professional Supervisor, and Dietitian. The Skin Integrity Committee did have consistent attendance of the integrated core membership, with rare exception. Skin integrity data were presented at the Skin Integrity Committee and PNMT Meetings for review, discussion, and development and implementation of corrective action plans for identified trends to reduce/eliminate the incidences of skin integrity issues/pressure ulcers and non-pressure ulcers locally and systemically. • The Medication Variance Committee was co-chaired jointly by the Pharmacy Director and Nursing Operations Officer. The Facility continued to include a	

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		Board Certified Behavioral Analyst (BCBA) as a core member, which facilitated review of the potential effects of variances on challenging behaviors. <u>Integrated Planning and Services for Individuals</u> Integrated planning requires disciplines to 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. • As reported in Provision R2, the SLPs and psychologists continued to improve collaboration on the development and implementation of behavioral supports and direct/indirect SLP interventions for individuals with alternative or augmentative communication systems. Also, as reported in Sections J and K, the treatment program for individuals diagnosed with psychotropic medications involved close collaboration between behavioral services, psychiatry, nursing, QIDPs, and other IDT members. • As reported in Provision J8, development of the process of combined case formulation involving behavioral issues and psychiatric diagnosis and treatment has required development of the ability to view an individual's care through the multiple perspectives offered by the different clinical disciplines through the tools that each brings. The process of creating a quality combined case formulation required that each clinical discipline provided good quality discipline specific understandings, and that these were brought together in a manner that provided a comprehensive understanding of the individual that drew from the contributions of the underlying discipline-specific assessments. Although, as noted in Section K, improvement is still needed in the plans for behavioral interventions and in integration of psychiatric planning with behavioral planning, the improvements in combined case formulation are an important step forward. • During the Positive Behavior Support Committee meeting, an SLP, Psychiatrist, and QIDP attended. Each of these individuals participated in the activities of the committee by actively reviewing the submitted interventions and providing comments regarding their disciplines. • A Speech and Language Pathologist was noted to have participated in 92% of the Positive Behavior Support Committee meetings from 1/1/2014 to 3/31/2014. • During a meeting to discuss skill acquisition programs, it was evident that Melissa Moehlman (Program Services), Susie Johnson (Residential Services), Terry Blackmon (Behavior Health Services), and Sara Bohl (Behavior Health Services) had worked closely in developing a systematic approach to enhancing skill acquisition programs.	

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		There were numerous examples of interdisciplinary planning and integration of clinical services for individuals. For example: • Individual # 464 was an example of integrated care in the way that many disciplines came together to minimize risk for aspiration, following medical evaluation (including a barium swallow) that demonstrated his risk. The psychiatrist contributed a plan to minimize medications that could cause sedation and lethargy, the psychologist reviewed levels of supervision, speech and language were engaged around appropriate textures for diet and the overall team engaged in finding adaptive aids that would assist the Individual. • Individual #408 was an example of integrated care through engagement of the overall team, including medicine, psychiatry and psychology around efforts to reduce pica. • Individual #547 had had significant decompensation of psychiatric symptoms of Obsessive-Compulsive Disorder and related behavioral manifestations since Abilify had been discontinued due to metabolic disorder. More recently, additional medication changes had been made. The psychiatrist provided a well-thought-out rationale for delaying further consideration of community living options until these issues stabilized. She also provided a specific indicator for assessing when stabilization had occurred. • Individual # 464 was an example of integrated care in the way that many disciplines came together to minimize risk for aspiration, following medical evaluation (including a barium swallow) that demonstrated his risk. The psychiatrist contributed a plan to minimize medications that could cause sedation and lethargy, the psychologist reviewed levels of supervision, speech and language were engaged around appropriate textures for diet and the overall team engaged in finding adaptive aids that would assist the individual. • The Monitoring Team attended the ISP annual planning meeting for Individual #547 and found the ISP developed at that meeting clearly integrated the individual's preferences, needs and strengths. For example, this was observed with the plan for integration of the acquisition of sign language across all SAPs and SSOs. In one particularly well-integrated approach, the communication strategy was integrated with fostering the individual's friendship with another individual. There were also examples that demonstrated the need for further improvement. For example: • In a review of 16 records, in seven (44%), the risk plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. The exceptions were for Individuals #191, #437, #35, #445,	

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		#184, #112, #265 (both categories of risk), and #279. • Individual #545 had a Behavior Support Plan for Psychiatric Symptoms (BSPPS) in place, but did not have a BAIP. The psychiatrist asked the behavioral health specialist on two occasions about behavioral supports that could be implemented; the behavioral health specialist indicated that because these symptoms were biological in nature, there was no BAIP but that there were prevention strategies built in to the PSP. The Monitoring Team was concerned that there appeared to be no methodology for monitoring the implementation of these strategies or their effectiveness. The Behavioral Health Specialist did agree that the individual's compulsive behaviors needed to be more discreetly defined so that prevention strategies could also be more specific. Again, there was no methodology for testing or evaluating these prevention strategies. • As reported in Provision L1, there were numerous concerns regarding a lack of integration in treatment planning and intervention for Individual #44. The Monitoring Team observed Individual #44 at the living area, and offers the following observations, and concerns (please refer to Provision L1 for more detail): o While the individual was provided assistance with ambulation by physical therapy (PT), with gait belt assist, the individual would scream out loud, and when allowed to rest and lean on a table, would deescalate. When the Monitoring Team asked the PT professional if the Individual could be experiencing pain, and if an underlying medical condition could be contributing to possible pain, the PT professional reported "I will have to get back to you on that, and discuss that with the doctor". There was no specific medical plan develop to help ensure staff's appropriate identification of indicators of pain and worsening spasticity. This issue should have been addressed in an integrated manner when signs of pain first became evident. The individual has known "severe" osteoarthritis of the hip, and there was no documentation to indicate that the Individual had been physically assessed to evaluate for worsening osteoarthritis, worsening gait problems, worsening spasticity, or to assess for pain. o The IRRF did not have a risk assessment for pain. The entire section for pain was blank. o There was no meaningful assessment documented by PT/OT to help determine the underlying etiology of spasticity, osteoarthritis of the hip, and possible pain associated with musculoskeletal conditions. • As reported in Provision F2a3, for the annual ISP planning meeting attended for Individual #123, the IDT missed some opportunities to define integrated and coordinated approaches to skill acquisition that would support the individual's	

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		personal goal of independent living. For example, the relationship goal could have incorporated leisure planning for activities with friends and family as well as extended the use of telephone to calling to obtain information about preferred activities in the community. Similarly, money management training could have been integrated with the individual's program to follow a baking recipe, in which the individual could have made a grocery list from the recipe, shopped for the ingredients, paid for the ingredients and obtained the correct change and then mixed and baked the food item. It was noted that Program Development staff indicated this was latter strategy was the sort they intended to implement, even though this was not specifically described at the annual planning meeting. A review of the completed SAP for following the recipe did not include any of these. As noted in past compliance reports, collaboration and integrated planning continued to improve. As reported before, initiatives such as the Morning Debriefing and the numerous interdisciplinary committees and workgroups provided an excellent venue for integrated discussion and identification of issues needing collaborative planning. There were examples of excellent integrated planning, but also other examples in which this needed improvement. To achieve substantial compliance, the Facility needs to continue to help staff identify inconsistencies among assessments and related services, to improve the consideration of how risks in one area of functioning and health may affect other areas and the services needed, ensure assessments are timely so the information from one discipline can be considered by others when planning supports and services, and remind clinicians that they need to communicate with other disciplines when they identify changes in an individual's status.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services.	<u>Policy</u> DADS Policy 009.2 Medical Care describes the responsibility of the attending primary care physician (PCP) to write initial consultation referrals and states "Routine medical/surgical consultation recommendations are addressed within five working days of receiving the consultation" and requires that there must be a clear explanation in the IPN if recommendations are not implemented. It also identifies IDT responsibilities to document implementation of recommendations. Although the Facility did not have a policy that directly addressed review of consultations, it did have a document that provided guidelines, Procedural Guidelines for On-Campus and Off-Campus Consultations, which was consistent with DADS policy. Both the policy and the guidelines address only medical consultations. The Medical Director reported that all consultations require a medical order, including MBSS. They reported the only possible exception would be oral surgery consultations ordered by the dentist,	Substantial Compliance

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		but they were not aware of any that had been ordered. <u>Procedures and Forms</u> The Facility provided a form titled "Consultation Report." This form served as the consultation note. Responses by Facility clinicians were to be written on the consultation note; a checkbox was available to indicate whether the Facility clinician agrees or disagrees with the consultant's recommendations. The Procedural Guidelines for On-Campus and Off-Campus, which provided the steps in processes for on-campus and off-campus consultations with non-Facility clinicians, stated the PCP (primary care provider) signs off on the report. For more information on the guidelines, please refer to the compliance report of the October 2012 compliance visit. <u>Review of Consultations by Facility Clinicians</u> The Monitoring Team reviewed a sample of 13 medicl consultation reports for 10 individuals (Individuals #24 (X2), #93 (X2), #95, #96, #141, #230, #384, #415, #517, and #579 (X2), and five Modified Barium Swallow Studies (MBSS) for Individuals #19, #35, #380, #465, and #566 • For the medical consultations: o Thirteen of 13 (100%) had evidence of review by a PCP. ▪ Thirteen of 13 (100%) had evidence on the consultation form of review by a PCP (initials and date). Thirteen (100%) had a progress note in the Integrated Progress Note (IPN) section of the Active Record. Of those thirteen, the IPNs were completed within five business days for 11 (85% of total). ▪ Eleven (85%) documented acceptance of the recommendations either on the form or in an IPN; two (Individuals #93 12/10/13 and #141) did not document acceptance or rejection. • For the MBSS consultations: o Five of five (100%) documented review with a note on the consultation report and/or progress note in the IPN. Four (80%) had IPNs; of those, three (60% of total) were completed within five business days. o Five of five (100%) documented acceptance of the recommendations. • Overall: o Eighteen of 18 (100%) documented review by a Facility clinician, through either a notation on the consultation report or an IPN, or both. o Sixteen of 18 (89%) documented acceptance of recommendations. No consultation forms or IPNs documented referral to the IDT. However, the guidelines for consultations established a process for consultation recommendations to be read at morning unit meeting. The PCP is to sign off, give the signed consultation to the sick call	

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		nurse, who gives it to the Nurse Case Manager, who takes it to the unit morning meeting, where QIDPs and other IDT members are informed. Observations of unit morning meetings found instances in which this occurred. In addition, the standard agenda for the Morning Medical Debriefing included a section for "Review Follow Up Items" as well as a section for additional notes. Items found on minutes reviewed by the Monitoring Team included IDT response to issues arising post discharge from hospital, review of actions taken to resolve individuals' health issue and the effect of those actions, and systemic actions such as reporting on ADRs but did not find, in the sample reviewed, documentation of follow-up by IDTs on referrals. Although it is possible no referrals to IDTs had occurred that would have had action to report, the Monitoring Team continues to suggest this would be a good place to document that the IDT had reviewed recommendations, and what actions the IDT was taking. <u>Audits of Consultations</u> The Facility provided monthly reports of a sample of 20 audits of consultations each month. Audits covered a set of requirements for consultations; the reports listed the number of audits performed and the number that met each requirement. Regarding the requirements of this provision, of the 100 consultations audited: • Ninety five (95%) were signed and dated. • Ninety four (94%) had a note written in the IPN by the PCP (the audit did not report whether these were completed within five business days). • Six (6%) "recommended an IDT"; of those, three (3%) had minutes in the chart. Because documentation of review and acceptance of recommendations was routinely found on consultation forms and in IPNs, and observations of Clinical Morning Report meetings documented examples of follow up with IDTs, this provision is found to be in substantial compliance. The Monitoring Team suggests there be an easily accessible tracking of actions taken following referrals to IDTs.	

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 3/18/14 2. BSSLC Action Plans 3/18/14 3. Presentation Book for Section H 4. Provision Action Information for Section H 5. DADS Policy 004.2 Individual Support Plan Process 11/21/13 6. BSSLC Policy F.1: Individual Support Plan (ISP) Process, implementation date 11/9/13 7. BSSLC Policy F.2 ISP Process Monitoring Data Collection Process 2/15/14 8. BSSLC Policy H.1 Minimum Common elements of Clinical Care Ensuring Integration of Clinical Care 11/30/12 9. BSSLC Policy L.1 Medical Care 11/2/13 10. Active Records for Individual #265 and 464 11. Assessment Completion report 1/1/14-2/28/14 12. Overview of Auditing Clinical Indicator December 2013 through February 2014 for: a. Diabetes mellitus b. Hypertension 13. Audit Tool—Clinical Indicators for: a. Constipation b. Diabetes Mellitus c. Down's (sic) Syndrome d. Hypertension e. GERD f. Lipid Disorders g. Osteoporosis 14. Clinical Indicators Catalog **People Interviewed:** 1. Mary Ann Brett, MD, Director of Medical Services, and Penny Foerster, RN 2. Kori Kelm, Director of Habilitation Services **Meetings Attended/Observations:** 1. ISP annual planning meetings for Individuals #123, #547 and #599 2. Meetings attended by Monitoring Team members noted in several report Sections
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section H. 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 H, in conducting its self-assessment, the Facility: ▪ Used monitoring/auditing tools. For some provisions, Section I monitoring tools provided information. For more information about these tools and who implemented them, please refer to Section I. These tool included indicators that addressed compliance with some requirements of the Settlement Agreement but were limited to issues related to assessment of risk rather than to broader issues of clinical care. A useful feature of the way this information was provided was that the assessments for several provisions identified specific items from the Section I monitoring tools that were relevant to the provision requirements and provided data on those items. For example, for Provision H6, the item reported inclusion rate of clinical indicators in a sample of ISPs reviewed. The Facility is encouraged to review the Monitoring Team's report to identify indicators that are relevant to making compliance determinations. ▪ Used other relevant data sources and/or key indicators/outcome measures. Specifically, these included timeliness of assessments and trended data on hospitalizations and medical conditions. ▪ The Facility did not consistently measure the quality as well as presence of items. For example, the Facility reported timeliness but not comprehensiveness of assessments. The Facility reported inclusion of clinical indicators in ISPs but not appropriateness of those indicators. ▪ The Facility rated itself as being in compliance with no provisions of Section H. 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. ▪ Actions were reported as Complete, In process, or Not started. ▪ The Facility data identified areas of need/improvement. These included a need to complete scheduled assessments in a timely manner, for IDTs to respond consistently to a change in status, and for more consistent team member monitoring of action plans. Actions did address timeliness of assessments (and, actually, also addressed comprehensiveness) but did not address team member monitoring of action plans or response to change in status. ▪ The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. As noted in the above bullet, some issues identified by the Facility (and also by the Monitoring Team as reported in these findings) were not addressed with action steps. Many of the action steps listed were general and did not include specific steps. For example, actions for Provision H4 began with developing clinical indicators for several disciplines but did not list the actions that would be needed to accomplish those. The next action was to integrate the use of clinical indicators into facility tracking and trending; again, accomplishing this would require several action steps, and the Action Plan did not specify a plan to accomplish this action.
	Summary of Monitor's Assessment: Recent compliance reports had noted continuing progress on meeting the requirements of Section H. Progress was not as evident at this review. The status of timeliness and comprehensiveness of assessments continued to improve for some disciplines, but this remained variable. There were some initiatives occurring in the use of clinical indicators of health status, but there was also less clarity about how these would be used in making decisions on treatments and interventions.

	Provision H1: Assessments for the annual ISP were not routinely completed on a timely basis, as evidenced by the Facility's own self-assessment and by other findings of the Monitoring Team, but there was improvement noted. The Facility had implemented a tracking and follow-up process to ensure the timeliness of annual assessments; Monitoring Team findings of timeliness for samples of assessments were relatively consistent with Facility tracking data. Facility tracking found significant variability across disciplines. Similarly, there was variability across disciplines in timely completion of initial assessments for new admissions. As with timeliness, comprehensiveness of assessments improved for specific disciplines. Assessments in response to identified change of status occurred, but there were instances in which either signs of change of status did not result in identification of such change, or in which assessment was delayed. **Provision H2:** Both psychiatric and medical diagnoses were consistent with the appropriate diagnostic standards. Psychiatric diagnoses made recently were justified and clinically fit corresponding assessments. Medical diagnoses did not consistently clinically fit corresponding assessments; in some cases, observable signs did not lead to appropriate assessment. **Provision H3:** The Facility had continued processes to ensure treatments and interventions were initiated timely and based on medical diagnoses. There were continuing improvements in timely implementation of treatments and interventions but also examples in which treatments and interventions were not provided timely or were not clinically appropriate based upon assessments and diagnoses. **Provision H4:** There was no evidence that the use of clinical indicators for chronic conditions had expanded. The Facility had begun carrying out audits for chronic conditions, starting with hypertension and diabetes. These were too recent to determine how they were being used for review of systemic status of health care or to improve individual care. Similarly, the Facility had developed a catalog of clinical indicators that should lead to further evaluation and possibly determination of a change of status, as well as "alarm indicators" that should lead to immediate assessment, but it was not yet clear how this catalog was being used. **Provision H5:** There had been little progress since the last compliance visit in monitoring health status of individuals. As reported above, the use of clinical indicators of health status had not progressed. The development of a catalog of clinical indicators that could be used for assessment and for identifying changes of status could be a step forward, but there was no evidence that it was in use for monitoring health status of individuals. The Facility continued the use of Sick Call but did not indicate how information from that could be used to monitor health status of individuals. Clinical indicator tracking sheets had been replaced, at least in part, by the clinical indicator audits—a potentially useful tool but not one that lends itself to monitoring health status of an individual over time. Integrated Health Care Plans (IHCPs) did not commonly include clinical indicators to be monitored, and did not consistently identify the frequency of monitoring to be done. **Provision H6:** There were examples of timely modification of treatments and interventions in response to

	clinical indicators, and examples in which that did not occur. The focus of medical care had changed to audits of clinical indicators and of whether some specific diagnostics, exams, and other treatment activities had occurred. For other clinical disciplines and for risk assessment, the catalog of clinical indicators had been developed, but it was not clear how that was being used. Therefore, the Monitoring Team could not determine whether there had been any progress in use of clinical indicators for clinical management of individual treatments and interventions. **Provision H7:** There was a policy that covered most requirements of Section H. Not all requirements were fully implemented. The policy does not include some of the actions that have been implemented and have improved integration of planning and development of clinical indicators.

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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.	<u>Policy</u> DADS Policy 004.2 continued the requirement that IDT members complete required assessments and place them in the shared drive for IDT review no later than 10 working days before the annual ISP meeting and no later than five days prior to the initial admission ISP meeting. In the current ISP procedure, the IDT was to identify the assessments that were required for the annual ISP meeting at the ISP Preparation meeting. BSSLC Policy F.1 Individual Support Plan (ISP) Process was revised. Regarding assessments, this policy requires that assessments be placed on the shared drive no later than five working days prior to the initial ISP meeting for new admissions and 10 working days prior to the annual ISP meeting; this had note changed from the prior version of the policy. The Facility established new BSSLC Policy F.2 ISP Process Monitoring Data Collection Process. Consistent with DADS policy and BSSLC Policy F.1, it requires that assessments be completed "10 working days prior to the ISP". <u>Extent to which assessments are conducted routinely</u> Assessments for the annual ISP were not routinely completed on a timely basis, as evidenced by the Facility's own self-assessment and by other findings of the Monitoring Team, but there was improvement noted. In the current ISP procedure, the IDT was to identify the assessments that were required for the annual ISP meeting at the ISP Preparation meeting. Each of the sample ISPs clearly defined the assessments that were to be completed. Findings included: • The Facility had implemented a tracking and follow-up process to ensure the timeliness of assessments. According to a document entitled Assessment Completion, 1/1/2014-2/28/2014, of 810 assessments due between the dates of	Noncompliance

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		1/1/2014 and 2/28/2014, 426 (53%) were completed by the due date. Of the late assessments, 72 (9%) were one to five days late and 73 (9%) were six to ten days late (that is, were late but completed by the date of the ISP meeting. • In a sample of nine recent ISPs reviewed, none (0%) had all assessments included and completed on a timely basis prior to the ISP annual meeting. • Overall for this sample, the rate of timeliness was 45% based on the requirements listed in the ISP Preparation meeting documentation. • As described below, the Monitoring Team found assessments were still not always being updated in response to significant changes, particularly as they related to protection from harm. In January 2014, the Facility began to use a new ISP Process Monitoring database to track assessment completion dates. Weekly reports are now being sent to Department Heads regarding delinquent and due assessments. Daily email reminders are sent to IDT members when assessments have not been posted at 13 days and nine days prior to the ISP meeting. The Monitoring Team looks forward to seeing improvement in timeliness as a result at the next monitoring visit. During an interview, the Monitoring Team requested the assessments available on the shared drive for Individual #538, whose ISP annual meeting was scheduled within ten working days. The QIDP provided the Assessments/Reported Needed for the Annual ISP Meeting sheet that identified which assessments were required and accessed the assessments. Eight of 10 (80%) assessments determined to be needed for the annual ISP meeting had been completed and posted on the Share Drive; in addition, the Habilitation Therapy assessment or update was posted timely but had not been listed as required. For some disciplines, the Monitoring Team reviewed a sample of assessments for timeliness: • Five of five (100%) Annual Comprehensive Nursing Assessments were completed 10 working days prior to the date of the ISP meetings. This was a higher percentage than the number (39 of 51) reported on the Facility's Assessment Completion report. • Eight of eight individuals' OT/PT assessments/updates in Sample P.1 (100%) were dated as having been completed at least 10 business days prior to the annual ISP. This was consistent with the number (46 of the 49 required) reported on the Facility's Assessment report. • Nine of nine individuals in Sample R.1 (100%) were provided a communication assessment per policy and/or Master Plan. For nine of nine individuals in Sample R.1 (100%), assessments/updates were dated as having been completed at least 10 working days prior to the annual ISP. This was consistent with the	

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		number (25 of 27) reported on the Facility's Assessment report. The Facility's Assessment Completion report found significant variability across different disciplines and assessments. While habilitation and communication assessments were usually completed on time, dental and psychiatric assessments were consistently delinquent. Assessments for the initial ISP for new admissions were also not consistently completed timely. The Facility reported 12 admissions during this six month period. The Monitoring Team reviewed the ISP and assessments for a sample of three of these. The ISP annual planning meeting was held for each of these within 30 days of admission. For example, for Individual #464, the following assessments were not completed until well after the ISP meeting was held: Nursing, Medical, Psychiatry, Vocational, Water Safety and Dental. In addition, no Psychological or Behavioral Assessment was provided. For Individual #265, 10 of 12 assessments (83%) were completed at least five working days prior to the initial ISP meeting, but Vocational and Psychological/Behavioral assessments were not. Initial assessments were generally timely for some disciplines. For the disciplines reported below, the Monitoring Team did not determine whether these were complete at least five working days prior to the initial ISP meeting. • Twelve of 12 individuals admitted since the last review (100%) received an OT/PT screening or assessment within 30 days of admission or readmission. • Twelve of 12 admitted individuals (100%) since the last review received a communication screening or assessment within 30 days of admission or readmission. • Three of three (100%) Admission Comprehensive Nursing Assessments were completed within 30 days of admission. • Between the last visit and March 10, 2014, Individuals #200, #265, #279, #322, #356, #382, #464, #534 and #584 were admitted. Nine of nine (100%) took psychiatric medications and all had received Appendix B CPEs. Some assessments are required more frequently than annually. • Three of three (100%) Quarterly Nursing Record Reviews/Quarterly Physical Assessments were completed by the last day of the month in which the quarterly nursing assessment was due. <u>Comprehensiveness of Scheduled Assessments</u> Progress was noted in certain discipline specific assessment processes and outcomes throughout this report. Examples included findings of substantial compliance in	

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		Provisions M2, P1, and R2. Assessments by other disciplines continued not to be consistently of sufficient quality overall to reliably identify the individual's strengths, preferences and needs. Per interview with the Medical Director, Medical Services has begun a process to assess comprehensiveness of assessments, and 60 annual medical assessments have been reviewed. • As reported in Provision O2, comprehensiveness of communication assessments was somewhat variable in a sample of assessments for 13 individuals reviewed by the Monitoring Team. However, for 15 individuals who had their assessments completed since October 2013, all 22 of 22 (100%) components were identified as being present for 15 of 15 assessments (100%). Thus, assessments being completed currently were consistently comprehensive. • As reported in Provision M2, the Nursing Department had fully implemented the revised Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment forms. Most components of the assessment met a 90% criterion for a sample reviewed by the Monitoring Team. The significant items that fell below 90% compliance included: o As was found in the last compliance review, individuals' overall nursing summaries for both the annual and quarterly nursing assessments regarding each high and/or medium risk rating did not consistently qualify the clinical data by indicating whether or not progress was made toward the stated goals and/or the effectiveness of the health care plans. For example, often the overall nursing summaries stated for the identified risks, "stable," "no changes since the last review," "had a good quarter," "currently the individual is well," and/or included raw clinical data without qualifying whether the data indicated that there was progress or lack of progress toward the stated goals for the related risk conditions o Other items that fell below 90% compliance were variable; no trends were identified. o Comprehensiveness of communication assessments was somewhat variable in a sample of assessments for 13 individuals reviewed by the Monitoring Team. However, for 15 individuals who had their assessments completed since October 2013, all 22 of 22 (100%) components were identified as being present for 15 of 15 assessments (100%). Thus, assessments being completed currently were consistently comprehensive. <u>Assessments in Response to a Change of Status</u> The Facility did not provide information on a formalized process to identify and address change of status. One process involved post-hospitalization assessments. Other changes could result in referrals from the IDT. Response to changes of status was variable.	

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		Overall the Monitoring Team had concerns regarding the overall sense of urgency when responding to or mitigating observed signs of health decline. • Based on a review of records of six individuals (Individuals #172, #322, #445, #193, #291, and #184) for whom assessments had been completed to address the individuals' at risk conditions, four (67%) included an adequate nursing assessment to assist the team in developing an appropriate plan. This was not the case for Individuals #193 and #184. For example, the nursing assessment for Individual #193 did not specify any underlying medical conditions that could be the cause of fluid imbalance or any rationale for performing weekly specific gravity checks. This was a decrease in the compliance rate of 80% noted by the Monitoring Team in its last report. • Two of two 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). Both of these assessments were provided upon return from the hospital. Two of two PNMT assessments in Sample O.2 (100%) were completed within no more than 30 days of the date initiated, or no more than 45 days in extenuating circumstances. However, when the assessments completed by the IDT in response to PNM issues are considered, seven of 11 IDT assessments in Sample O.1 and O.2 (64%) were completed within no more than 30 days of the date initiated, or no more than 45 days in extenuating circumstances. Individuals #191 and #19 both were identified as needing assessments to rule out mealtime issues and the need to assess Head of Bed (HOB) Elevation. There was no evidence that these assessments occurred. • For Individual #38, who had a significant history of pneumonia, multiple observations/assessments on multiple days identified overt signs and symptoms of declining health and increased likelihood of severe aspiration. The MBSS was scheduled for 12/20/13 but was not able to be completed due to hospitalization. Although there were significant signs of aspiration, there was no follow up to ensure that the MBSS was completed while the individual was in the hospital. • As reported in Provisions G1 and L1, there was no indication of any plan to assess the individual's possible increase in pain either in terms of an assessment for pain itself or in terms of assessments for changes in underlying conditions affecting ambulation. The Facility needs to take more assertive action to ensure scheduled assessments are completed in time to permit IDT review prior to ISP planning meetings. The Facility must also develop a greater sense of urgency when addressing changes of health status of individuals.	
H2	Commencing within six months of	Psychiatric diagnoses were consistent with the DSM format.	Noncompliance

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	the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	As reported in Provisions J2 and J6, psychiatric diagnoses were justified in 10 of 12 (83%) evaluations sampled. The two evaluations for which diagnoses did not have adequate justifications were done several years ago and did not have discussions to clarify the manner in which the diagnostic criteria were met. Thus, current diagnoses were justified and clinically fit corresponding assessments. Furthermore, the Monitoring Team found in reviewing case formulations in a sample of Behavior Assessment and Intervention Programs (BAIPs) and Behavior Support Plan for Psychiatric Symptoms (BSPPSs). Information in the formulations was consistent with diagnoses. For medical diagnoses, use of ICD terminology was also consistent. In a sample of 10 individuals with fractures, do not resuscitate orders (DNRs), and malignancy, nine indicated correct ICD terminology for diagnoses on the acute problem list. One did not specify a specific seizure disorder in ICD terminology (Individual #53). However, diagnoses did not consistently clinically fit corresponding assessments or evaluations, or observable signs did not lead to appropriate assessment. For example: o Individual #323 had an approximately 1 cm diameter hyper-pigmented lesion on the right cheek; however, this lesion was not documented on the annual medical assessment, as the physical exam reported normal skin findings. The Monitoring Team is concerned that such a pronounced, dark lesion, was not identified and assessed by the medical provider. o When Individual #44 was provided assistance with ambulation by physical therapy (PT), with gait belt assist, the individual would scream out loud, and when allowed to rest and lean on a table, would deescalate. The individual has known "severe" osteoarthritis of the hip, and there was no documentation to indicate that the Individual had been physically assessed to evaluate for worsening osteoarthritis, worsening gait problems, worsening spasticity, or to assess for pain. o As reported in Provision L1 for Individual #38, there was not follow-up evaluation for abnormal CT and other important lab values and diagnostics. These could have resulted in revision of diagnosis.	
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	The Facility had continued processes to ensure treatments and interventions were initiated timely and based on medical diagnoses. Several sections of this report document continuing 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. The information in Provision H1 also provides a caution—even if treatments are timely and	Noncompliance

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	assessments and diagnoses.	appropriate based upon assessments and diagnoses, their effectiveness and timeliness in terms of health of individuals also depends on whether assessments are comprehensive and whether they are done when there are signs of a change of status. In its Self-Assessment, the Facility reported an overall compliance of 63% of samples reviewed for Section I of the Settlement Agreement with initiating assessments within five days of an individual being determined at risk. The Facility reported one process that has continued is the IDT referral system through Sick Call, the PTR, or direct referral to the IDT. A second reported process is review by the PNMT of every individual post-hospitalization. Finally, the Facility reported that medical policy requires individuals be seen by a primary care provider within 24 hours of a visit to the Emergency Room during weekdays and on the next business day on weekends. In seven of 10 individual records reviewed from Sample O.1 (70%), when an individual experienced a change in status that would initiate a referral or review to/by the PNMT, there was evidence of an IDT referral to the PNMT within five working days of the ISPA meeting. It was clear that the PNMT responded quickly (within five working days or sooner as needed) when receiving a referral. As reported in Provision O2, twelve of 12 individuals (100%) identified at admission with therapy needs received a comprehensive OT/PT assessment within 30 days of identification. Due to BSSLC providing comprehensive assessments rather than screening upon admission, the Monitoring Team included the presence of assessments as meeting and surpassing compliance with this metric. There were significant examples of individuals for whom interventions and treatments were not initiated, or were not followed up, based on information in assessments or that should have led to assessments. • As reported in Provision F2d for Individual #286: o The individual was referred to the ophthalmologist on 11/07/13 and seen on 11/20/13. There was no documentation indicating why the referral was delayed for almost one month after the IDT determined at the falls prevention ISPA meeting on 10/11/13 that it was needed. o The falls prevention ISPA on 10/11/13 stated the IDT believed the individual needed to be more aware of the environment and would send a referral to the SAP department to develop a SAP in this area. At an ISPA meeting held on 2/4/14 to discuss transfer to another residence as a possible falls protection strategy, the Habilitation Therapist especially noted that the individual was not aware of the environment "below chin	

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		level." The Monitoring Team was unable to find any evidence in the record that either the Program Development Unit or Habilitation Therapies had developed any training or therapy to address this. Upon request of the Monitoring Team for this documentation, the Facility provided a referral to Habilitation Therapy that was not submitted until 1/7/14, more than three months later. In response, an assessment by a Habilitation Therapist was dated January 27, 2014; there was no evidence the IDT had met to discuss the findings and any additional actions that might be needed as a result. • As reported in Provision O2 for Individual #38 who had a significant history of pneumonia. o Multiple observations/assessments on multiple days identified overt signs and symptoms of declining health and increased likelihood of severe aspiration. Signs and symptoms noted began in earnest on 12/3/13. The SLP noted on 12/3/13, 12/4/13, 12/5/13, and 12/6/13 before a diet texture change was recommended. Once the recommendation was made due to concerns over risk of aspiration, the order was not written for another three days. Once the diet was changed, there was no more follow up by the SLP until ten days later (a similar issue occurred with Individual #230). Nonetheless, there were examples of timely implementation of interventions and treatments. • With regard to plan implementation for Individuals in Sample O.1 and O.2, for whom PNMT assessment and follow-up occurred: o In two of 11 individuals' documentation reviewed (18%), supporting documentation was present to confirm implementation of individuals' action plan within 14 days, or sooner as needed, of the plan's finalization. o In two of 11 individuals' plans reviewed (18%), 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. • For 13 of 13 individuals in Sample R.1 and R.2 for whom the IDT directed a revision in the communication dictionary (100%), the communication dictionary was revised within 30 days.	
H4	Commencing within six months of the Effective Date hereof and with full implementation within two	At the last visit, the Facility reported that data tracking sheets for individuals are now maintained for eight conditions: constipation, diabetes, hypertension, lipid disorders, osteoporosis, seizure disorders, cerebral palsy, and degenerative spine disease. The	Noncompliance

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	years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	Medical Director reported the Facility is in process of setting up a database to record these data. For this visit, in response to a request for a list of clinical indicators as a required or recommended part of assessing and documenting health status for chronic conditions, or as part of systemic monitoring of status of health and health care, the Facility provided a list including only diabetes mellitus, Down's (sic) syndrome, hypertension, lipid disorders, and osteoporosis. In addition, the Facility provided audit tools not only for those conditions but also for constipation. Thus, there was no evidence that the use of clinical indicators for chronic conditions had expanded; in fact, there was no evidence of the use of data tracking sheets for the two conditions added at before the last visit, cerebral palsy and degenerative spine disease. When asked the current status of integrating the use of clinical indicators into facility tracking and trending and into clinical discipline assessments, the Medical Director stated this was just starting. At the time of the last compliance visit, the Facility provided a blank copy of the tracking sheet for each condition. The Monitoring Team did not request, and the Facility did not provide, tracking sheets. The Medical Director reported most information has been shifted to audit tools that have been developed for clinical indicators. The Facility did provide audit reports, including completed audit tools, for December 2013 through February 2014. The Medical Director reported these audits started with hypertension and diabetes; all eight individuals with diabetes and 5% of individuals with hypertension were audited. Per the reports, the eight individuals with diabetes were audited during the three month audit period provided to the Monitoring Team, and three of 30 individuals with hypertension (10%) were audited each of the three months. The audit forms each listed 10 questions that should be documented in the charts. Each could be rated Yes, No, or N/A; a column was available for comments. The monthly reports, and the overall report for the three months, provided data from the monthly reports, including whether some laboratory and vital signs data were present and the number of individuals whose levels were within accepted limits, as well as some actions that were to be taken, such as the number of individuals who were on appropriate diets. It was not clear how this information would be aggregated over time and used for review of systemic status of health care, nor how it was being used to improve individual care. Nevertheless, it has the potential to be used for both purposes. The Director of Habilitation Services provided a Clinical Indicators Catalog. This was a listing for each of 23 risk areas, mostly risks listed on the Integrated Risk Rating Form, and risk criteria, clinical indicators, and "alarm indicators." The alarm indicators described significant indicators that should lead to immediate notice to nurses and PCPs. Clinical indicators were mostly signs that should lead to further evaluation and possibly determination of a change of status. The purpose of this catalog, as described by the Director of Habilitation Services, is to help improve the Integrated Health Care Plans. For	

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		therapists, it helps get baseline information into assessments, as the therapist could select specific indicators for a specific individual. She pointed out that there are some other conditions for which clinical indicators would be measured, such as spasticity, for which range of motion would be an indicator (using a goniometer for specific measure) that would be specific to each individual. She stated that different scales could be used in addition, such as description of reflexes and/or of tone. In general, though, there was not evidence that clinical indicators were widely used to track effects of treatments and interventions. • As reported in Provision P2, for zero of five individuals (0%) reviewed, the ISP/ISP Addendums 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. • As reported in Provision R3, for four of four individuals' records (100%) reviewed, there were measurable objectives related to individual functional communication outcomes included in the ISP. • As described in Provision K4, treatment target data collection was not consistently sufficient to assess progress. • As reported in Provision M3, four of ten (40%) individuals' plans for specific risk conditions identified appropriate clinical indicators to be monitored and the frequency of monitoring. • As reported in Provision M5, of a sample of individuals with high and/or medium risks, for specific risk conditions were not stated as functionally measurable objectives. For those who had assessments/summaries, not all relevant clinical indicators were consistently included in the IRRF clinical data. A different issue arose regarding psychiatric treatment in the context of use of Behavior Support Programs for Psychiatric Symptoms (BSPPSs). The Psychotropic Medication Treatment Plan (PMTP) has an entry for a treatment efficacy scale. Although objective behavioral measures of psychiatric symptoms were established when Behavior Assessment and Intervention Plans (BAIPs) were in place, the use of rating scales was common when there was a BSPPS rather than a BAIP (see Section K for more information about the BAIP). Although there had been some improvements in use of behavioral data and rating scales for psychiatric symptoms to track efficacy of medications, there was some concern that some of the rating scales used had no norms for individuals with intellectual disabilities and might not provide valid and accurate measures. This would be an area for further review and evaluation by the Facility psychiatry staff.	
H5	Commencing within six months of the Effective Date hereof and with	There had been little progress since the last compliance visit in monitoring health status of individuals. As reported above, the use of clinical indicators of health status had not	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.	progressed. The development of a catalog of clinical indicators that could be used for assessment and for identifying changes of status could be a step forward, but there was no evidence that it was in use for monitoring health status of individuals. The Facility continued the use of Sick Call but did not indicate how information from that could be used to monitor health status of individuals. Clinical indicator tracking sheets had been replaced, at least in part, by the clinical indicator audits—a potentially useful tool but not one that lends itself to monitoring health status of an individual over time. As reported in Provision I1, according to the self-assessment for Provision I3, only 34% of Integrated Health Care Plans (IHCPs) included clinical indicators to be monitored, and only 54% identified the frequency of monitoring. At the same time, ISP meetings observed by the Monitoring Team included an open discussion among IDT members including in most instances presentation and discussion of clinical data. It seemed that discussion did identify relevant clinical data, but documentation of the specific data to be tracked was not consistently put into the IHCP. ISPs did not consistently include appropriate functional and measurable objectives incorporated into the ISP to allow the team to measure the efficacy of plans to address risks, nor were clinical indicators to be monitored, and the frequency of monitoring, documented. As reported in Provision M3 regarding review of Integrated Risk Rating Forms (IRRFs) and Integrated Health Care Plans (IHCPs), only 40% of plans for specific risk conditions included functional and measurable objectives incorporated into the ISP to measure efficacy of the plans. Only 40% of plans for specific risk conditions identified appropriate clinical indicators to be monitored and the frequency of monitoring. In addition to the lack of use of clinical indicators to track health status, there were questions about the consistency and efficacy of monitoring progress. For example, the Facility reported that there were significant concerns about the implementation of monthly reviews of progress by the QIDP. The Monitoring Team confirmed this finding. Overall, the Monitoring Team found that QIDP Monthly Reviews were not consistently completed in a way that provided for meaningful evaluation of progress, program revision or to support future plan development. QIDP Monthly Reviews for the past three months for nine individuals with recent ISPs were reviewed. The Monitoring Team observed there continued to be progress in the actual timely completion of the monthly reviews but there was little progress noted in the substance of the recent monthly notes; 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. Most of the monthly reviews provided little actual progress evaluation or led to any program modification. The Facility was aware of this concern and was taking corrective action, as reported in Provision F2d.	

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		As reported in Provision O2, only one of 11 individuals' physical and nutritional management plans (PNMPs) reviewed (9%) included the specific clinical indicators of health status to be monitored; only one of 11 plans reviewed included definitions of triggers (individualized objective signs of possible aspiration or thresholds for return to evaluation by the Physical and Nutritional Management Team). For only four of 13 individuals with PNMPs (31%), there was evidence that their progress was reviewed and documented based on the action plan in the ISP/ISPA at least monthly. One positive finding was reported in Provision P2. Individuals in a sample of those receiving direct OT/PT services were consistently provided with comprehensive progress notes (IPNs). As reported in Provision P2 regarding individuals receiving OT/PT interventions, monthly QIDP notes primarily stated that service was provided. No detail regarding the implementation of the services, the effectiveness, or the need to revisit identified concerns was contained within the monthly review. For four of four individuals (100%) receiving direct speech services, progress notes occurred at a minimum monthly and were comprehensive. However, progress notes for individuals receiving indirect Speech Services were not comprehensive and did not identify recommendations/revisions to the program as indicated and related to the individual's progress or lack of progress.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	The last compliance report stated the Facility had begun to develop and collect data on a set of clinical indicators, but that tracking of change in data from indicators was not yet available; modifying treatments and interventions in response to changes was dependent on actions taken by clinicians and IDTs as they noticed changes. Since the last compliance visit, the focus of medical care had changed to audits of clinical indicators and of whether some specific diagnostics, exams, and other treatment activities had occurred. For other clinical disciplines and for risk assessment, the catalog of clinical indicators had been developed, but it was not clear how that was being used. Therefore, the Monitoring Team could not determine whether there had been any progress in use of clinical indicators for clinical management of individual treatments and interventions. As reported in Provision F2d, there had been progress in the implementation of monthly reviews by QIDPs, but the substance of these reviews did not consistently ensure revisions in interventions if there was a lack of expected progress. There were examples of modifying treatments and interventions in response to clinical indicators: • For four of four individuals (100%), recommendations/revisions were made to	Noncompliance

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		the communication intervention plan as indicated related to the individual's progress or lack of progress. Individual #546 had his plans reviewed and his use of signs modified based on improved progress. • As reported in Provision M3, Eight of ten (80%) Acute Care Plans were initiated within12 hours upon diagnoses and treatment of infection. There were also examples in which treatments and interventions were not modified in response to clinical indicators: • As reported in Provision L1, Individual #44 had repeated falls, unsteady gait, and apparent pain. The individual had osteoarthritis of the hip. Assistance with gait belt in ambulation had continued without further assessment of possible worsening of osteoarthritis or pain. • As reported in Provision Q1, the dental office did not have data available to comment on restorative treatments, so the Monitoring Team could not determine whether such treatment was completed as needed.	
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 Policy H.1 Minimum Common elements of Clinical Care Ensuring Integration of Clinical Care, implemented 11/30/12, established integrated clinical services policy. This policy defined minimum common elements of clinical care. The definition included that care is provided timely in accordance with assessments and/or 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	Noncompliance

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		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, although progress was continuing. In response to a request for State or facility policy or procedure guiding integrated clinical services, the Facility provided BSSLC Policy L1 Medical Services. As reported in Provision G1, this policy requires PCPs to play an integrated role, but it does not reference integrative actions required. It does not reference other requirements of this Section, such as the use of clinical indicators of health status. It does discuss requirements for annual medical assessments but not assessment of other clinical disciplines. The Facility might consider including in policy and procedures some of the actions that have improved integration of planning and development and use of clinical indicators, such as the Morning Medical Debriefing and the development of tracking sheets for chronic conditions and inclusion of clinical indicators in nursing protocols and the Pathway for Oral Intake, in order to formalize these processes and promote consideration of similar use of data in other areas. To move toward substantial compliance, the Monitoring Team continues to make the following recommendation. Currently, the policy 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).	

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 (3/18/14) 2. BSSLC Action Plan (3/18/14) 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. BSSLC Policy P.1 Habilitation Therapy Services 1/30/14 7. BSSLC Policy P.2 Physical Nutritional Management Plan 1/30/14 8. BSSLC Policy O.1 Physical and Nutritional Management Team (PNMT) 1/30/14 9. PNMT Discharge Flow Chart (9/27/13) 10. Record reviews: Sample O.1: Individuals #19, #29, #35, #38, #68, #141, #191, #230, #318, and #437 11. Record reviews: Sample O.2: Individuals #141 and #496 12. Record reviews: Sample O.3: Individuals #89, #149, #226, #428, #465, and #481 13. Record reviews: Sample O.4: Individuals #14, #16, #29, #37, #44, #51, #53, #69, #89, #92, #94, #97, #134, #163, #186, #193, #215, #243, #249, #259, #269, #272, #273, #291, #304, #318, #322, #323, #330, #331, #366, #343, #370, #422, #423, #428, #436, #445, #449, #453, #461, #492, #508, #519, #523, #527, #543, #554, #570, #582, #591, and #597 14. Records reviews for compliance analysis for Individuals #141, #191, #437, #35, #172, #322, #445, #193, #291, #184, #58, #112, #265 (two categories of risk) #279 and #464 15. Additional Integrated Risk Rating Form (IRRF) and accompanying Integrated Health Care Plan (IHCP) for Individuals #526, #528, #27, #279, #118, and #381 16. Record reviews Individuals #123 and #599 17. PNMT assessment template 18. PNMT Action Plan template 19. Integrated Risk Rating Form (IRRF) template 20. Integrated Health Care Plan (IHCP) template **People Interviewed:** 1. Kori Kelm, Director of Habilitation Therapies 2. Tracy Searles Physical Therapy Assistant (PTA) **Meetings Attended/Observations**: 1. Quality Assurance/Quality Improvement Council 4/9/14 2. ISP annual planning meetings for Individuals #123 and #599 3. PNMT meeting 4/8/14 4. Mealtimes and transitions (Bowie, Childress, and Driscoll) 5. Daily activities on Driscoll, Childress, Bowie, and Fannin
	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 always 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 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. ▪ The self-assessment did not report data on many areas of required compliance (refer to Provision I.3) ▪ Used other relevant data sources and/or key indicators/outcome measures, primarily the risk database ▪ For the most part 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 not being in compliance with any provision of Section I. This was consistent with the Monitoring Team's findings. The Facility also provided as part of its self-assessment 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. ▪ Actions to address areas of needed improvement were not comprehensive and sequenced with steps clearly identified for actions over the next six months. None of the Provisions in Section I were self-assessed as in compliance and none were determined to be in compliance by the Monitoring Team. The Facility will need to examine its Action Plan and make appropriate modifications. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcome and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities.
	Summary of Monitor's Assessment: The BSSLC processes to demonstrate compliance with this section of the SA had not improved from that reported in the last review and in fact had experienced significant regression in many areas. As reported in Provision I.3 in seven of eight (88%) metrics compliance scores had decreased from that last reported by the Monitoring Team. The Facility had made only marginal improvements in fully implementing its At-Risk Individuals policy to guide the risk assessment process. Improvement was noted in the processes used to identify a change in status. The resulting IDT meetings did not always result in timely plans with sufficient specification of details. The Monitoring Team noted, from meetings observed, improvement in the IDT process and ISP meeting content. Having written policy and procedural direction, and additional staff training, appeared to have contributed to the improvements observed by the Monitoring Team. Although the Monitoring Team observed IDT participation and discussion during the risk discussion at the ISP meetings it attended, further improvements are needed. This is especially true in the consistent use of clinical data in discussions making determinations of risk and in developing IHCPs.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management	The statewide risk assessment procedure, with guidelines for rating risk, was in use at the Facility. This was supported with Facility Policy I.2 At-Risk Individuals. As reported in Provision M.3, the Facility had continued to implement and improve/refine the Integrated Risk Rating Form (IRRF) and Integrated Health Care Plan (IHCP) processes. Efforts reported in the Facility's Self-Assessment regarding improvements made since the last compliance review included:	Noncompliance

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	system to identify individuals whose health or well-being is at risk.	• The Facility continued to complete the Clinical IDT Referral form on individuals seen in morning sick call. The nursing staff places the forms on the front of the charts along with the reason for the sick call. After the primary care providers (PCPs) examine individuals a determination is made whether the individuals had a change from their baseline. If so, the PCPs sign the forms and return them to the nursing staff. The nursing staff forwards the forms to be entered into the database for the QIDPs to review. When a Change of Status is identified the QIDP sets up an Individual Support Plan Addendum (ISPA) meeting. • The nursing operations officer (NOO) created a spreadsheet to track all quarterly, annual, and ISP dates to ensure the RN Case Managers complete their nursing assessment timely. • The QIDP prepared the Monthly Review Reports on each individual's completed IHCP, which were placed on the S-drive for review by the respective team disciplines. The reports included information on updates or progress made on the action steps. The NOO reviewed the monthly reports and followed up on issues related to nursing, as indicated. • The RN Case Managers assess the educational needs of the DSPs regarding aspiration triggers, positioning, and preventative care on a quarterly basis as needed. The RN Case Manager Supervisor was available to consult/reinforce on problems with trigger sheets as needed. However, as reported in Provision O7, RN Case Manager review of trigger sheets was inconsistent. Considerable training of staff involved in risk identification activity and IDTs responsible for the development of Integrated Risk Rating Forms (IRRFs) and Integrated Health Care Plans (IHCPs) had occurred but as reported in Provisions I.2 and I.3 did not appear to result in the provision of consistent and sustained implementation. In its last report the Monitoring Team noted significant improvement in compliance scores, although still far short of what would be necessary to demonstrate substantial compliance. This report shows regression in compliance scores in most areas. For example, seven of the eight (88%) metrics measured under Provision I.3 showed lower rates of compliance than that reported by the Monitoring Team in its last report. Additionally, the Facility self-assessment reported continued low rates of compliance in important areas. For example, the Facility self-assessment reported that only 52% of ISPs included prevention interventions to minimize risk conditions, only 34% of IHCPs included clinical indicators to be monitored, and only 54% of IHCPs identified the frequency of monitoring specified by the IDT. The Facility reported that since the last review by the Monitoring Team it had focused considerable effort on identifying the need for change of status meetings and related follow-up. The Facility identified five primary processes that were in place to assist in the	

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		identification of change of status. These were: 1. Post hospitalization discharge meetings. 2. Unit based morning sick call meetings that included the results of physician rounds and QIDP input. 3. Facility morning medical meeting. 4. Unit incident management meeting. 5. Facility incident management meeting. As reported in Provision O.2, the Facility did demonstrate progress in this area although the Monitoring Team determined that change of status meetings did not always include all the necessary disciplines to effect good discussion and decision-making. The Facility acknowledged that developing appropriate clinical indicators associated with risk mitigation needed improvement, as did IHCP implementation. As reported in Provision M.1, individuals' overall nursing summaries for both the annual and quarterly nursing assessments regarding each identified high and/or medium risk rating did not consistently qualify the clinical data by indicating whether or not progress was made toward the stated goals and/or the effectiveness of the of health care plans. For example, often the overall nursing summaries stated for the identified risks, "stable", "no changes since the last review", "had a good quarter", "currently the individual is well", and/or included raw clinical data without qualifying whether the data indicated that there was progress or lack of progress toward the stated goals for the related risk conditions. The Monitoring Team observed two ISP annual planning meetings specifically to assess the risk assessment process. Staff present at the ISP were the actual staff who worked with the individual and were knowledgeable about the Individual. The Individual was present at both meetings and in one case (Individual #123) was an active participant in the discussion. The IDT used the Risk Level Guidelines required by State policy. The ISP meetings observed by the Monitoring Team included an open discussion among IDT members including in most instances presentation and discussion of clinical data. Discussion did not always reflect consideration of relevant data and information. For example, for Individual #599 the potential side effects of medication affecting the Individual's diagnosed osteoporosis were not considered. In both meetings observed by the Monitoring Team risk related discussion and decision-making was improved from that observed during previous reviews and for the most part the risk level determinations made by the IDT seemed appropriate to the clinical circumstances under discussion.. Additional information and data regarding risk assessments and risk mitigation can be found in Provisions M.3 and O.2 of this report.	

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		Based on this review this Provision was not in compliance. Low compliance rates in some areas, 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 was not yet fully 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 16 records (Individuals #141, #191, #437, #35, #172, #322, #445, #193, #291, #184, #58, #112, #265 (two categories of risk) #279 and #464) 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 16 (100%) individuals. This metric was also reported as 100% in the last monitoring report. The Facility self-assessment reported a compliance rate of only 63% which was an improvement from the 50% reported in its last self-assessment. The Facility sample of 24 was for the period 8/1/13 through 1/31/14. The Monitoring Team sample included more recent assessments. This may explain the wide variances between self-assessment compliance rates determined by the Facility and Monitoring Team compliance rates noted in Provision I.3 of this report. The records of these 15 individuals (one Individual was reviewed for two separate risk categories) were reviewed to determine if the IDT determined changes in circumstance should have resulted in changes to an at-risk assessment, rating, and IHCP, and if the assessment process started timely. For nine Individuals (60%), the IDT determined through review that the changes in circumstance did not require changes in the at-risk rating, and mitigation plan. There were six (40%) examples of risk events or changes in status that warranted further assessment. There was documentation that the IDT started the assessment process as soon as possible but within five working days of the individual changes in an at-risk condition for five (83%) individuals. This was not the case for Individual #112. <u>Nursing</u> Based on a review of records of six individuals (Individuals #172, #322, #445, #193, #291, and #184) for whom assessments had been completed to address the individuals' at risk conditions, four (67%) included an adequate nursing assessment to assist the team in developing an appropriate plan. This was not the case for Individuals #193 and #184. For example, the nursing assessment for Individual #193 did not specify any underlying medical conditions that could be the cause of fluid imbalance or any rationale for performing weekly specific gravity checks. This was a decrease in the compliance rate of 80% noted by the Monitoring Team in its last report. Some nursing assessments referenced above were deemed minimally adequate by the Monitoring Team. Other examples of areas needing improvement are found in Section M of this report.	Noncompliance

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		Physical/Nutritional Management Based on a review of records of four individuals (Individuals #141, #191, #437, and #35) for whom assessments had been completed to address the individuals' physical and nutritional management at risk conditions, one (25%) included an adequate physical and nutritional management and/or OT/PT assessment to assist the team in developing an appropriate plan. This was not the case for Individuals #191, #437, and #35. For example, Individual #191's IDT recommended the assessments associated with the diagnosis of pneumonia include a determination of sleeping positions and how this might affect recurring pneumonia. There was no evidence this occurred. This was a decrease in the compliance rate of 100% noted by the Monitoring Team in its last report. Please refer to Provision O.2 for more specific examples. Polypharmacy Based on a review of records of one individual (Individual #265) for whom assessments had been completed to address the individuals' at risk conditions, none (0%) included an adequate polypharmacy assessment to assist the team in developing an appropriate plan. Psychiatry Based on a review of records of five individuals (Individuals #58, #112, #265, #279, and #464) for whom assessments had been completed to address the individuals' at risk conditions, one (20%) included an adequate psychiatric assessment to assist the team in developing an appropriate plan. This was the case for Individual #58. This was a decrease in the compliance rate of 100% noted by the Monitoring Team in its last report. The Facility had experienced turnover in its psychiatry staff which may have contributed to this decline. Medical Services It was evident to the Monitoring Team by reviewing medical provider's IPNs, annual medical summaries, and IRRFs for Individuals #44, #58, #38, #323, #118, #303, #249, #24, and #595, that specific risks and necessary supports and services were not consistently identified and incorporated into the IRRF assessments. For example: • Specific monitoring and reporting parameters were not updated on the IRRF to address chronic pain for an individual with chronic and severe osteoarthritis. Individual #44, who had a known osteoarthritis of the hip, was being assisted to ambulate by physical therapy staff. During periods of ambulation the Individual would scream out loud, and when allowed to rest and lean on a table, would deescalate. When asked, the physical therapy staff indicated suspecting either an environmental issue or underlying pain but did not identify what medical condition could be contributing to possible pain. The IRRF did not have a risk assessment for pain. The entire section for pain was blank. Given that ambulation might have been causing pain, and that physical therapy staff were	

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		carrying out an ambulation exercise, the lack of information to the IDT may have led to actions that resulted in preventable pain. • Specific monitoring and reporting parameters, and other supports and services such as monitoring for side effects of therapy for malignancy, were not updated on the IRRF assessments. • The IRRF was not updated to include specific monitoring and reporting parameters for an Individual who had experienced a life threatening bowel perforation. Based on this review this Provision was not in substantial compliance because the IDT was not consistently assessing and reassessing Individual according to policy requirements and adjusting IHCPs accordingly in all areas of risk.	
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 16 records (Individuals #141, #191, #437, #35, #172, #322, #445, #193, #291, #184, #58, #112, #265 [two categories of risk] #279 and #464) 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 14 (88%)) cases. The compliance rate reported in the last review was 100%. The exceptions were Individuals #445 and #184. The Facility self-assessment did not report a compliance rate. ▪ Implemented a plan that met the needs identified by the IDT assessments in 11 (69%) cases. The exceptions were for Individuals #322, #445, #193, #184, and #279. The compliance rate reported in the last review was 86%. The Facility self-assessment did not report a compliance rate. ▪ Included preventative interventions in the plan to minimize the condition of risk in nine (56%) cases. The exceptions were for Individuals #322, #445, #193, #184, #265 (both categories of risk), and #279. The compliance rate reported in the last review was 100%. The Facility self-assessment reported a compliance rate of 52%, a decline from the 57% reported in its prior self-assessment. ▪ When the risk to the individual warranted (three cases), the Facility took immediate action in three (100%) cases. The compliance rate reported in the last review was 100%. The Facility self-assessment did not report a compliance rate. ▪ Integrated the plans into the ISPs in 11 (69%) cases. The exceptions were for Individuals #191, #437, #35, #445, and #184. The compliance rate reported in the last review was 100%. The Facility self-assessment reported a compliance rate of 49%. ▪ In seven (44%), the risk plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. The exceptions	Noncompliance

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		were for Individuals #191, #437, #35, #445, #184, #112, #265 (both categories of risk), and #279. The compliance rate reported in the last review was 86%. The Facility self-assessment did not report a compliance rate. ▪ In four (25%), appropriate functional and measurable objectives were incorporated into the ISP to allow the team to measure the efficacy of the plan. The exceptions were for Individuals #141, #191, #437, #35, #322, #445, #184, #58, #112, #265 (both categories of risk), and #279. The compliance rate reported in the last review was 86%. The Facility self-assessment did not report a compliance rate. ▪ Included the clinical indicators to be monitored and the frequency of monitoring in one (6%) cases. The exceptions were for Individuals #191, #437, #35, #172, #322, #445, #193, #291, #184, #58, #112, #265 (both categories of risk), #464, and #279. The compliance rate reported in the last review was 86%. The Facility self-assessment reported a compliance rate of 54%. Compliance rates decreased in seven of the eight (88%) metrics reported above, In its last report the Monitoring Team noted improvement in these metrics. The "risk screening assessment and management system" required under Provision I.1 is not yet fully effective. Based on this review the Monitoring Team determined this Provision was not in compliance.	

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 (03/18/14) 2. BSSLC Action Plans (03/18/14) 3. 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 4. DADS Policy and Procedure 007.3 Psychiatry Services (05/01/2013) 5. DADS Policy and Procedure 001.1 Use of Restraint (04/10/12) 6. DADS Nursing Protocols: Pretreatment/Post Sedation monitoring and Post Anesthesia Care (2013) 7. Section J Audit Tool – State Office Format (used starting 06/13) 8. BSSLC Protocol for Reiss Screening (revised 08/2013) 9. BSSLC Corrective Action Plan (CAP) for Reiss Screen referral process (07/2013) 10. BSSLC Psychiatric Medication Treatment Plan (PMTP), second version (revised 08/2013) 11. BSSLC Consent for use of Psychotropic Medication for Behavior Support (revised 08/2013) 12. BSSLC Policy and Procedure C3 Medical Dental Restraint (Implemented 11/02/2013) 13. 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 14. 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) 15. Minutes of the Pharmacy and Therapeutics Committee (P&TC) and the Psychotropic Medication Oversight Committee (PMOC), since the last compliance visit 16. A list of all Comprehensive Psychiatric Evaluations (CPEs) done since the last visit 17. Individual Support Plan (ISP) materials for Individual #599, for the ISP held on 04/08/14 18. Copy of the ISP Addendum (ISPA) shell for pretreatment sedation 19. Polypharmacy justifications for all individuals treated with psychotropic medication who have tardive dyskinesia (TD) 20. A list of individuals prescribed intraclass polypharmacy and interclass polypharmacy, including the names of medications prescribed and each medication's start date 21. A tabulation that compared rates of Facility use of polypharmacy over the period from January 2011 until the present 22. 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 23. A list of individuals who had medical support plans and dental support plans to reduce the need for pre-treatment sedation 24. The number and percentage of individuals who had dental procedures, who also received pre-treatment sedation - oral or total intravenous sedation (TIVA) 25. A list of all individuals screened for TD with Dyskinesia Identification System (DISCUS) evaluations 26. A list of all individuals screened with Monitoring of Side Effect Scale (MOSES) side effect evaluations 27. DISCUS forms done over the past year that were rated "5" or higher 28. A list of individuals diagnosed with TD and the Active Problem List (APL) for each of those individuals 29. Sample J1: Record Reviews for Individuals #51, #62, #65, #112, #133, #215, #239, #243, #251, #255, #304, #367, #481, #528, and #545 Materials reviewed for each individual were a. Social History b. Most recent Psychiatric Evaluation (Appendix B format if done) c. Most recent Annual Psychiatric Review/ Annual Psychotropic Medication Review d. Most recent Positive Behavior Support Plan (PBSP) or Behavior Assessment and Intervention Program (BAIP) or Behavior Support Plan for Psychiatric Symptoms (BSPPS), and Functional Behavior Assessment 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/DISCUS Side Effects Screenings for the past six months j. All Quarterly Drug Regimen Reviews (QDRRs) for the past six months k. Most recent Health Risk Assessment Rating – tool and team meeting sheet l. If the individual is assessed at high risk on the basis of polypharmacy or challenging behaviors –copies of the plan to reduce risk (ISP addenda) m. Medical and/or dental plans to increase cooperation/participation and reduce the need for pre-treatment sedation n. Most recent Annual Nursing Summary o. Most recent Neurology Consultation p. The most recent Human Rights Committee (HRC) review for each psychotropic medication prescribed to the individual 30. Sample J2. Individuals who had episodes of medical restraint--Individuals #118 (3/4/14), #140

(1/10/14), #217 (2/11/14), #258 (1/16/14), #417(02/20/14), #445 (3/3/14), #472 (02/21/14), #473(02/28/14), #486 (02/18/14), #595 (01/15/14). Each episode was reviewed for safety during the procedure: Materials reviewed included medical orders; physician specified monitoring schedules, restraint checklists, pre and post sedation nursing checklists, integrated progress notes, (IPNs) and dental clinic notes that documented medical monitoring for safety during the procedures. Each episode was also reviewed for plans to minimize the need to use medical restraint: Materials reviewed included individual ISP and Individual Support Plan Addenda (ISPA) information regarding the need for pre-treatment sedation and the development and implementation of such plans, including completed data sheets if a program was developed and implemented.

31. Sample J3: Reviews for individuals with BSPPS. Materials reviewed for each individual were
    a. Most recent Psychiatric Evaluation (Appendix B format if done)
    b. Most recent Annual Psychiatric Review/ Annual Psychotropic Medication Review
    c. BSPPS
    d. Most recent Individual Support Plan (ISP)
    e. Most recent Annual Medical Summary
    f. Most recent APL
    g. All Psychiatric Medication Reviews for the past six months
    h. All MOSES/DISCUS Side Effects Screenings for the past six months
    i. All Quarterly Drug Regimen Reviews (QDRRs) for the past six months
    j. Most recent Health Risk Assessment Rating – tool and team meeting sheet
    k. Most recent IRRF
32. Sample J4: All Moses and DISCUS done after 02/01/2014 for Individuals #1, #59, #65, #123, #133, #144, #163, #243, #250, #255, #263, #264, #276, #312, #327, #347, #488, #439, #492 and #540
33. A list of all meetings and rounds that were typically attended by the psychiatrist, and which categories of staff always attend or might attend
34. A list and copy of any new forms used by the psychiatrists
35. Details on any changes in the employment of current psychiatrists and details regarding the employment of any new psychiatrists, including board status, whether contracted or employed, and number of hours per week
36. Description of administrative support offered to psychiatrists (e.g. secretarial and administrative scheduling of psychiatric consultations
37. Log of behavioral health prep meetings that take place prior to the ISP
38. List of individuals who had a Behavioral Support Plan for Psychiatric Symptoms (BSPPS)

People Interviewed:

1. Donna Bradley-Schrick, BCBA (04/08/14)
2. Reeba Chacko, MD, Psychiatrist (04/07/14)
3. Danielle Daniels-Hazziez, Psychiatry Assistant (04/07/14)
4. Karla Kuusisto, MD, Psychiatrist (04/07/14)

Meetings Attended/Observations:

1. Positive Behavior Support Committee (PBSC) meeting 04/08/14
2. ISP meeting for Individual #599 on 04/08/14
3. Psychotropic Medication Oversight Committee (PMOC) meeting 04/08/14

	4. Medical Morning Meeting on 04/08/14
	Facility Self-Assessment: The Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) results of the self-assessment; and 3) self-rating. For Section J: In conducting its Self-Assessment, the Facility reported that the State Office Audit Tool for psychiatry was being completed by the Psychiatry Department. The Facility reported that between October and December 2013 nine assessments were completed by a psychiatry assistant and three by a psychiatrist. Compliance percentages varied from 30% (for several items on Provision J4) to 100% (for several items on Provisions J12 and J14). The inter-rater agreement for the three months varied from 88% to 100%. The Facility reported that the Psychiatry Department had an internal system and database to track completed psychiatric evaluations. The number of completed evaluations was compiled and submitted for review in the Quality Assurance and Quality Improvement (QA/QI) Council meeting. The Psychiatry Department also had an internal system and database to track completion of annual psychiatric updates. The Facility had newly introduced peer reviews by psychiatrists for the quality of their CPEs. No data was available as yet on that measure. In the Self-Assessment the Facility reported ongoing tracking data for polypharmacy (including the number and percent of individuals treated with interclass and intraclass polypharmacy). That information was helpful. Overall, the Self Assessment was responsive to the items addressed by the Monitoring Team in the previous visit, and it presented data on both areas of strength and weakness. The attention of the Facility to comments made by the Monitoring Team has enabled progress on several sections including J2, J3, J6, and J13, and contributed to the Facility coming into compliance for Provision J8. The Facility rated itself as being in compliance with Provisions J1, J10, J11, J12, J13, J14 and J15. The Monitoring Team found Substantial Compliance for Provisions J1, J8, J10, J12, J14 and J15. Provision J8 was found by the Monitoring Team to be newly in substantial compliance due to development of a good Facility process for combined assessment and case formulation and adequate implementation of that process. The Monitoring Team did not agree with the Facility about Provisions J11 and J13. In each case progress was made, but for the reasons outlined in the assessment of status section of this report, specified requirements had not yet been met. The Facility provided as part of its self-assessment an Action Plan that reported actions being taken or planned to achieve compliance. Some of the Action Steps appeared to be relevant to achieving compliance, but many were very general and less helpful, for example the Action Step for Provision J4. The Facility should define the provision-specific outcomes it hopes to achieve as a result of these Action Steps as well as how they will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities. This would change the focus of the Action Plans from

	measuring inputs and outputs to one that would allow the Facility to determine if the Action Plans were producing the requisite outcomes for compliance. That could further the integration of the Self-Assessment and Action Plan documents, such that staff could visualize the results of the self-assessment, and address any identified deficiencies and the measurable outcome intended to be achieved.
	Summary of Monitor's Assessment: The Lead Psychiatrist had left shortly before the compliance visit, bringing psychiatric staffing to two FTEs. Progress was made in the areas of Comprehensive Psychiatric Evaluations (CPEs), combined assessment and case formulation, and monitoring medication treatments for their efficacy. In the area of psychiatric evaluations, there was significant progress, in particular around the need to justify the psychiatric diagnoses. Additional short paragraphs were now in place next to the diagnosis that provided such justifications. When those paragraphs were present, a large majority of the evaluations were good and some were exemplary. In the area of combined behavioral assessment and case formulation the work processes were strong. There was some progress in the area of monitoring medications via the inclusion of graphic data of information needed for tracking in the psychiatric treatment review (PTR) psychiatry clinic. Considerable progress was made for many provisions even though the relevant provisions were not yet in substantial compliance for all provision requirements. Comments for each provision follow: Provision J1: The Provision remained in substantial compliance. Provision J2: Further progress was needed to complete evaluations for individuals who did not have one and to resolve Not Otherwise Specified (NOS) diagnoses. Provision J3: Improvements were noted in the presentation information about psychiatric treatment. There needed to be more evidence of non-pharmacological supports for individuals with BSPPSs. Provision J4: The Facility did not yet have programs in place to reduce the need for medical restraint. Provision J5: The loss of the half time psychiatrist meant that adequate staffing was not in place to provide services required by the SA. Provision J6 Improvements were noted in diagnostic justifications. Provision J7: Reiss Screening remained strong but the required CPEs were not yet in place. Provision J8: The Facility had a good process in place for combined assessment and case formulation, and

	the Provision was found to be in substantial compliance. Provision J9: Improvements were needed for IDT determinations of which treatments (medication, behavioral interventions or other) were needed, and there needed to be better delineation of non-pharmacological supports when medication treatments were chosen. Provision J10: The required elements of the Provision were discussed by the IDT at the ISPA meeting, were included in the PMTP and were presented to the LAR by the psychiatrist as part of the consent process. The Provision remained in substantial compliance. Provision J11: Increased focus was noted to reductions in polypharmacy that was not clinically necessary. Provision J12: Although transition to electronic administration of the physician comments section screens stalled, those sections were nonetheless completed manually, and the Provision remained in substantial compliance. Provision J13: Progress was noted in the presentation of graphic information to support medication monitoring for efficacy. Provision J14: The Facility continued to provide the required annual consent for medications for all individuals in the Sample group and the status of substantial compliance is continued. Provision J15: The Provision remained in substantial compliance.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	<u>Qualifications and Experience of the Psychiatrists</u> The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	<u>Facility Use of Psychotropic Medications</u> The focus of this provision was to assure that all individuals treated with psychotropic medications had received appropriate psychiatric evaluations and diagnoses. In the Self Assessment of March 18, 2014 the Facility reported that 135 of 291 (46%) individuals who lived at the Facility were treated with psychotropic medications. <u>Psychiatric Evaluations and Annual Updates</u> In the Self Assessment of March 18, 2014 the Facility reported that psychiatric evaluations (initial CPEs and/or annual evaluations) were in place for 107 of 151 (71%) of individuals followed by psychiatry. That was an improvement over the 92 of 140	Noncompliance

		(66%) individuals who had a CPE in place at the time of the last review. One hundred and thirty-five of 151 (89%) individuals followed by psychiatry took psychotropic medications. One hundred and four of 135 (77%) of those individuals had CPEs in place. DADS Psychiatry Policy required that CPEs be re-evaluated on an annual basis and the Facility started to do annual re-evaluations in Fall 2013. Annual updates were completed for 14 of 151 (9%) individuals between 10/01/13 and 03/06/14. CPEs were also needed for individuals who screened positive on Reiss Screens on admission or who had a positive Reiss screen during change of status evaluations for new or changed symptoms (behavioral change of status). For details, see discussion under Provision J7. <u>Process for Evaluation and Diagnosis</u> Psychiatrists wrote CPEs on the basis of a face-to-face mental examination and other observations, discussions with staff members and family members, and after reviews of internal and external records. The Monitoring Team reviewed the CPEs of the 15 individuals in Sample J1. CPEs were in place for 12 of 15 (80%) individuals. At the time of the visit CPEs were all being done using the Appendix B format that is required by the Settlement Agreement (SA). <u>Ongoing Evaluation of Diagnosis</u> Continued evaluation of psychiatric evaluation and diagnosis was part of many Facility processes and was built into many IDT functions. During the current visit there were no scheduled PTR reviews so the Monitoring Team was not able to observe that process, but the Monitoring Team was able to review documentation of ongoing review of psychiatric diagnoses. Active discussions of diagnosis were noted in a number of PTR reviews for individuals in Sample J1. The Monitoring Team also attended the ISP for Individual #599. Overall, the inclusion of psychiatric diagnoses as part of the overall discussion at many interdisciplinary processes throughout the Facility showed a maturation of the clinical process at the Facility and a deepening of the staff's commitment to a comprehensive understanding of individuals supported by the Facility. <u>Clinically Justified Diagnoses</u> The Monitoring Team reviewed the CPEs of the 15 individuals in Sample J1. CPEs were in place for 12 of 15 (80%) individuals and the diagnoses were assessed to be justified in nine of 12 (75%) CPEs. The improvement was facilitated by the addition of a brief paragraph that followed the diagnosis itself. In that paragraph the psychiatrists commented on reasons the diagnosis was selected and the manner in which the DSM criteria were met. There was often a helpful discussion on why alternative diagnoses were rejected. Citations of key symptoms were frequent. That was helpful since it both solidified the diagnosis and also provided a source for the selection of key symptoms that would be the focus of subsequent clinical interventions. More detailed discussion on the quality of the CPE is provided under Provision J6.	

		Not Otherwise Specified (NOS) Diagnoses Review of the Department of Psychiatry database showed that one or more NOS diagnoses were in place for 70 of 104 (67%) CPEs for individuals who took psychiatric medications. That was a high number. During the previous visit the Facility had identified that efforts would be made to resolve NOS diagnoses through CPEs or annual updates. In the Self Assessment for the current visit the Facility reported that only 14 annual updates have been completed since October. It is possible this was related to staffing shortages, since there is now a vacancy for a half time psychiatrist. Timeliness of Psychiatric Evaluations for New Admissions The Facility reported that during the period of 9/1/13 to 3/6/14 there were 11 admissions to the Facility. Nine of 11 took psychiatric medications at the time of admission. Nine of nine (100%) of those individuals had CPEs completed within 30 days. DSM Diagnoses in the Clinical Record: The Monitoring Team reviewed the APLs for the 15 individuals in Sample J6. All individuals had a diagnosis in the DSM format. Monitoring Team's Compliance Rating The Monitoring Team again noted that the diagnostic process at the Facility was supported by the inclusion of input from many disciplines, in many places. Overall, the level of psychiatric care was high and 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. These needed further attention and the Facility remained in noncompliance on this provision.	
J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	Facility Process for the Treatment Program The key requirement of the provision was that medications should not be used as a substitute for a treatment program. By design, the treatment program for individuals diagnosed with psychotropic medications involved close collaboration between behavioral services, psychiatry, nursing, QIDPs, and other IDT members. Much of the clinical process for creating and monitoring the treatment program for individuals supported by psychiatry took place at PTRs, where meetings were held at least quarterly for individuals who were clinically stable, monthly for children and for individuals who were less stable, and more often than that as the clinical circumstances required. PTRs were attended by IDT members as above, by Primary Care Providers (PCPs) when their schedules allowed, and sometimes by family members/guardians (via telephone). Psychiatrists also consulted with PCPs at many other venues, including the Medical Morning Report. PTR appointments typically lasted 30 to 45 minutes. In	Noncompliance

		addition to PTRs the IDT met when new medications were proposed, when there was a need to follow-up on use of restraint, when there was a change of clinical status, and for other clinical circumstances. The overall treatment program was the ISP generated by the entire IDT. Prior to the ISP meeting, there was an ISP preparatory meeting where the Behavioral Health Specialist (BHS), psychiatrist, and behavior analyst convened to review the overall plan for integrated behavioral care. That forum created/reviewed the overall plans for behavioral care for the coming year. Key elements of the overall behavioral treatment program were BAIPs/BSPPS that contained a combined case formulation for behavioral challenges, counseling programs, and other related programs such as habilitation. These were integrated with broader support programs offered by the entire IDT. The overall behavioral plan was documented in the Integrated Risk Rating Form (IRRF) component of the ISP. The IRRF section provided a 2-3 page summary comprised of the history (psychiatry and behavioral health), current supports, (psychiatry and behavioral health) current status (psychiatry and behavioral health), and recommendations/rationale. The recommendations sections listed the BAIP or BSPPS and also listed other supports. IRRF sections with that format were provided for 13 of 15 (86%) individuals in Sample J1. The Monitoring Team explored the treatment program in place by review of the records for the 15 individuals in Sample J1, and the 12 individuals in Sample J2. As described in more detail below, some individuals were included in both of the samples; overall, records reviews were conducted for 23 of 135 (17%) individuals treated psychotropic medications. <u>BAIP/PSP Information about Psychiatric Treatment</u> BAIPs provided information on the behavioral treatment program put in place by the Behavioral Services Department. BAIPs also provided information on the psychiatric treatment in place. BAIPs were typically eight to 10 pages long. Typical sections included (1) an overview with a brief description of the individual including age, date of admission and a description of the individual's abilities and disabilities, psychiatric diagnosis (given in DSM format), and a summary of behavioral treatments, (2) the individual's background, including social history, history of behavioral interventions, and a case formulation, (3) a structural and functional assessment with the usual sources of information, (4) an intervention plan, accompanied by behavioral objectives and success criteria for the program, development and implementation, evaluation and revision. BSPPSs provided similar information but did not include an active behavioral treatment component. Information on all treatments included two tables. The first included information on target symptoms, function, proposed treatments, least restrictive treatments, and	

justification. The second table provided information on psychiatric diagnosis, symptom, efficacy tracking and psychotropic medication(s). A case formulation followed.

An example of the presentation for Individual # 251:

Psychiatric Diagnoses:
Axis I: *299.80* *Pervasive Developmental Disorder NOS*
298.9 *Psychotic Disorder NOS*
Axis II: *318.0* *Moderate MR*/ID

Summary of Behavioral Treatments

Targeted Symptoms	*Function*	*Proposed Treatment*	*Least Restrictive Treatment*
Psychotic Symptoms	*Psychiatric*	*Behavioral Support Plan for Psychiatric Symptoms/rating scale data collection/counseling treatment plan*	*Behavioral Support Plan for Psychiatric Symptoms/rating scale data collection/counseling treatment plan*
Physical Aggression	*None identified*	*Behavioral Support Plan for Psychiatric Symptoms/observational data collection/counseling treatment plan*	*Behavioral Support Plan for Psychiatric Symptoms/observational data collection/counseling treatment plan*

Axis Psychiatric Diagnosis	**Psychiatric Symptoms**	**Efficacy Tracking**	**Psychotropic Medication and Curra Dose**
Psychotic Disorder NOS 299.80	*Hallucinations paranoia*	*PSRS/BNRS*	*Risperidone (Risperdal) 1.25mg*
Pervasive Developmental Disorder NOS 298.9	*Aggression*	*Observational data*	*Depakote (Divalproex) 500*

BAIP/BSPPSs were in place for 15 of 15 individuals (100%) in Sample J1. Eleven of

		fifteen (73%) individuals had BAIPs; four of 15 (27%) had BSPPSs. The Monitoring Team reviewed the information in BAIP/BSPPSs to assess whether they provided accurate information about the psychiatric components of treatment. There has been a major improvement in the clarity of presentation of psychiatric information and reporting is now in a format that is comparable to that used in the PTR clinic and in PMTPs. That made it much easier to see how the psychiatric and behavioral treatment were combined and should make the documents much easier for IDT members to use. The same psychiatric diagnosis was cited in the psychiatry database (reflecting the most up to date diagnosis) and the BAIP/BSPPS for 10 of 15 (67%) individuals in Sample J1. It was of course possible that the departmental database reflected changes in diagnosis after the BAIP was written, but the percentage of different diagnoses between the BAIP/BSPPS and the database seemed high. Information about the psychotropic medications individuals took was the same for 12 of 15 (80%) individuals and when there were differences, it was for a single medication. Information on whether tracking for efficacy was provided via data (operationally defined behaviors) or rating scales was provided for 15 of 15 (100%) individuals. BAIP/BSPPS also provided a combined case formulation, and they were present for 15 of 15 (100%) of the individuals in Sample J1. For example, for Individual #251: *"Axis I diagnosis of Psychotic Disorder NOS and Pervasive Developmental Disorder NOS and Neuroleptic Induced Parkinsonism. She has a history of hallucinations and paranoia, for which she is treated with Risperdal. Risperdal is gradually being challenged. Data on the hallucinations is obtained by using the PSRS/BNRS scales. Depakote is being used to target aggression. At this point a functional assessment is not possible as she is not displaying any targeted behaviors. Behavioral Services will provide education about (the individual's) psychiatric diagnoses to the Direct Support Professionals who work with her on a daily basis."* The above was a typical case formulation that included information on both psychiatric and behavioral treatment. More information on case formulations is provided under Provision J8. <u>Non-Pharmacological Supports for Individuals with BSPPS:</u> The requirements for treatment plans for individuals who took psychotropic medications included a requirement for non-pharmacological treatment, intervention, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible (see SA requirements outlined in Provision J9). BAIPs provided the required non- pharmacological support, but BSPPSs did not.	

		Various IDT members could provide non-pharmacological supports as outlined in the ISP. In Sample J1, Individuals #62, #481, #528, and #545--four of 15 (27%)--had BSPPSs. The Monitoring Team wanted to view a larger sample of individuals with BSPPS for the presence of non-pharmacological supports. The Monitoring Team was provided with a list of individuals who had BSPPSs. They include 41 of 135 (30%) individuals who took psychotropic medications. The Monitoring Team made a haphazard selection of eight individuals from the list. They were added to the four individuals from Sample J1, who had BSPPSs. The twelve individuals were designated as Sample J3. Twelve of 12 (100%) of individuals in Sample J3 had a BSPPS that included information on medication and treatment. Case formulations were completed for 10 of 12 (83%) individuals. IRRF statements in the format described above were present for nine of 12 (75%) individuals. For seven of 12 (58%) individuals, the IRRF section on behavioral heath recommended that the ISP should include programming/activities as determined by the IDT during the ISP meeting. The Monitoring Team reviewed the ISPs of individuals in Sample J3 for the presence of non-pharmacological treatments, interventions, or supports to minimize the need for psychotropic medication to the degree possible. Generally, all ISPs contained some elements of programming intended to improve individual's independence and improved level of functioning. Examples were ISPs that included programs to achieve self administration of medication and ability to identify coins (Individuals #62 and #545), learning to dial a phone, and increasing vocabulary via age appropriate activities (Individual #528), handing money to a cashier (Individual #538), increased communication with sentences of adequate length and complexity (Individual #321), effective communication using pointing (Individual #121), greater independence despite visual impairment (Individual #33), identifying colors as a step toward medication self-administration (Individual #184), greater independence in dining by wiping place after eating (Individual #273), skills to recognize the correct dollar amount of a purchase and tie own shoes (Individual #379), and increasing ability to take turns in a group activity (Individuals # 528 and #481). In the opinion of the Monitoring Team the above activities promoted independence. However, they were not treatments, intervention, or supports that minimized the need for psychotropic medication to the degree possible. Two of twelve (16%) individuals in Sample J3 had counseling program and for those individuals the counseling programs provided the required non-pharmacological supports. For the remaining 10 of 12 (83%) the Monitoring Team was not able to identify needed non-pharmacological supports. The Facility might explore the development of support programs by the Behavioral Health/Psychological Services Department that would more directly address the requirements of Provisions J3 and J9, including for individuals who are not currently	

		experiencing challenging behaviors. Appropriate Use of Medication To review Facility processes that monitor for appropriate use of medication, the Monitoring Team reviewed three types of clinical meetings: • The Monitoring Team reviewed the PTR documentation for individuals in Sample J1. PTR notes were 3-5 pages in length and included a dictation from the psychiatrist that not only reviewed diagnosis (see discussion under Provision J2) but also reviewed the treatments provided by psychology and others to assure that medication treatment was a part of the overall behavioral plans. PTR documentation included graphs of several months' data on (a) medications prescribed, (b) challenging behaviors, and (c) data monitoring psychiatric symptoms/ rating scales. For more information, please also see Provision J13. • On 04/08/14 the Monitoring Team attended the ISP annual planning meeting for Individual #599. The psychiatrist provided detailed information about medications via the behavioral health section of the IRRF, and discussed how the individual's medication attenuated symptoms related to her Autism. • On 04/08/14 the Monitoring Team observed the PMOC, the Facility Committee that reviewed use of psychotropic medications generally, and in particular, polypharmacy. For details, see discussion under Provision J13. No evidence was noted that showed inappropriate use of medication. Medications used for staff convenience The Monitoring Team addressed whether medication was used for staff convenience by examination of the records, and by observations made during PMRs and other activities during the visit, and by interviews with staff. There was no evidence that medications were used for staff convenience. Medications used for punishment The Facility reported that there were two instances in which chemical restraints were used since the last visit, for Individuals #248 (01-08-14) and #112 (12-09-13). In each case the psychiatrist participated in the oversight of the restraint, completed and signed the Post Chemical Restraint Chemical Review. There was no evidence that the medication was used a punishment. Summary and Monitoring Team's compliance rating Information on psychiatric treatments including psychotropic medication treatment was reported in BAIPs and BSPPSs, in the same format used for PTRs. That represents progress since both of those areas had previously been problematic. There was no evidence that medications were used for staff convenience or for punishment. For individuals with BSPPS, improvements were needed for non-pharmacological	

		treatment, intervention, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible. For more information on treatment plans for individuals with mental illness, please also see the discussion for Provisions K4, K5, and K8.	
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>Policy and Procedure</u> A new Medical Dental Restraint Policy (BSSLC C3 Medical Dental Restraint, implemented 11/02/2013) was in place. Amongst other things, the Policy clarified the need for restraint plan development by the IDT and need for monitoring based on the nursing protocols for pre and post sedation monitoring and post anesthesia care. <u>Rates of use of pre-treatment sedation</u> For dental procedures the Facility reported that TIVA was used for 56 of 545 (10%) procedures performed from 09/01/2013 to 03/04/14. For the same period the Facility reported oral pretreatment for one of 545 procedures. The Facility also reported that since the last visit there were six uses of pretreatment sedation for medical procedures. <u>Monitoring for safety during medical restraint</u> Facility procedures to monitor for safety were described in DADS Nursing Protocols: Pretreatment and Post Sedation monitoring, and Post Anesthesia Care. 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 then every shift for 72 hours. During the last visit the Monitoring Team was informed that vital signs for TIVA procedures from hour 24 through 72 would be documented on post-sedation vital sign checklists. The Monitoring Team reviewed the Facility monitoring for safety during pre-treatment sedation for the ten individuals in Sample J2. Six of 10 (60%) received TIVA in the dental clinic, and four of ten (40%) received pretreatment for medical appointments (three for ophthalmology clinic, one for a bone scan). The process in place at the Facility was to document nurse monitoring on a combination of the medical restraint form and a post procedure flow sheet. For TIVA that was the flow sheet for post anesthesia care. For oral pretreatment it was one of two versions of a post sedation vital sign flow sheet. Ten of 10 (100%) individuals had completed medical restraint	Noncompliance

		forms. Post procedure forms were started for seven of 10 (70%) individuals, and were completed for required duration for five of 10 (50%). Efforts to reduce the need for pre-treatment sedation The Facility reported that an ISPA shell for pretreatment sedation was available to IDTs and an audit for compliance was to be scheduled with the QA department. That process had not yet been started. Dental plans to reduce the need for sedation were reported to be in place for 5 individuals and referrals for a plan were made for 17 individuals. Medical plans to reduce the need for sedation were reported to be in place for four individuals. Four of 10 (40%) of the individuals in Sample J3 had been referred for development of a plan to reduce the need for pretreatment. None of the individuals had a plan in place. Monitoring Team's Compliance Rating for Compliance At this time the Facility is not in substantial compliance with the requirements of the SA.	
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.	Psychiatric Staffing At the time of the visit there were two full time psychiatrists at the Facility, Drs. Chacko and Kuusisto. The total level of effort was 2.0 FTEs of psychiatric time. The Facility had unfortunately lost the services of Dr. Morgan, who was working as half time psychiatrist. The Facility was recruiting for the position. Dr. Morgan was also the Lead Psychiatrist. For now, Dr. Chacko will take on that role, with active assistance from Danielle Daniels-Hazziez, Psychiatry Assistant. Administrative support offered to the psychiatrists was one psychiatry assistant who 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 psychiatrists, printed/copied/psychiatry documents and attended IDT meetings to obtain information as directed by psychiatrists; there was another psychiatry assistant who also scheduled PTRs and attended IDT meetings, 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 QAQI meetings and assisted the Lead Psychiatrist with meetings and activities related to the SA. There was one behavioral health administrative clerk who transcribed PTR dictations, typed psychiatry reports, updated the psychology department database with information about psychotropic medications and provided PBSC administrative support. Determination of Required FTEs 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	Noncompliance

		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 ISPAs, and to respond to clinical/administrative issues that concerned psychiatry. At the time of the visit the level of psychiatric staffing was 2.0 FTEs. <u>Team's Compliance Rating</u> Due the departure of Dr. Morgan, the Facility did not have the level of staffing (2.5 FTEs of psychiatry) that was needed to fulfill the requirements of the SA. While Dr. Chacko and Ms. Daniels-Hazziez were filling in for Dr. Morgan's duties in an admirable manner, the Facility is not currently in compliance with the requirements of the provision.	
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 03/18/24, the Facility reported that CPEs were in place for 107 of 151 (71%) of the individuals followed by psychiatry. That compared to 92 of 140 (66%) of individuals followed by psychiatry at the time of the last visit. <u>Review of Completed Evaluations</u> The Monitoring Team reviewed the psychiatric evaluations of the 15 individuals in Sample J1. They had been completed for 12 of 15 (80%) of the individuals. The Facility had started to do annual psychiatric updates, and these were present for six of 15 (40%) individuals. CPEs reviewed were six to ten single spaced pages and they followed the recommended format. As a rule the sections on history of present illness, past history, family history, substance use, medical history, developmental information, social history, substance use, current medications, and mental status all exceeded required standards. There were significant improvements in the section on diagnostic justification. The Facility has now introduced a paragraph of explanation of the diagnosis and its justification. The Monitoring Team found that the psychiatric diagnoses were justified in 10 of 12 (83%) evaluations. The two evaluations for which diagnoses did not have adequate justifications were for Individuals #51 and #65. Both of those evaluations were done several years ago and did not have discussions to clarify the manner in which the diagnostic criteria were met. Examples of good justifications were: For Individual # 62: Patient meets criteria for ADHD by fact that she is easily distracted, difficulty sustaining attention in tasks and difficulty paying attention to detail. She often	Noncompliance

		does not seem to listen when spoken to directly, does not follow fully on instructions. She often avoids engaging in tasks that require sustaining mental effort such as school work and often appears to be highly distracted. She is often fidgety, is impulsive in terms of leaving the class situation, and has difficulty waiting for her turn. Chronic tic movement is evidenced by multiple motor tics. These tics occur several times a day and she does not meet the criteria for Tourette's Disorder. For Individual #695: Axis I - OCD and PDD. He meets criteria for OCD mainly because of the fact that he has repetitive behaviors, particularly putting things in order, doing things in a repetitive fashion like walking around the chair 3 times, putting lights on and off in a certain fashion, needing to rearrange people's dining mats. The function of this is not ascertainable. It is difficult because of communication deficits. There is a preoccupation to perform his compulsions and if prevented from performing, he at times may engage in aggression. He also meets the diagnosis of PDD; and he has a history of developmental delays. He has a history of engaging as a younger child in stereotypic behaviors of hand flapping, head banging. He had difficulty relating to his peers. He also reportedly was fascinated by inanimate objects and had some issues with pronominal reversals in early speech development. At this point patient has difficulty relating to his peers in an age appropriate fashion. He makes poor eye contact and there is definitely impairment in development of social interaction and impairment in verbal and nonverbal communication skills. <u>Use of NOS Diagnoses</u> NOS diagnoses were present for 70 of 151 (46%) of individuals followed by psychiatry. That was a high number. Per Appendix B guidelines, efforts to resolve those diagnoses should continue. <u>Conclusions and Monitoring Team's Compliance Rating</u> Much progress has been made on this provision. The introduction of diagnostic justification statements helped solidify diagnoses. The introduction of the annual updates provided an excellent vehicle to address any changes in diagnosis since the CPE. The Monitoring Team recommends that for each individual, psychiatrists should review the CPE that is in place at the time of the annual review. If needed, the justification for the current diagnoses should be included in the update. Going forward the reasons and justification for new/changed diagnoses should be included in the following annual update. The Facility should strive to complete evaluations for the individuals who do not yet have them, and continue efforts to resolve NOS diagnoses whenever possible.	
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 completed the Reiss Screen process for all individuals who lived at the	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.	Facility in 2011. Individuals who were followed by psychiatry and who were treated with psychotropic medications were not screened since comprehensive psychiatric evaluations were already required for those individuals. During previous visits the Monitoring Team confirmed that the initial screening was done correctly and that individuals who screened positive received the required comprehensive psychiatric evaluations. Reiss Screens since the Last Visit Between the last visit and March 10, 2014, Individuals #200, #265, #279, #322, #356, #382, #464, #534 and #584 were admitted. Nine of nine (100%) took psychiatric medications and all have received Appendix B CPEs. The quality of their CPEs was reviewed under Provision J6. Reiss Screen for ongoing Screening for Psychopathology and for Clinical Change of Status Evaluations Facility procedure is to screen individuals who either (1) had change-of- behavioral-status evaluations (as outlined in a protocol for Reiss screening, revised 08/2013) or (2) had been discharged for six months from psychiatric care. In that case the Reiss Screen was one of several efforts to monitor for continued stability. Since the last visit there were no follow-ups to discharges from the clinic; Individuals #195 and #353 had change of status evaluations and were referred for psychiatric evaluations since their Reiss Screens exceeded the cutoff values. The Psychiatry Department did not include them in the list of individuals receiving psychiatric services and their CPEs were pending. Individuals #323, # 56, and #206 had positive Reiss Screens during the previous review period, were referred for psychiatric services and were receiving those services. Their CPEs were also pending. . Facility Self- Assessment and Self-Rating In the materials provided to the Monitoring Team the Facility did not self-rate substantial compliance since the provision required that all individuals with a psychiatric diagnosis of prescribed psychotropic medication needed to have a CPE. As of March 2014 CPEs were in place for 107 of 151 (71%) individuals who were followed by psychiatry. Accordingly, the Facility did not self-assess substantial compliance for this visit. Monitoring Team's Compliance Rating The Facility provided Reiss Screens as required. Individuals who took psychotropic medications were not screened, since they already required CPEs for that reason. However, there were individuals who lived at the Facility who had received neither a Reiss Screen nor a psychiatric evaluation. Overall, 71% of individuals who needed psychiatric evaluations per the requirements of the Provision had them. That was an improvement since the last visit, when CPEs were in place for 66% of the individuals who needed them. CPEs were also needed for individuals who had positive Reiss	

		screens and some of those evaluations were still pending. The need to complete required 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.	<u>System for Combined Assessment and Case Formulation.</u> The provision required the Facility to integrate pharmacological treatments with behavioral and other interventions, through combined assessment and case formulation. During the visit the Monitoring Team reviewed with the Facility the continued development of the case formulations. PBSPs had now been replaced with BAIPs/BSPPSs. All individuals followed by psychiatry had either a BAIP or a BSPPS, and the template for both documents included a combined case formulation. The process of generation of the case formulation started at the PTR that was attended by the IDT including the BHS and psychiatrist. The PTR is described more fully as part of Provision J9; it was a place where biological and psychosocial considerations were discussed jointly. Among other things, PTRs were a venue for joint deliberation and exchange between the various clinical disciplines, as treatments were developed to address individual needs. Preparation for the creation of the case formulation required discipline specific processes. For behavioral services that involved the process of structural and functional analysis to elucidate the purpose of learned behaviors. For psychiatry the core understanding of the individual was obtained via the comprehensive psychiatric evaluation which included a mental status examination, review of past records and treatments, family history, and more. The two understandings were then brought together, initially at the PTR and more formally at a behavioral health preparatory meeting that took place before the ISP annual planning meeting. That meeting was attended by the psychiatrist, BHS, and behavior analyst. The Monitoring Team reviewed the logs that confirmed that the behavioral heath preparatory meetings had taken place. The Monitoring Team reviewed the case formulations for the 15 individuals in Sample JI. This was a sample intended to cover an array of clinical circumstances. The sample was divided between (a) individuals who were clinically stable (b) individuals who had undergone recent medication changes, and (c) new admissions. The case formulations were evaluated for their quality. In assessing quality, the Monitoring Team first assessed whether the formulation brought together key clinical information from behavioral and biological perspectives in a clinically meaningful way that offered an integrated understanding of the individual. Fifteen of 15 (100%) of the case formulations did so. The Monitoring Team next assessed whether the case formulations offered some degree of synergism - which added to the quality of separate readings of the discipline-specific assessments (for example the CPE). To at least some	Substantial Compliance

extent, all did. The Monitoring Team then looked at the case formulations for the presence of specific elements deemed by the Monitoring Team to represent good clinical practice. These are listed in the following paragraphs.

1. Differentiation of Function

It was good clinical practice for the IDT to examine challenging behaviors and to assess whether they represented learned behaviors or psychopathology. The distinction is important to properly select treatments. For example medications are best suited to treat symptoms of psychopathology. The matter of differentiation of function was addressed in all 15 case formulations reviewed, in a variety of ways. For example:

- Individual #133*: "(The individual has) a diagnosis of Major Depressive Disorder. His symptoms have been in remission on a low dose of Risperdal and a high dose of Zoloft. Both his depressive mood symptoms and possible psychotic symptoms are being monitored with the Brief Bipolar Disorder Symptom Scale (BDSS). It is unlikely he could be successfully treated in the future without continuation of psychotropic medications since this is a biological mood disorder. (The individual) also has a pattern of behaviors which include physical and verbal aggression. A functional analysis demonstrated an escape function primarily. In his BAIP verbal aggression will be monitored as a possible precursor to physical aggression."*
- Individual #239: *(The Individual) is a (age provided) male who was admitted on (date provided) to BSSLC. He has an Axis I diagnosis of Generalized Anxiety Disorder. He is prescribed one medication, sertraline, to treat anxiety symptoms. Behavioral Services Department has been tracking anxiety symptoms with the Anxiety, Depression and Mood Scale. Observation data on SIB has been collected with interval observation. (The Individual) has a BAIP which targets physical aggression and self-injury. Both of these behaviors also represent a large component to getting his needs met. His psychiatric symptom of anxiety will respond best to treatment of his medication while the behavior plan will provide the least restrictive needs of reducing frequency of physical aggression and self-injury.*

Both of these case formulations focused on the area of differentiation of function between psychiatric symptoms treated by medication and learned behaviors addressed by the behavior plan. The case formulations could have been improved by describing some of the observable behaviors assessed to represent psychiatric symptoms (anxiety, depression, etc). Nonetheless, the differentiation of psychiatric and behavioral "targets" is reasonable and clear. Some cases simply did not provide such clarity. For example:

- Individual #304 "(The individual) is a (age provided) Caucasian female who has a diagnosis of Mood Disorder secondary to Seizures. The majority of her characteristics, including SIB, are treated with Paroxetine. SIB has been associated with seizure activity in the frontal and temporal lobes (Gedye, 1989; Gedye, 1992). Involuntary SIB is often associated with seizure activity

		including banging her head, slapping her ears and/or head, biting her hand, hitting her chin, scratching her face or arms, and in some cases, knee to face contact. She is seeing a neurologist for seizures and has a BAIP that addresses SIB. There is significant psychiatric and behavioral overlap in these symptoms. Functional assessment shows SIB is likely primarily maintained by a physical function. (The Individual) participates in programming at Program Services. She does go out into the community and is involved in community outings. (The individual's) family is also involved." The above summarizes a complex clinical circumstance, and suggests that for this individual SIB is a behavioral symptom associated with complex partial seizures. The case formulation does not describe peri-ictal SIB (for example the period leading up to the seizures) a phenomenon that occurs from time to time. Such a symptom would likely be viewed as integrally linked to that seizure in the manner that the more common post-ictal confusion is linked to the seizure. Instead, the formulation describes that although the functional assessment shows that the SIB is likely maintained by the physical function, both medication and a behavior plan are in place to reduce SIB generally. In likelihood, the medication and behavior plan address inter-ictal (the period of time between seizures) SIB that is separate from the seizures. Cases such as the one described here are a clinical reality, and the treatments were likely appropriate. However, the presentation left unnecessary uncertainty about what the SIB that was <u>not</u> directly connected to the epilepsy represented. The presentation also did not specify or discuss the symptoms that were the basis for the diagnosis of mood disorder – presumably that diagnosis was based on more than the presence of SIB. Other complex cases were also part of Sample J1 and provided an understanding of the role of medications and the behavior plan, even when both treatments addressed the same behaviors. For example: "Individual #255 is a (age provided) African American male who lives BSSLC. (The Individual) carries an Axis I diagnoses of Autistic Disorder and Attention Deficit Hyperactivity Disorder (ADHD), Combined Type. (The Individual) has an Axis II diagnosis of Profound Intellectual Disability. (The Individual's) medical history contains many facts that point to a biological origin for some of his diagnoses (many complications and difficulties during pregnancy and birth were described, including childhood seizures. • "Individual #255 is a (age provided) African American male who lives BSSLC. (The Individual) carries an Axis I diagnoses of Autistic Disorder and Attention Deficit Hyperactivity Disorder (ADHD), Combined Type. (The Individual) l has an Axis II diagnosis of Profound Intellectual Disability. (The Individual's) medical history contains many facts that point to a biological origin for some of his diagnoses (many complications and difficulties during	

		pregnancy and birth are described, as were childhood seizures." "The individual has some behaviors that are thought to be related to his autism: SIB, intrusiveness and physical aggression. Intrusiveness is also a feature of ADHD. Inappropriate sexual behavior and stealing are intrusive behaviors, since they involve violating another person's boundaries. Individuals with autism have impaired ability to interact socially with others. They also have difficulty regulating their emotions" "(The Individual) is prescribed Depakote and Clonazepam to help him control his impulsive behavior by increasing his reaction time." "(The individual) has learned that he can use his behaviors for certain functions. For example, his SIB, physical aggression and inappropriate sexual behavior serve the function of getting attention. He learned that by taking others' possessions, he can gain access to tangibles. (The Individual) also learned that refusals can allow him to escape or avoid activities that he does not like. (The Individual's) new BAIP targeted the challenging behaviors of SIB, physical aggression, inappropriate sexual behavior, refusals and stealing/taking others possessions." The case formulation for Individual #255 also provided a good description of the individual, his family and his past medical difficulties. The formulation stated that Clonazepam and Depakote targeted impulsivity, and the BAIP targets SIB, physical aggression, inappropriate sexual behavior, refusals and stealing/taking others possession. The case formulation for the individual provided helpful information, but it left key questions unanswered. For example, how were "impulsive behaviors" tracked for purposes of medication efficacy? Was there a way to use the information about his reaction time (or time to react)? Was impulsivity measured by something other than the target behaviors for the BAIP? It is true that these questions will be addressed in the medication treatment plan too, but they seem central to his treatment needs and could have been included here too. Overall, the Monitoring Team found that the case formulations reviewed provided differentiation of function statements that were sufficient to satisfy the requirements of the SA. As reflected in the comments above, there are always ways to improve on quality, and the Facility should strive to do so. 2. <u>Psychiatric Diagnosis</u> The Monitoring Team first reviewed the case formulations to see whether the psychiatric diagnosis was present. In 15 of 15 (100%) formulations, it was. Finally, the Monitoring Team examined whether the information contained in the	

		formulation was consistent with that diagnosis. The standard here is different than the matter of diagnostic justification required for Provisions J2 and J6. Here the question is whether information that was included in the formulation was understandable in terms of the cited diagnoses. In 15 of 15 cases (100%) the information contained in the formulation was consistent with the diagnosis. 3. Psychiatric Medication Information Accurate information on psychiatric medication was provided in 15 of 15 (100%) formulations. 4. Information on Key Medical Conditions The Monitoring Team reviewed available information on the individuals in Sample J1 for inclusion of key information about the individual's medical conditions that was needed to have a general understanding of the case. For 12 of 15 (80%) individuals that information was included. (For example, see comments above on Individuals #255 and #304). 5. Information on Adaptive Functioning. Behavioral treatment most often focuses on challenging behaviors, but a general understanding is enhanced by the presence of information on adaptive functioning as well. Six of 14 (40%) of the formulations provided some information of adaptive functioning. That is an area that could be improved. Additional Venues for Integrated Behavioral Care The IDT process that centered on the PTR was not the only process on campus that contributed to a combined and shared understanding of the individual. Other processes were the Medical Morning Report which was attended by medicine, psychiatry, behavioral services, OT, PT, and other clinical services. That was an excellent venue for integrated care and good communications between disciplines was made possible by a well run meeting that was inclusive devoid of unnecessary jargon. The high levels of integration observed during previous visits were again evident. Examples of integrated care observed across the campus during the current visit or noted in documentation provided by the Facility were: • Individual # 464 was an example of integrated care in the way that many disciplines came together to minimize risk for aspiration, following medical evaluation (including a barium swallow) that demonstrated his risk. The psychiatrist contributed a plan to minimize medications that could cause sedation and lethargy, the psychologist reviewed levels of supervision, speech and language were engaged around appropriate textures for diet and the overall team engaged in finding adaptive aids that would assist the individual.	

		• Individual #408 was an example of integrated care through engagement of the overall team including medicine, psychiatry and psychology, around efforts to reduce pica. Processes that enhanced integrated care were also evident at ISP meetings that were attended by a large portion of the IDT. During the visit the Monitoring Team attended the ISP meeting for Individual # 599. During that meeting and in particular during the IRRF discussion there was good sharing of information between clinicians. For example, it emerged that for that the individual appeared to have beneficial effects that resulted from the use of hormone treatments provided. That information prompted the BHS clinician to reflect on how that information could modify behavioral interventions, and the same was true for the psychiatrists. At the next visit, the Monitoring Team will be interested in seeing the follow-up to the discussions that took place during the IDT. <u>Summary and Monitoring Team's Compliance Rating</u> Processes for improving integrated care have been ongoing for several years, as described in the previous reports of the Monitoring Team. Development of the process of combined case formulation has required development of the ability to view an individual's care through the multiple perspectives offered by the different clinical disciplines through the tools that each brings. The process of creating a quality combined case formulation required that each clinical discipline provided good quality discipline specific understandings, and that these were brought together in a manner that provided a comprehensive understanding of the individual that drew from the contributions of the underlying discipline-specific assessments. Continued improvement is always possible; that notwithstanding, the combined case formulations that were in place provided what was required by the SA, and the provision is in substantial compliance with the requirements of the SA.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other	<u>Facility Process</u> This provision focused on the way in which the IDT, including the psychiatrist, came together to determine appropriate behavioral treatment, including the use of psychotropic medication. The process in place, built around the PTR and enhanced by the ISP preparatory meetings, was strong, and ensured the inclusion of the psychiatrist at key decision points. For a general description of that process, please see Provision J3 of this report. No PTR reviews were scheduled during the current visit so the Monitoring Team did not observe the process for this review. During the current visit the Monitoring Team reviewed the records of PTRs over the past year for the 15 individuals in Sample J1; the documentation indicated that the high clinical standards noted during previous visits were maintained. The Monitoring Team requested and reviewed the dates and attendance sheets for the ISP preparatory meeting. Attendance sheets documented that	Noncompliance

	interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	the meetings had taken place as described. Particular requirements of the Provision were reviewed as follows: 1. <u>The IDT and psychiatrist should determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition:</u> The Monitoring Team reviewed the BAIP/BSPPS for each of the 15 individuals in Sample J1. The formatting of the BAIP/BSPPS assures that the IDT considers the question of the least restrictive interventions and actively considers where the proposed treatment is the least restrictive, per the judgment of the team. In 15 of 15 (100%) cases, the BAIP/BSPPS contained a summary of treatments and identified the least restrictive treatment. Provision J3 included the example of Individual #251. 2. <u>The PST and psychiatrist should determine whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone</u>: In clinical terms, the language describes the process of recommendation and assignment of the modalities of treatments. As described above the IDT and psychiatrist reviewed treatment on an ongoing basis at the PTR. In addition, recommendations for the annual plan were reconsidered and final determinations were made at the time of the pre- ISP meeting of the psychiatrist, BHS and behavior analyst. In discussions that took place during the visit, the Facility identified two places where the deliberations that were finalized at the pre-ISP meeting were documented. They were: a. Case formulations in the BAIP/BSPPS: The formulations (reviewed in more detail under Provision J8) typically addressed whether particular behavioral characteristics of the individual were understood to be the product of learned behavior or psychopathology. That understanding was critical to the understanding of the origins of behaviors of concern but did not directly address the matter of the particular modalities of treatment that would best serve the individual in the detail required per the language cited above. b. IRRF: The behavioral summary in the IRRF was an integrated document in the sense that it was fully shared by the various behavioral health services. The Monitoring Team reviewed these documents for each of the 15 individuals in Sample J1. The two documents were valuable and contained critical clinical information. However neither document clarified well why the particular modality of treatment was selected. Of course that could often be inferred. For example, referrals to counseling were made for individuals who had	

		language skills, and individuals who had communication difficulties were referred to speech therapy to enhance those communication skills. But inference alone was not sufficient, "other interventions" were rarely spelled out, and the IDT's reasons for referral to a particular combination of treatments were not always clear. 3. <u>For individuals who take psychotropic medication, the ISP must also specify non-pharmacological treatment interventions or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible:</u> Here too, there was need for improvement. As a clinical matter, it is always wise to deploy non-pharmacological interventions or supports that make it possible to minimize the need for psychotropic medication; when they are in place it is essential to include them in the treatment plan. In many IRRFs there was a reference to "other interventions identified by the IDT at the time of the ISP," but such statements were not specific. Beyond general clinical considerations, the need to spell out behavioral supports has become more critical with the introduction of the BSPPS (these are now in place for 41 of 135 [30%] of individuals who take psychotropic medications.) In the past, individuals had PBSPs, and the behavioral components of the PBSP could always be cited as the non-pharmacological intervention that fulfilled the SA requirement. In the absence of the new BAIP, additional supports were needed but were not always documented as present (see Provision J3). <u>Monitoring Team's Compliance Rating</u> Much progress has been made so far. The Facility has a strong procedure that provides for a good discussion of individuals' needs and the development of effective treatment plans. However, it is not always clear why particular treatments were, or were not, recommended for particular individuals, and the delineation of non-pharmacological treatments needs to be enhanced. For those reasons this provision remains in noncompliance.	
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	<u>Risk of Harmful Effects of Mental Illness vs. Possible Harmful Effects of Psychotropic Medication</u> <u>(Risk vs. Risk Analysis)</u> For new medications, the process of discussion, documentation, and review of the risks of medication treatment included the required risk vs. risk analysis. The process started in an IDT meeting to review the new medication discussion (documented as an ISPA), psychiatrist preparation and discussion with the legally authorized representative (LAR) of the PMTP and informed consent (IC), and presentation of the considerations to the Human Rights Committee (HRC). Review of ongoing medications took place during PTRs, through annual renewal of the PMTP and IC, and annual review	Substantial Compliance

	illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than the medications.	of the considerations by HRC. The Monitoring Team reviewed how each of these steps took place via analysis of the relevant materials from the records of the 15 individuals in Sample J1. <u>ISPA Determinations</u> Four of the individuals in Sample J1 had new medications. Risk vs. risk evaluations for three of the medications are reviewed below: • Individual #112 (Paxil) "Paxil is a medication with mild side effects. We are going to start a low dose and increase it slowly. Some individuals with SIB have improved with his medication. (The Individual) has never been tried on this class of medication before. (The individual) is hurting himself, so the risk of not trying the Paxil is greater than the risk of trying this medication if it might help decrease his SIB." • Individual #65 (Lithium) " On her current medications (the individual) is at risk for self harm due to her behaviors such as drinking thin liquids, SIB and problematic departure. (The individual) is at risk for harming others due to her physical aggression. (The individual) had a good response to lithium in the past. She will be monitored closely for adverse side effects if (the individual) has adverse side effects from lithium the medication can be tapered off. The common side effects of lithium are reversible when the medication is stopped." • Individual #545 "The team discussed the potential side effects of starting the Ativan. It was noted that (the individual) could have some tiredness due to the medication. The team then discussed the risk of not starting the Ativan and the possibility that (the individual) could still experience anxiety at a high level which could impact his productivity and quality of life. The team agreed that the risk of not starting the medication is greater than starting the Ativan." In each of the cases reviewed the IDT made the required determinations about risk of the illness and the proposed treatment. Those determinations were properly included in the materials provided to the HRC for review (see below). Nonetheless there was room for improvement in the ISPA documentation of the IDT's discussion about risk. In the sample reviewed an adequate discussion of risk vs. risk information was provided in 11 of 15 (73%) of the ISPAs. The Monitoring Team encouraged the Facility to review with IDTs the guidelines for risk vs. risk review at the ISPA level. An ISPA for new medication for Individual #255 for Paxil was held, but it did not follow the Facility ISPA shell for new medications and risk vs. risk was not addressed. <u>PMTP data</u> The 15 individuals in Sample J1 took a total of 40 medication treatments (new and	

		ongoing). For each of the 40 medications (100%) a PMTP was located. The PMTP contained a list of the common side effects of the proposed medication and check-off boxes indicating whether the risks of not treating the psychiatric condition are greater than the possible risks of medication treatment. The PMTP section was completed for each of the medications. The PMTP was prepared by the psychiatrist and reviewed with the IDT psychologist, QIDP, PCP and RN case manager, often at the PTR. PMTPs were completed and dated in all cases. Review and signature of the PMTP by all required participants reflected their meaningful participation in the process of review of new medications. <u>Consent for Treatment Data</u> The Monitoring Team also reviewed the 40 medication treatments in Sample J1. The informed consent (IC) document specified both risks of treatment and risks of non-treatment. The section on risk vs. risk was competed in 40 of 40 (100%) of the cases. <u>HRC Review</u> There were three items on the HRC review that pertained to the requirements of this provision. • Risk of having a PBSP and/or psychoactive medication • Risk of not having a PBSP and/or not taking psychoactive medication • Risk vs. Risk analysis: In the past, HRC reviews did not clearly differentiate between risks associated with the proposed medication vs. the overall treatment program, were not specific about which medication was being reviewed, and did not contain the needed analysis. These were all remedied during the current review. The form itself was improved and now clearly stated the needed information and the forms were properly completed in all cases. The matter of side effect information was addressed optimally: In the course of presentation of information about possible side effects, the individual's guardian was typically provided with two sources of information. First, there was a description provided by the pharmacy that contained exhaustive information about possible side effects. In addition, reflecting best practices, the psychiatrist highlighted information to the Legally Authorized Representative (LAR) about specific side effects that might be relevant to the individual, perhaps due to the greater overall frequency of those side effects, or perhaps due to factors that were specific to that individual, such as particular medical or psychiatric problems, vulnerabilities the individual might have, or past experience with similar medications. It was the shorter list of most important side effects that was cited in the PMTP and was repeated in the HRC review. <u>Alternative treatments:</u> In the past the Monitoring Team had encouraged the Facility to provide more detailed information about alternatives to the proposed treatment. The Facility has been	

		responsive to those concerns and has placed the relevant information in the medication consent form. The psychiatrist presents that information to the Legally Authorized Representative (LAR), and both the psychiatrist and LAR sign that document. The revised form for informed consent contained entries for treatment alternatives and for any recommended adjunctive treatments (such as environmental supports, psychological therapies, PBSP and others). The relevant sections on treatment alternatives were completed in 40 of 40 (100%) of the medication consents reviewed and all consents were properly signed/dated by the psychiatrist and by the LAR. (See further discussion on consent under Provision J14) <u>Conclusions</u> The required elements of the Provision were discussed by the IDT at the ISPA meeting, were included in the PMTP and were presented to the LAR by the psychiatrist as part of the consent process. HRC reviews were assisted by well prepared summaries that were specific to the individual, to his/her circumstances and the medication in question. Although there continued to be room for improvement in some of the details – for example the ISPA discussion of risk was not provided in one case - the system put in place was robust and had already assured that risk was addressed adequately at other places in the process as well. <u>Monitoring Team's Compliance Rating</u> With the improvements put in place the requirements of the provision have now been met and the Facility remains in compliance with the provision's requirements.	
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> The 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 psychiatry, medicine, nursing, psychology, and quality assurance. The Facility-level review augmented reviews of polypharmacy that took place at the level of the IDT. For example, individuals were reviewed for polypharmacy at PTRs (see discussion for Provisions J3, J9, and J10), polypharmacy was part of the discussion about proposed new medications (see Provisions J9, J10, J13 and J14), and polypharmacy was also the focus of IRRF discussions including at the annual ISP meetings (see discussion under Provision J8). <u>Review of Polypharmacy Data</u> The Monitoring Team attended the PMOC meeting on 04-08-14 where data on 139 individuals who received psychotropic medication were reviewed (note that elsewhere in this report the number of individuals who received medication is cited as 135; the	Noncompliance

	medications that are not clinically justified are eliminated.	small difference reflects different reporting dates). Fifteen of 139 (11%) individuals took more than one psychotropic medication from the same class (intraclass polypharmacy); 46 of 139 (33%) took a total of three of more psychotropic medication (interclass polypharmacy). Fourteen individuals had both interclass and intraclass polypharmacy. Overall, 77 of 139 (34%) Individuals had some form of polypharmacy. The Monitoring Team reviewed psychiatry polypharmacy rates since 2011. A graph of psychiatry polypharmacy rates showed a gradual and sustained decline from 42% in August, 2011 to the current rate of 34%, with little change over the past two visits. <u>Review of Individual Justifications for Polypharmacy</u> The Facility has enhanced the review of polypharmacy and at the time of the visit closely tracked different kinds of polypharmacy. There was a particular focus on (a) individuals who are undergoing review of polypharmacy regimens and who had active plans to challenge some of the medications (13 of 139, 10%) and (b) recent admissions (9 of 139, 6%) whose medication needs are being closely examined. The Facility has also generated a list of 16 individuals who had had several failed efforts to reduce medications and for whom medication reductions would not be wise. The Monitoring Team has not yet reviewed that list. Please note that pharmacy records provided information from slightly different dates than the self report. That is why above, the pharmacy reported 139 individuals with medications while the self assessment reported on 135 individuals with medication. Individuals on the list for whom medications are being actively challenged are reviewed every month and the status of efforts to reduce their polypharmacy was reviewed. <u>Conclusion</u> The Facility continued to make efforts to ensure that medications that were not clinically justified were eliminated. Nonetheless, the rate remained high. The need to continue to reduce the rates of polypharmacy remains the focus of detailed discussions with the Facility.	
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	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. DADS Policy 7.3 (effective 05/01/2013) for psychiatry stated that MOSES and DISCUS side effect screens would be provided following a change in medication dose, as determined clinically necessary by the psychiatrist. Physicians were required by policy to review and sign the side effect screening forms.	Substantial Compliance

	and/or changing needs, but at least quarterly.	<u>Efforts to Transition Data Entry in AVATAR</u> The Facility continued its transition to tracking MOSES and DISCUS evaluations via the AVATAR system. A DADS webinar was held on September 18th – 19th for the physicians and psychiatrists regarding MOSES/DISCUS entry into AVATAR. Additional steps taken to implement the new system for MOSES/DISCUS entry into AVATAR included a prescriber in-service training provided by two nurse case managers on 10/21/13, and an informal in-service was held by the nurse case manager supervisor with nurse case managers and physicians to attempt to work through the problems with data entry into AVATAR. Nonetheless, difficulties continued with the electronic entry of the physician rating component of the side effect screen. For example, the Monitoring Team was told that although physician ratings were done electronically, those did not always register in the system. For that reason, in early 2014 the Facility decided to resume use of a paper form for the physician review component. The Facility informed the Monitoring Team that use of the paper form for the electronic form would continue until the Facility was satisfied that the performance of the electronic system was satisfactory. <u>Completion of MOSES and DISCUS Screens for Individuals Taking Psychotropic Medications</u> The Monitoring Team selected a sample of 20 individuals (Sample J4), and requested all MOSES and DISCUS reviews done after 2/1/14. Twenty MOSES screens were completed for individuals, all dated in February and March 2014. Twenty of 20 (100%) had completed administrations and prescriber reviews for both the psychiatrist and primary care physician and for 19 of 20 (95%); the reviews were completed within 14 days. Nineteen of 20 (95%) included comments by both reviewers; for one of 20 (5%) one of the reviews was signed, but without comments. Twelve of 20 (60%) were in response to a change in medication dose, and eight of 20 (40%) were done as part of the requirement for a routine screening every six months. Eighteen DISCUS screens were completed for 17 individuals. Seventeen of 18 (94%) had a review form that was signed by the psychiatrist, one did not. All of the completed reviews were signed within 14 days. Fifteen of the 18 (83%) DISCUS review forms had detailed comments by the psychiatrist. Six of 18 DISCUS forms were done in response to a change in medication. The comments of the physicians were appropriate to the contents of the reviews, for example in the comments about the response to the change of dosing. <u>Completion of Side Effect Screens for Individuals taking Reglan</u> The Facility informed the Monitoring Team that eight of the 291 (3%) individuals who lived at the Facility took Reglan. The database showed that those individuals received	

		the required screenings. The Monitoring Team had examined the actual administrations during a previous visit and did not do so during the current visit. During the visit there were no PTR reviews and the Monitoring Team could not observe the current process. However, review of the PTR and QDRR documents from the individual in Sample J1 showed that there was good attention to results of the side effect screens. <u>Training for Side Effect Rating Scales</u> The Monitoring Team reviewed the training provided to nurses on the administration of the side effect rating scales. There were no changes since the last visit in initial and annual retraining for the side effect screens. The Facility provided a printout of training dates. 100% of the nurses completing nursing orientation had reviewed the MOSES/DISCUS videos. The annual training update for case managers was held on 01/09/14. It was attended by 20 nurse case managers. <u>Monitoring Team's Compliance Rating</u> At the last visit the Monitoring Team found the Facility in compliance with the requirements of this provision but commented that the continued compliance could not be sustained in the absence of completion of the physician sections that are an integral part of the MOSES and DISCUS screens. In face of continued difficulties with electronic administration of the physician review section of the screen the Facility has resumed paper administration that document of that portion of the review. The process in place provided the needed assurance for continuing administration and review of the 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 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	The PMTP in use at the Facility had entries for the required elements of the Provision, as follows: <u>Clinically justifiable diagnosis or specific behavioral pharmacological hypothesis</u>: The PMTP has a place for (1) the Axis I diagnosis, (2) the treatment rationale and (3) focus of treatment (psychiatric, behavioral or both). <u>Timeline for the therapeutic effects of the medication to occur:</u> 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. <u>By whom, when and how the monitoring (for efficacy) will occur:</u> The PMTP form clarified that "An evaluation of treatment efficacy will be conducted during PTRs to determine if the medication dose should remain the same or be increased or decreased. MOSES and/or DISCUS monitoring exams will be ordered and reviewed for any changes in potential side effects."	Noncompliance

	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.	<u>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).</u> The language cited for the previous item applies here, too and was included in the PMTP for each medication. <u>Objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy</u> The PMTP has an entry for "Treatment Efficacy Scale – Data or Scale." Rating scales were named. The Facility indicated 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. Rating scales commonly used included scales developed for use in intellectual disabilities, for example the Anxiety, Depression and Mood Scale (ADAMS) and the Dementia screening questionnaire for individuals with ID; rating scales used in general psychiatry, for example the Bipolar Disorders Symptoms Scales, the Positive Symptom Rating Scale and Brief Negative Symptom Scales that are derived from the Brief Psychiatric Rating Scale; and rating scales used in child psychiatry such as the Connor's scale for hyperactivity. The Monitoring Team reviewed the PMTPs for individuals in Sample J1. Individuals in the group took a total of 40 psychotropic medications and 40 of 40 (100%) had PMTPs. Four of 40 (10%) were written as part of the approval process for new medications, and 36 of 40 (90%) were updated as part of the psychiatrists' annual reviews that took place at the time of the annual ISP. The Monitoring Team was provided with PMTPs for 40 of 40 (100%) of the medications and all sections of the PMTPs were completed. The Monitoring Team then reviewed the way that PMTPs were implemented. In particular the Monitoring Team reviewed how the required monitoring took place for treatment efficacy. The Monitoring Team noted continued improvement in the development of data-based tracking that would assist the psychiatrists in their decision making. During the visit the Monitoring Team had productive discussions with the Facility psychiatrists about what was the best way for the BHS to present information at PTRs that would be best support real-time decision making during PTRs. For example the improved graphic presentations might enable decreases in the presentation of raw data that cannot be adequately processed in the fast-paced PTR. Discussions took place whether separate graphic presentations for each diagnosis were most helpful, vs. three consolidated graphic presentations of (a) all psychotropic medications (b) all relevant psychiatric targets/rating scales and (c) supplementary information on behavioral targets tracked by BHSs for non-pharmacological treatments. The Monitoring Team also discussed with the Facility about how rating scales were selected and validated, to be sure they adequately captured any given individual's symptoms, and whether pre-	

		treatment measures for the monitoring parameters were obtained for elective medication trials, so as to establish a pre-treatment baseline that is useful for subsequent decisions about treatment efficacy. In these areas some progress was made, but the system in place was not yet adequate to provide meaningful monitoring for efficacy. Monitoring Team's Compliance Rating PMTPs are now in place and Behavioral Data Sheets provided elements of data-based support for psychiatric decision making. Progress toward substantial compliance will continue to depend largely on (1) successful completion of the deployment of the system for efficacy tracking and (2) the demonstration by psychiatrists that their decision-making was informed by relevant behavioral data. Although progress has been made, the provision is not yet in substantial 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." During the last review the Monitoring Team found that a robust system for IC was in place. The consent was based on well-developed medication treatment plans that the psychiatrist then reviewed with the LAR along with the consent itself. In addition, the Facility HRC was provided with information that assured that the relevant information that pertained to risk and benefits was addressed and provided to the LAR. Accordingly, the Facility was found in substantial compliance with the requirements of the SA. Continued Provision of IC During the current visit the Monitoring Team reviewed the Provision for continued compliance by review of the informed consents and treatment plan documents for the psychotropic medications administered to the 15 individuals in Sample J1. The 15 individuals received a total of 40 medications; 36 of 40 (90%) were medications in place for over one year. For those individuals the consent was an annual renewal of the original IC. Four of 40 (10%) were medications started during the past year. For those individuals the current IC was the initial document. For the group as a whole 40 of 40 (100%) ICs included a signature of the psychiatrist and the LAR. For two of four (50%) new medications, the signed consent had been preceded by verbal consent obtained by the psychiatrist that was witnessed.	Substantial Compliance

		Forty of forty (100%) of the consents included presentations of the following elements in the IC document: • Psychiatrist Name • Name of the medication • Treatment alternatives (including a variety of options such as (a) different medications, (b) additional supports such as counseling, (c) a combination of medication and non medication treatments and (d) no medication treatment). • Additional supports (including BSP, BSPPS, counseling, environmental plan, and other psychotropic medications). • Risks of non-treatment • Risks of treatment • Monitoring (roles of psychiatrist , PCP, pharmacist, psychologist, nurse case manager QDDP and DSPs) Forty of forty (100%) of the PMTPs contained presentations of the following elements: • Name of the medication • Psychiatric diagnosis • Treatment rationale • FDA approval status for the medication • Expected (time for) drug response • Common side effects • Expected medication dose • Risk vs. risk information • Treatment plan for the coming year (dose continuation, medication challenge, etc.) <u>HRC Review of Consent</u> HRC reviews were provided for all medications. The HRC review sheet provided a place to indicate whether the presentation to HRC was for annual review of medication, a new medication, or a new admission. Consents included the reason for restriction (if any), risks of taking the psychotropic medication, risk of not taking the psychotropic medication, and a list of less intrusive alternatives. <u>Conclusion and Monitoring Team's Compliance Rating</u> The Facility continued to provide the required annual consent for medications for all individuals in the Sample group and the status of substantial compliance is continued.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance

	neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.		

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 (3/18/2014) 2. BSSLC Action Plan (3/18/2014) 3. BSSLC Presentation Book for Section K (4/7/2014) 4. Behavior Services department organizational chart and credential tracking 5. Positive Behavior Support Committee meeting minutes from 10/15/2013 through 3/4/2014 6. Documents that were frequently reviewed included the annual ISP, ISP updates, Skill Acquisition Plans (SAPs), behavior intervention plans (referred to in the report as PBSPs and BAIPs interchangeably), 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 document reviews were conducted in the context of the Self-Assessment. • The review of data monitoring practices in Provision K.4 included 10 individuals with Behavior Support Program for Psychiatric Symptoms (BSPPS) plans (Individuals #33, #62, #88, #121, #184, #273, #308, #332, #379, and #450) and five individuals with Behavior Assessment and Intervention Plans (BAIPs) (Individuals #13, #134, #205, #417, and #490). • The review of SFAs involving the assessment of behavior and mental illness in Provision K.5 included 10 individuals with BSPPS plans (Individuals #33, #62, #88, #121, #184, #273, #308, #332, #379, and #450) and five individuals with Behavior Assessment and Intervention Plans (BAIPs) (Individuals #13, #134, #205, #417, and #490). • The review of non-PBSP/BAIP interventions presented in Provision K.8 included a sample of 21 individuals. This sample was comprised of three individuals with behavior therapy plans (Individuals #76, #255 and #259), five individuals with counseling plans (Individuals #144, #248, #360, #539, and #568), three individuals with desensitization plans (Individuals #120, #242, and #488), and 10 individuals with BSPPSs (Individuals #33, #62, #88, #121, #184, #273, #308, #332, #379, and #450). • The review of behavior intervention plans in Provision K.9 included Individuals #4, #13, #133, #134, #186, #193, #205, #381, #427, and #468.. • The review of data graphs in Provision K.10 included the 10 individuals with BSPPS plans (Individuals #33, #62, #88, #121, #184, #273, #308, #332, #379, and #450) and the five individuals with Behavior Assessment and Intervention Plans (BAIPs) (Individuals #13, #134, #205, #417, and #490) that comprised the sample for Provision K.5. **People Interviewed:** 1. Terry Blackmon, PhD, BCBA-D – Chief Psychologist 2. Donna Bradley-Schrick, MA, LPC, BCBA – Behavior Analyst I 3. Sara Bohl, MA, BCBA – Behavior Analyst I 4. Fara Goodwyn, M.Ed., BCBA – Behavior Analyst I

	5. Jana Lehrmann, MA– Behavior Health Specialist V **6.** Direct Support Professionals: Approximately 15 staff were interviewed in the Education and Training Center **Meeting Attended/Observations:** 1. Positive Behavior Support Committee 2. Human Rights Committee meeting 3. Observations were conducted in the Education and Training Center.
	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. At the time of the site visit, BSSLC reported in the Self-Assessment that Provisions K.1, K.2, K.3, K.5, K.9, K.11 and K.13 were in substantial compliance with the Settlement Agreement. The Monitoring Team was in agreement with the Facility concerning Provisions K.2, K.3, K.9, and K.11. For Section K, in conducting its self-assessment, the following was noted. ▪ The Facility did not typically indicate specific tools used for the review of Section K. The only formal tool noted was the FBA/PBSP Evaluation Tool ▪ The Facility did use a variety of relevant data sources. These data sources included the departmental tracking databases for staff progress toward board certification, PBSC approvals, external peer review, treatment integrity, inter-observer agreement, Progress Note reviews, BAIP readability grade levels, intellectual assessment, and adaptive skill assessment. Although the Facility did not frequently describe the specific procedures used when compiling ratings and using these data sources, the outcome data achieved was often equal to that reviewed by the Monitoring Team. ▪ At times, the Facility presented information in meaningful ways. For example, the Facility described in detail the process for rating BAIPs submitted for PBSC review. In other areas, the information provided by the Facility was less useful. For example, although the Facility reported that psychological assessments were reviewed for accuracy, the measures reported consisted only of whether assessments were completed and if the assessments were current. The Facility also provided as part of its self-assessment an Action Plan that reported actions being taken to achieve compliance. The majority of components of the Action Plan were described as being in process or completed. Although these statements were accurate, it was important to note that for the most part they addressed quantitative rather than qualitative goals. For example, one item in the Action Plan was, "Review of treatment integrity on a monthly basis by the assigned BCBA." The conducting of such a review would likely be important. Without a qualitative component, however, it would be difficult to determine if the goal was completed in a manner that would assist with attaining substantial compliance with the Settlement Agreement. A qualitative component would not need to be exceptionally detailed or sophisticated. It would be sufficient in many instances to indicate the criteria for success, as well as how it would be determined

	whether those criteria had been met. In the example above, it might be useful to indicate (in addition to the number or percent of monthly reviews completed) the criteria for treatment integrity, how that would be measured, expectations for overall treatment integrity, and the percentage of reviewed intervention plans that met those expectations. It is recommended that BSSLC review the existing Action Plan to identify areas in which qualitative criteria would be advantageous.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at BSSLC from 4/7/2014 through 4/11/2014. Record reviews continued off-site following the site visit. The Facility had requested no review for Provisions K.2, K.5, K.6, K.7, and K.12. Although many Provisions continued to lack substantial compliance, progress had been achieved in several areas. • The Facility continued to address the need for BCBAs through recruitment and education. • A well-qualified Director of Behavior Services continued to be employed by the Facility. • A robust and evidence-based peer review process was in place. • Formal behavior intervention plans were sophisticated and comprehensive. • Staff instructions for behavior intervention plans were written in accessible language. Despite the numerous areas of improvement, the Facility continued to demonstrate limitations or a lack of progress in several areas. • Not all behavior intervention plans were developed by a BCBA. • Data collection and treatment monitoring reflected weaknesses that included the use of rating scales not intended for use with people with intellectual and developmental disabilities, infrequent use of indications on graphs of changes in interventions, and lack of documentation of treatment integrity and reliability on data graphs and progress notes. • Behavior Support Plans for Psychiatric Symptoms (BSPPSs) did not reflect adequate assessment of pertinent behavioral and environmental factors, and frequently did not offer strategies for strengthening coping skills or developing adaptive behaviors. • Counseling plans lacked an evidence-based approach to intervention. Even though substantial limitations were noted in some areas, it was evident that the Facility had invested considerable time and resources toward improving behavioral services. Some areas of noted weaknesses, such as the BSPPSs, were recently implemented. It was therefore not surprising that various challenges were experienced in the implementation process. It is recommended that the Facility continue in its on-going efforts toward substantial compliance with the Settlement Agreement.

#	Provision	Assessment of Status	Compliance
K1	Commencing within six months of the Effective Date hereof and with full implementation in three years,	<u>Historical Perspective</u> During the baseline site visit, BSSLC employed no Behavior Services staff who was certified as a behavior analyst. Two members of the department were in the process of	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.</td><td>completing the course work and/or supervision required for certification. A third individual had obtained a graduate degree from a behaviorally oriented program but was not pursuing certification.

In January 2012, only two psychologists were BCBAs. 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 Blackmon, Chief Psychologist.

In April 2013, 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. Of the remaining eight staff lacking board certification, only one was currently enrolled in BCBA courses.

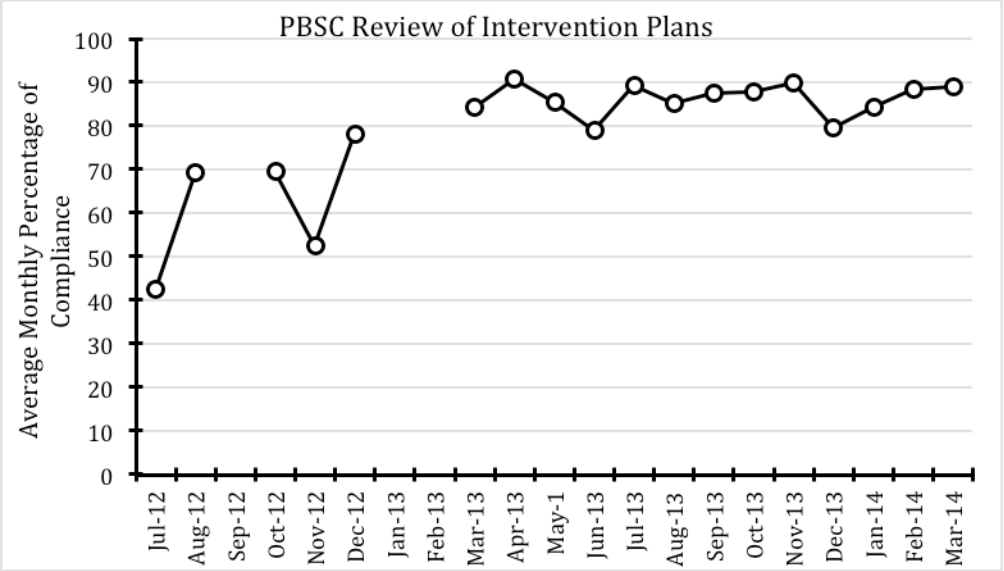
<u>Current Site Visit</u>
During the current site visit, Facility records regarding Behavior Support Department staff were reviewed. These records reflected that four of 15 staff (27%) was board certified as a behavior analyst. Of the remaining 11 staff, eight (73%) were actively pursuing board certification. Therefore, it was determined that 80% of the current Psychology Department staff either possessed or were actively pursuing board certification.

<table>
<tr><td></td><td>1/2010</td><td>10/2013</td><td>4/2014</td></tr>
<tr><td>Percent of staff who were BCBAs</td><td>0%</td><td>29%</td><td>27%</td></tr>
<tr><td>Percent of staff lacking BCBA who were pursuing board certification</td><td>26%</td><td>80%</td><td>73%</td></tr>
<tr><td>Percent of staff who were BCBAs or were pursuing board certification</td><td>26%</td><td>80%</td><td>80%</td></tr>
</table>
BSSLC maintained a process for auditing credentials of those staff members who possess board certification in applied behavior analysis.

During the current site visit, the Monitoring Team used a sample of 15 behavior intervention plans developed since the previous site visit to determine the percentage of plans completed by a BCBA. The specific individuals included in the sample were Individuals #13, #33, #62, #88, #121, #134, #184, #205, #273, #308, #332, #379, #417, #450, and #490. Based upon the information provided from the review, 15 of 15</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		behavior intervention plans (100%) were completed by or under the direct supervision of a BCBA. Although not in Substantial Compliance, the available documentation reflected that BSSLC had increased efforts to ensure that staff had or were progressing toward board certification. At the time of the site visit, however, only 27% of staff possessed board certification.	
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.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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.	<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. Observations and document reviews in July 2011 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. 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 including the lack of a system to track the global changes in PBSPs as a measure of the peer review process. Reviews conducted during the July 2012 site visit revealed only modest improvements in the peer review process at BSSLC. A review 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. The April 2013 site visit revealed substantial improvements in the peer review process at	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		BSSLC. PBSC meetings were more comprehensive with ample contributions from a variety of disciplines. In addition, data suggested that the quality of PBSPs had improved because of the PBSC review. During the October 2013 site visit, it was evident that BSSLC had maintained a robust peer review process. Review of behavior assessment and intervention was comprehensive and multidisciplinary. <u>Current Site Visit</u> <u>Internal Peer Review</u> During the current site visit, observations were conducted during the PBSC meeting. The meeting was attended by all members, all of whom contributed to the review process by asking questions and offering comments. Overall, the actions of the committee members reflected a careful review of assessments according to behavior analytic principles. A review of PBSC minutes from meetings held between 10/15/2013 and 3/4/2014 reflected that discussion observed during the site visit was representative of the typical level of consideration at all PBSC meetings. 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 October 2013 through March 2014 were reviewed as part of the current site visit. This documentation reflected that intervention plans at BSSLC were consistently rated at between 80% and 90% of full compliance at the time of initial submission to the PBSC.	

#	Provision	Assessment of Status	Compliance
		 In a review of the PBSC, the following was noted. • A policy was in place for internal peer review. • Membership of the PBSC consisted of behavior intervention authors, those who supervise implementation of plans, psychiatrists, speech pathologists, and QIDPs. • Minutes reflected that PBSC met for 17 of 21 (81%) possible weeks. The weeks that no meeting was held coincided with holidays. • Individuals with PBSPs were reviewed at least annually. <u>External Peer Review</u> The Facility provided documentation of two forms of external peer review. In the first method, for each month, an intervention plan reviewed that month by the PBSC was submitted for review by board certified behavior analysts who were on faculty at Texas State University. The external review utilized the same rubric used for PBSC review. The average internal compliance rating of all plans during the review period was 91%. The average external compliance rating during the same period was 95%. The second format for external peer review involved a Grand Rounds presentation of at least one case from each residential unit at BSSLC. Case presentations were conducted by Behavior Support staff during a meeting at BSSLC attended by the Texas State University faculty. The Texas State University faculty then offered recommendations regarding assessment and intervention.	

#	Provision	Assessment of Status	Compliance
		Overall, the peer review process at the Facility continued to reveal the positive attributes noted during the previous site visit. There was, however, one area of particular concern. Ten Behavior Support Plans for Psychiatric Symptoms (BSPPSs) were included in the review for Provision K.5 (Individuals #33, #62, #88, #121, #184, #273, #308, #332, #379, and #450). Of those 10, only two (20%) had been reviewed by the PBSC. Given the substantial weaknesses noted in Provision K.5 regarding the BSPPSs, it was suggested that BSPPSs would benefit from routine PBSC review. As the BSPPS format had only been implemented since the previous site visit, and the PBSC review process was first implemented with BSPPSs in February 2014, it appeared prudent to await for full review until the next site visit. The Monitoring Team strongly recommends the Facility provide a comprehensive review of BSPPSs.	
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, data collection for PBSPs consisted primarily of narrative reporting. 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. In January 2012, a sample of 18 records reflected that some areas of behavior data collection had improved substantially. Efforts at interobserver agreement (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. 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, 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. In April 2013, the increased number of BCBAs allowed the monthly review of PBSP data to be conducted by BCBAs. In addition, the Facility had initiated the use of a spreadsheet tracking system to coordinate and track PBSP reviews. In October 2013, progress was noted. Although substantial progress was evident in several areas, the Facility continued to demonstrate some limitations in ensuring that all behavior data were presented and used in a satisfactory manner.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Current Site Visit During the current site visit, the Monitoring Team selected a sample of 15 individuals for the review of data collection and treatment monitoring. These individuals included 10 individuals with BSPPS plans (Individuals #33, #62, #88, #121, #184, #273, #308, #332, #379, and #450) and five individuals with Behavior Assessment and Intervention Plans (BAIPs) (Individuals #13, #134, #205, #417, and #490). The table below reflects the results from the current site visit review regarding the collection and presentation of data.	

	1/2010	10/2013	4/2014
Treatment Target data collection sufficient to assess progress	0%	80%	47%
Replacement behavior or skill development data collection sufficient to assess progress	0%	87%	27%
Data reliability is assessed	0%	33%	0%
Treatment Targets analyzed individually	0%	73%	73%
Treatment Targets graphed sufficient for decision-making	60%	73%	20%
Replacement behaviors or skill development data graphed sufficient for decision-making	0%	80%	27%

Information gained from the record sample reflected that the Facility had experienced substantial declines in five of the six areas (83%). None of the areas was rated as fully successful.

Some of the limitations noted in the documentation and presentation of treatment data included the following.

- Eight of 15 records (53%) reflected inadequate data collection procedures. In each of these records, the data collection procedures involved, at least in part, the use of rating scales for which no norms existed for individuals with intellectual or developmental disabilities. As such, it was not possible to know if the measures provided by the rating scales were valid and accurate.
- Eleven of 15 records (73%) did not include data collection procedures for the training of replacement behavior or new relevant skills such as coping strategies. For the most part, this was due to the intervention plans not including a teaching component. As will be discussed elsewhere in the report for Section K, the lack of skill enhancement strategies in behavior interventions was of concern to the Monitoring Team.

#	Provision	Assessment of Status	Compliance

- In none of the reviewed records (0%) was information relating to inter-observer agreement (IOA) presented.
- In 12 of 15 records (20%), treatment data graphs lacked condition change lines or other indicators of changes in treatment modalities, drug dosages, or environmental conditions. Without indications of when changes occurred, it was not readily possible to identify potential responses to those changes.
- Eleven of 15 records (73%) did not include data graphs for the training of replacement behavior.

The availability and presentation of treatment data is only one aspect of the process of monitoring the benefit of intervention plans and psychotropic medications. It is also necessary to conduct thorough reviews of the available data and to introduce changes in the treatment process when data indicate changes are necessary.

	1/2010	10/2013	4/2014
Graphed data are reviewed monthly or more frequently if needed, such as due to use of restraints or changes in risk level	0%	100%	100%
Review is conducted by a BCBA	0%	100%	0%
Input from direct care staff is solicited and documented	0%	7%	60%
Modifications to the BAIP/BSPPS reflect data-based decisions	0%	47%	47%
Criteria for revision are included in the BAIP/BSPPS	0%	87%	53%
Progress evident, or program modified in timely manner (3 Months)	0%	60%	67%

Information gained from the record sample reflected that the Facility had achieved improvement in two of the six areas (33%), demonstrated no change in two of six areas (33%), and regressed in two areas (33%). One of the areas was rated as fully successful.

Some of the limitations noted in the documentation and presentation of treatment data included the following.

- None of the records (0%) reflected a review of monthly progress notes by a BCBA. This was a substantial decline from the previous site visit. It was reported by the Facility that all BCBAs did monitor the data trends for all individuals in their assigned areas and provided a detailed review of those individuals for whom a less than desired response to treatment was noted. Routine monthly monitoring was completed by a Behavior Health Specialist. None of the Behavior

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>Health Specialists were BCBAs.
• Seven of 15 records (47%) did not include adequate criteria for assessing the success or failure of the intervention plan. In some cases, this was due to the absence of the necessary criteria. In other circumstances, however, criteria were included, but were vague or subjective, such as relying upon the judgment of the treating psychiatrist.

<table>
<tr><th></th><th>BAIPs</th><th>BSPPSs</th></tr>
<tr><td>Treatment Target data collection sufficient to assess progress</td><td>40%</td><td>50%</td></tr>
<tr><td>Replacement behavior or skill development data collection sufficient to assess progress</td><td>80%</td><td>0%</td></tr>
<tr><td>Data reliability is assessed</td><td>0%</td><td>0%</td></tr>
<tr><td>Treatment Targets analyzed individually</td><td>100%</td><td>60%</td></tr>
<tr><td>Treatment Targets graphed sufficient for decision-making</td><td>20%</td><td>20%</td></tr>
<tr><td>Replacement behaviors or skill development data graphed sufficient for decision-making</td><td>80%</td><td>0%</td></tr>
<tr><td>Graphed data are reviewed monthly or more frequently if needed, such as due to use of restraints or changes in risk level</td><td>100%</td><td>100%</td></tr>
<tr><td>Review is conducted by a BCBA</td><td>0%</td><td>0%</td></tr>
<tr><td>Input from direct care staff is solicited and documented</td><td>100%</td><td>40%</td></tr>
<tr><td>Modifications to the PBSP reflect data-based decisions</td><td>20%</td><td>60%</td></tr>
<tr><td>Criteria for revision are included in the PBSP</td><td>100%</td><td>30%</td></tr>
<tr><td>Progress evident, or program modified in timely manner (3 Months)</td><td>60%</td><td>70%</td></tr>
</table>

Based upon the information obtained during the site visit, the recent adoption of the BSPPS contributed substantially to the decline in ratings. The table below provides a comparison of the ratings for BAIPs vs BSPPSs.

In five of the 12 areas (42%), BSPPSs were rated substantially lower than BAIPs. At the same time, there were some areas in which BSPPSs were rated higher than BAIPs. This was most notable in relation to evidence-based modifications to treatment strategies.</td><td></td></tr>
<tr><td>K5</td><td>Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological</td><td>The Facility requested the Monitoring Team not monitor this provision. The review of Provisions J.3, J.8, and J.9 required that some review of Provision K.5 be conducted. Monitoring and review in Provision K.5 is limited to issues pertaining to the assessment of operant behavior and identified behavior correlates for mental illness, as well as the integration of those two assessment areas.</td><td>Noncompliance</td></tr>
</table>

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.</td><td>
<u>Current Site Visit</u>
During the current site visit, the Monitoring Team selected a sample of 15 individuals for the review of Structural and Functional Assessments (SFAs), as well as the integration of assessments of behavior and mental illness. These individuals included 10 individuals with BSPPS plans (Individuals #33, #62, #88, #121, #184, #273, #308, #332, #379, and #450) and five individuals with Behavior Assessment and Intervention Plans (BAIPs) (Individuals #13, #134, #205, #417, and #490).

The table below depicts the ratings pertaining to SFAs.

<table>
<tr><th></th><th>1/2010</th><th>10/2013</th><th>4/2014</th></tr>
<tr><td>Assessment or review of biological, physical, and medical status</td><td>0%</td><td>100%</td><td>93%</td></tr>
<tr><td>Review of personal history</td><td>0%</td><td>100%</td><td>93%</td></tr>
<tr><td>A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis</td><td>0%</td><td>100%</td><td>40%</td></tr>
<tr><td>The process or tool utilizes both direct and indirect measures</td><td>0%</td><td>89%</td><td>40%</td></tr>
<tr><td>Identification of setting events and motivating operations relevant to the undesired behavior</td><td>0%</td><td>89%</td><td>33%</td></tr>
<tr><td>Identification of antecedents relevant to the undesired behavior</td><td>0%</td><td>89%</td><td>33%</td></tr>
<tr><td>Identification of consequences relevant to the undesired behavior</td><td>0%</td><td>89%</td><td>33%</td></tr>
<tr><td>Identification of functions relevant to the undesired behavior</td><td>0%</td><td>100%</td><td>27%</td></tr>
<tr><td>Summary statement identifying the variable or variables maintaining the target behavior</td><td>0%</td><td>100%</td><td>33%</td></tr>
<tr><td>Identification of functionally equivalent replacement behaviors relevant to the undesired behavior</td><td>0%</td><td>89%</td><td>33%</td></tr>
<tr><td>Identification of preferences and reinforcers</td><td>0%</td><td>89%</td><td>33%</td></tr>
</table>

Information gained from the record sample reflected that the Facility had achieved improvement in none of the 11 areas (0%), demonstrated no change in none of 11 areas (0%), and regressed in 11 of 11 areas (100%). Two of the areas (18%) were rated as fully successful.
</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance
		Some of the limitations noted in the documentation and presentation of treatment data included the following. 1. Nine of 15 records (60%) did not reflect the use of a comprehensive functional assessment process. All nine of these SFAs involved individuals with a BSPPS. The rationale for using a BSPPS, as opposed to a BAIP, is that the individual has been shown to experience primarily psychiatric symptoms that are well controlled by psychotropic medications or that the identified targets are entirely due to the underlying mental illness rather than environmental conditions. If either of those conditions was met, then conducting an accepted functional assessment could be difficult or even unnecessary. In the nine individuals for whom an accepted functional assessment was not used, however, documentation in the record suggested that neither of the above conditions had been met. • For Individual #62, assessments consisted of staff interviews and the QABF. The narrative of the SFA stated that no antecedents were identified for either physical aggression or teasing/taunting peers. The QABF was described as indicating a non-social function for all behaviors. The SFA summary indicated that all behaviors were manifestations of the individual's mental illness. During the review of the SFA, the Monitoring Team noted graphs that depicted the temporal breakdown of displays of the intervention targets from across nine months. Information on these graphs revealed that the majority of displays of each treatment target were restricted within bands of two to three hours. Such a pattern suggests that environmental factors influence if not control displays of the intervention targets. Furthermore, a single episode of verbal aggression was attributed to being awakened while sleeping on a couch and prompted to go to bed, a specific environmental event. The Monitoring Team also noted that disparate patterns were reflected in the QABF results for each intervention target. Although certainly not definitive findings, these results did suggest the possibility of environmental factors associated with each target, and perhaps different environmental factors for each target. Despite these indications included in the SFA, documentation did not reflect that a comprehensive functional assessment was considered or attempted. 2. Nine of 15 records (60%) did not reflect the use of direct observations as part of a comprehensive functional assessment. This was the element of a comprehensive functional assessment that most often was not completed, directly attributing to the low rating concerning the use of widely accepted functional assessment practices.	

#	Provision	Assessment of Status	Compliance
		3. In 10 of the 15 records (67%), setting events or motivating operations were not specifically identified. This was despite the inclusion of some information in the SFA, such as temporal graphs, that could have contributed to the identification of setting events and motivating operations. 4. In only five of 15 records (33%) were specific antecedents identified. In the 10 BSPPSs, targets were typically attributed to mental illness rather than environmental contingencies. In one BAIP, however, there was also a lack of identified antecedents. For Individual #490, it was stated in the SFA that no antecedents were identified. The assessment process included a review of temporal trends, staff interviews, the QABF, and direct observation. Direct observations, however, were very limited. Two observations were conducted (11/20/2013 and 1/8/2014). Each observation was limited to only 10 minutes, during which no targets were displayed. Individual #490 was described as presenting a variety of serious behaviors, including physical aggression, disrobing, suicidal statements, destruction, inappropriate toileting and problematic departure. In such circumstances, it was crucial that a thorough understanding of the behavior was developed. To accept as conclusive the lack of findings from two brief observations during which no behaviors were displayed was inadequate. A variety of procedures could have been initiated, including expanded observations and a functional analysis. It was also possible that by developing a better understanding of the contingencies maintaining desired behavior, additional insight into challenging behavior could have been established. 5. Only five of 15 records (33%) included the identification of specific consequences for intervention targets. These five records reflected the five BAIPs in the sample. No BSPPSs identified consequences. 6. In 10 of 15 records (33%), the functions maintaining the intervention targets were not adequately identified. In several records, this lack of identified functions was in part due to the intervention targets being attributed to mental illness. In all 12 records, however, it was evident that problems existed in either the provision or interpretation of functional assessments. • For Individual #13, the results of the QABF indicated that the individual's pica was maintained by attention. The hypothesis later presented in the SFA was that pica was a biologically maintained behavior. Although research has suggested a potential biological basis for some pica, this has not been definitively demonstrated. Furthermore, behavior analytic research includes several examples of pica being maintained by environmental factors. Assessment data to support the choice of the biological rather than functional source of the pica for Individual #13 was not provided in the record. During the current site visit, the same sample of 15 Structural/Functional Assessment	

#	Provision	Assessment of Status	Compliance
		reports was used to measure the integration of mental illness and behavior assessment. One individual, Individual #134, was not diagnosed with a mental illness. That individual's record was not including in ratings of differentiation between learned and biologically based behavior or the identification of behavioral indices of psychopathology.	

	1/2010	10/2013	4/2014
The assessment process included screening for psychopathology, emotional, and behavioral issues.	0%	33%	53%
The assessment process included differentiation between learned and biologically based behaviors.	0%	100%	7%
Identification of behavioral indices of psychopathology	0%	100%	0%
Use of one or more assessment tools with evidence of validity in use for people with intellectual disabilities	0%	100%	53%

Information gained from the record sample reflected that the Facility had achieved improvement in one of the four areas (25%), demonstrated no change in none of four areas (0%), and regressed in three of four areas (75%). None of the areas (0%) was rated as fully successful.

Some of the issues noted during the review included the following.

- Fourteen of the 15 records (93%) included an extensive history of the individual including behavioral challenges and mental illness. In only eight of the 15 records (53%) was this information reported in conjunction with current and appropriate assessments to support the presence or absence of a specific mental illness. The review did not address whether or not such assessments were completed, only whether such assessments were presented and integrated into the SFA. In some cases, the SFA included assessment results from instruments for which no research had been conducted to support their use in people with intellectual and developmental disabilities. In such cases, the instruments in question were not rated as having provided a screening for psychopathology.
- Only one of 14 records (7%) used evidence-based approaches to differentiate between learned behaviors and symptoms of mental illness.
- None of 14 records (0%) provided evidence specifically identifying a behavior or behaviors as reflective of a mental illness.
- Seven of 15 records (47%) included assessment results obtained only from instruments for which published data supported their use in people with

#	Provision	Assessment of Status	Compliance

intellectual and developmental disabilities.

The information developed as part of the current site visit revealed substantially lower compliance than noted during the previous site visit in October 2013. As it appeared that the recently implemented BSPPS interventions were in part responsible for the lower compliance, a comparison seemed warranted. The tables below depict the ratings from the previous site visit with the current ratings of BAIPs and BSPPSs.

	10/2013	BAIPs	BSPPSs
Assessment or review of biological, physical, and medical status	100%	100%	90%
Review of personal history	100%	100%	90%
A functional assessment reflecting a process or instrument widely accepted by the field of applied behavior analysis	100%	100%	10%
The process or tool utilizes both direct and indirect measures	89%	100%	10%
Identification of setting events and motivating operations relevant to the undesired behavior	89%	100%	0%
Identification of antecedents relevant to the undesired behavior	89%	100%	0%
Identification of consequences relevant to the undesired behavior	89%	100%	0%
Identification of functions relevant to the undesired behavior	100%	80%	0%
Summary statement identifying the variable or variables maintaining the target behavior	100%	80%	10%
Identification of functionally equivalent replacement behaviors relevant to the undesired behavior	89%	100%	0%
Identification of preferences and reinforcers	89%	100%	0%
The assessment process included screening for psychopathology, emotional, and behavioral issues.	33%	80%	40%
The assessment process included differentiation between learned and biologically based behaviors.	100%	0%	10%
Identification of behavioral indices of psychopathology	100%	0%	0%
Use of one or more assessment tools with evidence of validity in use for people with intellectual disabilities	100%	100%	30%

#	Provision	Assessment of Status	Compliance
		The information above reflects that the BAIP ratings from the current site visit are comparable with the previous site visit ratings in many of the rated areas. Ratings for the current BSPPSs, as well as ratings pertaining to the differentiation between environmentally based behaviors and symptoms of mental illness, however, are substantial lower. Therefore, it is evident that the BSPPS interventions were substantially although not entirely responsible for the overall lower ratings of compliance. It was concerning that rating scales not intended for use with people diagnosed with intellectual and developmental disabilities were frequently used at the Facility. Rating scales, although widely used, have the potential for introducing subjectivity into the assessment process. When rating scales are used beyond the intended population, the risks of subjectivity and erroneous findings are increased. It is important that the Facility explore replacing these rating scales with more objective measures. It was also concerning to the Monitoring Team that the BSPPSs in general, as well as the overall integration of the assessment of behavior and mental illness, lacked the rigor often evident in the assessments associated with the BAIPs. In several records, it simply was not evident that the potential environmental factors were considered or that the role of environmental reasons for behaviors had been explored. It would appear essential that the Facility improve the quality of behavioral assessments for individuals with a combination of behavior challenges and mental illness. • Individual #379 was diagnosed with Schizoaffective Disorder and was prescribed Zyprexa to address delusional statements. The statements in question consisted of claims of personal injury, such as bee stings, snakebites, chest pains, and being hit by a train. Information included in the assessment, however, suggested that these statements often produced attention or other desired outcomes. At one point in the assessment report, the individual was quoted as stating he had reported chest pains because he had never ridden in an ambulance. Despite this information, no functional assessment was attempted and all such statements were attributed to the diagnosed mental illness. No formal interventions other than psychotropic medications were presented. • Individual #308 was diagnosed with an autism spectrum disorder. He had a history of destructive and dangerous behavior for which he was prescribed an antipsychotic medication. The assessment revealed that, following a move to a new residence, the dangerous behaviors substantially subsided. Such a response to a change in living environment suggested an environmental or learned basis for the targeted behaviors. Despite this, the targeted behaviors were attributed to the individual's autism and intervention consisted primarily of psychotropic medication. The assessment reflected to indication that the potential for an alternate intervention strategy had been explored.	

#	Provision	Assessment of Status	Compliance
		Even in circumstances in which a person's challenging behavior is primarily due to a mental illness, a more robust approach to assessment and intervention can be beneficial. For example, the experience and expression of paranoid ideation can be influenced by the environment and lead to learned responses to environmental stimuli, both internal and external. A comprehensive behavioral assessment can identify the environmental conditions most likely to produce problematic expressions of paranoia and suggest behavioral strategies to teach new coping mechanisms and behavioral expressions. It has also been shown that the function or purpose of behavior can change based upon the individual's current circumstances. For example, during periods of depression a person may find the presence of other people to be aversive. Such a person may have learned that attempting to hit or bite people who come too close results in people staying further away. In other words, hitting and biting is maintained by escaping or avoiding interaction with others. Alternatively, when not depressed, this same individual may have learned that hitting and biting results in people providing beverages or snacks in order to keep the individual happy. Therefore, when not depressed the individual uses the same two behaviors to produce very different results. A comprehensive behavior assessment can identify the relationship between mood states (depressed vs non-depressed) and the function of the undesired behaviors, as well as the appropriate interventions for the behaviors in the different settings or conditions. In some mental illnesses, certain behavioral patterns are common. For example, a person with severe psychosis or depression will often bathe less frequently and may not maintain a healthy diet. Through behavior assessments, it is possible to identify the most powerful reinforcers for the person. When that person begins to experience serious depression or psychosis, the behavior analyst may be able to adjust reinforcers or reinforcement strategies to compensate in part for the individuals reduced motivation to bathe or eat.	
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.	The parties agreed the Monitoring Team would not monitor this provision. The rating of noncompliance will continue.	Noncompliance
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance	The parties agreed the Monitoring Team would not monitor this provision. The rating of noncompliance will continue.	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.		
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 A contract 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. In April 2013, a full-time employee had been hired to provide counseling services, but no individuals had been identified as in need of counseling services and no counseling plans had been developed. In October 2013, a variety of alternative interventions had been developed but not finalized. Current Site Visit At the time of the current site visit, the Facility submitted material regarding a variety of non-PBSP interventions. From these materials, 21 individuals were selected as the sample. This included three individuals with behavior therapy plans (Individuals #76, #255 and #259), five individuals with counseling plans (Individuals #144, #248, #360, #539, and #568), three individuals with desensitization plans (Individuals #120, #242, and #488), and 10 individuals with BSPPSs (Individuals #33, #62, #88, #121, #184, #273, #308, #332, #379, and #450). This material included treatment plans, counseling meeting minutes, and the latest treatment progress notes. As indicated above, the several different intervention strategies were reflected in the overall sample of non-PBSP interventions. These different strategies included the following. • Behavior Therapy plans, which involved an intensive behavioral procedure that targeted a specific skill to be strengthened or challenging behavior to be reduced. These plans were most often implemented by a BCBA. • Counseling plans, which were intended to provide a therapeutic environment for strengthening coping skills, insight, or other skills. Counseling plans were typically implemented by a Behavior Health Specialist with specific training in counseling. • Desensitization Plans, which involved the application of formal desensitization procedures to address undesired behavior brought on by specific environments	Noncompliance

#	Provision	Assessment of Status	Compliance

or circumstances. Desensitization plans were designed similar to Behavior Therapy plans and were typically implemented by a BCBA.

- Behavior Support Plans for Psychiatric Symptoms, which were used for individuals who experienced primarily psychiatric symptoms that were well controlled by psychotropic medications or for whom the identified targets were entirely due to an underlying mental illness rather than environmental conditions.

	1/2010	10/2013	4/2014
Needed services identified in the psychological assessment are implemented within 6 weeks of the assessment	0%	62%	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%	62%	71%
Services are goal directed with measurable objectives and treatment expectations	0%	62%	43%
Services reflect evidence-based practices	0%	62%	33%
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%	62%	100%
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%	62%	10%
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%	62%	29%
Service identified in ISP and, if applicable, BAIP	0%	62%	0%
Staff who provide therapeutic interventions are qualified to do so through specialized training, certification, or supervised practice.	0%	100%	100%
Staff who assist in therapy, or who supervise homework or milieu activities, receive training and monitoring from qualified therapists	0%	62%	100%

#	Provision	Assessment of Status	Compliance
		Information gained from the sample reflected that the Facility had achieved improvement in three of the 10 areas (30%), demonstrated no change in one of 10 areas (10%), and regressed in six of 10 areas (75%). Three of the areas (30%) were sufficient for a rating of substantial compliance. It should be noted that for the first and eighth areas of the 10 presented above, the ratings of zero reflected a lack of documentation in the submitted materials pertaining to those specific elements. In order to obtain a better perspective on the different intervention strategies, ratings were broken down by the type of intervention. The table below presents the overall ratings for the Provision, as well as the ratings for each type of intervention.	

	Total Sample	Behavior Therapy	Counseling Plans	Desensitization	Psychiatric Support Plans
Needed services (other than PBSPs, e.g. counseling) identified in the psychological assessment are implemented within 6 weeks of the assessment.	0%	0%	0%	0%	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)	71%	100%	0%	100%	90%
Services are goal directed with measurable objectives and treatment expectations.	43%	100%	0%	100%	30%
Services reflect evidence-based practices.	33%	100%	0%	100%	10%
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.	100%	100%	100%	100%	100%

#	Provision	Assessment of Status	Compliance

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.	10%	0%	0%	0%	20%
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.	29%	100%	0%	100%	0%
Service is identified in ISP and, if applicable, PBSP.	0%	0%	0%	0%	0%
Staff who provide therapeutic interventions are qualified to do so through specialized training, certification, or supervised practice.	100%	100%	100%	100%	100%
Staff who assist in therapy, or who supervise homework or milieu activities, receive training and monitoring from qualified therapists	100%	100%	100%	100%	100%
Average Rating	49%	70%	30%	70%	45%

Both the Behavior Therapy plans and the Desensitization plans reflect robust assessment procedures and sound behavior analytic strategies for changing behavior. If not for the two items pertaining to documentation and timeframes discussed earlier, these two types of plans would have met criteria for substantial compliance.

The Counseling plans and BSPPSs reflected substantially greater limitations. These limitations included the following.

- Counseling plans uniformly lacked the necessary assessment of intervention targets. General problem areas were typically noted, such as anger management, but there was no description of formal assessment procedures or findings.
- Both Counseling plans and BSPPSs lacked objective and measurable outcome measures or goals. Counseling plans often listed only that the intervention should increase behaviors requiring strengthening and reduce behaviors requiring weakening. Although the BSPPSs were somewhat better than the Counseling plans in this area, several BSPPSs reflected vague or subjective goals.

#	Provision	Assessment of Status	Compliance
		• Neither Counseling plans nor BSPPS reflected an evidence-based approach to intervention, as both lacked adequate assessment, formalized intervention strategies, well-defined targets, or specific treatment expectations and timeframes. • Both Counseling plans and BSPPSs lacked strategies for maintaining or generalizing skills. Concerning the BSPPSs, the lack of necessary skill enhancement strategies in those interventions would have precluded the implementation of maintenance or generalization strategies. It was of particular concern to the Monitoring Team that the BSPPSs typically lacked any strategy for addressing mental health issues through behavior analytic or other non-psychotropic approaches. It was suggested by the BSPPSs that behavior analysis was viewed as a strategy only for reducing undesired behavior. Research has shown, however, that applied behavior analysis, as well as other teaching and environmental adjustment procedures, can directly affect the signs and symptoms of mental illness and potentially reduce the reliance upon psychotropic medications. Based upon the information reviewed during the site visit, it was evident that non-PBSP interventions, particularly Counseling plans and BSPPS, lacked the rigor necessary to benefit the individuals living at the Facility. Furthermore, the materials reviewed reflected that the inclusion of behavior intervention strategies could complement the use of medications and provide a greater likelihood of successful intervention. As a result, a rating of noncompliance was determined.	
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.	<u>PBSP Approval and Consent</u> The Facility reported that only two behavior intervention plans require consent. Both plans had the necessary consents and Human Rights Committee approvals A review of Facility tracking data reflected that the average noted interval between approval of an intervention and implementation was approximately five days. As the expectation was that plans would be implemented within 14 days of approval, the Facility met requirements in this area. <u>PBSP Review</u> <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	Substantial Compliance

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<tr><td></td><td>Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.</td><td>2012, documentation reflected substantial improvement in several areas of Provision K9. The site visit review in April 2013 revealed continued improvement. In addition, the Facility presented a new combined format for behavior assessment and intervention called the Behavior Assessment and Intervention Plan (BAIP).

<u>Current Site Visit</u>
During the current site visit, the Monitoring Team selected a sample of 10 individuals for the review of formal behavior interventions. These individuals included individuals with recent ISPs, behavior assessments, and behavior interventions. The specific individuals included in the sample were Individuals #4, #13, #133, #134, #186, #193, #205, #381, #427, and #468.

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<tr><th></th><th>1/2010</th><th>10/2013</th><th>4/2014</th></tr>
<tr><td>Rationale for selection of the proposed intervention</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>History of prior intervention strategies and outcomes</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Consideration of medical, psychiatric and healthcare issues</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Operational definitions of target behaviors</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Operational definitions of replacement behaviors</td><td>0%</td><td>100%</td><td>90%</td></tr>
<tr><td>Description of potential function(s) of behavior</td><td>0%</td><td>100%</td><td>90%</td></tr>
<tr><td>Use of positive reinforcement sufficient for strengthening desired behavior</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Strategies addressing setting event and motivating operation issues</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Strategies addressing antecedent issues</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Strategies that include the teaching of desired replacement behaviors</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Strategies to weaken undesired behavior</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Description of data collection procedures</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Baseline or comparison data</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Treatment expectations and timeframes written in objective, observable, and measureable terms</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Clear, simple, precise interventions for responding to the behavior when it occurs</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Plan, or considerations, to reduce intensity of intervention, if applicable</td><td>0%</td><td>100%</td><td>100%</td></tr>
<tr><td>Signature of individual responsible for developing the PBSP</td><td>0%</td><td>100%</td><td>100%</td></tr>
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<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>The 10 BAIPs that were reviewed reflected sophistication and an overall sound application of behavior analytic strategies. Based upon the information obtained during the site visit, it was determined that the Facility was in substantial compliance with the requirements of Provision K.9 of the Settlement Agreement.</td><td></td></tr>
<tr><td>K10</td><td>Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.</td><td><u>Historical Perspective</u>
During previous site visits, BSSLC demonstrated consistent improvement in data graphing practices other than in 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. In April 2013, it was noted that BCBAs had begun a monthly review of treatment data. In addition, although IOA observations had increased, the total number per individual remained low.

<u>Current Site Visit</u>
During the current site visit, the Monitoring Team selected a sample of 5 individuals for the review of behavior data graphs. These individuals included the five individuals with Behavior Assessment and Intervention Plans (BAIPs) (Individuals #13, #134, #205, #417, and #490) included in the sample for K.5.

<table>
<tr><td>Graph Element</td><td>1/2010</td><td>10/2013</td><td>4/2014</td></tr>
<tr><td>The graph is appropriate to the nature of the data.</td><td>75%</td><td>87%</td><td>100%</td></tr>
<tr><td>Horizontal axis and label</td><td>75%</td><td>93%</td><td>100%</td></tr>
<tr><td>Vertical axis and label</td><td>75%</td><td>93%</td><td>100%</td></tr>
<tr><td>Condition change lines</td><td>75%</td><td>93%</td><td>0%</td></tr>
<tr><td>Condition labels</td><td>75%</td><td>93%</td><td>0%</td></tr>
<tr><td>Data points and path</td><td>75%</td><td>93%</td><td>100%</td></tr>
<tr><td>IOA and data integrity</td><td>0%</td><td>33%</td><td>0%</td></tr>
<tr><td>Demarcation of changes in medication, health status or other events</td><td>75%</td><td>93%</td><td>0%</td></tr>
<tr><td>Inter-observer agreement exists for PBSP data</td><td>1/2010</td><td>10/2013</td><td>4/2014</td></tr>
<tr><td>IOA for target behavior data.</td><td>0%</td><td>33%</td><td>0%</td></tr>
<tr><td>IOA for replacement behavior data.</td><td>0%</td><td>0%</td><td>0%</td></tr>
<tr><td>IOA meets minimum criteria</td><td>0%</td><td>0%</td><td>0%</td></tr>
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Information gained from the sample reflected that the Facility had achieved improvement in four of the 11 areas (36%), demonstrated no change in two of 11 areas (18%), and</td><td>Noncompliance</td></tr>
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#	Provision	Assessment of Status	Compliance
		regressed in five of 11 areas (45%). Four of the areas (36%) were sufficient for a rating of substantial compliance. The review reflected improvement in some areas over previous site visits concerning graph components. It was concerning, however, to find no treatment graphs that included indications of changes in medication, behavior intervention strategies, or environmental conditions. Progress notes did include graphs depicting the history of psychotropic medication dosages. As progress notes typically consisted of multiple pages with the medication graphs frequently on a different page than behavior intervention graphs, interpretation of relationships was impaired. The Facility reported a large number of IOA observations. None of the graphs reflected IOA information or included any information about treatment integrity. Based upon information provided, although areas of progress were identified, the Facility had not achieved compliance with the Settlement Agreement.	
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.	During the current site visit, the Monitoring Team selected a sample of 50 individuals for the review of the readability of formal behavior interventions. These individuals included all individuals with plans presented to the PBSC since the previous site visit according to the Facility tracking spreadsheet. The review revealed an average readability level for all 50 BAIPs of grade 7.7 with an initial range of grade 5.1 to grade 9.2.	Substantial Compliance
K12	Commencing within six months of the Effective Date hereof and with full implementation in two years, each Facility shall ensure that all direct contact staff and their supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	The parties agreed the Monitoring Team would not monitor this provision. The rating of noncompliance will continue.	Noncompliance
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain	At the time of the site visit, the Facility employed four staff who possessed board certification as a behavior analyst. This represented approximately one BCBA for every 73 individuals residing at the Facility and fell short of the required ratio of one BCBA for every 30 individuals. The Behavior Services department did include a sufficient number	Noncompliance

#	Provision	Assessment of Status	Compliance
	an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	of positions to achieve a 1:30 ratio. Should a BCBA credentialed employee fill each available position, the Facility would achieve approximately a 1:19 ratio. The Facility also employed sufficient Psychology Assistants to provide one Psychology Assistant for every two full-time psychologists.	

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. BSSLC Section N Self-Assessment updated: 3/18/14 2. BSSLC Section N Action Plan, updated: 3/18/14 3. BSSLC Section N Presentation Book 4. BSSLC Policy: I4.b Administrative Death Review Committee, (no date) 5. BSSLC Policy: I.4.c Clinical Death Review Committee, (no date) 6. BSSLC Policy L.1 Medical Care, dated 10/2/2013 7. Procedural Guidelines for Neurology Clinic, dated 9/20/2013 8. Procedural Guidelines for Ensuring that Pre-Treatment Sedation is Co-Ordinated through the Interdisciplinary Process, 3/27/2014 9. BSSLC Procedural Guidelines for Actions Following the Death of an Individual, 3/25/14 10. BSSLC Report of the Death of a Person Served for Individuals #38, #19, #253, #126, and #305 11. BSSLC Death/Discharge Summaries for Deceased Individuals #38, #19, #253, #126, and #305 12. BSSLC Quality Improvement Death Review of Nursing Services and recommendations for Deceased Individuals #38, #19, #253, #126, and #305 13. BSSLC Unusual Incident Reports (URIs) for Deceased Individuals #38, #19, #253, #126, and #305 14. List of all medical providers, including number of hours worked, case load, and employment status 15. For each medical provider a. Curriculum vita for all licensed medical providers b. Copy of current medical license for two medical providers (the Monitoring Team requested all but received two) c. Copy of current CPR certificate for all medical providers d. List of all CME obtained during the past 12 months for all medical providers 16. Nurse practitioner agreement 17. Copy of morning medical meeting minutes for 10/1/2013, 11/1/2013, 12/2/2103, and 1/2/2014 18. List of all individuals who were prescribed a Do Not Resuscitate order (DNR) 19. For the last five individuals on the list of DNRs (Individuals #87, #597, #273, #272 and #59): a. Most recent annual medical assessment b. Most recent ISP, or other relevant documentation indicating an interdisciplinary team (IDT) review c. Copy of ethics review for the DNR d. Copy of the consent for DNR e. Copy of the completed DNR form f. Copy of specific instructions to direct care, and other staff, regarding the DNR g. Copy of the medical provider's interdisciplinary progress notes (IPN) documenting the clinical rationale for the DNR 20. Integrated progress notes (IPNs) for individuals #546, #536, #44, and #115 21. Alpha list of all individuals who sustained a fracture during the reporting period

	22. Committee meeting minutes, and all other relevant documents indicating a Facility systems review of fractures, and attempts to mitigate fractures 23. For the first two and last three individuals on the list of fractures (Individuals #293, #318, #163, and #276): a. Most recent annual medical assessment b. Past six months quarterly medical assessments c. PT/OT assessments, and IPNs specific for the management of fracture d. Medical provider's IPNs specific for the assessment and management of fracture e. Medical provider's IPN documenting the possible etiology of the fracture f. Most recent two Integrated Risk Rating Forms (IRRFs) g. IDT minutes, ISP, or other documentation indicating an IDT review of the fracture h. Most recent bone density i. Most recent medication list 24. List of all individuals with diagnosis of malignancy, and history of malignancy 25. For Individuals #249, #24, and #595: a. Annual medical summary b. Most recent two physician quarterly reviews c. Most recent IRRF d. All IDT related minutes specific for diagnosis of malignancy e. Last six months IPNs by the medical provider that specifically documented assessment of malignancy f. All consultation reports specific for the diagnosis of malignancy 26. Active clinical records for Individuals #44, #38, #303, #118, and #323. 27. Alpha list of all individuals who experienced a bowel obstruction or bowel perforation during the reporting period. 28. For Individual #58: a. Current medical assessment b. Current medication list c. Medical quarterly review for past six months d. List of dates of all diagnosed bowel obstruction in the past three years e. For the most recent instance of bowel obstruction or perforation: i. All medical providers' IPNs, specific to the diagnosis and management of bowel obstruction or perforation, through full resolution ii. All medical diagnostic reports used to diagnose and monitor bowel obstruction or perforation, such as x-rays, and CT of the abdomen iii. All medical consultations specific to the management of bowel obstruction (such as GI consultations) iv. If hospitalized, copy of the hospital admission and discharge reports v. Copy of most recent two IRFFs vi. Copy of ISP, or other relevant documents specific to the IDT's intervention regarding bowel obstruction or perforation. 29. Community Living Discharge Plan (CLDP) for Individuals #118 and #303

	30. Post Move Monitoring (PMM) checklist for Individual #118 31. Active record for Individual #38 32. Copy of physician audits completed during the reporting period (separate by internal and external) a. Responses to requests for: i. Copy of all summaries, graphs and data (specific for each medical provider)—"None available" ii. Copy of action plan for deficient areas--"No policies or procedures available" iii. Copy of follow-up documentation for action plan, through resolution-- iv. Policy/procedures specific to how the Facility utilizes information from the medical audits v. Documentation on how the physician audit is utilized to enhance medical provider performance (ie, such as physician feedback)—"Not available" vi. Statement from the Medical director indicating that the results of the audit findings were personally discussed with each provider, and that the information was utilized within the context of peer review process—"Not available" vii. List of all indicators used to assess medical competency—"Not available" **People Interviewed:** 1. Mary Anne Brett, M.D., Medical Director 2. Natalie Montalvo, Facility Director 3. Debbie Williams, Chief Executive Nurse 4. Daniel Dickson, Director of Quality Assurance 5. Jill Quimby, RN, Quality Assurance Nurse 6. Wanda Wiktorik, RN, Quality Assurance **Meeting Attended/Observations:** 1. Settlement Agreement Medical and Nurse Monitors met with Medical Director, Chief Executive Nurse, Quality Assurance Nurse, and Quality Assurance Director on 4/10/14 and reviewed/discussed deaths occurring over the last six months.
	Facility Self-Assessment: Following its review of the self-assessment for Section N, the Monitoring Team noted that the Facility: • Did not use monitoring/audit tools that relied on sufficient indicators to allow the Facility to determine compliance with the Settlement Agreement, except that the Self-Assessment did state that the external and internal medical audits were conducted. The Self-Assessment did not give any information other than that the audits met timeframes and sample size requirements, audited essential and non-essential elements, and included audits of each provider. There was no information on the findings and whether any actions plans were established to address findings (that is, how these audits "facilitate the quality of medical care and performance improvement"). • The monitoring tools did not include sufficient methodologies, such as observations, interviews, and record reviews to determine status of compliance with the respective monitoring processes. For example, the Self-Assessment did not state the criteria or process for concluding Annual Medical Assessments adequately addressed the individual's health care needs. The data on HGBA1c as an outcome of Diabetes Mellitus provided information on diabetic control; there were no similar outcome

	measures presented to assess care of any other health conditions. • The Self-Assessment did 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 or percent of sample size of individuals/records as compared to the overall population was included in the Self-Assessment. The percentage of compliance for each data item monitored on the various monitoring and/or observation tools was not provided by months, quarters, and overall percentage of compliance. • The Monitoring Team could not determine if the Facility's monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results through inter-rater reliability process completed by the QA department. • At the time of this compliance review, the Facility had recently reassigned staff who would be responsible for conducting the audits/monitoring had been deemed competent by the Facility in the use of the tools and were programmatically competent. ▪ It was unknown to the Monitoring Team if sufficient inter-rater reliability process had been established between the various Facility staff responsible for the completion of the tools. The Facility determined that it was not in compliance with Sections L.1 through L.4, and the Monitoring Team concurred with this assessment.
	Summary of Monitor's Assessment: Following its review, the Monitoring Team was unable to find substantial compliance for Sections L.1 through L.4. The Facility has made little progress in areas of direct medical care, developing a medical quality assurance process, substantially implementing its medical care policy, or enhancing its medical audit and mortality review process. The Facility had continued to ensure a robust and meaningful morning medical meeting that helps to ensure dissemination of clinical information among the various clinical departments at the Facility. The following are some additional comments, and concerns for each Section reviewed by the Monitoring Team. **Section L.1:** The Monitoring Team concluded that the Facility is not in substantial compliance with Section L.1. Issues the Facility needs to improve include follow-up to acute medical conditions through resolution; regular assessment for pain, when necessary; updating and documenting the IRRF, and ISP with new medical diagnosis, and documenting all necessary supports and services on the IRRF and ISP; maintaining a functional DNR process; determining the underlying etiology of medical conditions; ensuring development of Community Living Discharge Plan (CLDPs) and a post move monitoring process that effectively addresses all significant medical and dental issues; and ensuring that adequate diagnostics, and consultations are provided as necessary, are some of the issues the Facility must improve on. Furthermore, it is essential that the medical providers assertively follow-up on issues such swallowing assessments, seizure logs, and accu-check reports. **Section L.2:** The Facility indicated by written documentation that it did not have available documents requested by the Monitoring Team to assess the Facility's medical audit process; therefore, the Monitoring Team was unable to determine the efficacy of this process. The mortality review process must be

	significantly revised to ensure that medical providers conduct a comprehensive case review of all deaths, and that meaningful recommendations are provided for each death, derived by a root cause analysis that assesses a historical review of all supports and services, including medical care. The Facility must conduct 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. For these reasons, the Monitoring Team determined that the Facility was not in compliance with Section L.2. **Section L.3:** The Monitoring Team determined that the Facility was not in substantial compliance with Section L.3, because it had not developed and implemented a medical quality assurance process, and because there was no documentation indicating that the Facility had an internal process to assess medical providers' clinical performance. **Section L.4:** Based on the Monitoring Team's understanding of clinical practice at the Facility, the medical care policy does appear to be comprehensive, and delineate most of the activities practiced at the Facility; however, because the Facility has not yet substantially implemented the medical care policy, the Facility is not in substantial compliance with the Section L.4.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the 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.	Section L.1 comprehensively assesses the Facility's ability to provide medical care, at the level of generally acceptable standard of care practice. To assess the Facility's effort towards substantial compliance for Provision L.1, the Monitoring Team discussed medical compliance issues with the medical director; met with members of the Facility's medical staff; and attended medical meetings. Through document review, the Monitoring Team assessed the Facility's medical administration, do not resuscitate orders (DNR), clinical management of acute medical conditions, management of bowel obstruction and perforation, medical management of fractures, medical management of malignancy, and the CLDP process. The Monitoring Team also reviewed the active medical records for comprehensive case reviews. The Monitoring Team experienced challenges when reviewing documents provided for Section L.1. Unlike documents provided for Section N and Section Q, of this report, many of the documents for Section L.1, were not collated or completely separated out by Individual. For example, the documents provided for the review of fractures consisted of a large pile of paper, without dividers, and various documents such as integrated risk rating forms, annual medical assessments, and integrated progress notes were clumped together, requiring the Monitoring Team to go through each page, and separate all documents into group of Individuals. This activity resulted in the Monitoring Team completing a limited review for Section L.1 of this report.	Noncompliance

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		Medical Administration The Monitoring Team assessed licensure status of the Facility's medical staff, clinical documentation practice, and the Facility's regularly scheduled interdisciplinary meetings. To help with the assessment the Monitoring Team reviewed the following documentation: • List of all medical providers, including number of hours worked, case load, and employment status • For each medical provider o Curriculum vita for all licensed medical providers o Copy of current medical license for two medical providers (the Monitoring Team requested all but received two) o Copy of current CPR certificate for all medical providers o List of all CME obtained during the past 12 months for all medical providers • Nurse practitioner agreement • Copy of morning medical meeting minutes for 10/1/2013, 11/1/2013, 12/2/2103, and 1/2/2014. Medical Providers: The Facility maintained one full time medical director, three full time medical doctors, and one nurse practitioner. Medical licenses were reviewed, and noted to be current for all licensed medical providers and the medical director. Of the five medical providers, one was a nurse practitioner who was directly supervised by the medical director, and co-supervised by staff physicians. The nurse practitioner practice agreement was signed by all relevant parties on 7/26/2012, and the Monitoring Team determined that a there were no related issues of concern with the practice agreement. All medical providers and the medical director were current with continuing medical education for general practice. Although requested, CPR certificates were not included in the documents received by the Monitoring Team, but the Facility did provided a document stating that CPR training was current. Medical Meetings The Facility conducted a daily medical meeting called the Morning Medical Debriefing. The Morning Medical Debriefing is chaired by the medical director and conducted five days per week. It is an integrated, multidisciplinary meeting that consists of medical providers, unit nursing staff, and representatives from various departments, including PT/OT, behavioral health, residential services, psychiatry, dietary services, quality assurance, dental, and pharmacy services. The purposes of the meeting are to triage and	

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		discuss urgent clinical issues, to ensure continuity of care, and to enhance clinical management of individuals. Issues discussed include, but are not limited to: Medical on call report; hospital report; infirmary report; psychiatric; behavioral health related issues; pending medical consultations; wound care, and infectious disease issues; and significant medical conditions. Review of the meeting minutes for 10/1/2013, 11/1/2013, 12/2/2103, and 1/2/2014 indicated a documented summary of the events discussed at the meeting, and there was indication that action plans were developed for clinically relevant issues discussed during the meeting. The Monitoring Team attended the April 9, 2014 meeting and was impressed of the comprehensiveness and efficiency of the meeting. The meeting enabled all members to gain greater insight into the clinical management of individuals reviewed during the meeting. Meeting minutes should be enhanced to ensure a standardized process for developing action plans for all relevant clinical issues, and a process to ensure that the action plans were completed and implemented. Summary: The Facility continued to maintain an efficacious, and efficient morning medical debriefing meeting that enables enhanced continuity of care. The Meeting was interdisciplinary, and robust discussion was observed. The Monitoring Team noted that the Facility had appropriate number of medical staff, and that all medical providers had current, valid medical licenses. The Nurse Practitioner Agreement was dated 7/2012; however, review and renewal of this agreement should be signed and dated at least annually. <u>Review of Do Not Resuscitate (DNR) Process</u> To assess the Facility's DNR process, the Monitoring Team requested the following information: • List of all individuals who were prescribed a DNR order. • For the last five individuals on the list of DNRs (Individuals #87, #597, #273, #272 and #59): o Most recent annual medical assessment o Most recent ISP, or other relevant documentation indicating and interdisciplinary team (IDT) review o Copy of ethics review for the DNR o Copy of the consent for DNR o Copy of the completed DNR form o Copy of specific instructions to direct care, and other staff, regarding the DNR o Copy of the medical providers interdisciplinary progress notes (IPN)	

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		documenting the clinical rationale for the DNR The Facility provided a document stating that the Facility did not have an ethics process to review DNRs; physician do not document clinical rationale for DNRs; the Facility does not provide specific instruction to direct care staff on how to support the individual in the event of a DNR; and the Facility was unable to obtain consents for DNR status. The Facility provided a document indicating a total of 14 active DNR orders, and provided copies of the most recent ISP, annual medical assessment, and associated DNR form. In addition, the Facility provided a statement for each labeled "resuscitative status". Despite being on the list of DNRs, the Facility provided a copy of resuscitative status forms for four of the five individuals (Individuals #87, #597, #273, #272) that stated the Individual was full code, and the forms were signed by the medical provider. The Monitoring Team was concerned because in addition to the resuscitative status forms, which indicated full code, the Facility also provided copies of the DNR order forms indicating that the Individuals had DNRs. Some additional concerns included: • The annual medical assessment for individual #272 indicated that the Individual had a DNR, and a DNR order form was provided for review indicating DNR, but the DNR resuscitative status form indicated that the Individual was full code, and there was no evidence of the medical provider documenting a change of status in the IPNs, or the rationale for the status change. • For Individual #59, the resuscitative status form indicated that the Individual had a DNR; however, the ISP documented that the Individual was full code; however, the copy for the Monitoring Team's review had the term full code lined out, and handwritten in was the term DNR. Summary: Because of conflicting documentation, the Monitoring Team was unable to accurately determine the current code status of the four out of the five examples provided for review. In addition, the Facility did not have a meaningful process to oversee the appropriateness of DNRs at the Facility; did not have a process for medical providers to specifically document qualifying conditions and the rationale for DNRs; did not have a process to instruct direct care staff on how to support individuals who have DNRs, during the end of life period; and did not provide an independent ethical review for DNRs. <u>Review of Acute Medical Care:</u> To assess the Facility's management of acute medical conditions, the Monitoring Team requested the initial and all follow-up documentation by the medical provider, through full resolution of the acute medical condition. The sample included the first acute	

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		medical condition that required intervention by the medical provider that occurred during the week of October 6, 2013; one sample for each of the medical provider's. Integrated progress notes (IPNs) were provided for individuals #546, #536, #44, and #115. Following is the Monitoring Team's review of acute medical conditions: • Of the four examples provided for review, the medical provider documented an initial assessment of the acute medical condition in one out of four examples (25%). The note was written in SOAP format. • The medical provider documented periodic assessment through full resolution of the acute medical condition through full resolution in zero out of four examples (0%). The following is a summary of some of the Monitoring Team's concerns and comments for specific examples: Individual #546: On 10/5/2013, a living area direct support professional (DSP) reported to the nurse that the Individual had developed diarrhea, and the nurse assessed the Individual timely, indicating that the Individual was at risk for "dehydration", and that the Individual would be monitored per diarrhea protocol. There was no further follow-up documentation for the assessment of diarrhea. Furthermore, the Individual's mother arrived that same day to take the individual on a home visit, and there was no documentation of the mother being informed of diarrhea, possible infectious agent associated with diarrhea, possible dehydration, or other issues that the Individual should have been observed for; especially possible bowel obstruction, which can manifest as loose stools. There was no indication that the nurse performed a focus nursing assessment by examining the abdomen for abnormal bowel sounds, tenderness, masses, or distention. The mother was not informed about the diarrhea or concerns regarding possible dehydration, or possible spread of an infectious agent causing diarrhea. There was no evidence to indicate that the medical provider was informed of the DSPs observation of diarrhea. In addition to diarrhea, the mother informed the nurse on 10/5/2013 that she had noticed the Individual having "drainage from ears". After examining the ears, the nurse reported that the only signs observed was "soft yellow wax". The nurse indicated that she would place the Individual on the sick call list for the medical provider to assess, following return from the home visit on 10/7/2013. There was no documentation that the Individual was evaluated at sick call for this issue, or to follow-up on reported diarrhea. Upon return from the home visit on 10/7/2014, the mother informed the nurse of rash on feet. The nurse did not document a focus nursing assessment, and there was no	

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		indication that the medical provider was informed of the rash. Reports of diarrhea and loose stools should prompt a comprehensive assessment for possible underlying infectious, metabolic, adverse drug reaction, or underlying gastrointestinal etiology. There was no evidence that such an evaluation was completed. Furthermore, a decision should have been documented to keep the Individual home for observation, or to ensure that the mother was aware of the diarrhea, and what to monitor for. In addition, the Monitoring Team is concerned that the nurse reported that she would place the Individual on the sick call list for ear drainage, however, there were no documents provided to indicate that the Individual was followed up for this condition. Furthermore, the mother's concern of the rash on the feet should have prompted the nurse to document a focus nursing assessment, and to notify the medical provider. Individual #536: The Individual was reported to have sustained a head injury on 10/6/2013. The nurse who performed the initial triage of the injury did not document on the IPN a neurological nursing assessment, as nurses who followed up on the issue did, but the nurse did indicate that a neurologic checklist would be completed for 24 hours. The nurse did not document a cause, or potential cause, of the injury; however, a nurse who followed up on the Individual indicated that the injury was secondary to a "fall". There was no documentation indicating a fall risk assessment was completed, with the exception of nursing staff reporting "gait steady", and there was no documentation indicating that a medical provider had followed up to assess the head injury, and to assess the Individual for fall risk. Given a head injury possibly secondary to a fall, the Facility should have ensured that a medical provider assessed the individual for potential complications from the fall, and to ensure that a medical provider assessed medical risks for a fall. Despite the more obvious head injury, a fall could result in other medical complications, such as occult fractures and possible internal injury. Furthermore, there was no Indication that medical causes of the fall were explored. Issues such as possible medication side effects, underlying illnesses such as infections and metabolic issues, or cardiovascular conditions such as orthostatic hypotension, should be explored. Individual #115: The medical provider was informed on 10/4/2013 of an inguinal rash, and documented a SOAP note with an assessment of intertrigo, and a plan to administer Lotrimin cream for seven days, and to "F/U" (follow-up). There was no documentation provided for review indicating that the medical provider followed this acute medical condition through resolution. Also, the only follow-up nursing note provided for review was completed on 10/5/2013, and nursing notes through 10/29/2014 did not indicate follow-up assessment for inguinal intertrigo, or to document resolution following treatment. IPNs should have been documented demonstrating periodic assessment by the medical provider through resolution of the condition, and nursing assessments should have regularly documented efficacy of treatment through resolution. No such	

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		documentation was provided for review. Individual #44: On 10/5/2013 the DSP reported that the Individual had fallen down onto (the Individual's) buttock. The nurse assessed the Individual but a focused nursing assessment was not documented. On 10/6/2013 the living area staff reported that the Individual was "pushed down by another peer", and again, there was no specific nursing assessment documented to assess for injury. The only statement by nursing staff, as documented on the IPN for the two fall injuries were "no injuries noted". On 10/8/2013, the IPNs documented yet another fall stating that the Individual "fell to (the Individual's) knees". The nurse documented that she was unable to assess the Individual because the Individual was "uncooperative". There was no indication that the medical provider was made aware of the continued falls, and possibility of injury, and no documentation to indicate that assertive measures were taken to assess for possible injury. As reported by the Monitoring Team in other subsections of Section L.1, the Monitoring Team observed the Individual with a very unsteady gait, and apparent pain. In addition, the Facility's physical therapist informed the Monitoring Team that the Individual could be manifesting pain. Given the severity of the underlying medical condition, recurrent falls, and possible manifestation of pain, assertive evaluation for possible underlying injury, such as an occult fracture, or worsening degenerative joint disease, should have been considered. Summary of the management of acute care: The Monitoring Team determined that the Facility did not assertively address acute medical conditions. There was evidence of medical issues not being fully assessed and reported to the medical provider for assessment, and evidence of the medical provider not following up on acute medical conditions through full resolution. <u>Clinical management of fractures</u> The Facility reported ten individuals as having a fracture during the reporting period. To assess the Facility's clinical ability to manage fractures, the Monitoring Team requested the following information: • Alpha list of all individuals who sustained a fracture during the reporting period • Committee meeting minutes, and all other relevant documents indicating a Facility systems review of fractures, and attempts to mitigate fractures • For the first two and last three individuals on the list of fractures (Individuals #293, #318, #163, and #276): o Most recent annual medical assessment o Past six months quarterly medical assessments o PT/OT assessments, and IPNs specific for the management of fracture o Medical provider's IPNs specific for the assessment and management of	

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		fracture o Medical provider's IPN documenting the possible etiology of the fracture o Most recent two IRRFs o IDT minutes, ISP, or other documentation indicating an IDT review of the fracture o Most recent bone density o Most recent medication list The Facility provided an alpha list of all fractures that occurred during the reporting period, which included four Individuals #293, #318, #163, and #276. The following is a summary of the Monitoring Team's findings for the document review related to the management of fractures: • The Facility did not provide committee meeting minutes, or other relevant documentation indicating that it conducts regular meetings to address fractures and mechanisms to reduce fractures, as part of a system review at the Facility. The Facility did provide a document stating that fractures are reviewed as part of the Facility's QA/QI process, but did not provide copies of documentation of the fractures reviewed. • In four out of four examples (100%) the medical provider conducted a prompt initial triage for reported fractures. There were was one example where treatment was delayed because the Individual was initially assessed and treated for a problem with the knee, and two days later it was realized that the Individual had a hip fracture (Individual #293). • In zero out of four examples (0%) the medical provider regularly followed the Individual through full resolution of the fracture. IPN documentation was not provided supporting that the medical provider regularly performed a physical assessment for follow-up to the known fracture. • In four out of four examples (100%) the medical provider obtained necessary diagnostics and prompt consultation for the assessment, and treatment of fracture. • In zero out of four cases (0%), the Medical provider documented a comprehensive assessment of all risk factors for fall and fracture. There was no documentation to indicate the medical provider's assessment as to the possible etiology of the fracture. • In zero out of four cases (0%), PT/OT documented a comprehensive assessment of all risk factors for fall and fracture. PT/OT assessments were not provided for four of the five examples. The only PT/OT assessment provided was for Individual #293.	

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		• In one out of four examples (25%), the IRFF was updated to reflect the current fracture, and re-assessment of risk for fracture. The only IRRF updated was for Individual #318. • In zero out of four examples (0%), there was documentation by the medical provider that demonstrated periodic assessment for pain, through resolution of healing. Summary: The Facility did not provide documentation demonstrating the medical providers' regular physical assessment of individuals who sustained fractures, through resolution of the fracture, or to periodically assess for possible pain. There was no documentation provided indicating that the medical provider assertively assessed the possible underlying cause of the fracture. <u>Clinical management of malignancy</u> To assess the Facility's ability to provide necessary clinical supports and services for individuals with diagnosed malignancy, the Monitoring Team reviewed the following documents: • List of all individuals with diagnosis of malignancy, and history of malignancy • For the five individuals with diagnosis of malignancy: o Annual medical summary o Most recent two physician quarterly reviews o Most recent IRRF o All IDT related minutes specific for diagnosis of malignancy o Last six months IPNs by the medical provider that specifically documented assessment of malignancy o All consultation reports specific for the diagnosis of malignancy Although the Monitoring Team requested a list of all individuals with diagnosis of malignancy, the Monitoring Team was provided a list of three Individuals who were reported to have a diagnosis of malignancy (Individuals #249, #24, #595). The Monitoring Team noted from the previous compliance reports, that additional individuals had a diagnosis of malignancy. It appeared these were all individuals for whom the malignancy diagnosis was first made after the last compliance visit, and that the Facility had not provided a list of individuals who had been diagnosed prior to the last visit. Following is a summary of the Monitoring Team's review of the documents provided for individuals #249, #24, #595: • Three out of three examples (100%) indicated appropriate clinical assessment, and follow-up by the medical provider, for the diagnosis of malignancy.	

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		• Three of three examples (100%) indicated that clinically appropriate consultations were provided for the diagnosis of malignancy.
		• One out of three examples (33%) included the diagnosis of malignancy on the IRRF. It should be noted, however, for the one IRRF that comment on the malignancy, Individual #595, there was no specific guidance on what needed to be monitored and reported. The IRRF is the means to communicate significant health care issues, and should clearly delineate all necessary supports and services.
		• Only one out of the three examples (33%) included documents, such as an ISP, or addendum to the ISP, that would indicate an IDT review of the malignancy; however, for the one example, Individual #595, the document only commented on the recent diagnosis but did not comment on additional supports and services that would be necessary to provide the Individual. For example, Individual #595 was diagnosed with prostate cancer, and would require life long hormone therapy. This issue was not addressed on the addendum to the ISP that was provided for review. Also, there was no documentation on enhanced triggers that would be necessary for staff to monitor, and report potential complications
		• In three out of three examples (100%), the medical provider documented regular follow-up monitoring possible recurrence of cancer.
		
		Summary: The Monitoring Team noted that medical providers had improved on documenting follow-up on recent diagnosis of malignancy; however, because the Facility did not provide a complete list of individuals with a known diagnosis, or history of malignancy the Monitoring Team did not have an opportunity to evaluate long-term follow-up of malignancy. Furthermore, the ISP, and IRRFs did not efficaciously address the diagnosis of malignancy, and all necessary supports and services.
		
		<u>Medical Management of Bowel Obstruction and Bowel Perforation</u>
		To assess the Facility's management of bowel obstruction and bowel perforation the Monitoring Team requested:
		• Alpha list of all individuals who experienced a bowel obstruction or bowel perforation during the reporting period.
		• For the first five examples on the list the alpha list for bowel obstruction and perforation (the Facility had only one example for review, Individual #58):
		  • Current medical assessment
		  • Current medication list
		  • Medical quarterly review for past six months
		  • List of dates of all diagnosed bowel obstruction in the past three years
		  • For the most recent instance of bowel obstruction or perforation:
		  o All medical providers IPNs, specific to the diagnosis, and	

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		management of bowel obstruction or perforation, through full resolution. o All medical diagnostic reports used to diagnose and monitor bowel obstruction or perforation, such as x-rays, and CT of the abdomen. o All medical consultations specific to the management of bowel obstruction (such as GI consultations) o If hospitalized, copy of the hospital admission and discharge reports • Copy of most recent two IRFFs • Copy of ISP, or other relevant documents specific to the IDT's intervention regarding bowel obstruction or perforation. The Facility did not provide copies of the current medical assessment, current medication list, quarterly medical review, a complete copy of the hospital admission assessment, IRRF, or IDT minutes documenting the IDT's assessment of the bowel perforation. The following is a summary of the Monitoring Team's review of the management of bowel perforation for Individual #58: • There was evidence that the nursing staff documented a hospital transfer prior to the acute hospitalization. • There was evidence indicating robust follow-up by the nurse liaison throughout the hospitalization for bowel perforation. Many hospital liaison reports were documented. • There was evidence indicating that the medical provider followed-up with the hospital attending physician, including a pre-hospital discharge discussion. This information was documented in IPNs by the medical provider. • There was no evidence provided documenting a post hospital physical assessment by the medical provider. • There was no evidence provided to indicate that the medical provider regularly assessed the Individual following discharge from the hospital. The medical provider documented one physical assessment during the four-week period following hospital discharge. The only physical assessment provided for review was a sick call visit for reported blood in the Individual's briefs, on 1/13/2014. A comprehensive assessment was completed at that time. • There was lack of evidence to indicate assertive post hospital assessment by the IDT. The post hospital ISP meeting was reported to have taken place on 2/7/2014, four weeks following discharge from the hospital. There was no evidence provided to indicate that the IDT met sooner to discuss the discharge. Furthermore, the ISP meeting minutes were not provided for review. • There was no documented discussion in the IPNs or other related documents of	

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		the medical provider's assessment as to the cause of the bowel perforation. The following are some additional comments and concerns regarding the management of Individual #58. • On the day prior to the hospitalization, 11/18/2013, the Individual was referred to nursing staff because the Individual "felt warm". The nurse documented a blood pressure of 98/65, which is suggestive of hypotension, and the nurse documented "refer to medical services for evaluation with attending". There was no indication that the medical provider responded to the nurse's request, and on the following morning, the Individual was noted to be acutely ill, and was triaged to the emergency department at the local hospital. • The surgeon documented in the intraoperative report, dated 11/20/2013, of possible bruising and inflammatory area of the omentum, and a perforation of the upper jejunum, and by physical inspection, the issue appeared to be trauma related. • The pathology report for the perforation indicated a "blowout" perforation; and signs of acute serositis of the omentum. The Facility pointed out that the investigation report noted that the surgeon stated an opinion that this was not due to trauma. • There was no evidence provided, such as IDT minutes, or copy of the ISP minutes, or other documents, as requested by the Monitoring Team, indicating the Facility's attempt to identify the underlying cause of the perforation. The Facility informed the Monitoring Team that the Individual had a history of low blood pressure measurements, which was considered as normal for the Individual. The medical provider did not document on the IPN for the acute medical condition, or on the annual medical assessment, that the reported blood pressure of 98/65 was normal for the Individual. Consistent with standard of care practice for an assessment for an acute medical condition, as in this case of possible infection, the medical provider should have documented that the recorded blood pressure of 98/65 was a normal finding for this individual and was not suggestive of infection. Summary: The Monitoring Team is concerned that the Facility did not attempt to determine the underlying etiology of the identified blowout perforation of the bowel. Blowout perforations are unique, and are usually caused by increased intraluminal pressure, causing the bowel to rupture. Causes of such types of perforation include bowel obstruction, or diverticulosis, and blunt trauma to the abdomen. There was no documentation, by review of the hospital records, that the Individual experienced a bowel obstruction or had diverticulosis.	

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		The Monitoring Team was also concerned that there was no evidence of a medical provider follow-up on the nurse's concern of 11/13/2013 that included hypotension; hypotension should have prompted a medical evaluation. In addition, the Monitoring Team is concerned there was no evidence to indicate that an IDT meeting occurred prior to four weeks following discharge from the hospital, and that there were no IPNs provided to the Monitoring Team documenting the medical provider's periodic physical assessment of the Individual following discharge from the hospital. Clinical Observations, Record Reviews and Review of the CLDP Process: While on-site during the compliance visit, the Monitoring Team reviewed the active clinical records of Individuals #44, #38, #323, #118, and #303. The following are some specific comments, and concerns for each example reviewed. On-site Observations: Individual #44: The Monitoring Team observed Individual #44 at the living area, and offers the following observations, and concerns. The Individual was provided assistance with ambulation by physical therapy (PT), with gait belt assist. During periods of ambulation the Individual would scream out loud, and when allowed to rest and lean on a table, would deescalate. When the Monitoring Team asked the PT professional if the Individual could be experiencing pain, the PT professional indicated that they suspect either an environmental issue, or underlying pain, but "we really don't know what is causing her to scream". When specifically asked if an underlying medical condition could be contributing to possible pain, the PT professional reported "I will have to get back to you on that, and discuss that with the doctor". The Monitoring Team has the following concerns: • The Individual has known "severe" osteoarthritis of the hip, and there has been no additional follow-up by an orthopedic specialist since 2010. • There was no documentation to indicate that the Individual had been physically assessed by the medical provider, during this reporting period, to evaluate for worsening osteoarthritis, worsening gait problems, worsening spasticity, or to assess for pain. • There was no integrated health care plan documenting unsteady gait, severe osteoarthritis, spasticity, or pain. • The IRRF did not have a risk assessment for pain. The entire section for pain was blank. • Although the IRRF documented high risk for falls, there was no documentation of the underlying etiology for falls, such as unsteady gait, osteoarthritis of the	

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		hip, spasticity, and fussed left hip. • There was no meaningful assessment documented by PT/OT to help determine the underlying etiology of spasticity, osteoarthritis of the hip, and possible pain associated with musculoskeletal conditions. • There were no diagnostic results identified in the active clinical record indicating evaluation of spasticity, and to assess progression of severe osteoarthritis of the hip. • There was no specific medical plan develop to help ensure staff's appropriate identification of indicators of pain and worsening spasticity, and no specific monitoring and reporting parameters for such manifestation. • Despite a history of multiple trials of analgesics and anti-inflammatory medications in the past, the Individual was not provided with regularly scheduled anti-inflammatory or other medications to address the Individuals severe osteoarthritis of the hip. • Reported curvature of the spine, and decreased proprioception documented on the PT assessment, was not documented on the annual medical assessment, and there were no medical provider's IPNs identified to assess these conditions. Summary: The Monitoring Team noted many discrepancies between various clinical assessments, such as PT/OT assessments and the annual medical summary. By review of the documents, many medical issues, such as osteoarthritis, assessment and treatment of pain, curvature of the spine, contractures, and spasticity, among other conditions, were not assertively assessed and managed. Individual #323: While making living area observations, the Monitoring Team noted that Individual #323 had an approximately 1 cm diameter hyper-pigmented lesion on the right cheek; however, this lesion was not documented on the annual medical assessment, as the physical exam reported normal skin findings. The Monitoring Team is concerned that such a pronounced, dark lesion, was not identified and assessed by the medical provider. Review of Community Living Discharge Plans (CLDP): The Monitoring Team reviewed the CLDP process for Individual's #118 and #303. Individual #118: Following its review of the CLDP and post move monitoring check list for Individual #118, the Monitoring Team noted several clinical issues of concern: • The Individual had a recent weight loss, which had resolved, and the action plan developed for this issue was to weigh the Individual every month, and to	

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		maintain a weight within the Individual's "EDWR". The Monitoring Team noted that the Individual's EDWR was 140 to 175 pounds; therefore, the Individual could potentially gain or lose 35 pounds before medical intervention would occur. Specific monitoring parameters were not listed for the monitoring weight, for example, if the Individual gained or lost five or more pounds in one month, the agency nurse should be notified. The post move monitoring plan only called for the Facility's Post Move Monitor to visualize the scale, and not report on current weight. • The Individual is known to have a seizure disorder; however, the specific type of seizure disorder was not listed on the active problem list or the CLDP. Page 6 of the CLDP indicated that the Individual was prescribed carbamazepine by the psychiatrist for "agitation secondary to autism", and did not indicate that this medication should have be monitored by a neurologist for the co-indication of behavioral indication and seizure disorder. The only action plan listed for seizure disorder was for staff to "look for jerking and falling". The plan did not describe specifics about the type of seizures, pre and post aura concerns, specific observations for reporting of seizure activity, and how to manage a seizure, and the post seizure episode. • The annual medical summary indicated "yes" for the need for a water safety program, but there was no action plan developed for this issue, prior to tge Individual being transferred out of the Facility. • The CLDP required many labs to be completed, and necessary to monitor; however, the post move monitoring checklist did not indicate specific parameters to assess when reviewing labs. It is important for the Facility to check that the provider monitors for abnormal laboratory results as identified in the CLDP and to ensure that the provider takes action when abnormalities are found; therefore, it is essential that the CLDP identify the parameters the Post Move Monitor should check. • The annual medical assessment indicated that because of maladaptive behaviors, pre-treatment sedation for medical appointments maybe needed. This was not listed as a support needed, nor was there a specific plan offered to the community agency for this concern. The Monitoring Team is concerned that this issue was not addressed, given the appointment failure rate for optometry, audiology, and dental appointments in the past. Additionally, this was not listed as a support needed, nor was there was there a plan developed to enable the Individual to obtain quarterly blood tests. • The Individual was noted to have a diagnosis of constipation, but this important clinical diagnosis did not have a support identified to monitor for worsening constipation, and did not have monitoring or reporting parameters developed for constipation. Given that this Individual is known to have constipation, is on	

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		pro-constipating medications, and has challenges to effectively communicate medical signs and symptoms, the Monitoring Team is concerned that the Individual is at risk for worsening constipation, and possible serious manifestations secondary to chronic constipation, such as bowel obstruction, and perforation. It is essential that the CLDP list this support so the provider will know to implement it and so the Post Move Monitor will check to determine that such monitoring is implemented. • The Monitoring Team was concerned that an attempt was made to obtain a modified barium swallow study on 9/12/2012; however, because of behavioral challenges this study was not completed. There was no further documentation on follow-up, or clinical rationale for not completing this unsuccessful diagnostic, and this issue was not further commented on in the CLDP. • On page 3 of the CLDP, there was a list of medications, and indications for the medication. The Monitoring Team noted a discrepancy between this list and the list of medications and indications on the annual medical summary that was used for the development of the CLDP. For example, the CLDP medication list indicated that the Individual was prescribed carbamazepine for "agitation/aggression", and did not indicate that this medication was also prescribed for seizure disorder. The annual medical summary listed Vyvanase, for ADHD, and sennosides/docusate for constipation; however, neither of these two medication were listed on the CLDP medication list. The Facility must ensure that all documents used for development of a CLDP are consistent with each other, or that there is documentation the differences are reconciled. • The Individual was noted to have significant behavioral challenges that resulted in failed dental appointments. It was determined that the Individual would require anesthesia (TIVA) for dental examinations and treatments. The only recommendation stated on the CLDP for dental services was to identify a dentist that could perform TIVA. There were no specific recommendations made on the frequency and indication for TIVA. The Monitoring Team noted the dental professional's assessment of poor oral health, and severe plaque, and that there was no support identified for oral hygiene. Given the severity of the Individual's dental issues, and need to TVIA because of challenging behaviors, there was no evidence indicating that a dental professional attended the CLDP meeting. • The Individual was unable to participate in a formal optometry examination, and the IDT determined that "it was not critical to keep taking (the Individual) when he is uncooperative and does not exhibit any signs of not being able to see or have visual difficulties seeing everyday activities". The final recommendation by the CLDP was "follow up with visual eye exam if the PCP begins to see changes in (individual's) visual functioning." • The annual medical assessment indicated that the rectal and genital examination	

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		was deferred, and there was no plan developed to ensure that this component of the examination was completed prior to the move. • The annual medical assessment indicated that the Individual required "blood pressure every Friday at hs (night) for high risk meds". There was no support listed on the CLDP to address this issue. Summary: The Monitoring Team determined that the Facility had not developed a clinically meaningful CLDP to address the Individual's medical and dental issues, and that the post move monitoring checklist did not assess for specific monitoring parameters to determine the health care status of the individual, and to ensure that clinically appropriate supports and services were in place. Individual #303: The following are some concerns, and comments specific to the CLDP, and post move monitoring (PMM) process for Individual #303. • The seven and 45 day post move monitoring report (PMM) indicated that the "PMM was able to get a visual of (the Individual's) medical equipment during the 45 day review"; however, there was no indication that PMM staff actually assessed the provision of critical medical supports, such as observing suction toothbrushing, tube feeding, and medication administration. There was no indication that PMM staff determined whether the provider had a process for assessing clinical parameters, such as oxygen saturation, how to determine the need for supplemental oxygen, use of nebulizer, and BMI, and positioning, among other medical services. • The weight range set for the Individual was between 111 and 139 pounds. The could potentially result in an individual gaining or losing 28 pounds before an action would be initiated. The Facility should set more specific parameters for staff to monitor. • The Individual had a diagnosis of seizure disorder; however, the accepting agency was not provided with specific signs and symptoms to monitor for issues such as an active seizure activity, and pre-seizure or post-seizure activity; and was not provided specific instructions on how to manage such conditions specific to this Individual. The Monitoring Team noted that the Individual was hospitalized for seizure activity, shortly following transfer to the community agency; hence, this is an important clinical issue that must be closely monitored. • The Individual was known to have recurrent urinary tract infections (UTIs), and following admission to the hospital for seizure disorder, during the 45-day monitoring period, the Individual was diagnosed on admission with a UTI. The Facility did not provide the agency with specific monitoring and reporting	

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		parameters to assess for possible UTI. For example, issues such as frequency, worsening incontinence, malodorous briefs, or possible periodic clinical assessments, should have been communicated to the accepting agency. A UTI could quickly develop into urosepsis if not identified and treated promptly. • After a hospital discharge, there was no documentation indicating that a Facility medical provider or the IDT reviewed the issues related to the hospitalization. The medical provider who knew the Individual well should have assessed the issues related to the hospitalization, and determined if appropriate pre-hospital supports and services were efficacious, and if appropriate post-hospital supports and services were in place. • The Individual has known medical diagnoses including asthma, chronic obstructive pulmonary disease (COPD), and recurrent pneumonia. The action plan for asthma included the need for oxygen to be administered prn (as needed). A plan for use of prn oxygen at the community agency was not clearly delineated on the CLDP, and oxygen was not identified on the CLDP as a needed support, nor was its use assessed by the PMM. The Monitoring Team was concerned that there were no specific monitoring parameters documented for agency staff to monitor and report for asthma or COPD exacerbation, and early signs of pneumonia. • The nursing assessment reports that oxygen, 2 liters per minute by nasal cannula, should be administered, and the medical summary indicated that oxygen should be administered prn; however, as this was not listed in the CLDP as a support need, it was not included on the monitoring checklist. Therefore, the PMM did not monitor to determine if the oxygen tank or oxygen concentrator was available, or if the oxygen tank or concentrator was functional. • The Individual has a medical diagnosis of osteoporosis, which can lead to non-traumatic fractures, and more readily enable traumatic fractures. There were no monitoring or reporting parameters specific to the development of potential fractures. • The CLDP indicated, under the heading of special treatments, the need for nasotracheal suctioning; however, nasotracheal suctioning was not documented on the PMM checklist. If the Individual did in fact need occasional nasotracheal suctioning, this support service must be carefully monitored, and immediately provided when necessary. Summary: The Monitoring Team determined that the CLDP, and post move monitoring for this Individual was ineffective, and did not address many medical conditions, and did not develop necessary monitoring and reporting parameters for many medical conditions, such as seizures, COPD, asthma, recurrent pneumonia, and constipation, among others.	

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		The Individual sustained a serious medical event that resulted in a hospitalization, and there was no evidence to indicate that the Facility's medical provider assessed the Individual to help ensure that appropriate support and services were, and are, currently in place. Individual #38: The Monitoring Team reviewed the active clinical record, and discussed the case with the Facility's medical director. The following are some of the more serious concerns and comments noted by the Monitoring Team: • The Individual was known to have a "huge" hiatal hernia, which was so severe that its transverse dimension was 15 cm, and there was loops of colon within the hernia. On 10/21/2013, a gastroenterologist concurred that the hernia required surgical intervention, and because of associated swallowing problems, reflux, and recurrent pneumonia, recommended surgical intervention by means of a reduction surgery. There was no further follow-up with the gastroenterologist documented within the active clinical record, until a hospitalization in 12/2013. • The Individual was known to "refuse medication", including anticonvulsant medication, which resulted in poorly controlled seizure disorder. Because of the "huge hiatal hernia", and recurrent seizures, the individual was predisposed to recurrent pneumonia; and it was reported in the active clinical record that the Individual did in-fact have frequent recurrent pneumonia, and resulting damage to the lungs. By its review of documentation in the active clinical record, the Monitoring Team determined that the Facility did not assertively address medication non-compliance. For example, the IDT met with the LAR and discussed the Individuals "medication refusal" on 8/8/2013, and noted that a G-tube maybe required. Because the LAR was not overly interested in pursuing a G-tube, further discussion was "tabled" until an IDT could take place when the LAR would be physically present to discuss G-tube placement. On 8/14/2013 an ISP addendum documented a meeting with the LAR to discuss medication refusal and need for G-tube. At that meeting, it was decided to perform two dementia scales, send the individual to a psychiatrist to evaluate for medication refusal, and to provide a cup and straw to help increase fluid intake, and to send the individual for a surgeon to evaluate for enteric tube placement. There were no additional IDT minutes, or other evidence indicating that the IDT discussed follow-up on G-tube placement, or the results of the dementia workup that the IDT had requested. It should be noted, however, that although not documented in the active clinical record, the facility director and medical director informed the Monitoring Team that there were many conversations with the LAR resulted in delay in moving forward with the enteric tube placement. • The Individual's GERD, episodes of seizures, and pneumonia exacerbated in	

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		December 2013, resulting in a prolonged hospitalization on 12/29/2013 with discharge on 1/22/2014. The Facility's medical director indicated that the Individual was scheduled for G-tube placement on 2/4/2014. Immediately following hospital discharge, the Individual experienced recurrent episodes of signs and symptoms of aspiration, as documented by the Facility's speech pathologist, following several swallowing assessments; despite such findings, the Individual was continued to be provided oral nutrition and hydration. In addition, on 1/23/2014, the medical provider documented an IPN that stated, among other things, a medical plan indicating that "poor compliance with meds, hydration and nutrition persists…IDT will meet to discuss; pt may need periodic ER visits to rehydrate until g-Tube is placed, and hiatal hernia is repaired." The Monitoring Team has serious concern that the Facility would permit this individual to return to the Facility prior to the placement of an enteric tube, especially with the knowledge of the Individual requiring a G-tube to ensure adequate nutrition, hydration, and to prevent known aspiration and recurrent pneumonia. It is alarming to the Monitoring Team that with such findings, as documented by the speech pathologist, suggesting continued overt aspiration, that oral hydration and nutrition was permitted at the Facility. • Review of integrated nursing progress notes from October 1, 2013, through January 27, 2014 documented numerous episodes of refusals of meals, and administration of Glucagon for hypoglycemia, as low as 20mg/dl; and there was no documented medical plan, by the medical provider, to more assertively address management of diabetes, and hypoglycemia. • Review of nursing integrated progress notes from October 1, 2013, through January 27, 2014, documented numerous occasions of the Individual refusing anticonvulsant medications, and there was no documented medical plan to more assertively manage seizure disorder, by the medical provider. • Review of the documented medical provider's IPNs for this reporting period, did not indicate necessary medical follow-up on several on several known medical conditions, and that may have had direct impact on the Individual's current medical condition, for example: o The Individual was know to have abnormal, and progressive, worsening of alkaline phosphatase, which was not fully evaluated as to its etiology. Progressive worsening alkaline phosphatase levels should always be assessed as to its underlying etiology. o The Individual was known to have episodes of elevated sodium levels, and periodic elevation of BUN, and creatinine ratio, suggestive of possible episodes of dehydration; and there was no specific medical plan to address such episodes. o A CT of the abdomen obtained on 2/28/2013 documented fatty atrophy	

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		of the pancreas, with multiple calcification in the region of the pancreas, as well as very large cysts on the kidney. The findings of the pancreas, in association with chronic worsening alkaline phosphatase, suggests possible serious pathology of hepatobilliary system or other serious medical condition. The medical provider did not address these findings on the annual medical assessment, in fact, the annual medical assessment, dated 9/16/2013, indicated that the abdominal CT from 2/28/2013 demonstrated "no acute findings". The Monitoring Team has serious concerns that the medical provider may have not read the body of the CT report, dated 2/28/2013, and may not have recognized the pathological findings, as documented above. o On 11/20/2012, an abdominal echography demonstrated a "large, shadowing echogenic gallstone within the gallbladder lumen. There was no documented evidence, in the active clinical record, demonstrating that this potentially serious medical issue was addressed by the medical provider. Taking into consideration the progressive elevated alkaline phosphatase, abnormal findings of the pancreas, and the large gallstone, the medical provider should have developed a medical plan to further evaluate such findings. Although this Individual was seen by a gastroenterologist for evaluation of severe hiatal hernia, the gastroenterologist was not made fully aware of these important medical issues. Furthermore, the annual medical assessment, dated 9/16/2013 did not comment on the results of the echography. The Monitoring Team has serious concerns that there was no documented evidence had assertively, and efficaciously followed up on the constellation of a large gallstone, abnormal laboratory findings, and pathological findings on the pancreas. o On 7/26/2011, the neurologist recommended an EEG and imaging of the brain, and to follow-up once the diagnostics were completed. There was no evidence in the active clinical records that the EEG, or follow-up with the neurologist had been completed, and it was not until 2013 when imaging of the brain was completed. The Monitoring Team has concern over the lack of assertive follow-up with the neurologists recommendations. • Ultimately, the Individual was again admitted to the hospital on 1/27/2014, with signs of severe dehydration, low protein level suggesting malnutrition. • An IPN, dated 1/28/2014, found in the active clinical record documented that the Individual had died on that day. Summary: The Monitoring Team found examples in which important medical supports and services	

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		were not provided as necessary, as there was no documented evidence to support timely and efficacious evaluation, and treatment of cholylithiasis, and possible associated pathology of the pancreas; no documented follow-up on large cysts of the kidney; delayed evaluation and treatment of severe hiatal hernia; delayed assessment of medication non-compliance, which may have resulted from the individual not being able to ingest medication because of swallowing dysfunction and not actual refusal; enabling the Individual to remain at the Facility with knowledge of significant aspiration risk, and inability to maintain hydration, nutrition, mediation management. This Individual should have been immediately triaged back to an acute care hospital to immediately provide intravenous hydration, nutrition, medication management, and to more urgently address G-tube placement. <u>Conclusion</u> The Monitoring Team concluded that the Facility is not in substantial compliance with Section L.1. Follow-up to acute medical conditions through resolution; regular assessment for pain, when necessary; updating and documenting the IRRF, and ISP with new medical diagnosis, and documenting all necessary supports and services on the IRRF, and ISP; maintaining a functional DNR process; determining the underlying etiology of medical conditions; ensuring an effective CLDP, and post move monitoring process addresses all medical, and dental issues; and ensuring that adequate diagnostics, and consultations are provided as necessary, are some of the issues the Facility must improve on. Furthermore, it is essential that the Facility that the medical providers assertively follow-up on issues such swallowing assessments, seizure logs, and accu-check reports. Because the Monitoring Team was provided with document requests that were not collated, and required significant time to sort, the Monitoring Team was unable to complete as many topics as in past compliance reports.	
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.	Provision L.2 requires the Facility to develop and implement a process to assess the clinical performance of medical providers. To comply with Provision L.2, the Facility adopted the DADS medical provider quality assurance audit process, and conducted both an internal and external audit each quarter. The Monitoring Team also reviewed the Facility's mortality review process by reviewing death review summaries, and met with the mortality review committee members, including Dr. Brett. To assess the Facility's ability to conduct clinical performance audits, the Monitoring Team requested the following documentation: • Copy of physician audits completed during the reporting period (separate by internal and external) o Copy of all summaries, graphs and data (specific for each medical provider) o Copy of action plan for deficient areas o Copy of follow-up documentation for action plan, through resolution	Noncompliance

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		• Policy/procedures specific to how the Facility utilizes information from the medical audits • Documentation on how the physician audit is utilized to enhance medical provider performance (such as physician feedback) • Statement from the Medical Director indicating that the results of the audit findings were personally discussed with each provider, and that the information was utilized within the context of peer review process • List of all indicators used to assess medical competency • BSSLC Policy: I4.b Administrative Death Review Committee, (no date) • BSSLC Policy: I.4.c Clinical Death Review Committee, (no date) • BSSLC Procedural Guidelines for Actions Following the Death of an Individual, 3/25/14 • BSSLC Report of the Death of a Person Served for Individuals #38, #38, #19, #253,#126, and #305 • BSSLC Death/Discharge Summaries for Deceased Individuals #38, #19, #253,#126, and #305 • BSSLC Quality Improvement Death Review of Nursing Services and recommendations for Deceased Individuals #38, #19, #253,#126, and #305 • BSSLC Unusual Incident Reports (URIs) for Deceased Individuals #38, #19, #253,#126, and #305 The Monitoring Team was provided several hundred pages of completed audit forms for the round eight of external medical audits; however, the Facility also included a document stating that the Facility did not have summaries, graphs, data, action plans or follow-up to action plans for the medical audit process. In addition, the statement also indicated that the Facility did not have available the specific policies or procedures for the internal and external audit process, a document on how the physician audit was utilized to enhance medical provider performance, such as physician feedback, and did not provide a statement by the medical director indicating that the audits were used within the context of a peer review process. Also, the Facility provided a statement reporting that they did not have a copy of the current indicators that were used to assess the medical competency component of the internal and external audit process. <u>Mortality Review Process:</u> 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; however, the medical director did develop a new procedure called Procedural Guidelines for Actions Following the Death of an Individual, 3/25/14. The Monitoring Team met with the Medical Director, Facility Director, Chief Executive	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>Nurse, Quality Assurance Nurses, and Quality Assurance Director and reviewed/discussed the Facility's Death Review Policies and Processes, as well as death information provided for review.

Since the compliance review, four deaths had occurred at the Facility. One death that occurred on 9/13/13 was included in the review because the Administrative and Clinical Death Review Committees had not been completed at the time of the last compliance review. The Monitoring Team's findings included:
• Of the five deaths reviewed, the average age was 60.8 years (ages varied from 46 to 72 years of age).
• Five of five (100%) deaths had a Certificate of Death completed. Four were completed by State of Texas Department of State Health Services – Vital Statistics Unit and one was completed by Certificate of Death City of Bryan Texas. The cause of individuals' deaths on the Certificate of Deaths are listed in the chart below:
<table><tr><td>1. Immediate cause of death: Severe Sepsis
Underlying causes of death: Lactic Acidosis and Acute Renal Failure due to Severe Sepsis</td></tr><tr><td>2. Immediate cause of death: Cardiopulmonary Arrest

Underlying causes of death: Anoxic Encephalopathy and Seizure Disorder</td></tr><tr><td>3. Immediate cause of death: Dementia – Alzheimer's Type

Underlying cause of death: Aspiration Pneumonia</td></tr><tr><td>4. Immediate cause of death: Acute Respiratory Failure

Underlying causes of death: Post Influenza Staphylococcal Pneumonia with Abscess</td></tr><tr><td>5. Immediate cause of death: Aspiration Pneumonia with Parapneumonic Effusion due to Pseudomonas Aeruginosa
Underlying cause of death: Respiratory Failure</td></tr></table>
The Monitoring Team's review of the death documents for compliance with the Facility's death review policies and processes found:
• Four of five (80%) deaths had medical histories/chronic diagnoses of aspiration and/or dysphagia, and/or high/medium risk conditions associated with aspiration pneumonia/pneumonia/respiratory compromise. There was concern regarding the high incidence of deaths associated with aspiration pneumonia/pneumonia, which was potentially preventable.
• Four of five (80%) decedents were enterally nourished.
• Four of five (80%) deaths occurred in the hospital and one (20%) death occurred at Hospice Facility.</td><td></td></tr>
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		• Five of five (100%) decedents had DNR orders at the time of death. • Zero of five (0%) decedents had an autopsy performed. • Five of five (100%) deaths had Unusual Incident Reports completed. • Five of five (100%) deaths had Quality Improvement Death Review of Nursing Services Reports completed by the Quality Assurance Nurse within five working days, per policy. • Five of five (100%) deaths were determined natural/not unusual. One of five (20%) had cardiopulmonary resuscitation (CPR) initiated and the individual was transferred to the hospital where the individual later died. • One of five (20%) Death Discharge Summaries was completed by the attending physician within five working days, according to policy. • Four of five (80%) of the Clinical Death Review Committee Meetings were conducted within 14 calendar days of notification of the deaths. One Clinical Death Review Committee Meetings was completed one day after the due dates, per policy. • Zero of five (0%) of Clinical Death Review Committee Meetings attendance signature sheets showed that external physicians participated. • Five of five (100%) Clinical Death Review Committee Meetings resulted in measurable recommendations for relevant disciplines and were tracked through to completion. This showed improvement from previous compliance reviews. • Five of five (100%) Administrative Death Review Committee Meetings were conducted within 21 calendar days after receipt of the minutes from the Clinical Death Review Committee Meetings. • There was no documentation provided indicating that cases had been summarized, and forwarded to the state office along with action plans, within the required 28 calendar days. • The Quality Assurance Nurse continued to: o 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. o Conduct Quality Improvement Death Reviews of Nursing Services Reports for each death and made appropriate recommendations for respective disciplines. o Maintain Death Review Tracking Sheet for recommendations through to resolution, as well as for ongoing recommendations. ▪ Five of five (100%) deaths that had clinical and/or administrative recommendations that were carried out through to resolution or were ongoing. 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	

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		Provision 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 remained 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. 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. 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 that would lead to systems improvement. It is essential that a root cause analysis of each death be completed, that assesses longitudinal supports, and services, and to identify all issues that had, or may have contributed to the death. Conclusion: The Facility indicated by written documentation that it did not have available documents requested by the Monitoring Team to assess the Facility's medical audit process; therefore, the Monitoring Team was unable to determine the efficacy of this process. The mortality review process must be significantly revised to ensure that medical providers conduct a comprehensive case review of all deaths, and that meaningful recommendations are provided for each death, derived by a root cause analysis that assesses a historical review of all supports and services, including medical care. The Facility must conduct 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. For these reasons, the Monitoring Team determined that the Facility was not in compliance with Section L.2.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a	Provision L3 requires the Facility to implement a quality assurance (QA) process for medical services. To assess the Facility's effort towards compliance for Provision L3, the Monitoring Team requested the following documentation: 1. Policy and procedure specific to a medical quality assurance process/program at	Noncompliance

#	Provision	Assessment of Status	Compliance
	medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	the Facility 2. Copy of all medical indicators used for medical QA 3. Copy of data, graphs, data analysis, and past six months of committee meeting minutes, specific to medical QA process 4. Copy of all recommendations (action plans) by medical QA committee to enhance medical outcomes at the Facility; also include evidence to support that the action plans were implemented, and followed up on for completion and efficacy 5. Copy of physician internal audits completed during the reporting period (separate by internal and external) a. Copy of all summaries, graphs and data (specific for each medical provider) b. Copy of action plan for deficient areas c. Copy of follow-up documentation for action plan, through resolution 6. Policy/procedures specific to how the Facility utilizes information from the internal medical audits 7. Documentation on how the physician audit is utilized to enhance medical provider performance (such as physician feedback) 8. Statement from the Medical Director indicating that the results of the audit findings were personally discussed with each provider, and that the information was utilized within the context of peer review process 9. List of all indicators used to assess medical competency As per Section L.2, of this report, the Facility provided written documentation stating that the Facility did not have summaries, graphs, data, action plans or follow-up to action plans for the medical audit process, therefore the Monitoring Team was unable to assess the Facility's internal medical audit process. The medical director informed the Monitoring Team that the Facility had not developed a medical quality assurance process, and there were no documents provided to support the development of a medical QA process, but that the Facility is in the process of doing so; as reported in the last compliance report, the Facility continues to develop clinical data tracking sheets for cerebral palsy and degenerative spine disease, that will be implemented in the future. In addition, the Facility had identified a specific staff person to further develop and implement a medical QA process for the Facility. <u>Conclusion</u> The Monitoring Team determined that the Facility was not in substantial compliance with Section L.3, because it had not developed and implemented a medical quality assurance process, and because there was no documentation indicating that the Facility had an internal process to assess medical providers' clinical performance.	

#	Provision	Assessment of Status	Compliance
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.	Section L.4 requires that the Facility maintain appropriate policies and procedures to ensure quality medical services at the Facility. To assess compliance the Monitoring Team reviewed a copy of the most current medical care policy, and all new policies and procedures developed during the reporting period, and was provided: • Medical Care Policy L.1, dated 10/2/2013 • Procedural Guidelines for Neurology Clinic, dated 9/20/2013 • Procedural Guidelines for Ensuring that Pre-Treatment Sedation is Co-Ordinated through the Interdisciplinary Process, 3/27/2014 • Procedural Guidelines for Actions Following the Death of an Individual, dated 3/25/2014 <u>Review of Medical Care Policy</u> The Monitoring Team reviewed the updated medical care policy and, based on the Monitoring Team's understanding of clinical practice at the Facility, the policy does appear to be comprehensive, and delineate most of the activities practiced at the Facility. The Monitoring Team noted, however, that the Facility had yet to substantially implement the medical care policy. The following are some specific comments, and concerns: • The policy requires that individuals are provided with adequate and necessary medical treatment, and per the Monitoring Team's review for Section L.1, of this report, there were many instances when medical treatment needed to be enhanced. For example, the Medical Provider did not fully delineate all necessary medical conditions, or supports and services for individuals transferring to the community; and there were instances when medical issues were not followed up on, such as those examples identified for Individuals #44, #38, #323, and #303. • The policy stated that pain needed to be regularly assessed, and the Monitoring Team identified several incidences when medical providers did not regularly document a clinical assessment for the management of pain, such as ongoing pain assessment following a fracture or for severe osteoarthritis. • It was required for the medical provider to play an integrated role in the management of nutritional, physical, and psychiatric needs of individuals, and there were examples when medical providers did not assertively collaborate with other disciplines such as speech pathology, as delineated in Section L.1, and Section O, for Individual #38. • Medical providers are expected to clearly and consistently document health status and health care needs of individuals; the Monitoring Team reported in Section L.1 that medical plans were not effectively developed for health care needs, and there were examples of acute care issues not being followed through	Noncompliance

#	Provision	Assessment of Status	Compliance
		full resolution, such as in the case of Individual #38, among others. <u>Review of Procedural Guidelines for Actions Following the Death of an Individual</u> The procedure calls for the "attending PCP" to complete the "death/discharge summary", which would than be reviewed by the medical director, and others at the "clinical death review committee". The Monitoring Team is concerned that the Facility relies on the individual's medical provider to complete the death summary, and strongly advises the Facility to have a physician that is not employed by the Facility, and that has expertise in developmental disability medicine, to perform a mortality review and to complete the death summary; at a minimum, the medical director should consider performing an independent mortality review, and to complete the death summary. Conclusion: Based on the Monitoring Team's understanding of clinical practice at the Facility, the medical care policy does appear to be comprehensive, and delineate most of the activities practiced at the Facility; however, because the Facility has not yet substantially implemented the medical care policy, the Facility is not in substantial compliance with the Section 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: 3/18/14 2. BSSLC Section M Action Plan, updated: 3/18/14 3. BSSLC Section M Presentation Book 4. DADS SSLC Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment, January 2014 5. DADS SSLC Procedure: Medication Administration Guidelines, January 2014 6. DADS SSLC Guidelines: Care Plan Development, December 2013 7. DADS SSLC Procedure: Medication Administration Observation Guidelines, December 2013 8. DADS SSLC Procedure: Nursing Competency Base Training, 9. DADS Procedure: Medication Errors/Incidents, November 2009 10. BSSLC Nursing Guidelines, Revised: 12/12/13 11. BSSLC Policy M.4, Isolation 3/5/14 12. BSSLC Policy for Influenza Vaccinations and Declination From, 3/14/14 13. BSSLC Nursing Organizational Chart 14. BSSLC Nursing Education Department Update, October 2013 through April 2014 15. BSSLC Nursing Annual Competency Based Fair Training Curriculum 16. BSSLC Nursing Orientation Curriculum 17. BSSLC Nursing Education Database and Accompanying Training Rosters 18. BSSLC Full Time Nursing Positions Filled and Unfilled Positions, to date 19. BSSLC Nursing Minimum Staffing Report, September 2013 through February 2014 20. BSSLC Nursing Staffing Analysis Report, September 2013 through February 2014 21. BSSLC Current RN Case Managers' Caseloads, Revised: 3/5/14 22. BSSLC Current Nursing Ratios for Direct Nursing Staff, Revised 3/4/14 23. BSSLC Nursing Overtime Hours by Shift for Last Six Months 24. BSSLC Summary of Contract Nursing Hours, by Shift for Last Six Months 25. BSSLC Nursing Meeting Schedules for the Week of April 7, 2014 26. BSSLC Nursing Managers Meeting Minutes, 11/13/13, 1/15/14, 1/23/14, and 2/5/14 27. BSSLC Infection Control Committee Meeting Minutes, 11/25/13 and 2/26/14 28. BSSLC Skin Care Quarterly Committee Meeting Minutes, 10/29/13, 1/30/14, and 4/8/14 29. BSSLC Nursing/Quality Assurance Audit Tool Meeting Minutes, 12/3/13 and 2/10/14 30. BSSLC Medication Variance Committee Meeting Minutes, 9/17/13, 10/29/13, 11/19/13, 12/17/13, 1/31/14, and 2/25/14 31. BSSLC Cardiopulmonary Resuscitation (CPR)/Emergency Response Committee "Special Meeting" Minutes, 9/16/13 32. BSSLC Emergency Response Committee Meeting Minutes, 1/16/14 33. BSSLC Nursing Education/Settlement Agreement Meeting Minutes, 12/17/13 34. BSSLC Case Management/Settlement Agreement Meeting Minutes, 12/3/13, 2/3/14, and 2/24/14

	35. BSSLC Settlement Agreement/Infection Control Meeting Notes, 12/3/13, 12/17/13, 1/21/14, 1/31/14, 2/24/14, and 3/3/14 36. BSSLC Settlement Agreement/Nursing Education/Skin Integrity Meeting Minutes, 2/25/14 37. BSSLC Quarterly Pharmacy-Nursing Collaboration Meeting Minutes, 4/9/13, 5/8/13, 7/25/13, 9/23/13, and 2/27/14 38. BSSLC Weekly Physical Nutritional Management Team Meeting Minutes for past six months 39. BSSLC Morning Medical Debriefing Meeting Minutes, 4/8/14 and 4/10/14 40. BSSLC Appointment/Consultation Log 41. BSSLC Emergency Medical Checklist Summary for the past six months 42. BSSLC List of Campus Location of Automated External Defibrillators (AEDs) 43. BSSLC CPR Drill Instructor Core Group, 3/1/14 44. BSSLC CPR Mock Drill Summary for past six months 45. BSSLC Emergency Response Committee Core Membership and Guidelines for Conducting Meetings 46. BSSLC Incident Management Review Team Meetings Minutes and Accompanying Emergency Drill Checklist for the past six months 47. BSSLC Competency Training and Development (CTD) Course Due/Delinquent List for CPR Basic, Printed 3/11/14 48. BSSLC Antibiogram, 2/1/13 through 2/1/14 49. BSSLC Infection Control Nurse Administrative Responsibilities 50. BSSLC Infection Control Nurse Clinical Responsibilities 51. BSSLC Infection Control Spreadsheet for Reportable Infections, 9/1/13 through 2/28/14 52. BSSLC CTD Course Due/Delinquent List for Infection Control, Printed, 3/7/14 53. BSSLC Individuals Current with Flu Vaccinations 54. BSSLC Employees Current with Flu Vaccinations 55. BSSLC Individuals Current with Tuberculosis Skin Testing/Screening 56. BSSLC Employees Current with Tuberculosis Skin Testing/Screening 57. BSSLC Employee Current with Hepatitis B Vaccinations 58. BSSLC Infection Control Monitoring Tools 59. BSSLC Medication Administration Monitoring Tools and Data Analysis for past six months 60. BSSLC Medication Variance Report, March 2013 through January 2014 61. BSSLC QA/QI Council Meeting Minutes, 2/26/14 62. Review of sample for five recent seizure records for Individuals #67, #195, #185, #428, and #223 63. Review of 10 of the most recently completed Medication Variance Reports for Individuals #191, #65, #144, #325, #554, and #464 (Individual #464 had five medication variances reported) 64. Medication Administration and/or Enteral Nutrition Administration Observations for Individuals #281, #112, #288, #427, #308, #475, #517, #335 65. Review of sample of six hospital records for recently and/or currently hospitalized Individuals #29, #395, #35, #87, #95, and #437 66. Review of sample of four records for individuals with recent and/or active skin integrity issues for Individuals #332, #223, #96, and #88 67. Review of sample of five records for individuals with recent and/or active reportable communicable diseases for Individuals #37, #68, #557 #149, and #362

	68. Review of sample of five records for individuals with recent and/or active Urinary Tract Infections for Individuals #276, #195, #533, #97, and #595 69. Review of sample of three recent Comprehensive Nursing Assessment/Summaries and Community Living Discharge Planning Packets for Individuals #52, #303, and #468 70. Review of sample for 11 most recently completed Admission, Annual and/or Quarterly Nursing Assessments selected from the Facility's At Risk List for individuals identified with high/medium risk health conditions from each unit (Individuals: #184, #269, #291, #584, #193, #445, #322, #464, #439, #313, and #172) **People Interviewed:** 1. Debra Williams, RN, Chief Nurse Executive (CNE) 2. Tammy Pavlu, Nursing Operations Officer (NOO) 3. Joy Sorensen, RN, RN Case Manager Supervisor 4. Johanna Schroeder, RN, Program Compliance Nurse 5. Jill Quimby, RN, Quality Assurance (QA) Nurse 6. Doris Poston, Nurse Educator 7. Joanne Guard, RN, Infection Control Nurse 8. Johnnie Johnson, RN, Infection Control Nurse 9. Kellie Fitch, RN, Hospital Liaison Nurse 10. Leona Sian, RN, RN Shift Manager/Durable Medical Equipment Nurse 11. Stephanie Hintzel, RN, Nurse Manager, Driscoll Gardens 12. Jane Barnett, RN, Nurse Manager, Bowie Springs 13. Susan Fletcher, Lead RN Case Manager, Fannin Villa 14. Numerous RN Case Managers and Staff Nurses 15. Trey Knittel, PharmD, RPh, Clinical Pharmacist 16. Robin Blankenburg, RPh, Director of Pharmacy 17. Mary Anne Brett, M.D., Medical Director **Meetings Attended/Observations:** 1. Meeting with Nursing Administration/Leadership to Review Section M Presentation Book, 4/7/14 through 4/10/14 2. Toured Fannin Villa and conducted Medication Administration Observations in Fannin C at 4:00 p.m. Med Pass, Medication Room Survey, and Emergency Equipment Check, 4/7/14 3. Medical Morning Meeting, 4/8/14 and 4/10/14 4. ISPA Meeting for Individual #59, 4/8/14 5. Skin Integrity Committee Meeting, 4/8/14 6. Observed an Impromptu Mock Medical Emergency Drill in Fannin C or the 2-10 Shift, 4/8/14 7. Record Reviews with RN Case Managers, 4/8/14 and 4/9/14 8. Nurse Manager Meeting (included QA Nurse), 4/9/14 9. Toured Bowie Springs, and conducted Medication Administration Observations in Bowie D at 4:00 p.m. Med Pass, and Medication Room Survey, 4/9/14 10. Pharmacy and Therapeutics Committee Meeting, 4/10/14
	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: Nursing Care Monitoring Tools and Nursing Protocol Audit Tools, Medication Room, Medication Administration Records, and Medication Administration Observation Audit Tools. • 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, and record reviews to determine status of compliance with the respective monitoring processes. • The Self-Assessment did 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 or 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. • The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results through inter-rater reliability process completed by the QA Nurse. 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 nursing staff responsible for conducting the audits/monitoring had been deemed competent by the Facility in the use of the tools and were programmatically competent. ▪ 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 but were not limited to: Skin Integrity Database, Medication Variance Database, Nursing Education/Training, and Infection Control Database. • 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 in substantial compliance with Provisions M.1, M.2, M.3, M.4, M.5 and M.6. The Monitoring Team concurs with their findings of substantial compliance with Provisions M.2, M.4, and M.6, but did not concur with the Facility's findings for substantial compliance with Provisions M.1, M.3, and M.5. While the entire Provision M.1 was not found in substantial compliance, most of the various requirements were either close to substantial compliance, or very close. For the Provisions that were not found in substantial compliance, the Facility's Action Plans addressed plans for each

	Provision that should assist them in moving forward toward substantial compliance in the near future.
	Summary of Monitor's Assessment: Based on the Monitoring Team's review, Provisions M.2, M.4, and M.6 continued to be found in substantial compliance. Provisions M.1, M.3, and M.5 were not found in substantial compliance. However, Provision M.1 was found to be very close to substantial compliance with all of the multiple requirements. **Provision M.1:** The Facility stated they were in substantial compliance with this Provision. Based on the Monitoring Team's independent review, this Provision was not found in substantial compliance. In order for this Provision to be found in substantial compliance all requirements of this Provision must meet substantial compliance. If the Hospital Liaison Activities, Infection Control Program, and Emergency Response System were standalone requirements they would be considered in substantial compliance. Significant progress was found in the Skin Integrity Management System and substantial compliance should be achieved in the near future if the positive practices are maintained. While improvement was found in Assessments and Documentation of Acute Changes there remained the need for continuous improvement in assessing and documenting acute illnesses/events that do not require the initiation of Acute Care Plans. The Nursing Department needs to ensure that these events follow the respective nursing protocols and are documented through to resolution. Staffing appeared to be sufficient to meet individuals' nursing care needs. There were no reports over that last six months where the established staffing ratios were not met. The Quality Assurance Processes appeared to be solidly in place for the Nursing Department auditors and the inter-rater reliability processes completed by the QA Nurse. **Provision M.2:** The Facility stated they were in substantial compliance with this Provision. Based on the Monitoring Team's independent review, this Provision continued to be found in substantial compliance. The Nursing Department needs to maintain the positive practices identified in the report and ensure that all risk conditions are thoroughly assessed and individuals' progress toward established goals are sufficiently summarized in Section VIII of the Comprehensive Nurse Review and in Section Nine of the Quarterly Nursing Record Review. **Provisions M.3:** The Facility stated they were in substantial compliance with this Provision. Based on the Monitoring Team's independent review, this Provision was not found in substantial compliance. Significant progress was found in the individualization, quality, and content of the Acute Care Plans since the guidelines for developing Acute Care Plans was recently revised. However, there were two active Corrective Action Plans that need to be closed and all nursing care monitoring tools and nursing protocol audits need to achieve and maintain at least the compliance scores required by the Nursing Department's currently established compliance thresholds over the next six months. There needs to be continued improvement in the Integrated Risk Rating Form and Integrated Health Plan Processes to ensure that all pertinent nursing related assessments are included in the clinical data to assist with determining risk conditions, and that plans are developed for each risk condition that sufficiently meet individuals' health care needs. **Provision M.4:** The Facility stated they were in substantial compliance with this Provision. Based on the

	Monitoring Team's independent review, this Provision continued to be found in substantial compliance. The Nursing Department continued to maintain a robust competency based educational program that tracked all required training and ensured the training was completed. There was evidence through interviews with nursing administration and management staff, as well as review of individuals' records, that demonstrated the required nursing policies, procedures, processes, and protocols were implemented and being followed sufficiently to meet individuals' health care needs. **Provision M.5:** The Facility stated they were in substantial compliance with this Provision. Based on the Monitoring Team's independent review, this Provision was not found in substantial compliance. The Facility continued to refine and implement the revised ISP, Integrated Risk Rating Form, and Integrated Health Care Plan Processes. However, these processes were continuing to evolve, but had not matured sufficiently to demonstrate substantial compliance. There needs to be continued improvement in the Integrated Risk Rating Form and Integrated Health Care Plan Processes to ensure that all pertinent nursing related assessments are included in the clinical data to assist with determining risk conditions, and that plans are developed for each risk condition that sufficiently meet individuals' health care needs. **Provision M.6:** The Facility stated they were in substantial compliance with this Provision. Based on the Monitoring Team's independent review, this Provision continued to be found in substantial compliance. The Facility continued to show sustained progress in all aspects of medication administration practices according to current generally accepted standards of practice. The Facility had a robust system for identifying, reporting, tracking and analyzing medication variances, as well as for taking corrective actions to mitigate medication variances.

#	Provision	Assessment of Status	Compliance
M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	<u>Monitoring Team Findings</u> The Monitoring Team verified the information presented in the Facility's Self-Assessment through: Review of the information presented in Provision M.1's Presentation Book; review of documents requested; meetings/interviews with Chief Nurse Executive, Nursing Operations Officer, Nurse Educator/Skin Integrity Nurse, QA Nurse, Hospital Liaison Nurse, RN Case Manager Supervisor, and Nurse Managers; and 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 in substantial compliance with Provision M.1; the Monitoring Team did not concur with their findings. This Provision of the Settlement Agreement requires the Facility to address various areas of compliance in order to meet substantial compliance. These requirements include: Staffing, quality assurance efforts, assessment and documentation of individuals with acute changes in status, availability of pertinent medical records, infection control, and mock medical drills and emergency response system. Additional	Noncompliance

#	Provision	Assessment of Status	Compliance
		information regarding the nursing assessment, development, and implementation of health care plans is found below in Provisions M.2, M.3, and M.5 of the report. Information and recommendations regarding nursing documentation for 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. <u>Staffing:</u> • At the time of the compliance review, the Facility census was 291. The Facility had a total of 116.5 budgeted nursing positions. There were a total of 108.5 filled, of which 59.5 RN, 48 LVN, and one Administrative Assistant positions were filled. A total of eight positions were vacant, for which five RN and three LVN positions were vacant. The Nursing Department continued to maintain a stable and highly dedicated and motivated staff. All Administrative and Management positions were filled. • As found in previous compliance reviews, the Nursing Department's Administrative and Management staff continued to have a robust and effective method of monitoring and analyzing staffing patterns daily, monthly, and longitudinally on each unit/cottage for each shift. This was accomplished by having a dedicated staffing coordinator who reviewed the schedule several times during the day, filling shifts as call-ins occurred and kept the Nurse Managers and other related staff informed. After hour, weekends and holiday shifts were maintained by the RN Shift Managers, who reviewed the schedule and filled open shifts as they occurred. The Nurse Managers and/or Administrative Nurses take rotations and were on call to come in to fill any needs on the campus. The Nursing Department's scheduling, monitoring and analyzing system continued to be exemplary. • 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. The RN Shift Manager/Durable Medical Equipment Nurse was responsible for overseeing the competency of the agency nurses and for providing additional training when required, particularly related to medication administration and efforts to mitigate medication variances. • For the past six months the established staffing ratios were met for all units/cottages and all shifts. The current turnover rate reported for all nursing was 19.8% (unit nurses 25.7% and professional staff 10%) based on the last six months average. According to the Nursing Department's analysis, the reasons for nursing turnover was because of nurses' desire to be closer to home, to return to school, or were terminated. The Nursing Department continued ongoing efforts to recruit,	

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maintain, and evaluate reallocations of nursing positions sufficient to meet the Facility's requirement to provide all aspects of nursing services.

Quality Assurance Activities:
The Monitoring Team verified the Nursing Departments' quality assurance processes through review of the Facility's Self-Assessment quality assurance data presented in Provision M.1's Presentation Book including supporting documentation, Nursing Administration/Management Meeting Minutes, Nursing/QA Nurse Audit Discussion Minutes, Nursing Administration Meetings with Nurse Auditors Meeting Minutes, QA/QI Council Meeting Minutes, Corrective Action Plans, Training Records, and interviews with the CNE, NOO, Program Compliance Nurse, and QA Nurse. The Nursing Department's quality assurance processes were found to be solidly in place as demonstrated below.

Facility's Self-Assessment Quality Assurance Data for Comprehensive Nursing Assessments:
According to the Facility's Self-Assessment's Annual Nursing Assessment quarterly data for August 2013 through January 2014, the chart below shows the percentage of compliance found with auditing/monitoring conducted by nursing auditors and the inter-rater reliability level of agreement found by the QA Nurse:

Nursing Department's Auditing/Monitoring Data

Nursing Audit/Monitoring Tools	August 2013 – October 2013	October 2013- December 2013	January 2014
Annual Nursing Assessment	91%	88%	84%
Infection Control	79%	78%	80%
Seizure Management	76%	69%	61%
Urgent Care/ER/Hospitalizations	78%	80%	75%
Urinary Tract Infections	50%	51%	80%
Acute Care Plans	82%	79%	Not available
Elevated Temperature	83%	100%	N/A
Pre-treatment, Post-sedation	No data	94%	N/A

QA Nurse's Auditing/Monitoring Data

Nursing Audit/ Monitoring Tools *	August 2013	September 2013	October 2013	November 2013	December 2013

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Urgent Care/ER/Hos-pitalizations	79%	96%	88%	96%	100%	
Annual Nursing Assessment	84%	93%	84%	N/A	93%	
Infection Control	94%	97%	94%	100%	97%	
Seizure Management	65%	100%	90%	80%	100%	
Urinary Tract Infections	69%	56%	81%	88%	81%	
Acute Care Plans	80%	100%	100%	100%	100%	
Elevated Temperature**	N/A	N/A	N/A	N/A	N/A	
Pre-treatment, Post-sedation **	N/A	N/A	N/A	N/A	N/A	

*Quarterly data for January, February, and March, 2014 were not yet available for review. These quarters were changed to reflect the state office request for quarterly data results.
**Not enough data available to perform inter-rater reliability checks.

According to the Facility's Self-Assessment, the quarter from August 2013 to October 2013, showed a downward trend in multiple areas that needed improvement. A Corrective Action Plan (CAP) was initiated due to the audits for Urinary Tract Infections (UTIs) was significantly lower than the other monitoring tools. In January 2014, there was an increase in the UTI audit scores. In February 2014, the CAP was amended and continued active. The Seizure Management audits were also trending downward. In February 2014, a CAP was initiated and remained active.

<u>The Monitoring Team's Review of the Quality Assurance Processes:</u>

- The Nursing Department did have a process for completing Nursing Care Monitoring Tools and Nursing Protocol Card Audits, including selection of tools, sample size, frequency monitored, and by whom. The Nursing Department had selected the following tools for monitoring: Elevated Temperature, Seizures, Urinary Tract Infection, Nursing Care Plan, Urgent Care/ER/Hospitalizations, Infection Control, and Annual Nursing Assessments. Other audits included: Medication Administration Records, Medication Room Checklist, and Medication Administration Observations.
- The Nursing Department had instructions/guidelines for completing each of the

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		monitoring/audit tools. The Nursing Department auditors included: Nurse Managers, Program Compliance Nurse, RN Case Manager Supervisor, Hospital Liaison Nurse, Infection Control Nurse, and Nurse Educator/Skin Integrity Nurse. • The Nursing Department and Quality Assurance Department did have processes for conducting inter-rater reliability checks between the Nursing auditors and the QA Nurse auditors at least quarterly for each monitoring/audit tool. • Based on review of at least two recent Corrective Action Plans (CAPs) for Urinary Tract Infections and Seizure Management, the Nursing Department utilized the QA Department's processes for developing and implementing corrective action plans for identified deficiencies for the respective monitoring/auditing tools. • The Nursing Department did have a system to track corrective action plans through to resolution, including a system for evaluating the effectiveness of the corrective action plans. The Nursing Department followed the QA Department's informal process/monitoring to measure the effectiveness of CAPs, which included Benchmark Meetings and Section Lead Meetings. Based on this compliance review, the quality assurance activities showed significant improvement. In order for this requirement to be considered in substantial compliance, the positive practices identified must be maintained over an extended period of time for the next six months and all Nursing Care and Nursing Protocol Audit must attain and be sustained with at least the compliance scores required by the Nursing Department's currently established compliance thresholds over the next six months. <u>Availability of Pertinent Records:</u> The Monitoring Team completed a comprehensive record review for Individuals: #184, #269, #291, #584, #193, #445, #322, #439, #313, #172, and #464 and found: • There was no difficulty in accessing the records onsite. However, some documents requested for offsite review were either not completed or were not copied for review: Those documented included: the most recent Quarterly Physical Assessment for Individuals #193 and 584, and the Integrated Risk Rating Form for Individual #584. • As reported in previous compliance reviews, individuals' names and demographic information printed on the records by the use of an addressograph card/machine were virtually illegible. • The legibility for most of the nursing documentation showed some improvement but the signatures were not consistently legible. • Random review of units found the All About Me Books contained Direct Support Professional Instruction Sheets. The location of the All About Me Books, Communication Notebooks, and Training Notebooks were readily accessible to the Direct Support Professionals. Interviews with the Direct Support Professionals	

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		showed they knew the location of these books. The individuals' plans that were asked about showed they were knowledgeable of their plans of care. <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 integration of services across disciplines. This was demonstrated through the Monitoring Team's attendance at the Morning Medical Debriefing Meetings, on 4/8/14 and 4/10/14. The meetings followed a structured agenda that included reports on the following items: On-Call Physician, On-Call Psychiatrist, On-Call Psychologist, Individuals in a Hospital, Individuals Sent to Emergency Room, Review of Follow up Items, ISP and IDT Meetings, Missed On and Off Campus Appointments, and Additional Notes. The nursing staff who routinely attended the meetings included the CNE, Hospital Liaison Nurse who provided a report on hospitalized individuals, and the RN Case Manager Supervisor. The RN Case Manager Supervisor was responsible for follow-up with the respective RN Case Managers, particularly for the On-Call-Physician's reports pertinent to overnight emergency room visits, problems, or issues. The Monitoring Team was provided copies of the two meeting minutes for review. The meetings followed the structured agenda and appeared to improve the communication/integration between disciplines and the comprehensiveness of the reports. Since the last compliance review, the NOO had redesigned the Appointment/Consultation Log into one centralized log for more accuracy in scheduling and tracking all appointments and consultations. The process for scheduling and tracking appointments and consultations had improved. The RN Case Managers were responsible for scheduling and entering appointments for their individuals into the Appointment/Consultation Log with oversight from the RN Case Manager Supervisor. The NOO also reviewed the log and addressed any identified concerns with the RN Case Manager Supervisor. Since the last compliance review, it was positive to find that the Shift Nurse Manager/Durable Equipment Coordinator had purchased for the Nursing Department eight GE Carescape Vital Sign machines. There were plans to purchase three or four machines over the next couple of months. In addition, all of the temporal thermometers in the Cottages were upgraded to professional quality grade equipment. The Nursing Department had been assisting the Medical Department with creating two additional treatment rooms in Driscoll and Childress by procuring treatment tables, Electrocardiogram (ECG) machines, and other medical equipment. It is imperative that the nursing and medical staff have professional grade medical equipment to use in order to obtain accurate assessments for vital signs, blood pressures, and ECGs. Additionally, a Central Supply Room was in the process of being set up and equipped	

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		with routine supplies for ready access. The Monitoring Team completed a comprehensive record review for Individuals: #184, #269, #291, #584, #193, #445, #322, #439, #313, #172, and #464 and found Acute Care Plans showed improvement with the incorporation of relevant nursing protocols and in the assessments and documentation in the Integrated Progress Notes. However, when individuals' had acute illnesses/events that did not require the initiation of an Acute Care Plan, but did require short term assessments and documentation of the acute illnesses/events for 24 hours up to 72 hours; the assessments and documentation was not consistently followed through to resolution. For example: • Individual #322 had a history of aspiration pneumonia and respiratory reactive airway disease and was rated at high risk for aspiration and medium risk for respiratory compromise. On 12/29/14 at 1230, the nurse documented that Individual #322 had a mild cough and clear nasal drainage. Individual #322 was assessed according to the respiratory distress/aspiration protocol. The vital signs were within normal limits, lungs were clear, and no distress was noted. The next nursing assessment was documented on 12/30/13 at 0130. Individual #322 was referred to sick call and seen in 12/30/13 at 3:12 p.m. Individual #322 was diagnosed with bronchitis and prescribed Albuterol Nebulizer treatment every eight hours for 72 hours, Dimetapp and Robitussin. There was documentation that treatment was started 12/20/13. The next assessments and documentation were on 12/31/13 at 0030, 1/2/14 at 1330 and 1/5/14 at 1320, when it was documented that the last dose of Dimetapp and Robitussin was given. There was no resolution note regarding the effectiveness of the treatment or if the bronchitis had resolved. Based on Individual's risk conditions for aspiration and respiratory compromise, and the assessments and documentation for this acute illness of bronchitis, the nursing staff did not consistently follow the protocols, and the management of care did not appear adequate to proactively identify and/or prevent respiratory complications. On 1/21/14 at 11:24 a.m., Individual #322 was seen in sick call and diagnosed with conjunctivitis and blepharitis and treated with Tobradex ophthalmic ointment and warm compresses. Orders were written for contact isolation for 24 hours. There was no nursing assessment documented prior to the sick call visit. There was no further nursing documentation until 1/22/14 at 2300, when a nursing assessment was completed for the conjunctivitis and blepharitis and treatment. There were no instructions provided to the DSPs for contact isolation documented. The next nursing documentation regarding the conjunctivitis and blepharitis was on 1/27/14 at 1200, which reported the last dose of Tobradex was administered and tolerated well. The nursing staff did not consistently follow relevant protocols and the management of care did not appear adequate to proactively identify and/or	

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		prevent the spread of infection. The assessment and documentation for Individual #322's care regarding conjunctivitis and blepharitis did not appear adequate. • Individual #584: On 2/21/14 at 1530, the nurse documented that the DSP reported Individual #584 had a red left eye. The nurse documented the assessment of the eyes but no vital signs were taken. Individual #584 was seen by the PCP on 2/21/14 at 1530, was diagnosed with pink eye of the left eye and prescribed Maxitrol eye drops for the left eye three times a day for seven days. The nurse documented an assessment of the eye, administered the initial dose on 2/21/14 at 1700, provided instructions to the DSP to report any discomfort, and reported no adverse reactions to the eye drops. On 2/22/14 at 1800, the nurse documented an assessment of the eyes but no vital signs were taken. The nurse documented that the eye drops were tolerated well, and provided instructions to DSPs to report any discomfort. Neither documentation included infection control precautions. There were no further nursing assessments and documentation provided for review until 3/22/14, which was unrelated to the pink eye diagnosis. Therefore, it was assumed there was no follow-up to managing Individual #584's pink eye problem. The Acute Care Plan for Pink Eye was not initiated until 2/24/14. There was no documentation on the Acute Care Plan that the pink eye was resolved. The assessment and documentation for Individual #584's care regarding pink eye was not adequate. • Individual #184 had an active medical problem for chronic bronchitis and was rated at medium risk for respiratory compromise. On 1/10/14 at 1000, the DSP reported that Individual #184 was coughing up mucous. The nurse completed and documented a respiratory assessment according to the respiratory distress/aspiration protocol. The PCP was notified and gave a telephone order Dimetapp 10 cc now and at 7:00 a.m., 4:00 p.m., and 9:00 p.m. for five days. The nurse's assessment was stated as, "Risk for ineffective airway clearance. The plans stated, "Nurse will continue treatment as ordered." There was no further nursing documentation regarding Individual #184's respiratory status and response to treatment until 1/15/14 at 0735. At that time the DSP reported Individual #184 was coughing. The nurse completed and documented a respiratory assessment according to the Respiratory Distress/Aspiration Protocol. Individual was sent to sick call and was seen by the PCP at 1015. Individual #184 was diagnosed with rhinorrhea and was prescribed nasal saline two drops to each nostril four times a day for five days. There was no further nursing assessment and documentation regarding the status of the rhinorrhea and response to treatment until 1/18/14 at 1700. Thereafter, there were nursing assessments and documentation daily on 1/19/14, and on 1/20/14, when the last dose of nasal saline spray was administered. The nurse documented there was no nasal drainage, nor any coughing noted or reported. However, the assessments were not completed according to the respiratory distress/aspiration protocol. Based on Individual	

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		#184's diagnosis of chronic bronchitis and risk condition for respiratory compromise at least daily assessments according to the respiratory distress/aspiration protocol should have been completed as proactive measures to ensure there were no respiratory complications until the problem was resolved. Refer to Section L, Provision L.1 for additional information regarding nursing assessment and documentation of acute changes in health status. That provision includes reports on cases in which nurses did not notify medical providers of the need for assessment of possible health care issues. • Individual #546 was reported by a direct support professional (DSP) to have developed diarrhea, and the nurse assessed the Individual timely, indicating that the Individual was at risk for "dehydration", and that the Individual would be monitored per diarrhea protocol. There was no further follow-up documentation for the assessment of diarrhea. The individual then went on a home visit, with no notice to the medical provider of the DSP's observation. In addition, there was no documentation of notice to the medical provider of reports from the individual's parent of "drainage from ears" (for which the nurse indicated she would place the individual on the sick call list for the medical provider to assess) and of a rash on feet. • Individual #44 had multiple falls. There was no indication that the medical provider was made aware of the continued falls, and possibility of injury, and no documentation to indicate that assertive measures were taken to assess for possible injury. <u>Review of Urgent Care/ER/Hospitalizations Information:</u> The Monitoring Team verified the Nursing Departments' Urgent Care/ER/Hospitalization compliance with the required Urgent Care/ER/Hospitalizations policy and protocol through review of the Facility's Self-Assessment Urgency Care/ER/Hospitalization data presented in Provision M.1's Presentation Book, Training Records, sample of active records for individuals recently/currently hospitalized with supporting documentation, and interviews with the CNE, NOO, Program Compliance Nurse, and Hospital Liaison Nurse. <u>Training Activities:</u> Refer to Provision M.4 for the number and percentage of nurses' competency-based trained on Management of Acute Illness and Injury and Documentation, Hospitalization, Transfers, and Discharges, and Urgent Care/ER/Hospitalizations Policies, Procedures, Processes, and Protocols. <u>Review of Urgent Care/ER/Hospitalizations Records:</u> Based on review of records for six individuals recently or currently hospitalized and/or transferred to emergency rooms or Long Term Acute Care (LTAC) Facilities for Individuals #29, #395, #35, #87, #95,	

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		and #437, the following was found: • Six of six (100%) records showed that the nursing staff promptly performed a focus and/or complete nursing assessment on individuals displaying signs/symptoms of potential or actual acute illness/injuries prior to the hospitalization based upon relevant nursing protocols. • Five of six (83%) records showed the nursing staff promptly notified the primary care provider of assessment findings for individuals displaying sign/symptoms of potential or actual acute illness/injuries, according to "What to tell the PCP" Protocol and/or other relevant nursing protocols, as applicable. • Six of six (100%) records included documentation that showed nursing staff notified individuals' respective primary care provider (PCP) or the physician on-call was contacted prior to transfers for medical orders and transfer orders for mode of transport (i.e., Emergency Medical Services or facility van), as applicable. • Five of six (83%) records showed that Transfer Forms were sent with individuals to respective receiving hospitals, or LTAC facilities, and/or emergency rooms, as applicable. • Six of six (100%) records showed the Hospital Liaison Nurse completed duties as required for Hospitalization, Transfer and Discharge Policy. • Five of six (83%) records showed documentation for nurse to nurse reports were completed prior to transfer to the receiving hospitals, LTAC facilities and/or emergency rooms, as applicable. • Four of four (100%) records showed nurse to nurse reports were conducted prior to individuals leaving the hospitals, LTAC facilities and/or emergency rooms, as applicable. Two individuals remained in the hospital at the time of the compliance review. • Four of four (100%) records showed documentation that comprehensive nursing assessments were completed within two hours upon individuals' return home and documented on the Post Hospital/ER/LTAC Nursing Assessment forms, and then they were placed in the Integrated Progress Notes section of the records, or as specified in the Facility's Record Guide, as applicable. Two individuals remained in the hospital at the time of the compliance review. • Three of three (100%) discharge records showed documentation upon individuals' return home from hospitals that PNMT Nurse Assessments/Evaluations were completed, as applicable according to policy. • Four of four (100%) records showed documentation that upon return to home from the hospitals that Acute Care Plans and/or Integrated Health Care Plans were developed in alignment with relevant nursing protocols, including documentation that Direct Support Professionals (DSPs) were trained on their section of the plans. Overall 95% compliance was found with the established criterion above, which was relatively consistent with the Facility's Self-Assessment overall Urgent	

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		Care/ER/Hospitalization monitoring data for the past six months. <u>Other Hospital Liaison Nurse Activities:</u> • 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 Hospital Liaison Reports and in the Integrated Progress Notes, along with daily email updates to IMRT members, physicians, and others as appropriate. The Hospital Liaison Nurse was backed-up by the Nurse Educator and by the Campus Shift Nursing Supervisors on weekends/holidays or at other times when Hospital Liaison Nurse or the Nurse Educator were not available. • Continued to attend the Morning Medical Debriefing Meeting and report on hospitalized individuals. The primary care providers (PCP) communicated any needed information with the Hospital Liaison Nurse and followed up with the hospital to obtain the requested information. • Continued to be integrated into the Interdisciplinary Teams (IDTs) meeting for transition and post-hospitalized individuals where input was provided regarding individuals' physical condition and any discharge needs. • Continued to provide the IDTs with communication from hospital staff; assisted with the discharge process by communicating with appropriate IDT members to allow for a smooth transition of individuals back to home; and functioned as a liaison between family members and hospital staff to assist family members understanding of the hospital process. • Continued to serve as a BSSLC team member, which meets collaboratively with Scott and White-Brenham Hospital personnel quarterly and as needed to discuss issues that need attention. BSSLC members included: Medical Director, CNE, NOO, QA Nurse, Infection Control Nurse and Facility Director. The purpose of the collaborative team meetings was to maintain continuity of care for hospitalized individuals. In February 2014, the team met and discussed sending individuals back to the Facility after 3:00 p.m., consents, and medication for individuals that the hospital pharmacy did not carry. • Continued to enter hospitalization data into the AVATAR system. The data included the reason and dates of admission, discharge, and discharge diagnoses. • Continued to serve as a backup to the PNMT Nurse to complete PNMT Nurse Post-Hospitalization Assessments/Evaluations. • Continued to maintain the Hospital and Emergency Room Visit Tracking Log that included verification of documentation for PNMT Nurse Post-Hospitalization Assessment/Evaluation, Hospital Liaison Report, and ISPA meeting date. • Coordinated the use of agency sitters for out of town hospitalizations, as needed. Based on the Monitoring Team's independent review, if this were a standalone	

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		requirement it would be considered in substantial compliance. Review of Infection Control Information: The Monitoring Team verified the Infection Control information presented in the Facility's Self-Assessment through: Review of the Infection Control information presented in the Section M Presentation book for Provision M.1 along with supporting documentation, which included the following: Infection Control Committee Meeting Minutes Nursing Administration/Management Meeting Minutes, Nursing/QA Nurse Audit Discussion Minutes, Nursing Administration Meetings with Nurse Auditors Meeting Minutes, QA/QI Council Meeting Minutes, Corrective Action Plans, Infection Control Training Records, Infection Control monitoring/auditing data including trend analyses, corrective action plans, and evaluation of effectiveness as indicated for: Infection Nursing Care Plans, Real Time Infection Control Audits, Environmental Round, Handwashing and Standard Precautions, and Corrective Action Plans. Reviewed the Immunization Database. Reviewed new/revised Infection Control policies, procedures, processes, and protocols. Reviewed the Infection Control Infection By Type Database. Reviewed a sample of active records for individuals who had recent or current infections. Conducted interviews with the CNE, NOO, Program Compliance Nurse, and Infection Control Nurses. The Infection Control Program was found to be robust and solidly in place as demonstrated below. New/Revised Infection Control Related Policies, Procedures, Protocols, and Guidelines: • BSSLC Policy W.10, Residential Services, Meal Time Services, 12/1/13 • BSSLC Policy M.4, Isolation, 4/1/14 Infection Control Training: • Infection Control Prevention and Practice Procedures were taught by the Infection Control Nurses during New Employee Orientation and at annual refresher training. According to the CTD Course Due/Delinquent List 11 employees were due/delinquent in annual infection control refresher training. • On April 1, 2014, the Infection Control Nurse provided retraining on Handwashing Procedures to the Driscoll C staff due to an outbreak of conjunctivitis. • Infection Control Nurses' Continuing Education Training attended by one or both Infection Control Nurses: o Healthcare Associated Infections Project, Antibiotics, the Environment and Clostridium difficile, March 12, 2014, Sponsored by Texas QIO Webinar o Influenza: Nothing to Sneeze At (57), February 28,2014, Sponsored by Merion Matters, Inc., King of Prussia, PA o Chronic Hepatitis B Virus Infection: Advancing Care, Changing Lives, January 1, 2014, Sponsored by CME Outfitters, Rockville, MD	

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		o Targeted Therapy for Hereditary Angioedema, January 30, 2014, Sponsored by OptumHealth Education, Minneapolis, MN o The Impact of Childhood Trauma and Violence on Physical Health Comorbidities, January 27, 2014, Sponsored by OptumHealth Education, Minneapolis, MN o Health Literacy: The Importance of Effective Patient Communication (20th Annual National Conference), Sponsored by OptumHealth Education, Minneapolis, MN o Expert Review: Best Practices in Managing the Indwelling Catheter, March 28, 2014, Sponsored by Saxe Communications, Burlington, VT o Oral Care in ICU: Don't Forget to Brush, Preventing Hospital-acquired Catheter-Associated Urinary Tract Infections: Case Study, March 29, 2014, Sponsored by Saxe Communications, Burlington, VT o ELC Epidemiology Workshop, March 4-5, 2014, o Guidelines for Investigation and Control of Invasive, Respiratory, Foodborne, and Vaccine-Preventable o Disease, January 2014, Sponsored by Texas Department of State Health Services, Infection Disease Control Unit and Emerging and Acute Infection Disease Branch o NDNQI Pressure Ulcer Training IV, March 19, 2014, Sponsored by the American Nurses Association, Silver Spring, MD o Dementia Care: Taking Texas to the Next Level, October 15, 2013, Sponsored by TMF Health Quality Institute, Houston, TX Refer to Provision M.4 for details of additional training <u>Infection Control Activities:</u> Information Regarding Immunizations: Based on information provided on tracking and responding to infectious and communicable diseases: • The Facility did maintain an up-to-date Immunization Database for tracking individuals' immunization status, including a retroactive review of immunizations. • Based on the data provided 98.7% of the individuals were current with seasonal influenza vaccinations, or appropriate declinations were signed. Two individuals' families declined the vaccinations because they were allergic to eggs. Influenza vaccine designed to protect individuals 65 years and older was administered to 23 individuals. • Based on the data provided 51% of the employees were current with seasonal influenza vaccinations, or appropriate declinations were signed. This total was a combination of all influenza vaccinations administered by the BSSLC staff and influenza vaccination employees obtained from their primary care physician, local	

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		clinics or pharmacies. The Facility was able to capture this information on the Declination for Flu Vaccination Forms implemented for the Flu Season 2013-2014. Influenza vaccination was not a mandatory requirement to work at the Facility. It was offered as a job benefit to employees who wish to receive it. • Based on the data provided 98.9% of the individuals were current with annual Tuberculosis (TB) screenings or appropriate declinations were signed. There were three new admissions to the Facility that had not received their TB screenings. For two newly admitted individuals there had been difficulty obtaining the screening information from the previous provider. Another newly admitted individual had been uncooperative in receiving the screening but the staff continued to ask the individual when he would like to take it by giving a choice on when it was to be administered. • Based on the data provided 99.2% of the employees were current with annual Tuberculosis (TB) screenings or had completed follow-up for converted skin tests. • Based on the data provided the percentage of individuals who had received the Hepatitis B Vaccine Series or who had Hepatitis Antibody Titers was not specifically indicated. However, individuals' Hepatitis B status were reported in the Immunization Database. • Based on the data provided the percentage of new employees that declined the Hepatitis B vaccine series was approximately 1-2%. Receiving the Hepatitis B vaccine series was not a mandatory requirement to work at the Facility. It was offered as a job benefit to employees who wish to receive it. Employees sign the Declination Vaccination Form that they have not had the Hepatitis B vaccine series and do not want it. Information Regarding Tracking and Responding to Infectious Illnesses and Communicable Diseases: • The Facility did use infection data as well as monitoring/audit data to identify local, systemic, and longitudinal infectious illness and communicable disease trends. On a monthly bases Infectious illnesses and communicable disease data were tracked, analyzed, trended and reported. • When trends were identified in the six months preceding the onsite compliance review: o The Facility did implement corrective actions to prevent/eliminate/reduce incidences of identified infectious illnesses and communicable diseases. o The Facility did follow up to ensure corrective actions were followed through to resolution. o The Facility did evaluate corrective actions for effectiveness. • The Facility did promptly identify local and systemic sporadic outbreaks of infectious illnesses and communicable diseases. • When/if trends were identified with regard to sporadic outbreaks of infections	

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		illnesses and communicable diseases in the six months preceding the onsite compliance review: o The Facility did immediately respond with corrective actions to prevent/eliminate/reduce the outbreaks. o The Facility did follow up to ensure corrective actions were followed through to resolution. o The Facility did evaluate corrective actions for effectiveness. Information Regarding Infection Control Committee: • The Infection Control Committee Meetings did have attendance of core membership. According to Infection Control Guidelines the required core membership included: Administration Representative, Nursing Representative, Medical Director, and Infection Control Nurse. Ad hoc members include: Food Service, Maintenance, House Keeping, Laundry Services, Clinical Services, and Residential Services. The Infection Control Nurse chaired the meeting. • Since the last compliance review, the Infection Control Committee did conduct the quarterly scheduled meeting. • The Infection Control Committee did have a structure format/agenda for conducting the meetings. • The Facility did use a generally accepted standardized method for tracking, analyzing, and trending infectious and communicable disease data. For example, a review of the past two quarters' Infection Control Committee Meeting minutes showed that infectious illnesses and communicable diseases data analyses and trending reports were presented by the Infection Control Nurse for review, discussion, and disposition. In addition, the November 2013 minutes included a review and discussion of the new Mealtime Management Policy, effective December 2013, from residential services and how it related to infection control issues. This policy was sent out for review by all nurses and Direct Support Professionals. The Infection Control Nurse was now a nursing representative at the monthly Physical Nutritional Management Team (PNMT) meetings. Information Regarding Infection Control Checklists: Based on review of the Facility's infection control checklists for the past six months: • Environmental Surveillance Rounds and Reports were completed quarterly campus-wide. • Based on the findings from the Environmental Surveillance Reports, the Facility did utilize the findings to develop and implement corrective action plans for identified deficiencies. • Handwashing and Standard Precaution Observation and Reports were completed monthly and during New Employee Orientation. • Based on the findings from the Handwashing and Standard Precaution Reports, the Facility did utilize the findings to develop and implement corrective action plans for	

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		identified deficiencies. Information Regarding Antibiogram/Epidemiology Reports: Based on the information provided on Antibiogram/Epidemiology Reports between February 2013 and February 2014: • Documentation show the Infection Control Nurse did prepare an annual Antibiogram/Epidemiology Report based on the State Laboratory and/or local hospital Epidemiology Reports and the monthly Pharmacy's reports of antibiotics prescribed to assess the effectiveness of the antibiotics prescribed for the respective infectious organisms. • Documentation did show monthly Antibiogram/Epidemiology Reports were submitted to the medical and Pharmacy and Therapeutic Committee. Information Regarding "Real Time" Infection Control Reporting/Auditing: Based information provided on "Real Time" reporting and auditing of infectious and communicable diseases over the last six months: • The Facility did have "Real Time" reporting and auditing of infectious and communicable disease for reviewing care plans developed for infectious and communicable diseases as well as interventions to ensure individuals had care provided consistent with relevant nursing protocols. For example, the Infection Control Nurse cross checked the daily/weekly Pharmacy WORx's list of antibiotics prescribed with the "Real Time" Infection Control Reports, as well as with the Infection Control data entered into AVATAR. Conducted daily, weekly and monthly "Real Time" Infection Control audits. The RN Case Manager Supervisor was notified of any discrepancies identified for correction. • Based on a review of a sample of individuals with recent and/or current infections "Real Time" Audits, six of nine (67%) audits were completed, which resulted in accurate identification and reporting of infectious and communicable diseases. When deficiencies were identified on the "Real Time" Audits there were recommendations on the audit forms for corrective action that were submitted to the respective Nurse Managers to carry out. Refer to Provision M.3 for information for reports on a sample of individuals reviewed with recent and/or current infectious and communicable diseases. Based on the compliance review, the Infection Control Program continued to be well organized, managed, and met the generally accepted standards of infection control for long term care facilities. If the Infection Control Program for this Provision if this were a standalone requirement it would be considered in substantial compliance. <u>Review of Skin Integrity Information:</u> The Monitoring Team verified the Skin Integrity information presented in the Facility's Self-Assessment through: Review of information presented in Provision M.1 of the	

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		Presentation Book along with supporting documentation, which included the following: Nursing Administration/Management Meeting Minutes, Nursing/QA Nurse Audit Discussion Minutes, Nursing Administration Meetings with Nurse Auditors Meeting Minutes, QA/QI Council Meeting Minutes, Skin Integrity Committee Meeting Minutes, and Physical Nutritional Management Team Meeting Minutes including any Corrective Action Plans. Skin Integrity Training Records. Skin Integrity monitoring/auditing data including trend analyses, corrective action plans, and evaluation of effectiveness as indicated for: Skin Integrity Nursing Care Plans, and Corrective Action Plans. Reviewed the Skin Integrity Database. Reviewed new/revised Skin Integrity policies, procedures, processes, and protocols. Reviewed a sample of active records for individuals who had recent or current skin integrity issues. Conducted interviews with the CNE, NOO, Program Compliance Nurse, and Nurse Educator/Skin Integrity Nurse. Relevant Self-Assessment data were updated during the onsite compliance visit. The Skin Integrity management system was found to be robust with significant improvement since the last compliance review, as demonstrated below. <u>New/Revised Skin Integrity Related Policies, Procedures, Protocols, and Guidelines:</u> There were no new or revised skin integrity related policies, procedures, protocols, and guidelines. <u>Skin Integrity Training:</u> • During the Annual Competency Fair in March 18-19, 2014, 95% of RNs and LVNs were trained on the American Nurses Association Sponsored Continuing Education Activity Entitled NDNQI Pressure Ulcer Training IV. At the time of the compliance review the Nursing Administration reported that 100% had received this training. This training was included in New Nurse Orientation. • The Nurse Educator/Skin Integrity Nurse created a poster board that reviews skin integrity information, as well as urinary tract infections. This poster board described how to prevent both issues. The poster board was posted in the homes in a central location, for a week at a time, for staff to review. • The Nurse Educator/Skin Integrity Nurse created a colorful pamphlet entitled "Prevent Pressure Ulcers." This pamphlet reviewed what a pressure ulcer is, who is at risk, where pressures begin, and how to prevent them. These pamphlets were placed throughout the campus for staff to read. • The Nurse Educator continued to create and publish the BSSLC Nurse Newsletter. The newsletter encompassed multiple interdisciplinary areas, including risks. The newsletter had input from the CNE, Pharmacy Director, and Medical Director. Refer to Provision M.4 for additional training information. <u>Skin Integrity Activities:</u>	

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		Review of Skin Integrity Records: Based on review of records and observations for four individuals with recent or current skin integrity issues for Individuals #332, #517, #88 and #96, findings included: • Four of four (100%) records included documentation that acute changes for skin integrity conditions were promptly assessed and thoroughly describes as to location, appearance, size/depth, and pain status, as well as underlying causes. • Four of four (100%) records included documentation that acute changes in status for skin integrity conditions were promptly reported to the respective primary care provided, and when indicated, referred to the Skin Integrity Nurse and/or PNMT. • Four of four (100%) records included documentation of development and implementation of individualized Acute Skin Integrity Care Plans sufficient to meet individuals' skin integrity needs, including incorporation of relevant nursing protocols; primary care provider orders/wound care orders when applicable, and staff training. • Four of four (100%) records included documentation that the Acute Skin Integrity Care Plans were consistently carried out according to the plans. • One of one (100%) record included documentation that Acute Skin Integrity Care Plans were followed through to resolution, as applicable. Two individuals' skin integrity issues were not resolved. Individual #332 was admitted to the hospital on 2/9/14 due to a deteriorating pressure ulcer on the right ischial tuberosity and fever. Individual #332 remained hospitalized at the time of the compliance review. • Two of two (100%) records included documentation that individuals who were at risk for chronic skin integrity condition also had Integrated Health Care Plans sufficient to meet skin integrity needs. There was documentation that the Direct Support Professionals were trained on their plans. During the onsite compliance review, the Monitoring Team, accompanied by the CNE, NOO, Program Compliance Nurse, Shift Supervisor, Nurse Manager, and RN Case Managers, observed dressing changes, treatments, and status of wound healing for Individuals #332, #517, and #96. Correct clean techniques were followed for changing dressings to wounds and treatments were applied according to wound care orders. All three individuals were positioned according to their PNMPs and their prescribed pressure relief devices were in place. After the observations, proper disposal of biohazard waste was discussed with the nursing staff in attendance. The Monitoring Team was provided with a copy of the Infection Control Policy, Section 4: Disposal of Regulated Biohazard Waste. Even though the policy did not specifically include the disposal of dirty dressings, the nursing staff were cautioned to ensure that dirty dressing may contain infectious drainage/blood were and should be properly disposed. Individual #332 was not observed because he was still hospitalized for a deteriorating pressure ulcer on the right ischial tuberosity.	

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		Information regarding Skin Integrity Committee and Physical Nutritional Management Team (PNMT) Meetings: Review of Skin Integrity Committee and PNMT Meeting minutes the Facility provided for the past six months showed: • The Facility did have a Skin Integrity Committee and PNMT Meetings that addressed incidence of skin integrity issues/pressure and non-pressure ulcers. o The Skin Integrity Committee did have consistent attendance of the integrated core membership, with rare exception. Core membership consisted of: Skin Integrity Nurse, Chair, CNE, NOO, Medical Director or designee, RN Case Manager Supervisor, Habilitation Therapy Representative, PNMT Nurse, QA Nurse, Nurse Managers, Psychology Representative, Qualified Intellectual Disability Professional (QIDP) Representative, Direct Support Professional Supervisor, and Dietitian. Refer to Section O for status of PNMT Meeting attendance. o The Skin Integrity Committee did have a structure format/agenda for conducting the meetings. o Since the last compliance review, the Skin Integrity Committee consistently met quarterly as scheduled. • The Nursing Department/Skin Integrity Nurse did analyze and trend skin integrity issues/pressure and non-pressure ulcers data monthly/quarterly and longitudinally to identify local and systemic trends. • The Facility did maintain a tracking system/database for tracking skin integrity issues/pressure and non-pressure ulcers, including data for Facility and hospital/LTAC acquired. For example, refer to the Decubitus Report below for data from September 2013 through February 2014: Decubitus Report Note: Number of pressure ulcers acquired was new for the respective month reported.	

Month	Sept 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014
Number of Individuals with Pressure Ulcers newly identified during the Month	8	8	9	5	3
Number of Active Pressure Ulcers acquired in the Facility	13	11	13	10	4
Number of Active Pressure Ulcers acquired outside the Facility	1	11	8	0	1
Number of Pressure Ulcers – Stage I	0	2	0	0	0

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Number of Pressure Ulcers – Stage II	13	16	17	8	5		2
Number of Pressure Ulcers – Stage III	0	0	0	0	0		1
Number of Pressure Ulcers – Stage IV	1	2	2	0	0		0
Number of Pressure Ulcers - Unstageable	0	2	1	1	0		0
Number of Pressure Ulcers – Suspected Deep Tissue Injury	0	0	1	1	0		0

*March 2014 data was not yet available.

The above skin integrity issues/pressure and non-pressure ulcers data showed a significant decline over the past six months. The supporting documentation provided the Monitoring Team showed the Nurse Educator/Skin Integrity Nurse worked collaboratively with all relevant Facility disciplines, including the integrated Skin Integrity Committee and PNMT members, as well as with local hospitals and LTACs. The documents reviewed showed significant efforts had been put forth to reduce/prevent the incidences of skin integrity issues/pressure and non-pressure ulcers. These efforts appeared to be effective. At the time of the compliance review, there were two individuals with active pressure ulcers.

- Skin integrity data were presented at the Skin Integrity Committee and PNMT Meetings for review, discussion, and development and implementation of corrective action plans for identified trends to reduce/eliminate the incidences of skin integrity issues/pressure ulcers and non-pressure ulcers locally and systemically. The Skin Integrity Nurse presented skin integrity data to the PNMT Meetings on the second week of the monthly meetings.
- The Nursing Department/Skin Integrity Nurse did track skin integrity issues/pressure ulcers and non-pressure ulcers corrective action plans through to resolution, when indicated.
- The Skin Integrity Committee and PNMT Meetings did evaluate skin integrity issues/pressure ulcers and non-pressure ulcers corrective action plans for effectiveness.

Based on this compliance review, the management of skin integrity showed significant improvement. Based on the Monitoring Team's independent review, if this was a standalone requirement, it would be considered in substantial compliance. The Skin Integrity Nurse should continue positive practices identified in the report and continued to make improvements when needed by working collaboratively with the Skin Integrity and PNMT Committees and IDTs to reduce/prevent the incidences pressure ulcers. The

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
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Facility should adopt a zero tolerance policy for the incidence of pressure ulcers.

<u>Emergency Response System Information:</u>
The Monitoring Team verified the Emergency Response information presented in the Facility's Self-Assessment through: Review of the Emergency Response information presented in Provision M.1 of the Section M Presentation book along with supporting documentation, review of Emergency Response Committee Meeting Minutes, Incident Management Review Team Meeting Minutes, and other related documents and observations.

<u>New/Revised Emergency Response System Policies and Procedures:</u> There were no new or revised emergency response policies and procedures.

<u>Emergency Response System Training:</u>
• Of the six CPR Drill instructors, 100% successfully completed competency-based training on the CPR Instructor's Manual.
• According to the CTD Course Due/Delinquent list, printed on 3/11/14, for CPR Basic, one employee was due. This was a former employee who was rehired and was in New Employee Orientation at the time the list was printed. There were no due/delinquent employees for CPR for Healthcare Providers.

<u>Emergency Response System Activities:</u> Based on information provided on Mock Medical Emergency Drill data for the past six months:
• The Facility did maintain a formal schedule for conducting Mock Medical Emergency Drills, according to policy.
• Since the last compliance review, the monthly Mock Medical Emergency Drills data, August 2013 through January 2014 showed:
<table>
<tr><td>Aug-Sept-Oct 2013</td><td>Overall Compliance</td><td>Nov-Dec-Jan</td><td>Overall Compliance</td></tr>
<tr><td>Scheduled</td><td>27</td><td>Scheduled</td><td>27</td></tr>
<tr><td>Completed</td><td>26</td><td>Scheduled</td><td>27</td></tr>
<tr><td>Passed</td><td>26</td><td>Passed</td><td>27</td></tr>
<tr><td>Percent Passed</td><td>100%</td><td>Percent Passed</td><td>100%</td></tr>
<tr><td>Percentage Completed</td><td>96%</td><td>Percentage Completed</td><td>100%</td></tr>
</table>
*February 2014 and March 2014 data were not yet available.
• The drills did include a variety of scenarios. During the onsite compliance review, the Monitoring Team observed an impromptu Mock Medical Emergency Drill conducted in the Fannin C bathroom on the 2-10 shift. The nurses, direct support professionals, and psychology staff in the home immediately and appropriately
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#	Provision	Assessment of Status	Compliance
		responded to the drill and passed the drill successfully. • A system was in place to track the completion of corrective actions taken to address failed drills. For example, the Nursing Department maintained a monthly CPR Mock Drill Database that summarized the outcome of each drill completed, which included corrective actions needed, the date the trained was completed and by whom. The QA Director provided oversight for the drills. A review of the CPR Mock Drill Database, September 2013 through January 2014, showed no failed drills. Occasionally, the database indicated that staff were prompted on-the-spot on components of the drill that needed improvement. The results of the monthly drills were reported to the Incident Management Review Team for review and further disposition, if indicated. • The Facility did have an adequate system to document actual emergencies. • The Facility's Risk Manager or designated staff did review actual emergency event data. For example, a review of the 9/16/13 CPR/Emergency Response Committee showed a special meeting was conducted for an actual medical emergency event that required CPR and the use of the AED. The committee reviewed the AED strip and video of the event. After review of this information the committee made recommendations for corrective actions, which included retraining the direct support professionals to stay with the nurse to assist with moving the individual from the chair to the floor and to check with the manufacturer of the AED to see if the internal clock could be adjusted to match the video recordings. All evidence of the corrective actions was submitted to the CPR/Emergency Response Committee for further review, discussion and disposition, as indicated. • The Facility did track and analyze monthly and quarterly Mock Medical Emergency Drill data and submitted the information to the QA Department. This information was reported to the QA/QI Council. • The Facility did have an Emergency Response Committee that met quarterly as scheduled. Since the last compliance review, 100% of the quarterly scheduled Emergency Response Committee meetings were held. o The Emergency Response Committee was comprised of an integrated core membership. The core membership was comprised of: The CNE, chair, Medical Director or designee, QA nurse, Risk Manager, Nurse Managers, CTD Representative, QA Director, Shift Nurse Supervisor/Durable Medical Equipment Coordinator, Residential Services Representative, and others as needed. o Of the core membership, 100% attended CPR Emergency Response Committee Meetings. o Emergency Response Committee meeting minutes did show the Committee reviewed and discussed Mock Medical Emergency Drill reports, analyzed up-to-date data related to both drills and actual emergencies, availability	

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		and function of emergency equipment, compliance with completing the various emergency checklists, related corrective action plans, if any, as well as other issues pertaining to emergency response, and made substantive recommendation for improvements. o When the Committee developed local and/or systemic corrective actions, the Facility's Risk Manager or designee did follow them through to resolution. Regarding to emergency medical equipment: • Based on a list the Facility provided, 100% of the residential and/or other areas on campus where individuals were provided supports had AEDs and emergency equipment readily accessible to staff. • Based on the Monitoring Team's observations, the Facility did have the emergency equipment and AEDs throughout the campus in designated areas with it stored securely and readily accessible for use. • Based on the Monitoring Team's observations, the Facility did have visible signs posted throughout the campus to indicate where the emergency equipment and AEDs were located. • Based on the Monitoring Team's observations of nursing staff demonstrating emergency equipment checks 100% of nursing staff were familiar with the use and operation of the emergency equipment. • Based on the Monitoring Team's observations of emergency equipment and AEDs in residential and/or other areas on campus, 100% were available and in good working order. • Based on the Monitoring Team's observations emergency equipment and AEDs located in residential and/or other areas on campus the Monthly Walkthough Emergency Equipment and AED Checklists completed by the Risk Manager or designee showed 100% were completed for the month to date. • Based on the Monitoring Team's review of the emergency equipment and AEDs located in residential and/or other areas on campus showed 100% of the Emergency Equipment and AED Checklists were completed daily by designated nurses. Monthly the Unit Nurse Managers reviewed the checklists to ensure they were completed daily and the required emergency equipment was present and in good working order. The Facility's Emergency Equipment and AED Checklist Summary data, August 2013 through January 2014, showed the monthly percentage of compliance for checking the emergency equipment and AEDs daily, was well as documentation that monthly corrective actions were taken by the respective Unit Nurse Manager for identified deficiencies: Emergency Equipment and AED Checklist Data August | September | October | November | December | January	

#	Provision	Assessment of Status	Compliance
		<table><tr><td>2013</td><td>2013</td><td>2013</td><td>2013</td><td>2013</td><td>2014</td></tr><tr><td>99%</td><td>98.1%</td><td>98.7%</td><td>99.7%</td><td>98.5%</td><td>97.3%</td></tr></table> *February 2014 and March 2014 data were not yet available. Based on this compliance review, the emergency response system continued to meet the requirements of this Provision. If this requirement were a standalone requirement it would be considered in substantial compliance. The Facility stated they were in substantial compliance with this Provision. Based on the Monitoring Teams independent review, this Provision was not found in substantial compliance. In order for this Provision to be found in substantial compliance all requirements of this Provision must meet substantial compliance. If the Hospital Liaison Activities, Infection Control Program, and Emergency Response System were standalone requirements they would be considered in substantial compliance. Significant progress was found in the Skin Integrity Management System and if the positive practices are maintained substantial compliance should be achieved in the near future. While improvement was found in Assessments and Documentation of Acute Changes there remained the need for continuous improvement in assessing and documenting acute illnesses/events that do not require the initiation of Acute Care Plans.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	<u>Monitoring Team Findings:</u> The Monitoring Team verified the Nursing Assessment information presented in the Facility's Self-Assessment through: Review of the Nursing Assessment information presented in Provision M.2's Presentation Book along with supporting documentation; meetings/interviews with CNE, NOO, Program Compliance Nurse, and RN Case Manager Supervisor; review of Nursing Administration/Managers Meeting Minutes, and review of active 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. <u>New/Revised Policies, Procedures, Processes, and Protocols:</u> • DADS SSLC Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment, January 2014 <u>RN Case Managers Training:</u> Nursing Administration/Management reported that all RN Case Managers had been trained on the revised Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment, January 2014. Refer to Provision M.4 for report of additional training for RN Case Managers.	Substantial Compliance

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		Facility's Self-Assessment Quality Assurance Data for Comprehensive Nursing Assessments: According to the Facility's Self-Assessment's Annual Nursing Assessment quarterly data for August 2013 through January 2014, the chart below shows the percentage of compliance found with auditing/monitoring conducted by nursing auditors and the inter-rater reliability level of agreement found by the QA Nurse:	

Nursing Department's Auditing/Monitoring Data

Nursing Audit/Monitoring Tools	August 2013 – October 2013	October 2013-December 2013	January 2014
Annual Nursing Assessment	91%	88%	84%

QA Nurse's Auditing/Monitoring Data

Nursing Audit/ Monitor-ing Tools	August 2013	September 2013	October 2013	November 2013	December 2013
Annual Nursing Assess-ment	84%	93%	84%	N/A	93%

*Quarterly data for January, February, and March, 2014 were not yet available for review.

The Monitoring Team's Review of Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment:
Since the last compliance review, the DADS SSLC Guidelines for Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment and Forms was revised in January 2014. Although the revised forms contained essentially the same assessment items, the revisions included a section for Community Living Discharge Planning information, the date column in the pre-medication section was corrected, corrected the "do/do not" in Section VII, and added more lines to several sections to accommodate additional documentation. The Nursing Department had fully implemented the revised Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment forms.

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		During the compliance review, the Monitoring Team met with a representative RN Case Manager from each unit, accompanied by the CNE, NOO, and Program Compliance Nurse. Selected records were reviewed for individuals with recent or currently active Acute Care Plans. The Monitoring Team also generally discussed the completion of admission, annual, and quarterly nursing assessments using the Comprehensive Nursing Reviews/Quarterly Nursing Record Reviews/Quarterly Physical Assessments revised in January 2014. The Monitoring Team stressed the importance of ensuring that each individual's high and medium risk ratings that required nursing interventions were thoroughly assessed and that each risk rating was summarized sufficiently to indicate whether the health status was improving, maintaining or improving, as well as the progress/effectiveness of each Integrated Health Care Plan. The Monitoring Team further stressed the importance for Nursing Administration to ensure that the nursing assessments requested onsite for review offsite contained the Nursing Physical Assessment required to be completed along with the annual, admission Comprehensive Nursing Review and with the Quarterly Nursing Record Review. When Nursing Physical Assessments are not provided, the accuracy of the nursing assessments cannot be determined. Since the last compliance review, the Nursing Department had continued to make improvements in the following areas: • The RN Case Manager Supervisor, along with the Nurse Educator, audited 14 quarterly/annual nursing assessments for timeliness, quality, accuracy, and completeness. These audits were sent to the NOO for review, and then forwarded to the QA Department for tracking and trending. • The NOO created a spreadsheet to track all quarterly and annual ISP dates. This was to ensure that the RN Case Managers were completing their assessments timely. Follow-up was completed on an individual basis with the respective RN Case Managers by the RN Case Manager Supervisor, if needed. • The Program Compliance Nurse created an Admission Checklist for Nursing. This checklist included the physical assessment, care plans, if necessary, immunizations, and TB screening status. Once the checklist was completed it was sent to the RN Case Manager Supervisor for review and follow-up. • A Nursing Admission Summary was created and implemented to use for all newly admitted individuals. Summaries were reviewed by the RN Case Manager Supervisor who evaluated the admission nursing assessments for completion and accuracy, and took corrective action as needed.	

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		• A Nursing Discharge Summary spreadsheet was created and implemented to indicate the date of discharge, whether nursing discharge summaries were completed, by responsible RN Case Manager, and for follow-up information. This spreadsheet was used by the RN Case Manager Supervisor. • The RN Case Manager Supervisor, Program Compliance Nurse, and CNE met monthly, at a minimum, to discuss action plan steps and progress related to the Settlement Agreement. • The QIDP team sends out weekly reminders when assessments were due for the ISPs. The NOO created a spreadsheet to track annual and quarterly nursing assessments, as well as ISP due dates, that was used for follow up with the appropriate RN Case Manager if the deadline was not met. This information was shared with the RN Case Manager Supervisor. The Monitoring Team reviewed a sample of the 11 most recently completed Admission, Annual Comprehensive Nursing Assessments and/or Quarterly Nursing Record Reviews/Quarterly Physical Assessments selected from the Facility's At Risk List for individuals identified at high/medium risk health conditions and from each unit for Individuals #184, #269, #291, #584, #193, #445, #322, #439, #313, #172, and #464. The 11 Admission/Annual Comprehensive Nursing Assessments and/or Quarterly Nursing Record Reviews/Quarterly Physical Assessments were reviewed using a monitoring tool comparable to the tool used by the Facility, which included the requirements in the revised Guidelines: Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment found significant improvement in the timeliness of completion: • Three of three (100%) Admission Comprehensive Nursing Assessments were completed within 30 days of admission. • Five of five (100%) Annual Comprehensive Nursing Assessments were completed 10 working days prior to the date of the ISP meetings. • Three of three (100%) Quarterly Nursing Record Reviews/Quarterly Physical Assessments were completed by the last day of the month in which the quarterly nursing assessment was due. According to the monitoring tool used by the Monitoring Team, an overall compliance scored of 89% was achieved. Two individuals' records requested to review offsite did not include copies of the Nursing Physical Assessments. Individual #193's Annual Comprehensive Nursing Review completed on 12/20/13, did not have a copy of the	

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		Quarterly Physical Assessment. Individual #584's Quarterly Nursing Record Review did not have a copy the Quarterly Physical Assessment. Consequently, this missing information reduced the overall compliance score. Since the Quarterly Physical Assessment records were not provided, it was assumed that they were not completed. When these two nursing assessments were eliminated from the data analysis, the remaining nursing assessment data showed an overall 95% compliance score. The nursing assessment data showed improvement in the overall compliance as compared to the nursing assessment quality assurance data reported to the Facility Self-Assessment. However, the Facility's Self-Assessment data did not include the overall compliance scores for the quarter of January, February, and March 2014. Since the Comprehensive Nursing Review/ Quarterly Nursing Record Review/Quarterly Physical Assessments guidelines and forms were revised, there was evidence that improvements were made, as reported above, which may have contributed to the overall compliance scores found by the Monitoring Team. <u>Nursing Discharge Summaries and accompanying Community Living Discharge Planning Packets:</u> The Monitoring Team reviewed three recent Nursing Discharge Summaries and accompanying Discharge Packets for Individuals #52, #303, and #468, who were recently discharged into community living. Since the last compliance review, the Comprehensive Nursing Review/Quarterly Nursing Record Review/Quarterly Physical Assessment guidelines and form were revised to also be used for Community Living Discharge Planning and the former Nursing Discharge Summary form was discontinued. Consequently, some of the nursing assessments and summaries were completed on both of the forms. The review found continued improvement in completing the required nursing assessments and discharge summaries, with the supporting documentation contained in the Community Living Discharge Planning Packets: Findings included: • Three of three (100%) Nursing Discharge Summaries were completed within 45 days prior to individuals' move into community living. • Three of three (100%) Nursing Discharge Summaries included individuals' assessments, clinical services' needs, and health status in relation to each significant identified health clinical indicator, such that the receiving agency could understand their present health status in order to respond to their health care needs. • Three of three (100%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' preferences. • Three of three (100%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' Special Instructions.	

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		• Three of three (100%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' medications. • Three of three (100%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' Immunization Records • Three of three (100%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' MOSES/DISCUS, as applicable. • Three of three (100%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' IRRF. • Three of three (100%) Nursing Discharge Summaries and Discharge Packets contained documentation regarding review/training provided to the group home nurses on individuals' IHCP and/or other related health care plans, as needed. • Three of three (100%) Discharge Packets contained documentation that review/training provided to the group home nurses on individuals' DSP Instruction Sheets This Provision continued to meet substantial compliance. The positive practices found must be maintained, with a need to continue to demonstrate effective steps over time to make improvements when needed, particularly as related to ensuring that individuals' identified high and medium risk ratings requiring nursing intervention were sufficiently summarized to demonstrate their progress toward established goals and the effectiveness of health care plans, as well as ensuring that Nursing Physical Assessments are completed along with the Comprehensive Nursing Assessments and/or Quarterly Nursing Record Reviews.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated	<u>Monitoring Team's Findings:</u> The Monitoring Team verified the nursing care planning information presented in the Facility's Self-Assessment through: Review of the nursing care planning information presented in Provision M.3 Presentation Book; review of documents requested; meetings/interviews with CNE, NOO, Program Compliance Nurse, and RN Case Manager Supervisor, RN Case Managers, observations; 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.3 and the Monitoring team did not concur with their findings. <u>New/Revised Policies, Procedures, Processes, and Protocols:</u> DADS SSLC Guidelines: Care Plan Development, December 2013	Noncompliance

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	by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	RN Case Managers and RN Training: Nursing Administration/Management reported that all RN Case Managers and RNs had been trained on the revised Guidelines: Care Plan Development, December 2013. Refer to Provision M.4 for report of additional training for RN Case Managers. Facility's Self-Assessment Quality Assurance Data for Comprehensive Nursing Assessments: The Facility quarterly data for August 2013 through January 2014 are provided in charts in Provision M1. According to the Facility's Self-Assessment, the quarter from August 2013 to October 2013, showed multiple areas that need improvement. A Corrective Action Plan (CAP) was initiated due to the audits for Urinary Tract Infections (UTIs) that was significantly lower than the other monitoring tools. In January 2014, there was an increase in the UTI audit scores. However, in February 2014, the CAP was amended and continued active. The Seizure Management audits were also found trending downward. In February 2014, a CAP was initiated and remained active. The Monitoring Team's Review of Acute Care Plans and Integrated Health Care Plans Processes and Record Review: Since the compliance review, the new Guidelines: Care Plan Development, December 2013, was fully implemented by the Nursing Department in January 2014. The previously used generic care plans had been discontinued. The new guidelines for the development of Acute Care Plans and Integrated Health Care Plans provided more explicit instructions than the previous care plan guidelines, which should lead to improvements in individualization, quality, and content of the plans. During the compliance review, the Monitoring Team met with a representative RN Case Manager from each unit, accompanied by the CNE, NOO, and Program Compliance Nurse. Selected records were review for individuals with recent or currently active Acute Care Plans for Urinary Tract Infection and Seizure Management selected from each unit. The Acute Care Plans and accompanying documentation in the Integrated Progress Notes and other associated documentation were reviewed from the onset of the acute change in status through to resolution and/or to date. The Acute Care Plans and supporting documentation showed progressive improvement in the individualization, quality, and content of the plans. These records were included in the offsite review and report. While touring the units the Monitoring Team interviewed DSPs. The DSPs were able to quickly locate and show individuals' All About Me Books, Communication Notebooks, and Training Notebooks. The DSPs without hesitation were able to find the DSP Instruction Sheets for Individuals ##223 and #88 and to explain their care	

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		responsibilities for these individuals. The Monitoring Team reviewed offsite a total of 10 Acute Care Plans and documentation for recent and/or current active infections, of which nine were Urinary for Tract Infections and one was for bacterial pneumonia and bacteremia, for Individuals #37, #68, #557, #149, #362, #276, #195, #533, #97, and #595. These showed the following results: • Eight of ten (80%) Acute Care Plans were initiated within12 hours upon diagnoses and treatment of infection. • Seven of ten (70%) Integrated Progress Notes documented the initiation of Acute Care Plans and DSP Training. • Seven of ten (70%) Acute Care Plans had baseline data sufficient to identify the rationale that led up to the necessity for care plans. Assessment included measurable data. • Eight of ten (80%) Acute Care Plans had goals sufficient to measure the desired outcomes for which the care plans were design to resolve. • Nine of ten (90%) Acute Care Plans were individualized sufficient to meet the individuals' health care needs for managing the infections. • Nine of ten (90%) Acute Care Plans incorporated relevant protocols and physician orders for treatment, including Nursing Protocols for: When contacting the PCP, Antibiotic Therapy, UTI, Respiratory Distress/Aspiration, Pain, and infection control measures, as indicated. • Ten of ten (100%) Acute Care Plans included how frequently interventions were to be completed, by whom, and where documented. • Ten of ten (100%) Acute Care Plans included DSP Instruction Sheets. • Nine of ten (90%) Acute Care Plans' DSP Instructions Sheets were individualized. sufficient to meet individuals' health care needs for infections. • Eight of ten (80%) Acute Care Plans' DSP Instructions sheets contained documentation that DSPs were trained on all three shifts. • Four of four (100%) Acute Care Plans that were resolved had the date noted. • Three of four (75%) Acute Care Plans resolved had an Integrated Progress Notes documenting the resolution. Individual #68's Acute Care Plan noted it was resolved on 1/9/14 but a copy of the Integrated Progress Note for 1/9/14 was not provided for review. • Eight of ten (80%) Integrated Progress Notes showed that the Acute Care Plans were consistently carried out as stated in the plans, including relevant Nursing Protocols for: Antibiotic Therapy, UTI, Respiratory Distress/Aspiration, Pain, and infection control measures, with rare exception. • Integrated Progress Notes included documentation that the Acute Care Plans were carried out as stated in the plans, with few exceptions.	

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		• Six of nine (67%) Acute Care Plans included copies that showed "Real Time" Audits were completed for the infections. Individual #68's Acute Care Plan that was initiated on 4/4/14, had not yet had time for a "Real Time" Audit to be completed as of 4/9/14. A review of the above Acute Care Plans found an overall 84% compliance score. This showed a slight improvement from the compliance scores reported in the Facility's Self-Assessment. The Acute Care Plans and Integrated Progress Notes were reviewed for the period of November 2013 through April 2014. There was progressive improvement found in the individualization, quality and content of Acute Care Plans and Integrated Progress Notes over this period, particularly since the revised guidelines for developing Acute Care Plans. Areas that need continued improvement included: • The Integrated Progress Notes should consistently include assessments and documentation of all requirements stated in the respective Nursing Protocols. All of the Nursing Protocols included in the Acute Care Plans should be consistently assessed and documented in the Integrated Progress Notes as stated in the plans. Frequently missing in shift notes was monitoring/assessment and documentation for adverse drug reactions and effectiveness of the prescribed antibiotic therapy. It is imperative that individuals are consistently monitored/assessed for adverse drug reaction and effectiveness. Adverse drug reactions have the potential to rapidly occur at any time during the course of medication administration. It is critical that adverse drug reactions are identified and responded to promptly at the onset. Many drugs have the potential to cause serious if not life-threating reactions. For example: o Individual #279's Acute Care Plan for Urinary Tract Infection initiated on 3/6/14, was not revised when Individual #279 developed a rash on face and upper body. On 3/13/14, the DSP reported the rash to the nurses who assessed the rash and sent Individual #279 to sick call. The PCP contacted the Clinical Pharmacist for a differential diagnosis of the rash. An Adverse Drug Reaction to Bactrim DS was diagnosed. An Adverse Drug Reaction Report was completed for Bactrim DS and allergy to Sulfonamides was added to records. The antibiotic was changed to Amoxicillin on 3/13/14. The Acute Care Plan was not revised. The RN Case Manager should have revised the Acute Care Plan to reflect the change of medication and the need to monitor the adverse drug reaction rash. However, the Integrated Progress Notes did contain documentation that the adverse drug reaction rash was monitored on each shift until resolved. Nursing Management should ensure that Acute Care Plans are revised when changes occur that requires a change to nursing interventions in the plans of care. • For individuals with Urinary Tract Infections, the Acute Care Plans included the	

#	Provision	Assessment of Status	Compliance
		encouragement of fluid intake. If ensuring adequate hydration was important, the amount of daily fluid intake should be determined for each individual by the PCP/dietitian to ensure adequacy. Then, to ensure the fluids are provided, they should be tracked on an intake and output sheet and monitored daily by the nursing and DSP staffs. • Acute Care Plans reviewed in homes that did not have dedicated nurses on the 10-6 shifts stated nursing interventions would be carried out on all three shifts. However, in those homes without dedicated 10-6 shift nurses, the Integrated Progress Notes did not show that the nursing interventions were carried out on this shift. The frequency for nursing interventions stated in the Acute Care Plans should be realistic. If it is imperative that nursing interventions are carried out on the 10-6 shifts the RN Campus Nurses should carry out and document the interventions. • In reviewing the DSP Instruction Sheets it was difficult to discern whether staff were trained on all three shifts. The DSP Instruction Sheets for signatures did not consistently identify the shift for which the DSPs were trained. Even though some homes do not have dedicated nurses on the 10-6 shifts, it is important that the DSPs are trained on all three shifts. The DSP Instruction Sheet for signatures should also include the shift for which they were trained. The Monitoring Team reviewed offsite a total of five Integrated Health Care Plans, Seizure Records, and associated Integrated Progress Notes for recent seizure activity for Individuals #67, #195, #185, #428, and #223. Findings included: • Five of five (100%) episodes of seizure activity showed the Seizure Records were completed correctly. • Four of five (80%) episodes of seizure activity were assessed/managed according to the Status Epilepticus/Seizure Activity Nursing Protocols and documented on the Seizure Records and in the Integrated Progress Notes. A review of Seizure Records and associated Integrated Progress Notes above found an overall 90% compliance score for nursing seizure management responsibilities. This showed an increased compliance compared to the Facility's Self-Assessment seizure monitoring data. The revised Seizure Record showed significant improvement in completeness. However, the following area needed continued improvement: o Individual #67: On 3/31/14 at 1915, there was documentation that Individual #67 had a 10 minute seizure. The PCP was notified and Diastat 10 mg was administered per rectum. The medication was documented as effective in stopping the seizure activity. A nursing assessment was completed that showed vital signs as temperature 97.9, pulse 83, respirations 18, blood pressure 123/78 and oxygen saturation at 97% on room air. A nursing assessment with vital signs was completed again until 4/1/14 at 0030. At that time vital signs were as temperature 99, pulse 79,	

#	Provision	Assessment of Status	Compliance
		respirations 18, blood pressure 90/60 and oxygen saturation at 95% on room air. Because of the 10 minute seizure requiring Diastat 10 mg, nursing assessments and vital signs should have been completed every 15 minutes until return to baseline measurements. Individual #67 was not monitored/assessed on each shift for 72 hours per protocol. Nursing Management should ensure that Status Epilepticus/Seizure Activity Nursing Protocols are consistently followed. • Three of five (60%) individuals had an Integrated Health Care Plans sufficient to meet individuals' seizure management needs. • One of five (20%) Integrated Health Care Plans' DSP Instruction Sheets was provided for review and/or had documentation that DSPs were trained on all three shifts. • A review of the Integrated Health Care Plans for Seizure Management found an overall 40% compliance score. Areas that need continued improvement included: o Two individuals did not have a sufficient Integrated Health Care Plan for seizure management. Individual #195's Integrated Health Care Plan did not include an action step for labs to monitor psychoactive medication blood levels. Individual #185's Integrated Health Care Plan did not include an action step for DSP Instructions. Both of these action steps are important to sufficiently manage seizure activity. <u>The Monitoring Team's Review of Integrated Risk Rating Form (IRRF) and Integrated Health Care Plan (IHCP) Processes.</u> Since the last compliance review, the Facility had continued to implement and improve/refine the IRRF and IHCP Processes. Efforts reported in the Facility's Self-Assessment regarding improvements made since the last compliance review included: • The Facility continued to complete the Clinical IDT Referral form on individuals seen in morning sick call. The nursing staff places the forms on the front of the charts along with the reason for the sick call. After the PCPs examine individuals a determination is made whether the individuals had a change from their baseline. If so, the PCPs sign the forms and return them to the nursing staff. The nursing staff forwards the forms to be entered into the database for the QIDPs to review. When a Change of Status was identified the QIDPs sets up ISPAs. • The NOO created a spreadsheet to track all quarterly, annual, and ISP dates to ensure the RN Case Managers complete their nursing assessment timely. • The QIDP prepared the Monthly Review Reports on each individual's completed IHCP, which were placed on the S-drive so that they could be available for review by the respective team disciplines. The reports included information on updates or progress made on the action steps. • The RN Case Managers assess the educational needs of the DSPs regarding	

#	Provision	Assessment of Status	Compliance
		aspiration triggers, positioning, and preventative care on a quarterly basis as needed. The RN Case Manager Supervisor was available to consult/reinforce on problems with trigger sheets as needed. However, as reported in Provision O7, RN Case Manager review of trigger sheets was inconsistent. The Nursing Department did not have a separate audit tool for Section I. The Facility's Section I Monitoring tool was used for auditing. The Hospital Liaison Nurse, along with the Program Compliance Nurse, completed the Section I audits monthly. Section I Audit data were not provided for review. The Monitoring Team reviewed the most recently completed Integrated Risk Rating Forms (IRRFs) and Integrated Health Care Plans (IHCPs) selected for 10 individuals from across campus with high and/or medium risks for specific health indicators, including Individuals #184 for urinary tract infection, #269 for aspiration, #291 for skin integrity, #584 for dental, #193 for fluid imbalance, #445 for infections, #322 for hypothermia, #439 for choking, #172 constipation, and #464 for weight. Of the 10 individuals' IRRFs and IHCPs reviewed: • Nine of ten (90%) individuals' had a comprehensive interdisciplinary assessment completed. • Five of ten (50%) individuals' assessments were adequate to support risk level determination for specific risk conditions. • Five of ten (50%) individuals' assessments provided substantive clinical information that helped to address specific risk conditions. • Nine of ten (90%) individuals' had an interdisciplinary plan developed to address the specific risk conditions. • Eight of ten (80%) individuals' plans for specific risk conditions were implemented within fourteen days of the approval of the plan. • Four of ten (40%) individuals' plans for specific risk conditions met the needs identified by the interdisciplinary assessment. • Four of ten (40%) individuals' plans for specific risk conditions included preventative interventions to minimize the risk conditions. • Eight of ten (80%) individuals' plans were integrated into the ISP. • Seven of ten (70%) individuals' plans for specific risk conditions showed sufficient integration among all appropriate disciplines. • Four of ten (40%) plans for specific risk conditions included functional and measurable objectives incorporated into the ISP to measure efficacy of the plans. • Four of ten (40%) individuals' plans for specific risk conditions identified appropriate clinical indicators to be monitored and the frequency of monitoring.	

#	Provision	Assessment of Status	Compliance
		Overall 61% compliance score was found for completing specific risk conditions on the IRRFs and HICPs. This showed a decreased compliance from the previous compliance review. The areas that need continuous improvement included: • All of the records requested for offsite review were not included. Individual #584's IRRF was not provided for offsite review and was assumed not completed. However, Individual #584's IHCP was provided for offsite review. There were no plans provided for offsite review for Individuals #145 and #184. Therefore, these records could not be evaluated and were assumed they were not completed. • As was found in previous compliance reviews, related clinical data that had an interrelationship with other individual risk conditions and interrelationships with groups of risk conditions were not incorporated when determining risk conditions for which to clinical data were pertinent. This limited the inclusion of pertinent clinical data from which to adequately determine risk ratings. For example: o Individual #464 was admitted on 10/31/13, with the IRRF completed on 11/25/13. Historical clinical data stated Individual #464 had a rapid weight loss of 12 pounds in less than 90 days prior to admission. Clinical indicators for nutritional deficiencies were not included in the clinical data, nor were the clinical data of the diagnoses of GERD, for which Individual #464 had a risk condition for gastrointestinal, or of a Stage II non-healing surgical wound secondary to surgery for a fracture of the right hip, for which Individual #464 had a risk condition for skin integrity. The plan included weekly weights. However, the plan did not include laboratory tests for nutritional deficiencies, or dietary protein supplements to promote healing, or daily monitoring of food intake. • Nursing interventions included in the action steps were generally very brief and lacked specificity. The plans rarely included relevant nursing protocols for managing potential acute events. The frequency and details of nursing interventions were not implemented with the frequency necessary to be proactive in minimizing risk conditions. For example: o Individual #172's action steps for constipation stated, "DSP Instruction Sheet" but did not describe what the DSP would do related to constipation. The monitoring frequency stated "Quarterly/DSP training book". It did not specify who would monitor the DSP training book or for what. Considering that Individual #172 had a risk condition for constipation, quarterly tracking the DSP training book for bowel elimination did not appear to be frequently enough to adequately determine elimination patterns or to minimized the risk condition. • The goals for specific risk conditions were not stated as functionally measurable objectives. For example: o Individual #322 had a risk condition for hypothermia. The goal stated,	

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		"Individual #322 will be provided appropriate clothing to suit the weather and environment to reduce the chance of hypothermic events." How would this be measured? The specific adjustments to clothing and when to adjust should have been included in the action steps and in the DSP Instruction Sheet. There was no intervention for the use of a warming blanket for hypothermic events. The IRRF stated that Individual #322 had orders for temporal temperatures every shift according to nursing protocol for temporal temperatures of equal to or less than 97.0F. There was no baseline data for temperatures included in the clinical data. Taking temperature was not included in the list of items to be monitored every shift by staff nurses and weekly/per necessary (PRN) by the RN Case Manager. The accuracy for taking temporal temperatures to assess for hypothermia was questionable. A review of the above individuals' most recently completed annual or quarterly Comprehensive Nursing Reviews found that eight of ten (80%) contained an adequate assessment of the specific risk conditions and summaries of specific risk conditions in the Summary Section of the Comprehensive Nursing Reviews . Even for those who had assessments/summaries, all of the assessment clinical data were not consistently included in the IRRFs. It is imperative that nursing assessment data are incorporated into the IRRF clinical data. The Facility stated they were in substantial compliance with this Provision. Based on the Monitoring Team's independent review, this Provision was not found in substantial compliance. In order for this Provision to be found in substantial compliance the active CAPs for urinary tract infections and seizure management must be closed and all nursing care monitoring tools and nursing protocol audits must attain and be sustained with compliance scores of at least the compliance scores required by the Nursing Department's currently established compliance thresholds over an extended period of at least six months. The IHCPs for specific nursing related risk conditions must attain and be sustained with compliance scores of at least 90% or greater over an extended period of at least six months.	
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 verified 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; meetings/interviews with CNE, NOO, Program Compliance Nurse, and Nurse Educator; and, review of Nursing Education Curricula, Nursing Training Database and supporting training rosters. 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	Substantial Compliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>with their findings.

The Monitoring Team conducted a reduced compliance review based on the last three compliance reviews that found the Facility in substantial compliance with this Provision.

<u>New/Revised State/Local Policies, Procedures, Processes, and Protocols:</u>
• DADS SSLC Procedure: Nurse Competency Based Training Curriculum, December 2013

<u>Training Activities:</u>
• Annual Competency Based Fair refresher training and New Nurse Orientation were based on the Nurse Educator Handbook approved by the state office. 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 required training, the respective Nurse Managers, CNE, NOO, and respective nurses were notified and training was rescheduled.
• The Nurse Educator continued to follow-up with new nurses after orientation was completed. The Nurse Educator went to new nurses' assigned areas and asked them if they had any questions/concerns, and if there was anything needed to aid in the transition. All information was documented and kept in the Nurse Educator's files.
• The Annual Competency Fair was held on March 18 and 19, 2014. Check-off stations included a written competency-based test regarding policies and procedures, a medication calculation exam, G-Tube insertion and care, emergency equipment use, and the National Pressure Ulcer Advisory Panel (NPAUP) test regarding skin management.
• Required training provided through the Nursing Education Department and percentage of completion for nurses that occurred over the past six months is reported in the chart below:
<table><tr><td>Title of Required Nurses' Training:</td><td>Percentage of Nurses Completing the Required Training</td></tr><tr><td>Annual refresher competency-based training according to the Nursing Education Handbook and BSSLC SSLC Nursing Guidelines. Training included all incumbent nurses and agency nurses. All competencies were standardized.</td><td>95% of RNs completed training with three nurses pending due to extended sick leave.
96% of LVNs completed training with two nurses on extended sick leave.
88% of agency nurses completed with one pending.</td></tr><tr><td>New Nurse Orientation according to the</td><td>100% completed training for all nurses</td></tr></table></td><td></td></tr>
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		Nurse Educator Handbook and Brenham SSLC Guidelines. This is taught for all new nurses, including agency nurses.		
		Nursing Protocol Card Training for all 23 Cards	100% (A set of 23 cards were provided to each incumbent nurse. The training on and issuing of Nursing Protocol Cards was included in New Nurse Orientation for all nurses, including agency nurses.)	
		State mandated Physical Assessment Class for Incumbent RN Case Managers and RNs. This class is now taught in New Nurse Orientation for all RNs.	88% RNs completed training with eight new RN hires/rehires and one RN pending due to extended sick leave.	
		Mosby Class –ENT	97% RNs completed training with two RNs on extended sick leave.	
		Mosby Class – Head and Neck.	100% RNs completed training	
		Mosby Class – Heart	100% RNs completed training	
		Mosby Class – Neurology	100% RNs completed training	
		Mosby Class – Musculoskeletal	100% RNs completed training	
		Mosby Class – Chest and Lungs	100% RNs completed training	
		Mosby Class – Medication Administration Class.	100% completed training for all nurses	
		MOSES/DISCUS Review	100% RNs completed training	
		Enteral Nutrition – labeling supplies	99% completed training for all nurses except for one nurse pending due to extended sick leave.	
		Policy and Procedure for A.5 Training Requirements	99% completed training for all nurses except for one nurse pending due to extended sick leave.	
		Urinary Tract Infection Documentation	15 RNs completed training with Nurse Manager 10 LVNs completed training with Nurse Manager All nursing staff reviewed in Annual Competency Fair	
		Policy and Procedures for: Home Manager on Call, Meal Time Services, Disposal of Gloves, and Board of Nursing Statement on Social Media	99% completed training for all nurses except for one nurse pending due to extended sick leave.	
		Death Review Recommendations for J.F.	99% completed training for all nurses except	

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			for one nurse pending due to extended sick leave.	
		Policy and Procedures for: Behavioral Crisis, Medical Restraint, Behavioral Services	99% completed training for all nurses except for one nurse pending due to extended sick leave.	
		Enteral Nutrition Revised Policy	98% completed training for all nurses except for two nurses pending extended sick leave.	
		Death Review Recommendations for M.B., R.B., and D.W.	98% completed training for all nurses except for two nurses pending extended sick leave.	
		Policy and Procedure N.10 Adverse Drug Reaction	99% completed training for all nurses except for one nurse pending due to extended sick leave.	
		American Nurses Association Sponsored Continuing Education Activity Entitled NDNQI Pressure Ulcer Training IV	95% completed training for all nurses except for nurses on extended sick leave.	
		• All staff in New Employee Orientation were trained on the AUVI-Q pen (epinephrine auto-injector) to be used for life-threating allergies. • The Nurse Educator attended two National Rural Health Association (NRHA) conferences: Multicultural and Multiracial Healthcare Conference in December 2013 and the National Rural Health Policy Institute in February 2014. • The Nurse Educator continued to create and publish the BSSLC Nurse Newsletter. The newsletter encompassed multiple interdisciplinary areas, including risks. The newsletter had input from the CNE, Pharmacy Director, and Medical Director. • It was positive for the Monitoring Team to find that all nurses observed during the tours in Bowie and, Fannin were carrying their protocol cards, as required. Additional training provided to nurses by the Infection Control Nurse and Skin Integrity Nurse is report in Provision M.1. The degree of adherence to the nursing protocols was reported in the other appropriately related Provisions of this Section. Care was found consistent in Acute Care Plans with protocols for incorporated for relevant protocols, such as antibiotic therapy, infections, seizure management, skin integrity, and other conditions. Nursing assessments and documentation followed the Acute Care Plans and associated the protocols, and the requirements in various protocols for reporting to the medical practitioner were followed. However, when individuals' had acute illnesses/events that did not require the initiation of an Acute Care Plan, but did require short-term assessments and documentation of the acute illnesses/events for 24 hours up to 72 hours, the assessments and documentation were not consistently followed through to		

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		resolution. In order for this Provision to continue to be in substantial compliance, the Nursing Department should consider implementing the Nursing Care Monitoring Tools for Assessment and Documentation that was previously used to ensure that nursing assessments for short term care are completed according to the respective nursing protocols and followed through to resolution. The Facility's Self-Assessment stated they continued to be in substantial compliance with this Provision. The Monitoring Team concurs that this Provision continued to be 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, 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 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.	<u>Monitoring Team Findings:</u> The Monitoring Team verified 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 CNE, Nursing Operations Officer, QA Nurse, and RN Case Manager Supervisor; attendance at a ISPA 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 Provision M.5 and the Monitoring Team did not concur with their findings. <u>The Monitoring Team's Review of Integrated Risk Rating Form (IRRF) and Integrated Health Care Plan (IHCP) Processes.</u> Since the last compliance review, the Facility had continued to implement and improve/refine the IRRF and IHCP Processes. Efforts reported in the Facility's Self-Assessment regarding improvements made since the last compliance review included: • The Facility continued to complete the Clinical IDT Referral form on individuals seen in morning sick call. The nursing staff places the forms on the front of the charts along with the reason for the sick call. After the PCPs examine individuals a determination is made whether the individuals had a change from their baseline. If so, the PCPs sign the forms and return them to the nursing staff. The nursing staff forwards the forms to be entered into the database for the QIDPs to reviews. When a Change of Status was identified the QIDPs sets up ISPAs. • The NOO created a spreadsheet to track all quarterly, annual, and ISP dates to ensure the RN Case Managers complete their nursing assessment timely.	Noncompliance

#	Provision	Assessment of Status	Compliance
		• The QIDP prepared the Monthly Review Reports on each individual's completed IHCP, which were placed on the S-drive for review by the respective team disciplines. The reports included information on updates or progress made on the action steps. The NOO reviewed the monthly reports and followed up on issues related to nursing, as indicated. • The RN Case Managers assess the educational needs of the DSPs regarding aspiration triggers, positioning, and preventative care on a quarterly basis as needed. The RN Case Manager Supervisor was available to consult/reinforce on problems with trigger sheets as needed. The Nursing Department did not have a separate audit tool for Section I. The Facility's Section I Monitoring was used for auditing. The Hospital Liaison Nurse, along with the Program Compliance Nurse complete the Section I audits monthly. Section I Audit data were not provided for review. The Monitoring Team reviewed the most recently completed Integrated Risk Rating Forms (IRRFs) and Integrated Health Care Plans (IHCPs) selected for 10 individuals from across campus with high and/or medium risks for specific health indicators, including Individuals #184 for urinary tract infection, #269 for aspiration, #291 for skin integrity, #584 dental, #193 for fluid imbalance, #445 for infections, #322 for hypothermia, #439 for choking, #172 constipation, and#464 for weight. Of the 10 individuals' IHCPs reviewed, overall a 61% compliance score was found for completing specific risk conditions on the IRRFs and IHCPs. This showed a decreased compliance from the previous compliance review. The areas that need continuous improvement included: • Nursing interventions included in the action steps were generally very brief and lacked specificity. The plans rarely included relevant nursing protocols for managing potential acute events. The frequency and details of nursing interventions were not implemented with the frequency necessary to be proactive in minimizing risk conditions. • The goals for specific risk conditions were not stated as functionally measurable objectives. A review of the above individuals most recently completed annual or quarterly Comprehensive Nursing Reviews found that eight of ten (80%) contained an adequate assessment of the specific risk conditions and summaries of specific risk conditions in the Summary Section of the Comprehensive Nursing Reviews. Even for those who had assessments/summaries, not all relevant clinical indicators were consistently included in the IRRF clinical data. It is imperative that nursing assessment data are incorporated into the IRRF clinical data. • Based on the review of the above individuals' IHCPs associated with nursing's responsibilities for the identification of nursing problems/diagnoses, development	

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<tr><td></td><td></td><td>of associated care plans, progress toward stated goals, and the effectiveness of the plans, more experience needs to be gained with the use of the IHCPs before substantial compliance can be determined.

As was found in past reviews, there was some general improvement in the IRRF and IHCP process found in the records reviewed. The Facility should focus on ensuring that the IDTs continue to exercise clinical judgment in correlating the interrelatedness of areas of risks within the risk group, as well as between the various risk groups. There was also 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 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 Facility stated they were in substantial compliance with this Provision. Based on the Monitoring Team's independent review, this Provision was not found in substantial compliance. In order for this Provision to be found in substantial compliance, the IHCPs for specific nursing related to clinical indicators for risk conditions must attain and be sustained with compliance scores of at least 90% or greater over an extended period of at least six months.

Refer to Provision M.3 and Section I for additional information regarding compliance with the IRRF and IHCP processes.</td><td></td></tr>
<tr><td>M6</td><td>Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally</td><td>Medication Variances by Disciplines – March 2013 through January 2014
<table><tr><th>Month
Year</th><th>Mar
'13</th><th>Apr
'13</th><th>May
'13</th><th>Jun
'13</th><th>Jul
'13</th><th>Aug
'13</th><th>Sep
'13</th><th>Oct
'13</th><th>Nov
'13</th><th>Dec
'13</th><th>Jan
'14</th></tr><tr><td>Phar-
macy</td><td>31</td><td>10</td><td>8</td><td>6</td><td>8</td><td>8</td><td>6</td><td>32</td><td>8</td><td>7</td><td>8</td></tr><tr><td>Nurs-
ing</td><td>90</td><td>67</td><td>133</td><td>162</td><td>124</td><td>118</td><td>116</td><td>134</td><td>108</td><td>104</td><td>165</td></tr><tr><td>Medi-
cal</td><td>6</td><td>14</td><td>9</td><td>10</td><td>9</td><td>6</td><td>9</td><td>16</td><td>10</td><td>6</td><td>10</td></tr><tr><td>Dental</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>2</td><td>0</td><td>0</td></tr><tr><td>Total</td><td>127</td><td>91</td><td>150</td><td>184</td><td>141</td><td>132</td><td>131</td><td>182</td><td>128</td><td>117</td><td>183</td></tr></table>*Medication Variance data for February 2014 was not finalized.
The Medication Variance data showed fluctuation from month to month by all</td><td>Substantial Compliance</td></tr>
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#	Provision	Assessment of Status	Compliance
	accepted professional standards of care with regard to this provision in a separate monitoring plan.	responsible departments, with the exception of Dental. A review of the Medication Variance Committee Meeting minutes, as well as minutes reviewed at the last compliance review, showed that Medication Variances were continued to be analyzed and trended by all responsible departments, and with appropriate local and/or systemic corrective action taken for all identified medication variances. <u>Completion of 10 Most Recent Medication Variance Reports:</u> The Monitoring Team reviewed ten of the most recently completed Medication Variance Reports for Individuals #191, #65, #144, #325, #554, and #464 (Individual #464 had five medication variances reported). Findings include: • The Medication Variance Reports were fully completed for physician notification and type of variance, and were reviewed by the department supervisor with corrective action taken in ten or ten (100%) examples. • The Medication Variance Reports were completed for severity index in seven of ten (70%) examples. The three Medication Variance Reports that did not include the severity index were from Cottages E and G, and Childress 505. It is important that all fields on the Medication Variance Reports are completed according to the Medication Variance Policy. • The department supervisor documented appropriate corrective action on the Medication Variance Report forms in ten out of ten (100%) examples. • Nursing Administration reviewed the Medication Variance Reports before they were entered into the Medication Variance Database for any corrections and further corrective action when indicated. • Medication variances were incorporated into the medication variance AVATAR database and after analysis and were presented to the Medication Variance Committee for review in ten out of ten (100%) examples. An additional sample of medication variance reports was reviewed and reported on in Provision N8. Findings were consistent. <u>Self-Audits for Medication Administration Observations, Medication Rooms, and Medication Administration Records:</u> Nursing Administration and the QA Nurse continued to conduct Medication Administration Observations, Medication Rooms, and Medication Administration Records as described below: • Medication Administration Record (MAR) Audits: o The Nurse Managers conducted audits on five individuals' MARs from each home every week. o The QA Nurse conducted audits on every MAR on every home once a month for inter-rater reliability checks.	

#	Provision	Assessment of Status	Compliance
		• Medication Room Audits: o The Nurse Managers conducted audits on one medication room every week, except for the Cottages where two medication rooms are audited every week. o The QA Nurse conducted audits on control drug counts for completeness, accuracy and security, the security of medication room, equipment check log, and refrigerator temperature log on every home once a month for inter-rater reliability checks. • Medication Administration Observations: o The Nurse Managers conducted Medication Administration Observations quarterly on each nurse for one year. If the nurse scored 90% or above for four consecutive observations, then, they were only observed twice per year. For new nurses and/or nurses who had a score of less than 90%, they continued on quarterly observations, or more often at the discretion of the Nurse Manager. o The Shift Managers conducted Medication Administration Observations on the 10-6 shift. o The QA Nurse conducted Medication Administration Observations quarterly for inter-rater reliability checks. The Monitoring Team reviewed the Medication Administration Observations, Medication Rooms, and Medication Administration Records audit data reported in the Facility Self-Assessment, along with supporting documentation provided to validate the information reported. The chart below shows the overall results of these audits, August 2013 through January 2014. The audit results for February 2014 and March 2014 were not yet available for review: Medication Administration Observations, Medication Rooms, and Medication Administration Records, August 2013 through January 2014	

Audits Completed	Aug 2013	Sep 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014
Medication Administration Observations	100%	100%	100%	100%	100%	99.2%
Medication Administration Record	94%	95%	99%	95%	98%	94%
Medication Room	95%	99%	98%	99%	99%	98%
Overall Average	96%	98%	99%	98%	99%	97%

Overall none of the above audits fell below 90% compliance. However, the Monitoring

#	Provision	Assessment of Status	Compliance
		Team's review of the individual unit's monthly audit reports and accompanying plans of corrective showed when local deficiencies were identified, that corrective action was taken even though the unit's overall score was 90% or above. <u>Monitoring Team's Survey of the Medication Rooms and Review of the Medication Administration Notebooks:</u> • While onsite, the Monitoring Team accompanied the CNE, NOO, respective Nurse Manager, Program Compliance Nurse, and RN Shift Supervisor, surveyed the Medication Rooms and reviewed the Medication Administration Record Notebooks, in Bowie B and Fannin A and C, using the standardized Medication Room and Medication Administration Record Notebook Audit Tools. The findings of the surveys of the medication rooms and review of the Medication Administration Record Notebooks were consistent with the Facility's Self-Assessment Medication Room and Medication Administration Record Notebook audits, as described above. • The Monitoring Team was provided with Signature Rosters for the Medication Administration Record Notebooks for all Units. All signatures of nurses administering medications were current. <u>Monitoring Team's Medication Administration Observations:</u> Using the standardized Medication Administration Observation form, the Monitoring Team conducted medication administration observations for oral and/or enteral and/or otic routes of administration in Fannin C and Bowie B, accompanied the CNE, NOO, respective Nurse Manager, Program Compliance Nurse, and RN Shift Supervisor. Individuals observed included Individuals #281, #112, #288, #427, #308, #475, #517, and #335. General observation: • All individuals observed who required a PNMP, had a current PNMP with strategies for medication administration. • All individuals who required specific adaptive equipment had it available on the medication carts. The adaptive equipment was properly sanitized per Facility policy. • The nurses administering medications consistently referred to and followed individuals' PNMPs, such as, texture, how pills were to be administered, presentation techniques, required adaptive equipment, positioning equipment and their stated use. • The nurses administering medications consistently followed generally accepted safe medication administration practices for oral and enteral routes of administration. • Individuals were told the name of the medications and their purpose, with rare prompting by the Nurse Managers for newly hired nurses.	

#	Provision	Assessment of Status	Compliance
		• Individuals were provided privacy during medication administration, either in a private room or shielded with privacy screens. • The DSP staff consistently assisted the nursing staff by bringing one individual at a time to receive medications. • Individuals who had Self-Administration of Medication Programs were reinforced. Specific observations: • Individual #308: During the medication pass on 4/8/14, Individual #308 was observed drinking liquids too fast; taking large gulps after swallowing medications. This had the potential to cause aspiration of liquids. However, no triggers related to aspiration were observed. According to Individual #308's PNMP he was at medium risk for choking due to the need for special dining instructions for staff to follow at meal times. The PNMT was not tracking any identified triggers. The Medication Administration instructions did not require any adaptive equipment, medication texture was to take medication whole, liquid consistency was for thin liquids, and position was to remain seated or standing with head and chin in neutral position. Because Individual #308 was observed rapidly gulping liquids, the Nurse Manager made a referral to the PNMT for evaluation. Documentation was provided to the Monitoring Team that showed on 4/8/14, Individual #308 was evaluated by the Speech-Language Pathologist at the evening medication pass and was found to rapidly gulp down liquids. As a result of the observation/evaluation the Speech-Language Pathologist made recommendations for the IDT to review. Such recommendations included: The team may want to implement a training program (SAP) to teach him to drink slowly and take breaks instead of drinking entire glasses of liquid at one time. Until he learns to drink slowly and to take a break when drinking the staff may need instructions added to the PNMP under mealtime, snacks, and/or medication administration to only pour one-half cup of liquid into a regular drinking cup at a time and refill after he drinks. As an alternative, a small juice glass can be added as adaptive dining equipment to meals, snacks, and/or medication administration to limit the amount of liquid he can consume at one time. Referral to Occupational Therapist for meal observation and medication pass observation with additional suggestions/recommendations prior to an ISPA. • The Monitoring Team reviewed the Medication Administration Guidelines for the requirement for reading the medication label three times when administering medication. It was discovered that Facility guidelines for Safe and Secure Practice stated, "Read the medication label three times; when reaching for the medication, immediately prior to pouring or opening medication, and when replacing the medication back into the drawer prior to disposal." Nursing Administration agreed since most medications were packaged individually, the guidelines should be revised to include a statement such as, "...or prior to disposal of the package. "	

#	Provision	Assessment of Status	Compliance
		• It was positive to find that all medication rooms, except in the Cottages where they were not needed, had secure lock boxes for key to narcotics stored in the medication carts. The Nurse Managers created a code for the nurses to access the narcotic keys. The narcotic keys were counted at the end of each shift, along with the narcotic medications. The key provided nurses access to the medication rooms and the medication carts. This Provision continued 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 variance procedures and processes demonstrated by this Facility are exemplary to their peers and should be recognized as such. Refer to Provision N.8 for additional information regarding medication variance.	

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 3/18/2014 2. BSSLC Action Plan 3/18/2014 3. BSSLC Presentation Book April, 2014 4. BSSLC Pharmacy Services and Safe Medication Practices Policy N.10, dated 3/7/2014. 5. BSSLC Adverse Drug Reaction (ADR) Annual Training policy, N10.1, undated. 6. For Individuals #67, #325, #453, #111, #546, #481, #360, #580, #37, #269, #591, and #485: a. Pharmacy documentation of a review for allergies, interactions, required diagnostics, appropriate indication, and dose b. Past six months laboratory data c. Current medication list d. EKG for past three years e. Most recent ophthalmology report f. Completed SPDI (single patient drug intervention reports) associated with the new medication order 7. QDRR schedule for past six months, and pending six months 8. List of all QDRRs, for the past six months, that were not completed within 14 days of the scheduled completion date 9. The first two completed QDRRs completed each month for October 2013 through March 2014 (Individuals #247, # 148, #363, #465, #415, #568, #281, #112, #86, #475, #321, and #101) a. Most recent two QDRRs b. Past six months MOSES and DISCUS assessments c. Most recent 12 months of lab results d. Most recent two EKG reports e. Most recent annual physician summary f. Most recent psychiatric assessment g. Most recent IRRF h. Evidence that the medical providers reviewed the pharmacists' recommendations; indication if they agreed or disagreed with the recommendations; and if disagreed, documentation of their clinical rationale 10. Past six-months committee meeting minutes, demonstrating a systems review for the Facility's usage of drugs with anticholinergic properties 11. Data, graphs, and data-analysis specific for the pharmacy's monitoring of the use of drugs with anticholinergic properties 12. Alpha list of individuals who are prescribed anticholinergic drugs 13. Drug class tracking spreadsheet for anticholinergics 14. August 8, 2013 Psychotropic Medication Oversight Committee (PMOC) meeting minutes, and PMOC

	agenda for 4/8/2014 15. For the first, and then every fifth individual on the list of individuals prescribed anticholinergic drugs, for a total of ten examples (Individuals ##26, # 39, #30, #243, #163, #251, #347, #265, #453, and #570) a. Most recent two QDRRs b. Current medical list c. Most recent medical, and psychiatric annual reviews d. Most recent MOSES and DISCUS assessments 16. PMOC meeting minutes for December 2013, and March 2014. 17. List of all individuals on polypharmacy 18. For the first, and than every second individual on the list of polypharmacy, for a total of ten individuals (Individuals #367, #167, #1, #382, #248, #439, #144, #215, #200, and #65): a. Most recent two QDRRs b. Most recent psychiatric assessment c. Current medication list d. Most recent ISP, or related document the use of polypharmacy 19. Alpha list of all individuals on benzodiazepine 20. Data analysis, and committee meeting minutes reflecting the Facility's systems review for benzodiazepine use 21. Drug class tracking spreadsheet 22. For the first five individuals on a list of benzodiazepines used for psychiatric indication, and first five individuals on a list of benzodiazepines used for neurological indication (Individuals #367, #167, #1, #471, #191, #539, #554, #43, and #159): a. Most recent two QDRRs b. Most recent IRRF c. Current medication list d. Most recent psychiatric assessment e. Most recent annual medical assessment 23. For Individuals #403, #243, #133, #300, #106, #24, #152, and #488): a. Most recent QDRR b. Most recent IRRF c. Current medication list d. Most recent six months laboratory data e. Most recent annual medical assessment f. Most recent psychiatric assessment g. Most recent ISP or addendum to the ISP documenting risk for metabolic syndrome 24. Most recent QDRR for Individuals #247, # 148, #363, #465, #415, #568, #281, #112, #86, #475, #321, and #101, and for the first two single patient drug intervention reports (SPDI) that were completed each month during the reporting period (Individuals #269, #248 (x2), #377, #464, #112, #41, #568, #398, #255, #417, and #588): a. SPDI (single patient drug intervention) report b. Copy of associated medication order

	c. Documentation of pharmacist's review of the order d. Clinical evidence for the medical provider following up on the recommendation, or alternative rationale 25. For the first two individuals of each month, during the reporting period, who either started a new neuroleptic drug, or who had a neuroleptic dose change: a. All MOSES and DISCUS assessments associated with monitoring the medication change (Individuals #205, #144, #205, #423 (x2), #408, #13, #349, #251, #243, #1, and #471) 26. Pharmacy and Therapeutics Committee (P&TC) meeting minutes for 2/6/2014 and 4/10/2014. 27. Adverse Drug Report (ADR) tracking spreadsheet. 28. List of all ADRs reported during this reporting period. 29. ADR training records 30. Complete Drug Utilization Evaluation (DUE) schedule for 2013 through 2015, to include all DUEs provided and pending 31. Copies of all DUEs provided during the reporting period Medication variance committee meeting minutes, for 10/2013 through 3/2014 33. All graphs, data tables, and data analysis for medication variances used by the Facility for a systems review of medication variances 34. List of all medication variances that occurred during the reporting period 35. For the first two reported medication variances that occurred each month during the reporting period (Individuals #400, #75, #195, #205, #367, #545, #57, #367, #322, #39, #89, and #335): a. Copy of completed medication variance report form b. All physician IPNs associated with the medication variance c. All nursing IPNs associated with the medication variance d. All pharmacy documentation, and communication related to the mediation variance e. All IDT minutes specific to the medication variance f. Documentation that the guardian was notified of medication variance of category C or worse **People Interviewed:** 1. Trey Knittel, PharmD, RPh (Clinical Pharmacist) 2. Robin Blankenburg, RPh (Pharmacy Director) **Meeting Attended/Observations:** 1. None
	Facility Self-Assessment: Following its review of the Self-Assessment for Section N, the Monitoring Team noted that the Facility: • Did use monitoring/audit tools that relied on sufficient indicators to allow the Facility to determine compliance with the Settlement Agreement; the Self-Assessment did state that the external and internal medical audits were conducted. The Self-Assessment did not give information other than that the audits met timeframes, sample size requirements, and if in compliance or not in compliance. There was not information on the findings and whether any actions plans were established to address findings • The monitoring tools did include sufficient methodologies, such as observations, interviews, and record reviews to determine status of compliance with the respective monitoring processes. For

	example, the Self-Assessment did state the criteria or process for assessing QDRRs, medication variances, adverse drug reaction reports, drug utilization reviews, and completion of the MOSES and DISCUS assessments. • The Self-Assessment did 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 or percent of sample size of individuals/records as compared to the overall population was included in the Self-Assessment. The percentage of compliance for each data item monitored on the various monitoring and/or observation tools was not provided by months, quarters, and overall percentage of compliance. • The Monitoring Team could determine that the Facility's monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results through inter-rater reliability process completed by the QA department. This was evident by the consistent review process among different compliance reports. ▪ It was unknown to the Monitoring Team if sufficient inter-rater reliability process had been established between the various Facility staff responsible for the completion of the tools; however, based on self-assessments for the past three compliance reports, the outcome of the self-assessment appeared consistent. As part of the Facility's quality assurance program, the self-assessment utilized monitoring tools that incorporated data to measure both process, and outcome for Sections N.1 through N.8. For example, when assessing compliance for Section N.7, the Facility developed a self-assessment process to determine if drug utilization evaluations were comprehensive enough. The Monitoring Team concurs with the Facility's self-assessment of substantial compliance with Sections N.1 through N.8.
	Summary of Monitor's Assessment: The Facility has maintained substantial compliance in Sections N.1, through N.8, for three consecutive compliance visits. This compliance review demonstrated that the Facility not only maintained clinically effective processes, but also continued to enhance its processes to further improve services to individuals served by the Facility. The Monitoring Team compliments the Facility Director for supporting the Facility to move forward to compliance with Provision N, as well as the entire pharmacy and other staff involved in developing, implementing, and maintaining processes not only to meet the requirements of the Settlement Agreement, but also to enhance pharmacy services and improve clinical outcomes. The pharmacy leadership demonstrates a clear understanding of the settlement agreement, and clinical pharmacy. Pharmacy leadership works directly with all relevant staff so staff understand what processes have been developed, and what their respective responsibilities are. The following are comments specific to each Section: **Section N.1**: Because all new medication orders reviewed demonstrated that the pharmacists documented review for clinical appropriateness, allergies, interactions, appropriate dose and necessary clinical

	diagnostics, the Monitoring Team determined that the Facility is in substantial compliance with Provision N.1. **Section N.2:** The Facility continues to produce exceptional QDRRs that should be considered as exemplary models, and is compliant with Section N.2. **Section N.3:** The Facility continued to ensure that metabolic syndrome, polypharmacy, anticholinergic use, stat chemical restraint, and benzodiazepine usage was addressed when completing QDRRs and ensured that regularly scheduled systems review of benzodiazepine, anticholinergic, and polypharmacy usage is conducted through relevant committee structure. For these reasons the Facility remains in substantial compliance. The Monitoring Team compliments the pharmacy for its exceptional clinical oversight of these important issues. **Section N.4:** The Facility continued to ensure that medical providers review and appropriately follow-up on pharmacy recommendations. **Section N.5:** Because the Facility maintained a functional process to assess for dyskinesia, that included more frequent monitoring when necessary, the Monitoring Team determined substantial compliance for Section N.5. **Section N.6:** The Facility maintained an ADR reporting process and reported a total of five ADRs during this review period. The Monitoring Team was pleased to see the addition of a severity scale for evaluating ADRs, robust staff training on the ADR process, and ADRs being reported by staff other then pharmacists. For these reasons, the Monitoring Team determined substantial compliance with Section N.6. **Section N.7**: The Facility maintained a process for providing clinically relevant DUEs, and provided four DUEs during the reporting period. The DUEs provided clinically relevant information, and provided medical providers and pharmacists with information to enhance clinical practice. The Facility provided DUEs for seven FDA advisories, and two scheduled DUEs that were based on operational need. The Facility continued to maintain a functional and clinically relevant DUE process. **Section N.8**: Because the Facility maintained a medication variance process that promptly addressed all reported medication variances, and tracked and trended variances of prescribing, documenting, dispensing, administering, and storage of medication; and because nursing, pharmacy and medical leadership participated in the medication variance process, the Monitoring Team determined substantial compliance.

#	Provision	Assessment of Status	Compliance
N1	Commencing within six months of the Effective	Provision N.1 requires that a pharmacist review all new medication orders to ensure that the medication is for a clinically appropriate indication; evaluate all diagnostics necessary for safe	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	administration of the medication; evaluate efficacy of the drug; ensure that the dose is clinically appropriate; and ensure that there were no contraindications, such as allergies and drug-drug interactions. The pharmacist also utilizes the WORx, drug safety computer program, when reviewing all medication orders. The WORx program is an automated process that assesses for possible drug-drug interactions, known allergies, and prompts the pharmacist to review necessary diagnostics. To document the pharmacist's review of new medication orders, the pharmacist completes a checklist, which is stamped on each new medication order. The stamp includes notation for appropriate indication, evaluation of labs, assessment for allergies, and dose. To assess continued compliance with Provision N.1, the Monitoring Team reviewed copies of the last two medication orders of each month, for October 2013 through March 2013, for a total of 12 new medication orders. In addition, the following information was reviewed for each example provided (Individuals #67, #325, #453, #111, #546, #481, #360, #580, #37, #269, #591, and #485) • Pharmacy documentation of a review for allergies, interactions, required diagnostics, appropriate indication, and dose • Past six months laboratory data • Current medication list • EKG for past three years • Most recent ophthalmology report • Completed SPDI (single patient drug intervention reports) associated with the new medication order The following is a summary of the Monitoring Team's review: • The pharmacist reviewed all new medication orders for potential allergies, interactions, appropriate doses, necessary diagnostics, and indications in 12 out of 12 examples (100%). • The Monitoring Team reviewed the medication order for potential drug interactions with the medication listed on the current medication list, and in 12 out of 12 examples (100%), the Monitoring Team identified no evidence of drug-drug interactions. • When clinically indicated, necessary laboratory diagnostics, EKGs, and consultations were obtained in 12 out of 12 examples (100%). Conclusion Because all new medication orders reviewed demonstrated that the pharmacists documented review for clinical appropriateness, allergies, interactions, appropriate dose and necessary clinical diagnostics, the Monitoring Team determined that the Facility is in substantial compliance with Provision N.1.	
N2	Within six months of the	To assess that the Facility conducts quarterly drug regimen reviews (QDRRs), that are consistent	Substantial

#	Provision	Assessment of Status	Compliance
	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.	with generally acceptable standard of care practice, and that the QDRRs are completed within the Facility's 14 day window for scheduled completion of QDRRs, the Monitoring Team reviewed the following documents: • QDRR schedule for past six months, and pending six months • List of all QDRRs, for the past six months, that were not completed within 14 days of the scheduled completion date • Average daily census • The Monitoring Team selected the first two completed QDRRs for October 2013 through March 2014 (Individuals #247, # 148, #363, #465, #415, #568, #281, #112, #86, #475, #321, and #101), and for those examples, the following information was also reviewed: o Past six months MOSES and DISCUS assessments o Most recent 12 months of lab results o Most recent two EKG reports o Most recent annual physician summary o Most recent psychiatric assessment o Most recent IRRF o Evidence that the medical providers reviewed the pharmacists' recommendations; indication if they agreed or disagreed with the recommendations; and if disagreed, documentation of their clinical rationale <u>Review of QDRR Schedule</u> By review of the QDRR schedule, the Monitoring Team noted that of the 291 individuals residing at the Facility, 289 (99%) individuals had their QDRR completed quarterly. The following is a summary of the Monitoring Team's findings of the document review for the selected sample (Individuals #247, #148, #363, #465, #415, #568, #281, #112, #86, #475, #321, and #101) • Of the 12 examples, there were seven instances of polypharmacy, and in seven out of seven examples (100%), the pharmacist addressed polypharmacy. • There were no examples that included administration of benzodiazepines. • The pharmacist assessed Laboratory and other diagnostics, such as EKGs and DEXA scans in 12 out of 12 examples (100%). • Metabolic syndrome was appropriately assessed in four out of the four examples (100%) that required a review for metabolic syndrome. • The QDRR indicated review by the medical provider in 12 out of 12 examples (100%), and when necessary demonstrated follow up to recommendations • The QDRR indicated review by the psychiatrist in four out of the four examples (100%) of the QDRRs that required review by the psychiatrist. • The completed MOSES and DISCUS were included as part of the assessments for the QDRRs in 12 out of 12 (100%) examples. The IRRFs documented potential serious side effects for	Compliance

#	Provision	Assessment of Status	Compliance
		prescribed medications side effects in 12 out of the 12 examples (100%). • The most recent IRRF documented clinically appropriate risks associated with pharmacotherapy in 11 out of 12 examples (92%). Individual #101 was prescribed Salifenacin, which stated on the QDRR as having "high" anticholinergic properties, but on the IRRF it was stated as having "medium" anticholinergic properties. Furthermore, the associated risk of dizziness and balance issues was not reported as a risk factor for potential falls. • By review of the annual medical assessment, clinical laboratory data, clinical consultations, and other diagnostics, the Monitoring Team concurred with the pharmacists that no new recommendations were required on 12 out of 12 QDRRs (100%). The Monitoring Team noted that previous QDRRs did have recommendations that were addressed prior to this reporting period. • When assessing osteoporosis, the pharmacist: o Commented specifically on the appropriateness of treatment in ten out of ten examples (100%). o Commented specifically on the efficacy of treatment for osteoporosis in ten out of ten examples (100%). • The QDRR clearly delineated effectiveness of all drugs prescribed in 12 out of 12 examples (100%) <u>Conclusion</u> The Facility continues to produce exceptional QDRRs that should be considered as exemplary models, and is compliant with Section N.2.	
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	Provision N.3 requires that the Facility evaluate its process to monitor stat emergency medications, polypharmacy, benzodiazepines, and to monitor factors associated with anticholinergics drugs and metabolic syndrome. The following is the Monitoring Team's review of Facility's processes for monitoring these medication related issues: <u>Review of Anticholinergic Usage</u> To assess the Pharmacists' participation in the monitoring of anticholinergic drug usage at the Facility, the Monitoring Team requested the following documents: • Past six-months committee meeting minutes, demonstrating a systems review for the Facility's usage of drugs with anticholinergic properties • Data, graphs, and data-analysis specific for the pharmacy's monitoring of the use of drugs with anticholinergic properties • Alpha list of individuals who are prescribed anticholinergic drugs • Drug class tracking spreadsheet for anticholinergics • August 8, 2013 Psychotropic Medication Oversight Committee (PMOC) meeting minutes, and PMOC agenda for 4/8/2014	Substantial Compliance

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

For the first, and then every fifth individual on the list of individuals prescribed anticholinergic drugs, for a total of ten examples (Individuals ##26, # 39, #30, #243, #163, #251, #347, #265, #453, and #570)

Most recent two QDRRs
Current medical list
Most recent medical, and psychiatric annual reviews
Most recent MOSES and DISCUS assessments

<u>Systems review of anticholinergic drug utilization:</u>
The Facility provided data, and summary of data analysis, indicating the usage of anticholinergic medications at the Facility. Data charts tracking the number of individuals prescribed anticholinergic medications indicated continued reduction in the usage of anticholinergic medications at the Facility. Review of the 8/8/2013 PMOC meeting minutes, 4/8/2014 PMOC agenda, and associated trends data, demonstrated the Facility's commitment to ensure that anticholinergic medications are used appropriately, and are closely monitored by the Facility. The PMOC minutes documented the Facility enhanced use of cyproheptadine, which has lower anticholinergic property then diphenhydramine. As of January 2014, the Facility reported the following:

Number of individuals prescribed anticholinergic medications
<table>
<tr><th></th><th>January 2010</th><th>January 2014</th></tr>
<tr><td>Benztropine</td><td>23</td><td>11</td></tr>
<tr><td>Cyproheptadine</td><td>0</td><td>4</td></tr>
<tr><td>Diphenhydramine</td><td>3</td><td>2</td></tr>
<tr><td>Glycopyrrolate</td><td>6</td><td>24</td></tr>
<tr><td>Hydroxyzine</td><td>10</td><td>5</td></tr>
<tr><td>Scopolamine</td><td>17</td><td>1</td></tr>
</table>
The Monitoring Team noted a marked reduction, and a low usage of Benztropine. In general, the Facility judiciously uses anticholinergics.

The following is a summary of the pharmacy's clinical review of anticholinergic medications during the QDRR process for Individuals #26, # 39, #30, #243, #163, #251, #347, #265, #453, and #570.

In ten out of ten cases (100%) the QDRR documented the indication for the use of all anticholinergics prescribed.
In ten out of ten cases (100%), the QDRR documented risks associated with the use of anticholinergics.
In ten out of ten cases (100%), the pharmacist documented the efficacy, or lack of efficacy, for the use of anticholinergics.

</td><td></td></tr>
</table>

#	Provision	Assessment of Status	Compliance
		Summary: The Facility demonstrated a review of anticholinergic medication usage in 100% of the examples reviewed by documenting specific usage and indication, as well as risk associated with anticholinergic use. Furthermore, the Facility conducts a systems review for anticholinergic usage, and when necessary develops strategies to help reduce anticholinergic usage. The Facility's review of anticholinergic drug usage, both at the individual and the systems level, is exemplary. <u>Review of polypharmacy usage</u>: To review the pharmacists' participation with assessing the appropriateness of polypharmacy, the Monitoring Team reviewed the following documents: • PMOC meeting minutes for December 2013 and March 2014. • List of all individuals on polypharmacy • For the first, and than every second individual on the list of polypharmacy, for a total of ten individuals (Individuals #367, #167, #1, #382, #248, #439, #144, #215, #200, and #65): o Most recent two QDRRs o Most recent psychiatric assessment o Current medication list o Most recent ISP, or related document the use of polypharmacy <u>Systems review of psychotropic polypharmacy</u> The Facility provided PMOC meeting minutes, and associated data graphs, and summary of the data for psychotropic polypharmacy. The Facility provided comprehensive data, and data analysis, of psychotropic polypharmacy usage. As of February 2014, a total of 135 individuals were prescribed psychotropic medications (46%); 44 individuals, of the 135 individuals who were prescribed psychotropic medications, were prescribed three or more psychotropic drugs (33%). Intraclass polypharmacy was prescribed to 14 out of the 135 (10%) individuals who were prescribed psychotropic medications. Specific to antipsychotic medications, the Facility reported that only seven individuals were prescribed intra-class antipsychotic polypharmacy. Committee meeting minutes demonstrated a comprehensive review of psychotropic polypharmacy, and documented strategies to further reduce psychotropic polypharmacy. In addition to reviewing system issues related to general and psychotropic polypharmacy, the Facility also conducts polypharmacy reviews, during which time the psychiatrist, nurse, pharmacist, and other members of the IDT meet to discuss individuals' prescribed polypharmacy, and develop clinical strategies to help reduce the polypharmacy burden. Individuals who are prescribed polypharmacy are reviewed at the polypharmacy reviews, at least every six months. The following is a summary of the documents reviewed for polypharmacy: • In ten out of ten examples (100%) the QDRR documented the indication for the use of each polypharmacy agent.	

#	Provision	Assessment of Status	Compliance
		• In nine of ten examples (90%), the QDRR documented serious risks for the use the polypharmacy combination. Unlike the nine QDRRs reviewed that had a specific section for polypharmacy, which delineated risks, efficacy, and appropriateness, the QDRR for Individuals #65 did not include such information. • In four out of ten examples (40%), the current IRRF assessment documented specific risks associated with polypharmacy. The Monitoring Team noted that for the six IRRFs that did not specifically address potential and known risk factors for polypharmacy, the IRRF had not been updated since the pharmacy's enhanced practice of including specific risks associated with polypharmacy; the four IRRFs that included specific polypharmacy risks had been completed following the pharmacy's enhanced practice. • In nine out of ten cases (90%), the QDRRs documented clinically justifiable recommendations for continued use, along with the clinical rationale for continued use or consideration for alternative treatments. The QDRR must document recommendations for each medication associated with polypharmacy. The QDRR for Individual #65 did not include such level of review. • In ten out of ten cases (100%), the pharmacist documented the efficacy, or lack of efficacy for the use of polypharmacy. The Monitoring Team noted that the pharmacist included a specific section on the QDRR that documented efficacy of drugs prescribed. Summary The Facility demonstrated a review of polypharmacy usage in 90% of the examples; review included documenting specific usage and indication, and demonstrated enhanced reporting of potential and known risks associated with polypharmacy on the more recent IRRF assessments. <u>Benzodiazepine usage:</u> The Monitoring Team requested the following documents to review the Facility's review of benzodiazepine use: • Alpha list of all individuals on benzodiazepine • Data analysis, and committee meeting minutes reflecting the Facility's systems review for benzodiazepine use • Drug class tracking spreadsheet • For the first five individuals on a list of benzodiazepines used for psychiatric indication, and first five individuals on a list of benzodiazepines used for neurological indication (Individuals #367, #167, #1, #471, #191, #539, #554, #43, and #159): o Most recent two QDRRs o Most recent IRRF o Current medication list o Most recent psychiatric assessment o Most recent annual medical assessment	

#	Provision	Assessment of Status	Compliance
		Trends analysis of benzodiazepine use at the Facility The Facility conducts a semiannual trends analysis of benzodiazepines usage, which is reviewed every six months at the psychotropic medication oversight committee (PMOC) meeting, as well specific review, at the Facility's psychiatric treatment reviews (PTRs), of each individual who is prescribed a scheduled benzodiazepine. As with the semiannual trends analysis, all individuals who are prescribed benzodiazepines are reviewed at the PTR at least every six months. The most recent completed PMOC meeting minutes, dated 10/8/2013, reflected a review of the Facility's usage of benzodiazepines, and reported that a total of 57 individuals were prescribed a benzodiazepine; however, at the time of this compliance review, the Monitoring Team was provided updated data that had not yet been presented at the April 2013 PMOC meeting indicating a total of 68 individuals being prescribed a scheduled benzodiazepine; therefore 68 out of 289 individuals who reside at the Facility (23%) were prescribed a scheduled benzodiazepine drug, of which 29 (10%) were prescribed for a neurology indication, and 39 (13%)individuals were prescribed benzodiazepines for a psychiatric. The most recent PMOC meeting minutes had not been completed at the time of this compliance visit, therefore the Facility's review and comments on the increased the total number of benzodiazepines was not available for review. Review of past PMOC meeting minutes have included a detailed analysis and summary for changes in benzodiazepine usage, and indicated that increased usage was secondary to the Facility's enhanced treatment for spasticity. Assessment of Benzodiazepine Usage Based on review of the clinical documents, per the document request, the Monitoring Team made the following determination, for nine of the ten examples requested (Individuals #367, #167, #1, #471, #539, #554, #43, and #159); one example provided for review, Individual #191, was not prescribed a benzodiazepine and the QDRR did not comment on benzodiazepine usage): • In nine out of nine cases (100%), the QDRR documented the use and indication for the use of the benzodiazepine. • In nine out of nine cases (100%), the QDRR documented risks associated with the use of the benzodiazepine. Impressively, in nine out of nine examples the IRRF documented specific risks for benzodiazepine usage. • In nine out of nine examples (100%), the QDRR documented efficacy or lack of efficacy for the benzodiazepine. • In nine out of nine cases (100%), the QDRR documented recommendations for continued use, along with the clinical rationale for continued use, or consideration for alternative treatments. Summary The Facility demonstrated a review of benzodiazepine usage in 100% of the examples reviewed by documenting specific usage and indication, as well as risk associated with benzodiazepine usage. Furthermore, the Facility conducts a systems review for benzodiazepine usage. .	

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		Assessment of Metabolic Syndrome Monitoring: The Monitoring Team selected the first five individuals on a list of all individuals that are on a neuroleptic, and also all individuals with a prescribed a neuroleptic who had a diagnosis of diabetes, for a total of eight examples (Individuals #403, #243, #133, #300, #106, #24, #152, and #488): • Most recent QDRR • Most recent IRRF • Current medication list • Most recent six months laboratory data • Most recent annual medical assessment • Most recent psychiatric assessment • Most recent ISP or addendum to the ISP documenting risk for metabolic syndrome The following is the Monitoring Team's findings from the document review for metabolic syndrome: • Eight out of eight QDRRs (100%) indicated specific review for metabolic syndrome. • Eight out of eight QDRRs (100%) assessed clinically appropriate risk factors to assess for metabolic syndrome (100%). • The associated IRRF documented a specific risk assessment for metabolic syndrome in eight out of eight examples (100%). • The QDRR documented the pharmacist assessment of risk versus benefit for either continuing or discontinuing the medication associated with metabolic risk in eight out of eight examples (100%). Summary QDRRs indicated a specific and comprehensive review for metabolic syndrome, and associated risks were clearly delineated in the current IRRF assessment. The Monitoring Team compliments the Pharmacy department for exemplary assessment of metabolic syndrome. Review of STAT Chemical Restraint usage: The Facility reported the use of two chemical restraints for behavioral exacerbation during the review period. There was evidence of an extensive review by the clinical pharmacist, and the reader is referred to Section C of this report for complete details. Conclusion: The Facility continued to ensure that metabolic syndrome, polypharmacy, anticholinergic, stat chemical restraint, and benzodiazepine usage were addressed when completing QDRRs and ensured that regularly scheduled systems review of benzodiazepine, anticholinergic, and polypharmacy usage is conducted through relevant committee structure. For these reasons the Facility remains in substantial compliance. The Monitoring Team is complementary to the pharmacy for its exceptional clinical oversight of these important issues.	

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N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	To assess the pharmacist's clinical recommendations, and clinical appropriateness of the medical providers' response to the recommendations, the Monitoring Team assessed the most recent QDRR for Individuals #247, # 148, #363, #465, #415, #568, #281, #112, #86, #475, #321, and #101, which were the same examples as reviewed for Section N.2, of this report. The Monitoring Team also reviewed the first two single patient drug intervention reports (SPDI) that were completed each month during the reporting period (Individuals #269, #248 (x2), #377, #464, #112, #41, #568, #398, #255, #417, and #588), and for this sample, the following additional information was reviewed: • Copy of associated medication order • Documentation of pharmacist's review of the order • Clinical evidence for the medical provider following up on the recommendation, or alternative rationale Review of the requested documents indicated the following: • Review of 12 QDRRs from the sample of individuals reviewed for Provision N.2 (Individuals #247, # 148, #363, #465, #415, #568, #281, #112, #86, #475, #321, and #101), indicated that in 12 out of 12 examples (100%) the medical provider signed the QDRR within 14 calendar days from the completion date of the QDRR. There were no examples of the medical provider not agreeing with the pharmacist's recommendations. • For the 12 SPDIs from the sample completed each month (Individuals #269, #248 (x2), #377, #464, #112, #41, #568, #398, #255, #417, and #588): o Twelve out of 12 SPDI reports and supporting documentation (100%) indicated that the medical provider either accepted the pharmacist's recommendations or provided clinical rationale for not following the pharmacist's recommendations. o There was supporting documentation that appropriate clinical action was taken for 10 out of 12 SPDIs (83%). There was insufficient evidence to indicate the medical provider's follow-up to the pharmacist's recommendations for the SPDI for individuals #41, and #398. o For the SPDI sample, a SPDI physician notification form was completed for 12 out of 12 examples (100%). • The Monitoring Team determined that 24 out of 24 (100%) of the pharmacist's recommendations were clinically appropriate. Conclusion: The Facility continued to ensure that medical provider's review and appropriately follow-up on pharmacy recommendations, and determined substantial compliance for Section N.4.	Substantial Compliance
N5	Within six months of the Effective Date hereof, the Facility shall ensure	To assess the Facility's ability to ensure clinically appropriate drug monitoring of tardive dyskinesia, the Monitoring Team reviewed: • For the first two individuals of each month, during the reporting period, who either started	Substantial Compliance

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	quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	a new neuroleptic drug, or who had a neuroleptic dose change: o All MOSES and DISCUS assessments associated with monitoring the medication change (Individuals #205, #144, #205, #423 (x2), #408, #13, #349, #251, #243, #1, and #471) • Most recent MOSES for individuals #247, # 148, #363, #465, #415, #568, #281, #112, #86, #475, #321, #101 (same sample as used for Section N.2 of this report) • The reader is also referred to Provision J.12 of this report for additional comments regarding drug side effect monitoring. The following is a summary of the Monitoring Team's review of the Facility's monitoring for dyskinesia: • More frequent monitoring for dyskinesia by MOSES and DISCUS assessments than the standard schedule was noted in 12 out of 12 examples (100%) that included either the addition of a neuroleptic, or dose change of a neuroleptic (Individuals #205, #144, #205, #423 (x2), #408, #13, #349, #251, #243, #1, and #471) • Of a combined 30 DISCUS assessments reviewed, 28 out of 30 (93%) were completed and signed by the medical provider. It should be noted that some of the individuals reviewed had more then one DISCUS assessment • For the most recent MOSES assessments reviewed for individuals #247, #148, #363, #465, #415, #568, #281, #112, #86, #475, #321, #101, 12 out of 12 examples (100%) were completed and signed by the medical provider. In addition, of a sample of 20 MOSES screens reviewed for Provision J12, twenty of 20 (100%) had completed administrations and prescriber reviews for both the psychiatrist and primary care physician and for 19 of 20 (95%); the reviews were completed within 14 days. Twelve of 20 (60%) were in response to a change in medication dose, and eight of 20 (40%) were done as part of the requirement for a routine screening every six months. In a sample of 18 DISCUS screens reviewed for Provision J12, 17 (94%) had a review form that was signed by the psychiatrist, one did not. All of the completed reviews were signed within 14 days. Fifteen of the 18 (83%) DISCUS review forms had detailed comments by the psychiatrist. Six of 18 DISCUS forms were done in response to a change in medication. The Monitoring Team recognizes that the Facility had recently switched to an electronic format for reporting on MOSES and DISCUS assessments, and at the time of this compliance visit, the computerized product was not fully functional, and required the Facility to include a hand written version of the assessment tools in order to document review. The Facility's use of a hand written version was acceptable, as it documented review. Assessment for dyskinesia is also assessed in Section J.12 of this report and the reader is referred to	

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		that section for a more detail analysis of MOSES and DISCUS assessments. Conclusion: Because the Facility maintained a functional process to assess for dyskinesia, that included more frequent monitoring when necessary, the Monitoring Team determined substantial compliance for Section N.5.	
N6	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the timely identification, reporting, and follow up remedial action regarding all significant or unexpected adverse drug reactions.	To assess the Facility's ADR (adverse drug reaction) process, the Monitoring Team requested all associated clinical documentation for the first, and then every second ADR, for a total of ten ADRs, that occurred during this review period; updated policies and procedures for ADRs; all data, trends analysis, summary review, and committee meeting minutes related to a system review of ADRs at the Facility; and staff training materials, specific to the ADR process. To assess compliance for Section N.6 the Monitoring Team reviewed the following information: • Pharmacy and Therapeutics committee (P&TC) meeting minutes for 2/6/2014 and 4/10/2014. • Adverse Drug Reaction Report tracking spreadsheet. • List of all ADRs reported during this reporting period. • BSSLC Policy: Pharmacy Services and Safe Medication Practices N.10, dated 3/7/2014. • BSSLC Policy: Adverse Drug Reaction (ADR) Annual Training, N10.1, 1/4/14, policy revision on 3/7/14 • ADR training records The pharmacy department provided an ADR tracking and trending spreadsheet that indicated five ADRs were reported during this reporting period (Individuals #444 (x2), #41, #149, and #276). Following pharmacy review none of the reported ADRs were reportable to the FDA MedWatch program, and one of the reported ADRs, Individual #149, was determined by the pharmacist not to be an actual ADR. The Facility reports ADRs at the quarterly P&TC meeting. Review of the P&TC meeting minutes for 2/6/2014 and 4/10/2014 indicated that all ADRs that were reported during the quarter were documented on the P&TC meeting minutes, and reflected a comprehensive review by the P&TC members, that included a review of each ADR, and summary of action steps that were taken specific each ADR. The Facility maintained a database of all ADRs that includes the individual's name, living area, ADR associated medication, date ADR was identified, type of clinical reaction, and if the ADR was or was not reported to the FDA. The Facility provided training rosters that indicated all direct support staff, nurses, medical providers, PT/OT, and pharmacists had been trained on identifying and reporting ADRs. At the time	Substantial Compliance

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		of this report, the following staff had been provided annual training on the Facility's ADR process: • Direct care staff: 444 out of 521 staff (94%) • Nursing staff: 125 out of 127 (98%) • Physical and occupational therapists: 24 out of 24 (100%) • Pharmacists: 4 out of 4 (100%) • Medical prescribers: 8 out of 8 (100%) • Psychology staff: 22 out of 22 (100%) The following is the Monitoring Team's summary of the four ADRs reported: • An ADR reporting form was completed for each ADR reported during the review period, in four out of four examples (100%). • The ADR reporting form was fully completed in four out of four examples (100%). • The pharmacist provided comments regarding the ADR in four out of four examples (100%). Section I of the ADR reporting form has a section listing action steps taken to prevent future ADRs from occurring. Section II of the ADR reporting form includes a section for the pharmacist to comment following P&TC review. • Clinically appropriate follow-up and/or treatment for the ADR was noted in four out of four examples (100%). • There was a severity level documented on the ADR reporting form in two out of four examples (50%). It should be noted that as of December 2013, the Facility had enhanced the ADR reporting process by including the modified Hartwig's Severity Assessment Scale, and this was reflected on the ADR reporting forms for Individuals #149 and #276. • For the five ADRs reviewed, two out of five (40%) were reported by pharmacists; one out of five was reported by a nurse (20%); and two out of five were reported by the medical provider (40%). The Monitoring Team noted that ADRs are now reported by a variety of staff, and not just pharmacy staff, which is a positive finding. • The ADR was reported by medical providers and nurses at the time of the initial clinical manifestation in three out of five examples (60%). The pharmacy identified the remaining two (40%) when doing QDRRs, which is a positive finding. Conclusion The Facility maintained an ADR reporting process and reported a total of five ADRs during this review period. The Monitoring Team was pleased to see the addition of a severity scale for evaluating ADRs, robust staff training on the ADR process, and ADRs being reported by staff other then pharmacists. For these reasons, the Monitoring Team determined substantial compliance with Section N.6.	
N7	Commencing within six months of the Effective Date hereof and with full	To assess the Facility's development and provision of drug utilization evaluations (DUEs) the Monitoring Team requested the following information: • Complete DUE schedule for 2013 through 2015, to include all DUEs provided and pending	Substantial Compliance

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	implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	• Copies of all DUEs provided during the reporting period • P&TC meeting minutes, February 6, 2014 <u>DUE Schedule:</u> The Monitoring Team reviewed the DUE schedule and noted that the Facility developed and implemented two scheduled DUEs, and seven unscheduled DUEs that were secondary to FDA alerts. <u>Review of completed scheduled DUEs:</u> The Facility provided copies of the following DUEs, that were completed during the reporting period: • Multivitamin therapy with enteral feeding • Phenytoin <u>FDA advisories:</u> The FDA issued many advisories during the six-month reporting period. The FDA advisories relevant to the medical providers at the Facility included warning for the following drugs: • Rosiglitazone • Onfi • Methylphenidate • Sodium phosphate • Acetaminophen • Testosterone • Saxagliptin The Monitoring Team reviewed the FDA MedWatch website, and determined that the Facility conducted all necessary DUEs associated with FDA alerts. The Monitoring Team noted that the DUEs provided an excellent review of drug utilization, and meaningful clinical information was well delineated in each report. The Facility determined what scheduled DUE would be developed and presented at the P&TC meeting, based on operational needs. Non-scheduled DUEs were developed secondary to FDA MedWatch alerts, which are monitored by the pharmacy department. Each DUE was completed by the pharmacy department and included a review of the current literature, prescribing practice at the Facility, and pharmacists recommendations. Completed DUEs were distributed to medical providers, and presented at the P&TC meetings. <u>Conclusion:</u> The Facility maintained a process for providing clinically relevant DUEs, and provided four DUEs during the reporting period. The DUEs provided clinically relevant information, and provided medical providers and pharmacists with information to enhance clinical practice. The Facility	

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		provided DUEs for seven FDA advisories, and two scheduled DUEs that were based on operational need. The Facility continued to maintain a functional, and clinically relevant DUE process; therefore, the Monitoring Team determined substantial compliance.	
N8	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall ensure the regular documentation, reporting, data analyses, and follow up remedial action regarding actual and potential medication variances.	The Monitoring Team assessed the Facility's medication variance process by reviewing the following documents: • BSSLC Policy N.12 Pharmacy Services and Safe Medication Practices, Medication Variances 2/12/14 • Medication variance committee meeting minutes, for 10/2013 through 3/2014 • All graphs, data tables, and data analysis for medication variances used by the Facility for a systems review of medication variances • List of all medication variances that occurred during the reporting period • For the first two reported medication variances that occurred each month during the reporting period (Individuals #400, #75, #195, #205, #367, #545, #57, #367, #322, #39, #89, and #335): o Copy of completed medication variance report form o All physician IPNs associated with the medication variance o All nursing IPNs associated with the medication variance o All pharmacy documentation, and communication related to the mediation variance o All IDT minutes specific to the medication variance o Documentation that the guardian was notified of medication variance of category C or worse The Monitoring Team attended the Medication Variance Committee Meeting on October 9. 2013. <u>Policy</u> BSSLC Policy N.12 Pharmacy Services and Safe Medication Practices, Medication Variances was taught to all new Facility and agency nurses during orientation. <u>Medication Variance Monitoring and Analysis</u> The Facility continued to maintain an excellent Medication Variance Database to record, track, analyze, trend, and report data. The Monitoring Team refers the reader to Provision M.6, of this report, for a comprehensive review of the Facility's data analysis of medication variances that occurred during the reporting period. <u>Completion of Medication Variance Reports</u> The Monitoring Team reviewed ten of the most recently completed Medication Variance Reports for Individuals #400, #75, #195, #205, #367 (x2), #545, #57, #322, #39, #89, and #335: • The Medication Variance forms were fully completed, and indicated the type of variance,	Substantial Compliance

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severity index, physician notification, and review by the department supervisor, in 11 out of 12 (92%) examples. A medication variance report form for Individual #39 was not included for review.

- The department supervisor documented appropriate corrective action on the medication variance report form in 12 out of 12 (92%) examples.
- Nursing Administration reviewed the Medication Variance Reports before they were entered into the Medication Variance Database for any corrections and further corrective action.
- Medication variances were incorporated into the medication variance database and after analysis by the pharmacy department, a summary was presented to the Medication Variance Committee for review in 12 out of 12 (100%) examples.

An additional sample of medication variance reports was reviewed and reported on in Provision M6. Findings were consistent.

Medication Variances Reported:

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. Medication Variances by discipline reported for the past 11 months, March 2013 through January 2014, showed the following results in the chart below:

Medication Variances by Disciplines – March 2013 through January 2014

Month/Year	Mar 2013	Apr 2013	May 2013	June 2013	July 2013	Aug 2013	Sept 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014
Pharmacy	31	10	8	6	8	8	6	32	8	7	8
Nursing	90	67	133	162	124	118	116	134	108	104	165
Medical	6	14	9	10	9	6	9	16	10	6	10
Dental	0	0	0	0	0	0	0	0	2	0	0
Total	127	91	150	184	141	132	131	182	128	117	183

*Medication Variance data for February 2014 was not finalized.

The Medication Variance data showed fluctuation from month to month by all responsible departments, with the exception of Dental. A review of the Medication Variance Committee Meeting minutes, as well as minutes reviewed at the last compliance review, showed that Medication Variances continued to be analyzed and trended by all responsible departments, and with appropriate local and/or systemic corrective action taken for all identified medication variances.

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		Medication Variance Committee Meetings: • Of the monthly Medication Variance Committee Meetings scheduled, six of six (100%) occurred as scheduled. • Of the six Medication Variance Committee Meetings conducted the attendance list showed that 100% of the core membership consistently attended the meetings. • The Committee continued to be co-chaired jointly by the Pharmacy Director and Nursing Operations Officer. The committee minutes showed that old business carried over from the previous meeting was followed up at the next meeting as indicated. The committee continued to analyze and trend monthly and quarterly Medication Variance Data Reports by: department, severity levels, types of medication variances, classification of medications, contributing factors leading to the medication variances, and any local and/or systemic corrective action taken by the respective departments and/or Facility-wide. In addition, monthly Medication Observations, Medication Administration Record Audits, and Medication Room Audits were reported at the meetings, including findings and any corrective actions taken locally and/or systemically by the Nursing Department. • The Board Certified Behavioral Analyst (BCBA) continued as a core member of the committee. Individuals who had medication variances related to omissions/extra doses of psychoactive medications were reported to the psychologists/BCBAs to follow-up for changes in behaviors, which may correlate with the medication variances. These individuals were observed with data collected for challenging behaviors, which may have resulted because of the psychoactive medication variances. Observations were made the day of the medication variance, the day before, and the day after. Any individuals' challenging behaviors that were found to correlate with psychoactive medication variances were reported to the committee for further review and disposition. • Case Analysis: The February 25, 2014, Medication Variance Committee Meeting minutes documented that a case analysis was performed by the Clinical Pharmacist on concurrent use of phenytoin and enteral nutrition, which may result in decreased serum phenytoin levels. There had been some discussion by the clinical staff regarding stopping enteral nutrition one hour before and after administering phenytoin. The case analysis stated, "Ideally, tube feedings should be held one to two hours before and after each phenytoin dose with adequate flushes before and after phenytoin administration. However, in some instances it is not feasible to stop feedings for up to eight hours/day (e.g. some individuals with reflux or other gastric condition who cannot receive large servings of food may require continuous tube feedings). The package insert for phenytoin recommends giving phenytoin consistently with regard to meals and other medications to compensate for any drug-drug or drug-food interactions that may be occurring." The committee accepted the recommendations from the case analysis. • The Monitoring Team reviewed the monthly Medication Variance Committee Meeting minutes, September 2013 through March 2014. A review of the committee minutes found they were consistent with the information found in the Facility's Self-Assessment for this Provision.	

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		Conclusion Because the Facility maintained a medication variance process that promptly addressed all reported medication variances, tracked and trended prescribing, documenting, dispensing, administering, storage of medication variances; and because nursing, pharmacy and medical leadership participate in the medication variance process, the Monitoring Team determined substantial compliance.	

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. BSSLC Self-Assessment, dated 3/18/14 2. BSSLC Action Plan 3/18/14 3. Section O Presentation Book 4. BSSLC Policy P.1 Habilitation Therapy Services 1/30/14 5. BSSLC Policy P.2 Physical Nutritional Management Plan 1/30/14 6. BSSLC Policy O.1 Physical and Nutritional Management Team 1/30/14 7. PNMT Discharge Flow Chart (9/27/13) 8. Work Standard (rev: 4/2/14) Record reviews: 9. Sample O.1: Individuals #19, #29, #35, #38, #68, #141, #191, #230, #318, and #437 10. Sample O.2: Individuals #141 and #496 11. Sample O.3: Individuals #89, #149, #226, #428, #465, and #481 12. Sample O.4: Individuals #14, #16, #29, #37, #44, #51, #53, #69, #89, #92, #94, #97, #134, #163, #186, #193, #215, #243, #249, #259, #269, #272, #273, #291, #304, #318, #322, #323, #330, #331, #366, #343, #370, #422, #423, #428, #436, #445, #449, #453, #461, #492, #508, #519, #523, #527, #543, #554, #570, #582, #591, and #597 13. 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 6 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 6 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 14. Caseloads of Physical and Nutritional Management Team (PNMT) dedicated and non-dedicated members 15. 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 16. PNMT members and PNMT back up curriculum vitas 17. QA reports/matrix since the last compliance review 18. List of referrals to the PNMT since the last compliance visit 19. PNMT RN post hospitalization assessments completed since the last compliance visit 20. PNMT assessment template 21. PNMT Action Plan template 22. Integrated Risk Rating Form (IRRF) template 23. Integrated Health Care Plan (IHCP) template 24. List of new employees since last compliance visit and their PNM related performance check offs 25. 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) 26. Facility documentation showing categories of staff requiring annual refresher training, numbers of staff requiring training, and numbers of staff who have successfully completed training 27. PNM Monitoring Tool template 28. Last three months of PNM monitoring data (including date, activity monitored, time of monitor, person conducting monitor) 29. For Individuals in Sample: a. All ISPs in the last 12 months b. All ISPAs in the last 6 months c. All IRRFs in the last 12 months d. All IRRF Action Plans in the last 12 months e. IHCP/Action Plan f. QIDP Monthly Reviews for the last 6 months g. Positive Behavior Support Plans (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 integrated progress notes (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. Trigger sheets completed in the last 6 months, including the current month p. PNMPs in the last 12 months, including pictures q. Dining Plans in the last 6 months, including pictures r. Completed PNM-related monitoring sheets in the last three months s. Evidence of effectiveness monitoring completed within the last six months t. Aspiration Pneumonia Enteral Nutrition (APEN) in the last 6 months u. 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, frequency of subsequent assessments and staff responsible, and monthly progress notes) v. Direct intervention plan and supporting documentation for implementation of the plan (i.e., monthly progress notes) w. Individual notebooks (PNM section) **People Interviewed:** 1. Kori Kelm Physical Therapist (PT), Habilitation Therapy (HT) Director 2. Tracy Searles Physical Therapy Assistant (PTA), 3. Christina Koehn CCC-SLP 4. Direct Care Professionals on (2) Childress, (2) Driscoll, and (2) Bowie. **Meetings Attended/Observations:** 1. PNMT meeting 4/8/14 2. Mealtimes and transitions (Bowie, Childress, and Driscoll) 3. Daily activities on Driscoll, Childress, Bowie, and Fannin
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section O, dated 3/18/14 and Action Plan dated 3/18/14. 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, The Self Assessment for Provision O.1 only included evidence of PNMT composition and attendance and did not include information regarding the need for a comprehensive PNMT policy or the need for specialized training

	in the form of continuing education. ▪ 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. ▪ The Facility rated itself as being in compliance with five of the provisions of Section O (Provisions O.1, O.2, O.3, O.5, and O.8). This was inconsistent with the Monitoring Team's findings. The Monitoring Team found BSSLC to be in compliance with Provisions O.1, O.5 and O.8 but not be in compliance with Provisions O.2, O.3, O.4, O.6, and O.7. o Provision O.2 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 meeting. Additionally, the IDT lacked evidence of comprehensive review and root cause analysis as well as an overall lack of urgency that was felt to pose an unnecessary risk to the individual. o Provision O.3 was found not to be in compliance due to PNMPs not being comprehensively reviewed by the individual's IDT in the annual ISP meeting. Additionally, the communication component of the PNMP was lacking detail as well as detail surrounding strategies to mitigate risk during meals. o Provision O.5 was found not to be in compliance The Action 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. All criteria identified as part of the provision requirements were not represented as part of the self-assessment. Methods to gauge quality and not just presence should be investigated and integrated as part of the Action Plan. Additionally, many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcomes and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities.
	Summary of Monitor's Assessment: Overall, while improvement continued to be noted in some areas, others showed a marked decline. BSSLC was able to maintain a fully functional PNMT but concerns were noted regarding the decreased interventions of the PNMT and involvement with guiding the IDT in their greater role in PNM care. Lack of guidance has resulted in lack of thorough and timely assessment **Provision O.1:** This provision was determined to be in substantial compliance. BSSLC had a Physical and Nutritional Management Team that included all the relevant professionals. **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 meeting. There were many instances in which proper assessment was delayed with lack of temporary modifications implemented to mitigate risk until completion. **Provision O.3:** This provision was determined to be not in compliance. PNMPs were now lacking detail how staff can improve communication with the individual as well as strategies to mitigate risk during intake. PNMPs were not consistently readily available to staff. **Provision O.4:** This provision was determined to be not in compliance. Staff were not consistently observed implementing the PNMP. Strategies during mealtime were not consistently implemented, nor were strategies to ensure correct positioning. It should be noted that positioning implementation did improve by 37% since the last review while dining decreased by 7%. **Provision O.5:** This provision was determined to be in substantial compliance. A formal process did exist that would ensure pulled staff members responsible for implementing individual specific plans for individuals with physical or nutritional management problems received individualized specific training prior to working with the individuals. Additionally, new staff as well as current staff was provided with initial comprehensive and annual refresher courses. **Provision O.6:** This provision was determined to be not in compliance. Concerns with monitoring data as well as method for scoring the monitoring form resulted in concerns regarding reliability of the process. **Provision O.7:** This provision was determined to be not in compliance. PNMPs were not being comprehensively reviewed by the individual's IDT during the annual ISP meeting or as part of the monthly QDDP review. It should be noted that a new process had just been implemented in which the Physical and Nutritional Management Plan Coordinator (PNMPC) will share monitoring information with the QIDP so that it can be integrated into the monthly review. The concern as stated in Provision O.6 is the reliability of the data. **Provision O.8:** This provision was determined to be in substantial compliance. Return to oral intake was included as part of the Habilitation Assessment and there was a clear determination of whether the individual was a candidate for an oral motor treatment program to improve potential for by mouth (PO) intake.

#	Provision	Assessment of Status	Compliance
O1	Commencing within six months of the Effective Date hereof and with full implementation within two	The following samples were utilized for Section O: Sample O.1 consisted of a non-random sample of eight 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	Substantial Compliance

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	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,	related issues [i.e., aspiration, choking, falls, fractures, respiratory compromise, weight (over 30 or under 20 BMI), enteral nutrition, GI, osteoporosis], required mealtime assistance and/or were 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 (e.g., 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 normally consists of individuals who were assessed, reviewed, and/or tracked by the PNMT over the last six months. BSSLC's process focused much more on the IDT providing assessment with PNMT support unless identified criteria were met which would then result in PNMT assessment. Therefore to address this area, the individuals contained within Sample O.1 were at times added to Sample O.2. It should be noted that only one individual received a comprehensive PNM evaluation and one individual received a focused PNMT assessment. Sample O.3 consisted of six 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 four individuals who were receiving oral motor therapy. Sample O.4 consisted of 43 individuals observed on Bowie, Childress, Fannin, and Driscoll during positioning and mealtimes This provision was determined to remain in substantial compliance. BSSLC had a policy that addressed the needed components to ensure implementation of the PNMT process. Components now included in the policy included requirements for continuing education for PNMT members, collaboration with the Dental Department to address the risk of aspiration during and after dental appointments including after the use of general anesthesia, the requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs, and requirements for continuing education for PNMT members. All of the components that were missing during the previous review were now included as part of the policies. **PNM Policy and Role of the PNMT:** The Facility now had evidence of a PNM Policy that addressed all the listed components,. The PNM policy did include: • 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,	

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	physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	the physical and nutritional management team; ▪ The roles and responsibilities of the PNMT; ▪ The composition of the Facility Physical and Nutritional Management Team (i.e., registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders) to address individuals' physical and nutritional management needs; ▪ 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; ▪ 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; ▪ A comprehensive PNM monitoring process designed to address 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	

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		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 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 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. 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. Newly added components to the PNM policy included: ▪ The requirement of PNMT members to have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs. Although not in policy, all coursework completed by members of the PNMT was relevant to the population served as well as PNM issues. ▪ Requirements for continuing education for PNMT members; Although this was not included as part of the policy, through review of CEUs completed, PNMT members were noted to have received relevant training. ▪ Collaboration with the Dental Department to address the risk of aspiration during and after dental appointments, including after the use of general anesthesia. The PNMT continued to be involved in reviewing and analyzing facility trends related to their scope of practice. This included but was not limited to pneumonia, weight loss, and skin breakdown. Evidence of this analysis was well documented in the PNMT minutes and included corrective action plans to address any noticeable negative trends. The PNMT continued to provide a review of facility PNMPs, weight issues, skin integrity, and pneumonia on a monthly basis. **<u>Core PNMT Membership</u>:** Based on interview with the Director of HT and review of PNMT minutes, the Facility PNMT did	

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		have the appropriate disciplines as defined in the Settlement Agreement. BSSLC had identified the Registered Nurse (RN), Physical Therapist (PT), Speech Language Pathologist (SLP), Occupational Therapist (OT), Registered Dietitian (RD) and Physician (MD) as standing core members. Additionally, a Senior Direct Support Professional (DSP-IV) continued to be present at many of the meetings. **Consultation with Medical Providers and IDT Members** For nine of 11 individuals in Sample O.1 and O.2 (82%), evidence was provided of routine participation of medical staff in meetings, review of assessments, and other needed activities. There was lack of consistent medical personnel present at the ISPA meetings in which issues related to PNM were discussed. For nine of 11 individuals in Sample O.1 and O.2 (82%), evidence was provided of routine participation of IDT members in meetings, review of assessments, and other needed activities. For example, Individual #437 did not have the Speech pathologist (SLP), Physical Therapist (PT) or Occupational Therapist (OT) present in the meetings in which the PNM related events were discussed. **Qualifications of PNMT Members** Six of six core PNMT members (100%) were licensed to practice in the state of Texas. Six of six core PNMT members (100%) had specialized training in working with individuals with complex physical and nutritional management needs in their relevant disciplines. **Continuing Education** Six of six core 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: Strategies for Sensory-Based Behavioral Challenges ▪ SLP attended: Implementing Oral Care/Free Water Protocol Studies in Acute Care ▪ OT attended: Medication Administration for Nurses ▪ RD attended: Nutrition and Oral Health ▪ RN attended: Essentials of Dysphagia Evaluation **PNMT Meetings** From 8/1/13 to 1/31/14, of the 24 weeks, the team met 27 times during the sampled time period. All core members of the PNMT were present for at least 80% of meetings. Attendance by core PNMT members for 27 meetings conducted during the time frame from	

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		8/1/13 to 1/31/14 was: ▪ Chairperson/Coordinator/PNMT PT: 96% attendance by core member ▪ RN: 93% attendance by core member ▪ OT: 89% attendance by core member ▪ SLP: 96% attendance by core member ▪ RD: 93% attendance by core member Other members identified by BSSLC as being core PNMT members had the following attendance figures: ▪ MD: 89% attendance The Facility PNMT did have a sustainable system fully implemented for resolution of systemic issues/concerns. The system included but was no limited to: ▪ 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, and PNMT 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 (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	**Identification of PNM risk** Two hundred sixty seven of 267 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 problems"). BSSLC continued to show an improvement in identifying those individuals who are at risk and assigning the appropriate risk classification as it relates to issues related to PNM. Eight of 11 individuals in Samples O.1 and O.2 (73%) 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). Individuals who were identified as having severe pharyngeal dysphagia with significant histories of pneumonia were identified as only being at a medium risk of aspiration. For example, individual #38 was only identified as being medium risk of aspiration when there was clear documentation stating that the individual had a large hiatal hernia, gross silent aspiration and poor dentition.	Noncompliance

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	physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	**Physical and Nutritional Management Team Referral Process** Seven of 11 (64%) individuals from Sample O.1 and O.2 were appropriately referred to the PNMT based on the criteria included in the Facility policy. The concern noted was that the policy stated that individuals did not require referral until the following criteria was met: • Two choking episodes in a year • Two Aspiration Pneumonias in one year This was noted to be a reactive approach. The current policy resulted in many individuals having pneumonias without being provided with a thorough review and or assessment. Additionally, individuals who did meet the criteria were not referred to the PNMT as dictated by policy. For example, Individuals #68, #191, and #318 were not referred for PNMT assessment although they all had two or more pneumonias over the past year. Individual #38 was not referred to the PNMT although the Individual was experiencing severe physical and nutritional issues including but not limited to multiple aspiration and pneumonia events as well as weight loss. It should be noted that the individual was admitted to the hospital on 1/27/14 with pneumonia and died shortly afterwards. In seven of 10 individual records reviewed from Sample O.1 (70%), when an individual experienced a change in status that would initiate a referral or review to/by the PNMT, there was evidence of an IDT referral to the PNMT within five working days of the ISPA meeting. During the last compliance visit, 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. This process has shown some decline since the previous compliance visit. Although the PNMT RN continued to provide initial review in a timely manner, the participation by the PNMT with the IDT was lacking and resulted in a significant decrease in determining the root cause of the PNM related event. For example, Individuals #191, and #437 were not seen by the PNMT as it was determined that this level of intervention was not needed. The concerns were that the reasoning behind not requiring PNMT intervention was not consistently provided and there was no evidence of PNMT support during the ISPA in which root cause and development of supports should have occurred. Because of this lack of PNMT support, evidence of root cause analysis was significantly lacking. A continued component of the PNMT meeting that was noted through review of PNMT minutes was the PNMTs involvement in the review of pneumonia and skin breakdown trends. Reviewing	

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		and identifying trends and the potential 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. The concern again was that detailed root cause analysis was not consistently provided at the IDT level. No individuals from Sample O.1 received a feeding tube since the last review; therefore, based upon the data provided as part of the document request, Individual #465 was chosen as this was the only individual who had recently received enteral nutrition. Based upon review of the PNMT minutes, The individual had not (0%) been referred to or discussed by the PNMT prior to the placement of the tube. **PNMT Assessment** Only two individuals received a type of PNMT assessment since the last review. One assessment was comprehensive while the other was focused on mealtime. This represented an increasingly concerning shift in which the PNMT was becoming less involved and providing less oversight to the IDT and to those who were in need of such services. Because of this shift, the effectiveness of the PNMT became difficult to fully measure. Two of two 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). Both of these assessments were provided upon return from the hospital. 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. Overall the Monitoring Team had concerns regarding the overall sense of urgency when responding to or mitigating observed signs of health decline. Two of two PNMT assessments in Sample O.2 (100%) were completed within no more than 30 days of the date initiated, or no more than 45 days in extenuating circumstances. However, when the assessments completed by the IDT in response to PNM issues are considered, seven of 11 IDT assessments in Sample O.1 and O.2 (64%) were completed within no more than 30 days of the date initiated, or no more than 45 days in extenuating circumstances. Individuals #191 and #19 both were identified as needing assessments to rule out mealtime issues and the need to assess Head of Bed (HOB) Elevation. There was no evidence that these assessments occurred. BSSLC had a priority process for the assessment of HOB elevation but once a need is identified with someone who is experiencing potential triggers then the individual should move to the top of the list. Another example was Individual #230 who was recommended on 3/19/2014 to have a modified barium swallow study (MBSS) due to a pharyngeal delay with observed overt signs of dysphagia,	

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		Rather than move forward with the order due to concerns with aspiration, the recommendation was held until the IDT meeting which did not meet until 14 days later. At that time, the IDT agreed and the recommendation was to consider a MBSS. As of 4/11/2014, the MBSS had not been scheduled. Additionally, there was no evidence since the 3/19/14 observation of any notes showing additional monitoring to ensure safety until a study could be scheduled and completed. The process currently in place at BSSLC was one in which the PNMT only required referrals should the below criteria be met: • Two choking episodes in one year; • Two Aspiration Pneumonia diagnoses in one year; • Results of PNMT Nurse Post-Hospitalization Assessment for individuals diagnosed with any of the following: o Aspiration Pneumonia; o GI Issues; o Fractures; o Skin Integrity; and o Seizures; • New or proposed enteral feeding; • Unresolved vomiting (>3 episodes in 30 days not related to viral infection); • Significant/unplanned/verified weight loss or gain of: o >5 pounds in one month; o 3 or more pounds per month for 3 consecutive months or 7.5% of bodyweight for 3 consecutive months; or o 10% of body weight in 6 months; As stated above, only one comprehensive PNMT assessment was completed since the last compliance visit. For the assessment completed for Individual # 141, all of the components needed to represent a comprehensive Physical and Nutritional Assessment were present. These components: • Contained date of referral by the IDT. This information was contained within the ISPA, ISP and/or PNMT assessment • Contained date assessment was initiated. This information was contained within the PNMT assessment, PNMT minutes, Habilitation Therapies Assessments, or PNMT minutes. • Contained evidence of review and analysis of the individual's medical history. This information was contained as part of the PNMT RN Assessment. • 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. • Included updated risk ratings based on the PNMT's assessment and analysis of relevant	

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		data. This information was contained within the IRRF, and Habilitation Therapy Assessments and/or PNMT evaluation as indicated. • Contained evidence of discussion of the individual's behaviors related to the provision of PNM supports and services, including problem behaviors and skill acquisition. • 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.) • Contained assessment of musculoskeletal status • Contained evaluation of motor skills • Contained evaluation of skin integrity as indicated by the PNMT RN Assessment. • Contained evaluation of posture and alignment in bed, wheelchair, or alternate positioning, including during bathing and oral hygiene. • Contained evaluation of current adaptive equipment. • 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 and the PNMT RN Assessment. • Contained evaluation of potential or actual drug/drug and drug nutrient interactions. • Identified residual thresholds, if enterally nourished. • Contained a tableside oral motor/swallowing assessment, including but not limited to mealtime observation. • Contained review of respiratory status. This was contained within the PNMT RN Assessment and discussed as part of the PNMT meeting. • Contained evidence of review/analysis of lab work. • Contained evidence of review/analysis of medication history over the last year and current medications, such as changes, dosages, administration times, and side effects. • 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. • Contained oral hygiene status. • Contained evidence of observation of the individual's supports at their home and day/work programs. • Contained evidence that the PNMT conducted hands-on assessment. • 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. • 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. • Contained the establishment and/or review of individual-specific clinical baseline data	

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		to assist teams in recognizing changes in health status. This information was contained as part of the PNMT Assessment, IRRF, PNMT minutes and ISPA. • 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. • Contained evidence of revised and/or new interventions initiated during the 30-day assessment process (i.e. revision of the individual's PNMP). • Contained recommendations for monitoring, tracking or follow-up by the PNMT. Missing from the process were clear clinical thresholds in which referral back to the PNMT and/or IDT would be appropriate. • Contained signatures with dates. Concerns noted with the current process were as follows: o Individuals who were expected (per policy) to be referred to the PNMT for assessment were not consistently provided with such assessment. For example, Individuals #318, #191, and #68 all had multiple pneumonias over the past 12 months but were not assessed by the PNMT. o Individuals who experienced PNM related hospitalizations were not consistently provided with comprehensive review or assessment that addressed all the needed components. o Participation and guidance by the PNMT has significantly decreased since the last compliance visit. For example, Individuals #437 and #191 did not have PNMT members, SLPs, OTs, or PTs present at the ISPA discussing the hospitalizations. These discussions were directly related to a PNM related hospitalizations. BSSLC may want to consider looking at the timeliness of the IDT response to hospitalizations. It was noted that the IDT would at times schedule the hospitalization change of status meeting so quickly upon return that no team member had an opportunity to see the individual or review the information. While quick, this results in a less than adequate opportunity for proper discussion and root cause analysis. o There was a lack of review of components that could have potentially influenced the aspiration event. For example, there was no evidence that mealtime was reviewed in response to Individual #191's aspiration event. o There was an overall lack of urgency in response to potentially dangerous signs and symptoms. These included but were not limited to overt signs of aspiration. A detailed example focuses on Individual #38 who had a significant history of pneumonia. Multiple observations/assessments on multiple days identified overt signs and symptoms of declining health and increased likelihood of severe aspiration. Signs and symptoms noted	

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		included but were not limited to regurgitating into the mouth, increased fatigue during meals, increased oral residue, coughing with struggle, oral pocketing and difficulty chewing. These issues began in earnest on 12/3/13. The SLP noted on 12/3/13, 12/4/13, 12/5/13, and 12/6/13 before a diet texture change was recommended. Once the recommendation was made due to concerns over risk of aspiration, the order was not written for another three days. Once the diet was changed, there was no more follow up by the SLP until ten days later (a similar issue occurred with Individual #230). Also recommended on 12/6/13 was a MBSS. The MBSS was scheduled for 12/20/13 but was not able to be completed due to hospitalization. Although there were significant signs of aspiration, there was no follow up to ensure that the MBSS was completed in the hospital. Another concern noted for Individual #38 as well as Individuals #230 and #496 was the lack of urgency in stopping a bedside swallow evaluation as well as modifying the texture and/or scheduling a MBSS. For example, these individuals were observed showing overt signs of aspiration on multiple occasions with no evidence of a timely change in diet texture or liquid consistency. For example, Individual #496's bedside indicated instances of gurgling and pooling sounds indicating severe spillage but there was no change in liquid consistency and the MBSS was not scheduled for 27 days, therefore exposing the individual to an increased risk of harm. In addition, on 1/22/14 and 1/23/14, Individual #38 was repeatedly provided bedside trials of liquids and textures although the Individual was showing overt signs of aspiration. This potentially resulted in a repeated assault on the Individual's airway. Please refer to Provision L1 for additional information. Per the Settlement Agreement, the physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems. Per review, while this occurred for those who were referred for a formal evaluation, this was not occurring on a consistent basis and in response to the needs of the individuals when a referral was made and the IDT led the process. In order for BSSLC to achieve substantial compliance, BSSLC must ensure that all areas identified as being part of a comprehensive assessment are at a minimum reviewed as part of the assessment process. Additionally, BSSLC must be able to show the needed documentation and process to ensure that all individuals with PNM issues are provided with the comprehensive assessments/services they needed in a timely manner. **<u>Integration of PNMT Recommendations into IHCPs and/or ISPs</u>** For four of 11 individuals (36%) in Sample O.1 and O.2, all recommendations by the PNMT were addressed/integrated in the ISPA, Action Plans, IRRFs and IHCPs. For example, there while there was evidence of the Individual #141's PNMT recommendations being discussed with the IDT, there was no evidence of integration of the PNMT findings into the IHCP as it related to potential triggers or thresholds for return to the PNMT. Another example was individual #38 whose SLP	

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		recommended "one sip at a time" ; upon review of the PNMP, the change was not revised to reflect the recommendation. It should be noted that this individual was experiencing severe signs of swallowing difficulties at the time. Plans resulting from PNMT/IDT recommendations for Sample O.1 and O.2 included the following components: • In three of 11 individuals' plans reviewed (27%), the plans addressed the individual's identified PNM needs as presented in the PNMT assessment. • In three of four individuals (75%) for whom HOBE assessments were conducted, the HOBE recommendations were integrated into individuals' plans. • In one of 11 individuals' plans reviewed (9%), there were appropriate, functional, and measurable objectives to allow the PNMT and/or IDT to measure the individual's progress and efficacy of the plan. • In two of the 11 individuals' plans reviewed (18%), there were established timeframes for the completion of action steps that adequately reflected the clinical urgency. • In one of 11 individuals' plans reviewed (9%), the plans included the specific clinical indicators of health status to be monitored. • In one of 11 individuals' plans reviewed (9%), the plan defined triggers. • In one of 11 individuals' plans reviewed (9%), the frequency of monitoring was included in the plans. As mentioned previously in Section O.2, unless there was a formal comprehensive assessment conducted by the PNMT, individuals did not receive the same level of plan development. It should be noted that if provided with a comprehensive PNM assessment, all the needed components listed above were addressed. **PNMT Follow-up and Problem Resolution** With regard to plan implementation for Individuals in Sample O.1 and O.2: • In two of 11 individuals' documentation reviewed (18%), supporting documentation was present to confirm implementation of individuals' action plan within 14 days, or sooner as needed, of the plan's finalization. • In two of 11 individuals' plans reviewed (18%), 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. The one sample that contained the needed documentation was the comprehensive assessment that provided for Individual #141. **Individuals Discharged from the PNMT** Only one individual was included as part of the PNMT caseload and therefore only one had the	

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		opportunity to be discharged from the PNMT. For individuals discharged by the PNMT in Sample O.2: ▪ One of one individual (100%) had an ISPA meeting with the PNMT and IDT to discuss the discharge of the individual from the PNMT to the IDT. ▪ One of one individuals' (100%) discharge summary/action plan provided objective clinical data to justify the discharge. ▪ One of one individuals' ISPA meeting documentation (100%) provided evidence that any new recommendations were integrated into the IHCP. Recommendations were integrated as part of the PNMP, which was referenced in the IHCP; therefore, recommendations were reflected in the IHCP. ▪ One of one individuals' ISPA documentation, PNMT minutes and/or action plan (100%) included criteria for referral back to the PNMT. It should be noted that individuals did not have individualized criteria. The referral criteria included as part of the PNMT assessment was a restatement of the PNMT policy. Individuals did not have criteria identified in the PNMT policy included as part of the IHCP. BSSLC's PNMT discharge process was as follows: • PNMT meets to discuss and set criteria for re-referral to the PNMT after discharge →PNMT and IDT Joint Meeting → ISPA meeting minutes to reflect D/C and criteria for re-referral to the PNMT → IHCP is updated to reflect criteria for referral to PNMT. • The PNMT would track until the revised IHCP is received with the referral criteria.	
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	**Identification of Individuals Requiring a PNMP** For the ten individuals in Sample O.1, ten of their annual ISPs (100%) noted that the appropriate disciplines were present to approve and integrate the PNMP in the ISP. A member of the Habitation Department was present at 100% of the meetings. Four of ten PNMPs (40%) were comprehensively reviewed by the individual's IDT in the annual ISP meeting. While all the ISPs contained evidence of review, and specified the changes required to the PNMP, missing from the review was whether the PNMPs remained functional in mitigating risks associated with PNM and the evidence supporting these statements. Only noting that the PNMP was reviewed or just listing the changes does not provide a general summary of whether the strategies that were included as part of the PNMP were resulting in positive outcomes and/or effectively mitigating the PNM related risks. Although review as part of the annual ISP meeting was lacking in content, the PNMPs were reviewed in a much more comprehensive manner as part of the ISPA process. Additionally, this is an area that had shown an improvement of 50% since the previous visit and now in place was a formal process in which monitoring information conducted by the PNMPCs was shared to assist the QIDP in providing a more detailed summary of status.	Noncompliance

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	activities that are likely to provoke swallowing difficulties.	In order to obtain substantial compliance, BSSLC must ensure that the PNMPs are consistently reviewed for their effectiveness as part of the annual ISP and not just in response to a change in status. It should be noted that this component has shown improvement with the more recent ISPs. Another concern noted was that the PNMP was not readily available to staff to reference. PNMPs are included in the "All About Me" books. On multiple occasions, "All About Me" books that contained the PNMP were left back at the home or were not present at the point of service. Having the book left at home made it more difficult to ensure correct positioning off site as evidence by multiple observations in which individuals were not positioned according to the PNMP. **PNMP Format and Content** A review of individuals' PNMPs from Samples O.1 and O.2 found: • PNMPs for 11 of 11 individuals (100%) were current within the last 12 months. • PNMPs for 11 of 11 individuals (100%) included a list of all high-risk levels and individual triggers as indicated. • In 11 of 11 most current PNMPs (100%), there were large and clear color photographs with instructions. • Eleven of 11 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 eight of eight 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 11 of 11 PNMPs (100%), positioning was adequately described per the individuals' assessments. • In 11 of 11 PNMPs (100%), the type of transfer was clearly described, or the individual was described as independent. • In 11 of 11 PNMPs (100%), bathing instructions were provided. • In 11 of 11 (100%) PNMPs, toileting-related instructions were provided, including check and change. • In 11 of 11 (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 or N/A. • In seven of 11 PNMPs/dining plans (64%), instructions related to mealtime were outlined, including for those who received enteral nutrition. The concern noted was that the detail had begun to lack in specificity regarding how staff should implement strategies. For example, Individuals #492 and #193 had had instructions in their plans to discourage fast eating and encourage slow eating but provided no further information	

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		regarding what type of encouragement or discouragement should be provided. Upon asking staff, the Monitoring Team received multiple interpretations on how to perform the task, thus resulting in an inconsistent approach. • In 11 of 11 individuals (100%) Dining Plans were current within the last 12 months. • Five individuals (100%) had feeding tubes with no oral intake. Five of five (100%) PNMPs/dining plans indicated the individual was to receive nothing by mouth. • In 11 of 11 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 four of four PNMPs/dining plans (100%) for individuals who ate orally, diet orders for food texture were included. • In four of four PNMPs/dining plans for individuals who received liquids orally (100%), the liquid consistency was clearly identified. • In four of four 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 the rationale was provided. • In 11 of 11 PNMPs (100%), medication administration instructions were included in the plan, including positioning, adaptive equipment, diet texture, and fluid consistency. • In 11 of 11 PNMPs (100%), oral hygiene instructions were included, including general positioning and brushing instructions. • Seven of 11 PNMPs (64%) included information related to communication (how individual communicated, how staff should communicate with individual). At times the detail was lacking on the PNMP. Lacking was consistent information regarding how staff should communicate with individuals. In order for BSSLC to move in the direction of substantial compliance, BSSLC must ensure adequate information is provided as part of the PNMP that will successfully guide staff in how to better communicate with the individual. **<u>Change in Status Update for Individuals' PNMPs Conducted by the IDT/PNMT</u>** For eleven individuals in Sample O.1 and O.2 for whom the IDT identified changes needed to be made to the PNMP, ten ISPA/PNMT minutes meeting documentations (91%) noted the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status. An example of a PNMP not being revised was for Individual #38 whose assessment recommended single sips but whose plan was not revised accordingly. For individuals for whom the PNMP was revised, there was supporting documentation that six of seven individuals' revised PNMPs (85%) had been implemented and for three of three (100%) reviewed, there was evidence that the revisions had been trained.	

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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 continued to overall do a better job engaging in safe mealtime practices, as indicated by the following: Per observations conducted by the Monitoring Team, 16 of 23 individuals' (70%) dining plans were implemented as written. This represented a seven percent decrease in implementation. Examples of dining plans not implemented included but were not limited to: • Individual #163 was observed taking large bites, poorly positioned and eating at an unsafe rate. • Individual #449 was observed not receiving liquids after every 2-3 bites as per the PNMP. Based on observations by the Monitoring Team: • Twenty of 28 individuals' positioning plans (72%) were implemented as written. This represented an improvement of 37% since the previous review. Implementation of positioning plans showed much improvement as the plans were implemented with greater consistency and the issues notes were not quite as severe as previously noted. Examples of non-implementation included: • Individual #453 was observed with hips forward and upper body leaning forward resulting in increased abdominal compression. Individual was noted to have increased saliva with coughing during observation. • Individual #331 was observed without his chest strap and leaning forward, resulting in increased abdominal compression. • Individual #53 was observed with a loose chest strap that was close to the neck therefore increasing risk of choking while not providing the support needed for adequate positioning. • Individual #44 was observed with her shoes on the wrong feet. This individual has fallen 42 times since October 2013. The Monitoring Team was told by staff that the shoes were put on by the Physical Therapist. Three of three individuals' transfer plans (100%) were implemented as written. A concern noted was the presence of gait belts remaining on individuals when they were eating. Per discussion with staff and OT, there was not a clear process that outlined if this practice was acceptable or not. Common practice is that if the individual is unlikely to stand on his or her own and attempt to move away from their location then the belt should be removed when not utilized. Regarding medication administration (100%), the nurse followed procedures in the PNMP;	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>medication observations as reported in Provision M6 also noted that nurses followed PNMPs. Furthermore, there was evidence that nurses understood PNM risk issues and took appropriate and rapid action during medication administration, and made referrals as needed.

<u>Knowledge of Staff Regarding PNMPs</u>
Staff Interview: Staff demonstrated improved knowledge of the Individuals' PNMPs. Based upon interviews with eight staff from Bowie, Driscoll, and Childress, knowledge of staff has continued to improve especially as it relates to positioning. The increased knowledge appeared to assist BSSLC as improvements as noted above with positioning was evident. 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>6</td><td>6</td><td>100%</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>5</td><td>83%</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>2</td><td>2</td><td>100%</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 nutritional management problems have successfully completed competency-based training in how to</td><td>This provision was found to be in Substantial Compliance. BSSLC provided comprehensive PNM related trainings as part of new employee orientation as well as part of annual refreshers and intermittent training based on changes in plans of care. All training that needed to be competency based was provided as such. Additionally, BSSLC had formalized the process for ensuring staff were trained prior to working with new individuals on different homes.

<u>NEO Orientation</u>
The PNM related core competencies (i.e., foundational skills) were comprehensive. New employee orientation (NEO) included the following elements:
▪ Lifting and Transfers;
▪ Positioning (Alternate, wheelchair, and bathing/showering);
▪ Adaptive Equipment;</td><td>Substantial Compliance</td></tr>
</table>

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	implement the mealtime and positioning plans that they are responsible for implementing.	▪ PNMP orientation and implementation; ▪ Optimal Dining; and ▪ Basics of Dysphagia. The above components were included as part of the four following classes offered by BSSLC: ▪ Lifting People ▪ Nutritional Management ▪ Seating and Positioning ▪ Dysphagia and Swallowing 100% of new employees between 10/1/13 and 3/15/13 successfully completed the PNM NEO core competencies (i.e., foundational skills) performance check-offs since the last onsite review. **PNM Core Competencies for Current Staff** As of 10/8/13, 100% of current staff that require training successfully completed the current PNM core competencies (i.e., foundational skills) performance check-offs. 100% of staff 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 (14 staff) ▪ Nutritional Management (14 staff) ▪ Seating and Positioning (7 staff) ▪ Physical Management-Dysphagia (14 staff) ▪ Optimal Dining (16 staff) ▪ Physical Management-Developmental Disabilities (2 staff) ▪ Sign Language (3 staff) **Annual Refresher Training** 98% of current staff that requires training had completed annual refresher competency-based training and performance check-offs within the last 12 months. Annual refresher training focused on dysphagia and lifting/transfers. **Individual-Specific Training** To assess whether the Facility had a process to determine whether staff had been trained on components of PNMPs for individuals they supported, the Monitoring Team reviewed three individuals from Sample 0.1 and reviewed evidence that staff working with these individuals had received all the training related to PNM. Based on that evidence and interview, the Monitoring Team determined the Facility did have a clear process in place. Staff responsible for training other staff did successfully complete competency-based training for	

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		the specialized components (i.e., non-foundational skills) of the individuals' PNMPs prior to training other staff on the PNMP/Dining Plan. An improvement noted was that a formal process (Workplace Standard rev: 4/2/14) was recently implemented as of 4/2/14 that outlined the process for ensuring pulled staff members responsible for implementing individual specific plans for individuals with physical or nutritional management problems received individual specific training prior to working with the individuals. It was the responsibility of the Home Supervisor to ensure no staff worked with the individual who had not received the training. If the pulled staff required training then the Home Supervisor would provide the needed training. This standard was in addition to the Red Dot Policy, which was implemented during the last compliance visit in October 2013. The Habilitation Therapy Department continued to train new staff on the individuals' PNMPs on the home in which they were assigned. This training occurred immediately after completion of new employee orientation. The Facility did have a process to validate that staff responsible for training other staff are competent to assess other staff's competency. Annually, each trainer was monitored to ensure reliability of training.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	**Facility's System for Monitoring of Staff Competency with PNMPs** The PNMP Policy (P.2) included the frequency of the monitors for individuals at risk as well as the areas in which the monitors are expected to be completed (i.e., bath, meal, and oral care). The monitoring policy included: • Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk • Identification of monitors and their roles and responsibilities • Revalidation of monitors on an annual basis by therapists and/or assistants to ensure format remains appropriate and completion of the forms is correct and consistent among various individuals conducting the monitor • Evidence that results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor or clinician • Inter-rater reliability schedule 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 section labeled compliance and noncompliance. Compliance was achieved with a score of 80% or higher. The problem was that	Noncompliance

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		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. BSSLC was well aware of this issue and stated that this would be addressed in the guidelines that were to be developed after the October 2013 review. As of 4/7/14, there was no evidence that these guidelines had been developed and/or revised to address this issue. 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 staff had received the necessary training on the forms, the forms and how they were scored were faulty and inaccurate due to the issue with question #3 on the monitoring form, which indicates compliance even if the plan is not implemented. Additionally, there was some concern regarding how competent the PNMPCs were in identifying issues through the monitoring process. An example of this was Individual #449; both the Mealtime Coordinator as well as PNMPC observed the meal but did not correct or identify concerns when the individual was noted to be taking too many bites without adequate wash down and liquid clearance. In order to move towards the direction of substantial compliance, BSSLC must correct the scoring issue with the universal monitoring form and improve reliability of data acquired through the monitoring process. Thirty five of 35 staff (100%) responsible for conducting the monitoring were provided with training; however, based upon evidence regarding reliability of data, it was unclear if the training provided contained the information needed to successfully complete the forms in a consistent and comprehensive manner. As stated previously, although there was evidence of training, there was a lack of guidelines that would ensure consistency across staff members. BSSLC may want to consider reviewing the current training provided to the PNMPCs regarding monitoring and determine if the information, as well as how the training is provided, needs revision. BSSLC did not have a system in place in which information regarding the completion of monitoring forms and its related data could be pulled, analyzed and trended. There was not a formal policy or procedure that outlined:	

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- How the data would be tracked and trended
- If reports results would be shared with QA/QI Council
- The development of corrective action plan

A graph showing the percentage of areas monitored for PNM during the months of October 1, 2013 to March 14, 2014 provided information approximately as follows:

	Bathing	Lifting/Transfer	Meal	Med Admin	Oral Care	Positioning	Snack
10/13	7%	5%	52%	14%	9%	5%	8%
11/13	11%	5%	44%	16%	10%	7%	7%
12/13	11%	4%	51%	10%	14%	5%	5%
1/14	8%	8%	32%	11%	14%	22%	5%
2/14	9%	18%	26%	10%	13%	17%	7%
3/14	14%	15%	24%	11%	12%	19%	5%

The above table demonstrates a proportionate number of monitors being focused on all areas in which PNM difficulties are likely to be provoked. The concern noted was that, based upon data submitted by BSSLC, as part of the document request, less than 1% occurred during third shift and positioning, which has been a persistent concern by the Monitoring Team, was monitored with very little frequency during that time.

Monitoring for Individuals in Samples

For individuals in Sample O.1, PNM compliance monitoring was done over the past three months for ten of ten individuals (100%), and 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 was done over the past three months for ten of ten individuals (100%), and 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 monthly
- Medium Risk: monitored once quarterly
- Low Risk: monitored semiannually

For the three months prior to the review, 27 of the expected 27 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

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		plan. For the past three months, problems were noted on two of the 27 monitoring forms; one of these required follow up. For that one, documentation of adequate follow-up was provided on the form for one of one (100%). Issues noted on the monitoring form were addressed on the spot to ensure safety and issues noted with wording on the PNMPs were submitted and modified.	
O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	**IDT and PNMT Monitoring to Assess Individual's Progress and/or Effectiveness of the Plans** Zero of 11 individuals' records in Sample O.1 and O.2 (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 (e.g., Habilitation Therapy). Five of 11 individuals' records in Samples O.1 and O.2 (45%) 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. The majority of QIDP monthly reviews only stated that services were provided; they 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. A new process had recently been implemented in which information from the completed monitors would be shared with the QIDP so that they can report accordingly in the monthly review. There was no evidence that this new process had achieved the desired effect as of 4/8/14. One of 11 individuals' records (9%) 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. 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. The transfer of these triggers to the IHCP as well as the PNMP was inconsistent. For example, Individual #141 had multiple triggers identified as part of the IDT/PNMT process (i.e., poor posture and lethargy); however, these were not integrated into the plans of care. In order to achieve substantial compliance, BSSLC must ensure that triggers are individualized and included as part of the PNMP as well as the IHCP and relevant Acute Care Plans. Three of four Trigger sheets (75%) were completed correctly by direct support staff. Two of four Trigger sheets (50%) were reviewed at a minimum daily by the appropriate shift RN.	Noncompliance

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		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's review of the trigger sheet was inconsistent. • Triggers were not representative of status (e.g., Individual #141's trigger sheet contained information regarding formula in mouth when individual ate by mouth).	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to return the individual to oral feeding.	This provision was determined to remain in substantial compliance. The Facility had a system in place that clearly tracked those individuals who would benefit from oral therapy. Return to oral intake was included as part of the Habilitation Assessment and there was a clear determination of whether the individual was a candidate for an oral motor treatment program to improve potential for by mouth (PO) intake. Notes were comprehensive and included all the needed information. **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. Six of six individuals who receive enteral nutrition (100%) were evaluated at a minimum annually as evidenced by review of their IRRF, ISP, Nutritional Assessment and Habilitation Therapies Assessment. Six of six individuals (100%) 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, and to a lesser extent as part of the APEN. One of one (100%) of the individuals who received enteral nourishment was admitted since the last review; and was reviewed to determine the medical necessity of the feeding tube within 30 days. **Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition** Six of six individuals (100%) from Sample O.3 who received enteral nutrition were appropriately evaluated by the IDT to determine if a plan to return to oral intake was appropriate. Return to oral intake was included as part of the Habilitation Assessment and there was a clear	Substantial Compliance

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		determination of whether the individual was a candidate for an oral motor treatment program to improve potential for by mouth (PO) intake. Individuals who were not ready for direct oral motor therapy were noted to be provided with interventions to: • Normalize thoracic muscle tone • Improve thoracic expansion/controlled respiration • Improve abdominal tone for flexion and rotation • Increase strength and stability of long and short neck flexors • Improve strength and flexibility of the pectoral, intercostal, and latissimus muscles • Improve stability of shoulder girdle • Improve balance and strength of cervical flexor and extensor muscles No individuals had received oral motor therapy since the previous compliance visit. Per interview with the OT, some individuals had been recommended but recommendation was not agreed upon by the IDT. Per report, there have been several individuals that have programming through the IDT but no formal treatment plans have been developed; therefore, the Monitoring Team was unable to assess whether oral motor programs continued to be comprehensive. Based upon the current census at BSSLC, it is likely that many individuals would benefit from increased oral awareness and strength to not only assist in moving them along the clinical oral pathway but to also assist with other areas such as saliva management. Therefore it is recommended that BSSLC improve their ability to identify those who would benefit from direct and indirect oral motor programs and ensure those individuals are provided with the needed care. Per report by the OT, there were multiple oral motor programs that would be initiated in the coming month so the Monitoring Team will look forward to their review during subsequent visits. The determination of substantial compliance will continue as all other metrics within this provision have remained at a high level. In order to maintain substantial compliance, it is expected that the oral motor programs that are in the process of beginning to be developed will meet all the expected standards during the next visit.	

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 3/18/14 2. BSSLC Action Plan 3/18/14 3. Section P Presentation Book 4. Universal Monitoring Form and Instructions (rev: 3/14/14) 5. BSSLC Policy P.2 Physical and Occupational Therapy: Physical and Nutritional Management Plan rev: (1/30/14) 6. BSSLC Policy P.1 Physical and Occupational Therapy: Habilitation Therapy Services P.1 (rev: 1/30/14) Record reviews: 7. Sample P.1: Individuals #19, #29, #35, #68, #141, #191, #318, and #437 8. Sample P.2: Individuals #305, #332, #478, #490, and #582 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 6 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 6 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. QA reports/matrix since the last compliance review 11. Habilitation Therapy Annual Assessment

	12. Habilitation Therapy Update 13. Wheelchair/Adaptive Equipment Maintenance Log (last 6 months) 14. List of new employees since last compliance visit and their PNM related performance check offs 15. Last three months of PNM monitoring data (including date, activity monitored, time of monitor, person conducting monitor) 16. For Individuals in Sample: t. All ISPs in the last 12 months u. All ISPAs in the last 6 months v. All IRRFs in the last 12 months w. All IRRF Action Plans in the last 12 months x. IHCP/Action Plan y. QDDP Monthly Reviews for the last 6 months z. PBSPs aa. Braden Scale forms bb. Annual weight graph cc. Nutrition tab, including assessments and reviews dd. HOBE assessments ee. PNMT assessments and any other PNMT documentation other than IPNs in the last 12 months, if not already submitted ff. OT/PT assessments in the last 12 months gg. Trigger sheets completed in the last 6 months, including the current month hh. PNMPs in the last 12 months, including pictures ii. Dining Plans in the last 6 months, including pictures jj. Completed PNM-related monitoring sheets in the last three months kk. Evidence of effectiveness monitoring completed within the last six months ll. Direct intervention plan and supporting documentation for implementation of the plan (i.e., monthly progress notes) mm. Individual notebooks (PNM section) **People Interviewed:** 1. Kori Kelm Physical Therapist (PT), Habilitation Therapy Director 2. Tracy Searles Physical Therapy Assistant (PTA), 3. Christina Koehn SLP 4. Direct Care Professionals on (2) Childress, (2) Driscoll, and (2) Bowie. **Meeting Attended/Observations:** 1. PNMT meeting 4/8/14 2. Mealtimes and transitions (Bowie, Childress, and Driscoll) 3. Daily activities on Driscoll, Childress, and Fannin
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section P, dated 3/18/14 and Action Plan dated 3/18/14. 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:
  - The monitoring/audit tools the Facility used to conduct its self-assessment included: Settlement Agreement Monitoring Tool for Section P.
  - 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.
  - The monitoring tools did include adequate methodologies, such as observations, record review and staff interview.
  - The Self-Assessment did 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).
- The Facility did not consistently present data in a meaningful/useful way. Specifically, the Facility's Self-Assessment:
  - Did not consistently measure the quality as well as presence of items.

The Facility rated itself as being in compliance with three of the provisions of Section P (Provisions P.1, P.2, and P.3). This was inconsistent with the Monitoring Team's findings. The Monitoring Team found BSSLC to be in compliance with Provisions P.1 and P.3 but not with Provisions P.2 and P.4.

- 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.
- Provision P.4 was found to not be in compliance due to concerns with monitoring data as well as method for scoring the monitoring form resulted in concerns regarding reliability of the process. It should be noted that BSSLC now had a comprehensive policy that should help lead the facility in the right direction.

The Action 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. All criteria identified as part of the provisional standards were not represented as part of the self-assessment. Methods to gauge quality and not just presence should be investigated and integrated as part of the Action Plan. Additionally, many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcomes and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities.

Summary of Monitor's Assessment:

	Overall, there continued to be improvement with the Occupational Therapy (OT) and Physical Therapy (PT) services provided at BSSLC. Assessments continued to show some improvement and did a respectable job in providing a comprehensive review of the individual. Concerns focused on BSSLCs ability to adequately monitor the implementation of services and the integration process between Habilitation Therapies and the integration into the ISP and collaboration post assessment with the rest of the IDT. **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. Areas regarding comparative analysis, listing potential side effects related to medications and investigating more ways to improve functional skills were slightly below the 90% threshold but still represented a comprehensive process. **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 at least monthly. **Provision P.3:** This provision was determined to be in substantial compliance. A formal process did exist that would ensure pulled staff members responsible for implementing individual specific plans for individuals with physical or nutritional management problems received individualized specific training prior to working with the individuals. Additionally, new staff as well as current staff was provided with initial comprehensive and annual refresher courses. **Provision P.4:** This provision was determined to be not in compliance. While policies and procedures were revised and represented a more complex process; concerns remained over the accuracy of data acquired through the process due to staff error and a faulty method of scoring which may result in inflated scores of compliance. Another concern was that the Facility did not consistently use the data to pinpoint areas of concern on a systemic basis; therefore, the need for training or development of an action plan would be difficult to determine.

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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	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. Areas regarding comparative analysis, listing potential side effects related to medications, and investigating more ways to improve functional skills continued to show improvement since the previous review. 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 8	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	individuals 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], required mealtime assistance and/or were prescribed a dining plan, were at risk of receiving a feeding tube, and/or who had 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 five individuals who received direct OT/PT services and was chosen based on a review of a list of individuals receiving therapy, including the focus of the therapy. **Timeliness of Assessments** Twelve of 12 individuals admitted since the last review (100%) received an OT/PT screening or assessment within 30 days of admission or readmission. Twelve of 12 individuals (100%) identified with therapy needs received a comprehensive OT/PT assessment within 30 days of identification. Due to BSSLC providing comprehensive assessments rather than screening upon admission, the Monitoring Team included the presence of assessments as meeting and surpassing compliance with this metric. Eight of eight individuals' OT/PT assessments/updates in Sample P.1 (100%) were dated as having been completed at least 10 business days prior to the annual ISP. Habilitation Assessments were consistently completed in a timely manner and therefore were available for review by the IDT prior to the ISP. Eight of eight assessments or updates in Sample P.1 (100%) were current within 12 months for individuals who are provided PNM supports and services. **OT/PT Assessment** 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: • Thirteen of 13 individuals' OT/PT assessments (100%) were signed and dated by the clinician upon completion of the written report. • Thirteen of 13 assessments (100%) included diagnoses and relevance to functional status. • Thirteen of 13 assessments (100%) included a section that reported health risk levels that were associated with PNM supports. This information was generally	

#	Provision	Assessment of Status	Compliance
		utilized for planning interventions and supports and for recommendations related to changes in the existing risk levels. • Twelve of 13 assessments (92%) included a comparative analysis section that clearly analyzed the individuals' level of functional status with previous years or assessments. • Eleven of 13 individuals' OT/PT assessments (85%) offered a comparative analysis of current functional motor and activities of daily living skills with previous assessments. • Thirteen of 13 assessments (100%) included medical history and relevance to functional status. • Thirteen of 13 assessments (100%) addressed health status over the last year • Thirteen of 13 assessments (100%) listed medications and potential side effects relevant to functional status. • Thirteen of 13 assessments (100%) included preferences, strengths, and needs. • Thirteen of 13 assessments (100%) included documentation of how the individual's risk levels impact their performance of functional skills. • Thirteen of 13 assessments (100%) included evidence of observations by OTs and PTs in the individual's natural environments (day program, home, work). • Twelve of 13 assessments (92%) included discussion of the current supports and services or others provided throughout the last year and effectiveness, including monitoring findings. This represented a 28% improvement since the last compliance visit. • Eleven of 13 assessments (85%) included discussion of the expansion of the individual's current abilities. • Eleven of 13 assessments (85%) included discussion of the individual's potential to develop new functional skills. • Eleven of 13 assessments (85%) included a functional description of motor skills and activities of daily living with examples of how these skills were utilized throughout the day. This represented a 16% improvement since the last compliance review. • Thirteen of 13 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. • Thirteen of 13 assessments (100%) included a monitoring schedule. The monitoring schedule primarily listed was the default schedule that is based upon risk. • Thirteen of 13 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.	

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		• Thirteen of 13 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. • Thirteen of 13 assessments (100%) provided a statement regarding "Factors for Community Placement" that is detailed and lays out the supportive services needed for successful living. • Thirteen of 13 assessments (100%) include recommendations for services and supports in the community. This information was present as part of the "Factors for Community Placement." • Thirteen of 13 assessments (100%) included evidence that communication and or collaboration was present in the OT/PT assessments as evidenced by dated signature. • Thirteen of 13 assessments (100%) recommended ways in which strategies, interventions, and programs should be utilized throughout the day. This information was primarily contained within the PNMP. Although some of the components did not meet the 90% threshold, based on an overall review and on the fact that no negative outcomes were noted that were linked to the absence of these components, it was determined by the Monitoring Team that the individuals received a comprehensive assessment. For five of five individuals (100%) for whom updates were completed, the updates provided the individuals' current status, a description of the interventions that were provided, and effectiveness of the interventions, including relevant clinical indicator data with a comparison to the previous year, as well as monitoring data and monitoring and re-assessment schedules.	
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	**OT/PT Interventions** For individuals receiving OT/PT supports and services, thirteen of 13 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 eight of 13 individuals in Samples P.1 and P.2 (62%), the ISP/ISPAs addressed each of the recommendations outlined in the current OT/PT assessment. This represented a 12% improvement since the last compliance visit. **Direct OT/PT Interventions** The records of individuals in Sample P.2 were reviewed and resulted in the following findings:	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	• Five of five individuals' direct intervention plans (100%) 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/consult identified the need for direct intervention with rationale. These could be annual assessments or consults completed during the year in response to changes in status or identified needs. • Although measurable outcomes were not included as part of the ISP or ISPA, they were clearly included as part of the OT/PT plan of service. For five of five individuals' records (100%) reviewed, there were measurable objectives related to functional individual outcomes included in the ISP or ISPA. • 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. There was also no evidence of review or acknowledgment by the QIDP in their monthly notes of treatment status; therefore, the Monitoring Team was unable to determine if treatment progress or discharge was shared with the rest of the IDT. An example of the Monitoring Team questioning the sharing of information was noted during the review of Individual #286 whose team requested a PT assessment to address the increased number of falls. The PT assessment was completed but there was no mention of its contents or findings during the subsequent IDT meeting. **Indirect OT/PT Programs** The implementation of these plans is discussed under Section O4 for PNMPs and in Section S for skill acquisition plans. **Integration of OT/PT Direct Intervention(s) and Indirect OT/PT Program(s) in the ISP** An OT or PT attended the ISP or ISPA meeting, unless adequate justification was provided in the Pre-ISP meeting documentation. Ten of 13 ISP annual meetings (77%) had a member from either OT or PT present to represent the disciplines. Nine of 13 ISPs or ISPAs (69%) integrated the OT/PT interventions. The ISP or ISPA did not consistently describe the supports based on the rationale provided in the therapy assessment. This represented an improvement of 19% since the previous compliance visit.	

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		In eight of 13 ISPs or ISPAs reviewed in Sample P.1 and P.2 (62%), skill acquisition programs/potential supports that had been recommended in the OT/PT assessment were present. Recommendations regarding skill acquisition programs/supports continued to show improvement as part of the Habilitation Assessment; however, these recommendations were not consistently integrated into the ISP. This represented an improvement of 7% since the previous compliance visit. 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. For four of 13 individuals with PNMPs (31%), 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 QIDP 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 QIDP note primarily stated that service was provided. No detail regarding the implementation of the services, the effectiveness, or the need to revisit identified	

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		concerns was contained within the monthly review. As stated in Provision O.7, a new process had been implemented in which the monitoring results would be shared with the QIDP who would then include the information as part of the monthly review. Since the process was recently implemented, the desired effect had not yet been achieved and will be reviewed during subsequent visits.	
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. This provision was determined to be in substantial compliance. A formal process did exist that would ensure pulled staff members responsible for implementing individual specific plans for individuals with physical or nutritional management problems received individualized specific training prior to working with the individuals. Additionally, new staff as well as current staff was provided with initial comprehensive and annual refresher courses.	Substantial Compliance
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	**Monitoring System** The Facility did not implement a system for the adequate monitoring of PNMPs. • See Provision O.6 The Universal Monitoring Plan (revised 3/14/14) was reviewed and included information regarding frequency of monitoring for individuals who were at a high risk of choking/aspiration. This frequency was set at: • High Risk: monitored once monthly • Medium Risk: monitored once quarterly • Low Risk: monitored semiannually The Facility now had a comprehensive OT/PT policy titled Habilitation Therapy Services P.1 (rev: 1/30/14). 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 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;	Noncompliance

#	Provision	Assessment of Status	Compliance
		• 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 Now included as part of the Habilitation Therapy Policy P.1 (re; 1/30/14) were elements that: • Include monitoring of the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual. These areas are related to issues noted earlier in Section P regarding lack of monthly monitoring and/or review of services to determine the effectiveness of the supports in mitigating risks and addressing noted concerns. Now that a formalized process has been developed and included as part of policy, the Monitoring Team is hopeful that improvements will begin to be noted by the next compliance review. For 13 of 13 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. For 13 of 13 individuals (100%), positioning devices and other adaptive equipment identified in the PNMP were clean and in proper working condition. Per review of the Wheelchair Repair Log, the date the wheelchair was repaired was consistently provided but the referral date was not consistently present. Because of this, the Monitoring Team was unable to determine if adaptive equipment that was noted to be in disrepair or needing replacement equipment was repaired or replaced within 30 days unless justification is provided, or unless the issue impacts the individual's health or safety, in which case action was taken within 48 hours.	

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. BSSLC Self-Assessment 3/18/2014 2. BSSLC Action Plan 3/18/2014 3. BSSLC Presentation Book April, 2014 4. BSSLC Policy Q.2 Total Intravenous Anesthesia (TIVA) dated 1/15/2014 5. BSSLC Policy III.21 Client Services/Medical Services, dated 11/2011 6. BSSLC Policy L.1 Medical Care, dated 10.2.2013 7. Document indicating the Facility's process for providing dental radiography 8. Document labeled Action Plan for Dental Desensitization Referral Process 9. Document labeled Goals, Behavioral objectives and Method Steps for Dental Desensitization 10. List of missed dental appointments 11. Document by the dental director indicating no pre-treatment oral sedation was used at the Facility during the reporting period 12. Document indicating that the Facility had not implemented a dental quality assurance process (QA) 13. Statement by the dental director documenting a policy directive to ensure that individuals will be provided timely TIVA services to meet the expected needs of the Individual 14. For Individuals #567, #159, #323, #335, and #118: a. Copy of TIVA records associated with the most recent use of TIVA anesthesia b. Annual dental summary c. Dental treatment record and integrated progress notes (IPNs) d. Copy of all nursing notes associated with post anesthesia monitoring of the individual, following general anesthesia, once back at the living area (or infirmary) 15. List of all individuals, organized by date when they were provided TIVA 16. List of dental office staff, qualifications of staff, and time dedicated to direct care and administrative service 17. Copy of last six months and following six months appointment schedule for annual dental examinations 18. As of the day prior to the compliance visit, alpha list of all individuals who were <u>not</u> current with their annual dental examination by the dentist, and also a list of all individuals who had not fully completed their annual dental examination, including the following information: a. Name b. Date of previous years annual dental examination c. Scheduled date for most recent dental examination 19. For the first, and every fifth individual listed on the current Monitoring Team's name key, for a total of five samples (individuals #646, #404, #172, #532, and #160): a. Past two annual dental reports, and associated IPNs b. All dental hygiene records, for past six months c. All IPNs specific to dental issues, for past six months d. Most recent ISP and/or IDT minutes specific to comments/recommendations for dental issues

	e. Copy of record/notes specific to most recent dental x-rays 20. Alpha list of all individuals who the Facility has identified as not being current with dental radiography 21. Alpha list of all individuals who have <u>not</u> had bitewing dental x-rays (or alternative to bitewings) within the past 24 months 22. For the first five and last five individuals on the list of individuals not having had bitewing radiographs within the past 24 months: a. Reason why dental x-rays are not current b. Copy of IDT minutes and/or ISP minutes, that comments on delinquent dental x-rays, and specific plan to address incomplete dental x-rays 23. Oral health care plans for the first and then every fifth individual listed on the current name key, for a total of ten examples (the Monitoring Team reviewed the first seven of the ten examples provided: Individuals #573, #408, #321, #69, #86, #93, and #404): a. Evidence that oral health care treatments were routinely assessed at the living area, such as oral hygiene spot checks b. Current ISP documenting oral healthcare needs c. Oral health care policy d. List of all pending restorative treatments e. Date when the underlying condition requiring the restorative treatment was first identified f. Date when the restorative treatment was completed, or date of pending treatment g. Documentation why restorative treatment has not been completed 24. Alpha list of all individuals who are provided suction tooth-brushing 25. Alpha list of all individuals identified as needing suction tooth-brushing, but not currently receiving suction tooth-brushing. 26. Document outlining procedure for the provision of suction tooth-brushing 27. List of all policies/procedures specific for "dental emergencies" 28. Alpha list for all dental emergencies that occurred during reporting period, and include: a. Name b. Description of dental emergency c. Date, and time dental emergency was first identified 29. For the first five individuals on the list of dental emergency visits (Individuals #112, #403, #573, #37, and #255): a. Progress notes documenting initial triage of the dental emergency (medical/or dental note) b. Dental progress notes/dental records from initial evaluation through full resolution of treatment for the dental emergency (all associated note/records specific for initial and follow-up treatment for dental emergencies) c. All documentation of IDT review/s, and recommendations, specific for the dental emergency **People Interviewed:** 1. John Roberts, DDS, Dental Director **Meeting Attended/Observations:** 1. Dental staff meeting, 4/8/2014
	Facility Self-Assessment:

	Following its review of the self-assessment for Section Q, the Monitoring Team noted that the Facility: • Did not use monitoring/audit tools that relied on sufficient indicators to allow the Facility to determine compliance with the Settlement Agreement. The Self-Assessment did not give information other than that the audits met timeframes, sample size requirements, and if in compliance or not in compliance. There was not information on the findings if any actions plans were established to address findings • The monitoring tools did not include sufficient methodologies, such as observations, interviews, and record reviews to determine status of compliance with the respective monitoring processes.. • The Self-Assessment did identify the sample 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 or percent of sample size of individuals/records as compared to the overall population was included in the Self-Assessment. The percentage of compliance for each data item monitored on the various monitoring and/or observation tools was not provided by months, quarters, and overall percentage of compliance. • The Monitoring Team could not determine that the Facility's monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results through inter-rater reliability process completed by the QA department. • It was unknown to the Monitoring Team if sufficient inter-rater reliability process had been established between the various Facility staff responsible for the completion of the tools. The Facility's self-assessment stated that the Facility was not in compliance with Sections Q.1, and Q.2, and the Monitoring Team concurs with the self-assessment of noncompliance.
	Summary of Monitor's Assessment: The Monitoring Team recognizes that the Facility had experienced many challenges in maintaining a dental director. The Facility had recently hired a new dental director who had not officially started his duties as dental director at the time of this compliance review. The Monitoring Team hopes that the new dental director will be effective in helping to bring the Facility into substantial compliance with Section Q. Unfortunately, at the time of this compliance visit, the Facility had not made progress towards compliance with the settlement agreement. The following are some specific comment with regards to Sections Q.1, and Q.2 Section Q.1: Following its review for Section Q.1, the Monitoring Team noted that the Facility had not made any meaningful improvements with dental services, and remains noncompliant with Section Q.1. The Facility must immediately enhance dental services by developing strategies to ensure efficient tracking and trending of dental database elements, such as scheduling issues, and treatments that had been provided and pending. The Facility must enhance oral hygiene programs at the living area, ensure timely provision of all dental services, and better track and trend restorative treatments. The dental office must also ensure the development of IPNs that clearly document all dental issues, treatments provided and that are pending, follow-up plans for dental services, and specific monitoring and reporting parameters for dental issues. Section Q.2: Because the Facility did not have an effective mechanism to track and trend dental services; did not have a dental QA process; had not implemented programs to help reduce the need for dental

	sedation; and did not ensure close monitoring following TIVA, and ensure appropriate communication of issues associated with the provision of TIVA, the Monitoring Team determined that the Facility is not in compliance with Section Q.2.

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Q1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	To assess the Facility's ability to provided necessary oral health care assessments and treatments, the Monitoring Team assessed dental administration; the provision of routine, restorative, and emergency dental services; dental hygiene; oral hygiene provided by the living area; the use of suction toothbrushing; and dental radiography. <u>Dental Administration:</u> The Facility had recently hired a new dental director who had not officially started his duties as dental director at the time of this compliance review. The Monitoring Team met with the new dental director and discussed issues regarding dental administration. In addition, the Monitoring Team requested the following information: • List of all staff of all dental office staff, and: o Name of staff, and title o Indicate if full time or part time o Average number of direct care hours provided each week o Caseload (number of Individuals under the direct care of each dentist) o Documentation of all DD dentistry continuing education during the past 12 months The Facility provided a document that indicated the following: • The Facility had one dentist who provided 25 hours per week of direct care • The Facility had one dental director who provided 40 hours per week of non-direct care • The Facility had two full time dental hygienists. • The Facility had two-full-time dental assistants. Summary: The Monitoring Team determined that the Facility has adequate staffing for its dental office. <u>Annual Dental Examinations and Routine Dental Hygiene</u> To assess the provision of routine dental services, the Monitoring Team requested the following information: • Copy of last six months and next six months appointment schedule for annual dental examinations • As of the day prior to the compliance visit, alpha list of all individuals who were	Noncompliance

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		not current with their annual dental examination by the dentist, and also a list of all individuals who had not fully completed their annual dental examination. Please include the following information: o Name o Date of previous years annual dental examination o Scheduled date for most recent dental examination • For the first, and every fifth individual listed on the current Monitoring Team's name key, for a total of five samples (individuals #646, #404, #172, #532, and #160): o Past two annual dental reports, and associated IPNs o All dental hygiene records, for past six months o All IPNs specific to dental issues, for past six months o Most recent ISP and/or IDT minute (specific to comments/recommendations for dental issues) o Copy of record/notes specific to most recent dental x-rays Review of the dental schedule for past and future six months annual evaluation appointments: The Facility did not provide a list of individuals scheduled for future annual dental assessments, as requested by the Monitoring Team. The Facility provided copies of what appeared to be weekly printouts of a calendar for the past six months, that included names of individuals who had a dental office visit, but was not specific for annual dental examination; therefore, the Monitoring Team was unable to assess timeliness of annual examinations. Also, the Facility did not have a process to efficiently track and trend dental appointments. The Monitoring Team requested a complete alpha list of individuals who were not current with their annual dental examination by the dentist. The Facility provided a list of 165 individuals, and stated "annual exams were completed unless it states attempted by it". Of the 165 individuals listed, 18 had either "attempted" or "refused" documented next to a date. Given that a specific list of individuals who were delayed with their annual dental examination was not provided, and because the information provided (which stated annual exams were completed most individuals on the list) only included 165 individuals, out of the 289 individuals who reside at the Facility, the Monitoring Team was unable to accurately determine the number of individuals who were current with their annual dental examination. Review of Dental Records: • There was an ISP, or other relevant IDT documentation indicating the individual's oral health care issues, pending treatments, challenging behavioral issues, and all necessary supports and services in zero out of five examples (0%).	

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		• IPNs provided a summary of the dental visit, indicating services provided, pending services, follow-up plan, and monitoring and reporting parameters in zero out of five examples (0%). There were no IPNs provided for review. • Comprehensive dental hygiene was provided as necessary, per documented recall interval on the annual dental assessment report, in zero out of five examples (0%). • Documentation indicating that dental radiography was completed as necessary was present in two out of five examples (40%) The following are specific comments and concerns following review of the five examples: Individual #464: By review of dental records, the Individual was known to the dental office staff as having a history of significant behavioral challenges that interrupted dental services; however, review of the most recent ISP did not indicate that this issue was addressed by the IDT. It was noted that during this reporting period, the Individual was scheduled for dental services on six occasions, during which time completion of the annual dental examination, quarterly dental hygiene, and dental radiography were scheduled; however, on five out of the six scheduled appointments the Individual experienced behaviors that prevented full completion of the scheduled dental service. On one occasion, the Individual did not show up for the scheduled appointment secondary to "a glitch with the schedule". The following are specific concerns following review of the annual dental summary, dental progress records, and annual dental examination record: • The annual dental examination report form was dated 12/3/2013, and indicated a "visual exam"; therefore, a comprehensive dental examination was not completed. Review of the list provided by the Facility indicated that the annual dental assessment was completed on 12/2/2013. In addition, the dental treatment record documented on 12/3/2013 indicated that the Individual was not cooperative and did not want to open the mouth. There were no dental records indicating that an annual dental examination was completed. • The annual dental examination report form was not fully completed. Important sections such as the review of medical systems, medical history, behaviors exhibited and extra and intra oral examination sections were not completed by the dentist. • The annual dental summary, dated 3/18/2014, was completed without evidence of the annual dental examination being fully completed. Furthermore, the annual dental summary form was not fully completed. There was no documentation to inform the IDT of the significant challenges, failed appointments, inability to complete dental hygiene, or the annual dental examination, or comment on a known dental decay on tooth number 3.	

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		Individual #404: • The annual dental examination record, dated 11/22/2013, documented "attempt", and the rationale for not completing the examination was stated as "could not evaluate due to pt behavior". There was no evidence that this issue was reported to the IDT for review. • Review of the annual dental examination report, dated 7/19/2013, stated that the examination could not be completed because "could not evaluate due to pt being uncooperative". • Review of the dental progress record indicated that comprehensive dental hygiene was not provided during the review period, despite documentation indicating that the Individual required dental hygiene every three months. Furthermore, the dental progress record indicated that the Individual had "very heavy calculus buildup". • The Facility provided an annual dental report, dated 8/12/2013, for review. The report indicated the number of failed appointments because of maladaptive behaviors, and for the need to consider TIVA sedation. There was no supporting evidence provided documenting an IDT meeting to facilitate TIVA sedation for dental services, and at the time of this compliance review, there was no evidence to indicate that dental services, including a complete oral examination, and comprehensive dental hygiene, had been completed. • The Individual was not on the list of individuals documenting the status of the annual dental examination. Individual #172: • The Individual underwent a complete annual dental examination, provided full dental imaging studies, and underwent comprehensive dental hygiene on 01/13/2014. An annual dental examination report, dated 9/20/2013 indicated that the examination was not completed because of behavior issues; however, on the list of annual assessments, this Individual was reported to have had completed an annual dental examination on 9/20/2013, despite the annual examination report indicating that the exam was not completed. • The Monitoring Team was concerned that on 12/11/2013, the dental progress record stated that "attended TIVA meeting in January. The team agrees for TIVA". This documentation suggests that the issue of TIVA was discussed with the IDT in January 2013, however, services were not provided for an additional 12 months. • The ISP provided for review, dated 1/29/2014, did not comment on dental issues. • Review of the dental progress record indicated that dental hygiene was not	

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		provided every three months, as required per the recall interval stated on the annual dental examination record. Individual # 532: • The annual dental examination was completed on 6/20/2013; however, the annual dental examination form was not fully completed, and did not indicate the presence or absence of dental carries, or comment on dental radiographs. • The annual dental report was dated 6/17/2013; however, the dental record documented that "annual report done", on 8/5/2013. Furthermore, the annual dental report stated that there were no maladaptive behaviors over the past year; however, the dental progress records indicated that dental hygiene was attempted on 7/31/2013 but was not completed because the Individual was "uncooperative". • Despite a recommended recall interval of four month for dental hygiene, the Individual went for six months without dental hygiene, from 9/18/2013, to 3/17/2014. • The Annual dental report indicated that the Individual required "improved brushing of teeth/gums to reduce inflammation in tissues"; however, review of the ISP did not find evidence provided that the IDT addressed this issue. Individual #160 • The Individual underwent TIVA sedation for annual dental examination, dental hygiene, and dental radiography on 1/13/2014. The previous completed annual dental examination was on 11/8/2011. • Despite a dental recall interval of three months for dental hygiene, review of the dental record that was provided for review, dated 1/31/2013 through 3/3/2014, indicated that comprehensive dental hygiene was not provided to the Individual during that period. • The most recent annual dental summary provided for review, dated 9/18/2013, did not comment on the need to arrange for TIVA sedation, nor did it provide insight into the Individuals oral healthcare issues. • An ISP was not provided for review, but an ISP addendum, which was undated, was provided for review. The addendum was documentation requesting the use of TIVA for dental services. • The Individual was noted to be on the list of Individuals documenting the status of their annual dental assessment, and it was documented that the Individual had completed an annual dental assessment on 1/31/2013; however, the annual examination report indicated that the assessment was not completed. Summary	

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		The Monitoring Team determined that the Facility did not have an functional dental schedule that enabled tracking of dental services beyond six months into the future, was not able to identify individuals who had, and had not fully completed their annual dental assessment, did not provide annual dental assessments timely, and did not provide dental hygiene as necessary. Furthermore, there was lack of meaningful documentation indicating that the IDT was fully informed of the individual's oral heath care issues, and necessary supports and services. <u>Dental Radiography</u> To assess if the Facility provides dental imaging, at the level of generally acceptable standard of care, the Monitoring Team requested the following documentation: • Alpha list of all individuals who the Facility has identified as not being current with dental radiography • Alpha list of all individuals who have <u>not</u> had bitewing dental x-rays (or alternative to bitewings) within the past 24 months • Policy and/or procedure specific to dental radiography • For the first five and last five individuals on the list of individuals not having had bitewing radiographs within the past 24 months: o Reason why dental x-rays are not current o Copy of IDT minutes and/or ISP minutes, that comments on delinquent dental x-rays, and specific plan to address incomplete dental x-rays The Monitoring Team was provided the following for review: • List of all individuals not current with dental radiography indicated 13 individuals were not up to date, based on the Facility's self-report. • The Facility provided seven of the ten requested samples (Individuals #318, #86, #412, #332, #309, #141, and #366): o Four individuals (57% of provided samples not current) were reported not current with dental radiography because of behavior, or compliance issues (70% of requested not current or not provided). o Three individuals were reported as not current with dental radiography because they were edentulous; however, these same individuals (Individuals #86, #412, and #141) were on the list of individuals who were not current with dental radiography. o Of the seven examples provided, one out of seven (14%) included an annual ISP that addressed the lack of dental radiography and associated issues preventing dental radiography through a clinical plan documenting necessary supports and services to better ensure dental radiography is obtained as necessary. • The Facility did not provide a policy documenting its position on dental	

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		radiography; however, it did provide a statement indicating that the Facility follow's the "ADA guidelines for Dental Radiographic Examinations". Summary: The Facility must develop and implement a policy that clearly delineates its practice regarding supports and services associated with dental radiography. All clinical supports and services, including dental radiography, that are not able to be provided, must be reviewed through the IDT process, and a clinically appropriate action plan developed to address the outstanding issue that prevents the necessary supports and services from being provided. <u>Oral Health Care at the Living Area</u> To assess the Facility's mechanism to ensure that oral health care needs were provided at the living area, the Monitoring Team requested the following documentation: • Oral health care plans for the first and then every fifth individual listed on the current name key, for a total of ten examples (the Monitoring Team reviewed the first six of the ten examples provided: Individuals #573, #408, #321, #69, #86, #93, and #404. • Evidence that oral health care treatments were routinely assessed at the living area, such as oral hygiene spot checks • Current ISP documenting oral healthcare needs • Oral health care policy Review of oral hygiene policy: The Monitoring Team was provided a documented titled "policies/procedures for oral health care at the living area". This document was undated, and not numbered. The document appeared to outline the Facility's practice of providing oral health at the living area, and discussed issues such as toothbrushing, and suction toothbrushing. Issues such as flossing and rinsing were not commented on in the policy. There was no comment on the process to periodically evaluate oral health practice at the living area, by periodic spot checks to evaluate efficacy of oral hygiene measures by staff and individuals. The Monitoring Team reviewed the first seven of the ten examples provided for review (Individuals #573, #408, #321, #69, #86, #93, and #404), and of the seven examples reviewed: • The ISPs specifically comment on the individual's oral health care issues, such as oral health care condition, challenges to oral health care assessments, required treatments, and necessary supports and services, in zero out of seven (0%) examples. • The annual dental reports documented a comprehensive summary of the individual's oral health care issues, all necessary supports and services for oral	

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		healthcare, plan to overcome barriers obstructing the provision of necessary oral healthcare, or general prognosis in zero out of seven (0%) examples. • There were no examples provided (0%) to indicate that the Facility routinely assessed the provision of oral health care, such as flossing, suction toothbrushing, and toothbrushing, at the living area. • The PNMP documented all necessary instruction for the provision of oral health at the living area in four out of seven examples (57%). The following are examples for some of the Monitoring Team's concerns regarding the lack of the IDTs' understanding of individuals' oral healthcare condition, challenges to oral healthcare, and necessary supports and services, as represented in the annual ISP: • Individual #573. The annual dental summary, dated 10/14/2013, was not fully completed, and did not document necessary dental and oral health supports and services. Furthermore, the dental summary form appeared ambiguous, as there was no indication of who completed the form, and many areas of the form were not completed. • Individual #408: The annual dental summary, dated 9/25/2013, indicated poor oral hygiene, and stated that "improved brushing of teeth/gums – remove remaining plaque to reduce inflammation in tissues"; however, there was no evidence provided to indicate that this issue was addressed by the IDT, or followed up on by the dental office. Review of the most recent ISP indicated that dental and oral health care issues were not addressed. • Individual #321: The ISP documented the "The IDT considered all information and preferences identified" for psychiatry, nutrition, occupational therapy, physical therapy, communication, nursing, and vocational training, but did not list dental services as a service that was reviewed by the IDT. • Individual #69: The annual dental summary indicated poor oral hygiene, and this issue or any other dental or oral hygiene issue was addressed in the annual ISP. • Individual #86: The PNMP did not address frequency of suction toothbrushing or related safety issues for suction toothbrushing. • Individual #404: The Individual was reported to have poor oral hygiene on the annual dental summary, however, as will all other ISPs reviewed for oral hygiene at the living area, the ISP did not address dental and oral health care issues. Summary: The dental office did not regularly monitor living area staff and individuals, to ensure appropriate provision of oral health care at the living area. Furthermore, review of the documents provided indicated that the annual ISPs did not include a comprehensive overview of oral healthcare issues, challenges, and necessary actions to overcome	

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		barriers to providing oral healthcare services, and all necessary supports and services to ensure that appropriate oral healthcare is provided. <u>Restorative dental care:</u> To assess effectiveness of the Facility's provision of restorative dental care, the Monitoring Team reviewed the following documents: • List of all pending restorative treatments • Date when the underlying condition requiring the restorative treatment was first identified • Date when the restorative treatment was completed, or date of pending treatment • Documentation why restorative treatment has not been completed • For the first five individuals on the name key for this compliance visit: o Copy of the most ISP or related document, indicating the IDT's awareness of the need for restorative treatment The Monitoring Team was provided a document by the new dental director informing the Monitoring Team that the dental office did not have data available to comment on restorative treatments; therefore the Monitoring Team was unable to determine the Facility's ability to provide restorative dental treatment. This response provides evidence that the Facility is unable to manage important database elements to track and trend dental services. <u>Suction Toothbrushing</u> To assess the Facility's process for providing suction toothbrushing, the Facility requested the following documentation: • Alpha list of all individuals who are provided suction toothbrushing • Alpha list of all individuals identified as needing suction toothbrushing, but not currently receiving suction toothbrushing. • For the first five individuals on the list of those who are provided suction toothbrushing please provide: o Copy of the most recent assessment results used to evaluate efficacy of suction toothbrushing for the individual o Copy of most recent oral health rating scale o Copy of the most recent ISP, and/or IDT minutes specific to the use of suction toothbrushing o Documentation assessing the efficacy of the use of suction toothbrush • Current policy/procedure for suction toothbrushing The Monitoring Team was unable to effectively review the Facility's process to provide	

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		suction tooth brushing, for the following reasons: • The Monitoring Team was provided a document that appeared to be a procedure for suction toothbrushing, that was called "Brenham State Supported Living Center Dental Department Tooth-brushing with Suction Toothbrush", dated 8/3/2012. However, the document did not indicate if this was a formal policy, procedure, or draft to be used as a policy or procedure, and at the end of the document it was stated "please call dental for any issues related to the machine not working, suctioning, or the need for replacement of equipment. Dental Clinic x1346", which suggested to the Monitoring Team that the document was used at the living area as instruction for providing suction toothbrushing. Another document was provided, that was unlabeled and not dated, and stated "No, all (sic) individuals needing STB are provided with specific oral care at BSSLC. The Alpha list included in question 35.3 is inclusive of all individuals needing and/or requiring suction tooth brushing". The Monitoring Team could not determine what the Facility meant by this document. • The Facility did not provide alpha lists of individuals who required suction toothbrushing, and who was provided suction toothbrushing. Instead, the Facility provided several lists that were not alpha, but listed by living area, and were not specific for who needed suction toothbrushing and who were provided suction tooth brushing. A third list was provided that was unlabeled, and was a list of 50 or more individuals, with no other meaningful information documented. • Documents requested for the specific examples necessary to assess the provision of suction tooth brushing were not adequate. For example, the Monitoring Team was provide with a copy of an IRRF for review, that did not have an individual's name or other demographics listed, even though the dental component of the IRRF was completed. Also, the Monitoring Team was provided 47 pages of a Functional Skills Assessment for Individual #26 that did not address the suction toothbrushing. • There was no evidence provided indicating that the dental office periodically assessed the provision of suction toothbrushing at the living area. Summary: The evidence provided indicated that the Facility did not have a functional policy or procedure for the provision of suction toothbrushing; did not have a process to periodically assess the provision of suction tooth brushing at the living area; and was unable to provide necessary lists documenting who was provided, and who required, suction tooth brushing. Furthermore, because documents were not properly labeled, among other reasons, the Monitoring Team was unable to assess examples for review of suction toothbrushing.	

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		Dental Emergencies To assess the Facility's process for managing dental emergencies, the Monitoring Team requested the following information: • List of all policies/procedures specific for dental emergencies • Alpha list for all dental emergency during past six months, and include: o Name o Description of dental emergency o Date, and time dental emergency was first identified • For the first five individuals on the list of dental emergencies (Individual #112, #403, #573, #37, and #255): o Progress notes documenting initial triage of the dental emergency (medical/or dental note) o Dental progress notes/dental records from initial evaluation through full resolution of treatment for the dental emergency (all associated note/records specific for initial and follow-up treatment for dental emergencies) o All documentation of IDT review/s, and recommendations, specific for the dental emergency • Policy for provision of emergency dental services Review of policy for dental emergencies: The Facility provided a policy labeled Client Services/Medical Services III.21, Dental, with a revised date of 11/2011. The policy indicated that the "dental director would be notified by the on-call physician of all dental emergencies, and that the dental director would determine necessary treatment and follow-up". At the end of the policy for dental emergencies it stated, "in the event the dental director is not available, the staff dentist will be contacted. If the staff dentist is not available, dental hygienists will be contacted". The Monitoring Team is concerned that the Facility does not have a clinically appropriate means to triage dental emergencies. Primarily, the Facility should either develop a call schedule for the dentists to rotate triaging dental emergencies, or when the on-call physician determines clinical needs, triage A dental hygienist should not be responsible to determine the triage process of a dental emergency, unless the Facility had specific protocols, approved by the dental director, for the hygienist to follow. Review of dental emergencies: The Facility provided a list of 15 individuals who were reported as having a dental emergency during the reporting period, and the Monitoring Team reviewed the first 5 of the 15 (Individuals #112, #403, #573, #37, and #255): • The IDT reviewed zero out of five dental emergencies (0%). There was no evidence to indicate that dental emergencies were communicated to the IDT.	

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		• There were zero out of five examples of IPNs documenting the dental emergency (0%). An IPN must be documented in non-dental language informing staff of the dental emergency, associated clinical issues, and monitoring and reporting parameters, as well as follow-up plans. • The Monitoring Team could not assess promptness of assessing dental emergencies, because there was no documentation, such as IPNs provided for review that documented when the dental emergency was initially identified by living area staff. • In zero out of five cases (0%), there was evidence to that the individual was followed up by the dentist through full resolution of the dental emergency. The following are some specific comments and concerns regarding the examples reviewed by the Monitoring Team: • Individual #112: The list of dental emergencies indicated that the Individual reported a "toothache"; however, the dental progress record indicated that the Individual had fallen and "busted (the individual's) lip." The Individual was assessed the same day by the hygienist, because a dentist was not available. The hygienist indicated that the Individual was to follow up with the dentist, and there was no documentation indicating that the Individual had followed up with the dentist. • Individual #404: The list of dental emergencies indicated that the Individual had a "toothache" on 10/3/2013, and the dentist indicated that there was no redness, swelling, or drainage, and that the tissues appeared healthy. No instructions were documented instructing staff to monitor for signs and symptoms of possible oral health disease, there were no follow-up instructions documented, and there was no indication that dental radiography was entertained. The Individual was seen five weeks later and it was noted that the individual had decay of tooth #6, and that tooth #12 had broken. The only documentation following up on this issue was that of 12/13/2013, which indicated a "post op follow up" secondary to oral surgery. The Monitoring Team noted that from the initial reported dental emergency, until the post-op assessment, was 9 weeks--10/3/2013 until 12/13/2013. • Individual #573: The Individual was assessed by the dentist for a "toothache", and the dentist determined that there was no dental issue. There was no evidence that staff were instructed to monitor for signs, symptoms of possible oral health care issue. • Individual #37: The Individual was assessed by the dentist to evaluate the tongue, and it was noted that the Individual has sustained an injury secondary to biting the tongue. Specific clinical details of the bite injury were not documented, and there was no evidence that staff was instructed on how and	

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		what to monitor. Furthermore, the dental record indicated that the issue would require that the lesion be "watched"; however, there was no evidence that the Individual followed up for this issue with the dentist. • Individual #255: The dentist evaluated this individual secondary to a lesion on the lower lip. There was no documentation by the dentist of following up on this lesion through resolution. Conclusion: The Monitoring Recognizes that the Facility has had many challenges in maintaining a dental director, and is hopeful that the new dental director will be effective in helping to bring the Facility in compliance with Section Q, of the Settlement Agreement. Following its review for Section Q.1, the Monitoring Team noted that the Facility had not made any meaningful improvements with dental services, and remains non-compliant with Section Q.1. The Facility must immediately enhance dental services by developing strategies to ensure efficient tracking and trending of dental database elements, such as scheduling issues, and treatments that had been provided and pending. The Facility must enhance it oral hygiene programs at the living area, ensure timely provision of all dental services, and better track and trend restorative treatments. The dental office must also ensure the development of IPNs that clearly document all dental issues, treatments provided, and that are pending, follow-up plans for dental services, and specific monitoring and reporting parameters for dental issues.	
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,	To assess compliance issues for Provision Q.2, the Monitoring Team reviewed the Facility's processes related to dental Quality Assurance, issues related to dental TIVA and dental scheduling, and programs to reduce the need for dental sedation. <u>Dental Schedule:</u> To assess the Facility's ability to maintain an efficient and effective dental scheduling system, and to determine if all dental services are current, the Monitoring Team requested the following documentation: • Copy of dental schedule for past six months, and pending six month period o List of all "missed" appointments and ▪ Reason for missed appointment ▪ Date appointment was missed ▪ Date follow-up appointment was scheduled ▪ Specific effort document to help mitigate future missed appointments. • Total number of missed dental appointments during that past six months • Total number of appointments scheduled • Number of missed appointments because of illness of the individual	Noncompliance

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	assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	• Number of missed appointments because of staffing issues at the living area • Number of missed appointments because of staffing issues at the dental office • Number of missed appointments because living area forgot to transport the individual to the dental clinic • Number of missed appointments because of a TIVA related issue (e.g., not enough TIVA days; another individual required that particular TIVA appointment for a dental urgency, etc.) • Number of missed appointments because appropriate consent was not obtained • Number of missed appointments because of other, non-specified issues • Committee Meeting minutes, associated data, and data analysis used by the Facility to improve compliance with dental services The Facility provided an additional set of documents labeled "appointment failure log", which indicated a list of individuals, beginning 9/3/2013, through 2/28/2014. Based on review of the documents provided: • Total number of missed dental appointments during the past six months: 284 • Total number scheduled: 820 • Number of missed appointments because of illness of the individual: 22 • Number of missed appointments because of staffing issues at the living area: 57 and 67 o The Facility entered two numbers for living area staffing issues • Number of missed appointments because of staffing issues at the dental office: o The Facility did not provided data for this request; however, upon review of the document provided it appears that this was due to a clerical mishap, and the duplicate number provided for living area staff (67), most likely represents the number of failed appointments secondary to dental office staffing issues. • Number of missed appointments because living area forgot to transport the individual to the dental clinic: 4 • Number of missed appointments because of a TIVA related issue (e.g., not enough TIVA days; another individual required that particular TIVA appointment for a dental urgency, etc.): 0 • Number of missed appointments because appropriate consent was not obtained: 0 • Number of missed appointments because of other, non-specified issues: 134 Of the 820 scheduled appointments to the dental office, there were 284 appointments that were missed (35%). The majority of missed appointments were secondary to non-	

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		specified issues, and living area and dental office staffing issues. The Facility should further explore non-specified issues associated with missed appointments. The Facility provided a copy of the dental office's schedule beginning 09/30/2013, through 3/2/2014. The schedule appeared to be a printout of an electronic calendar, and the printout did not fully document the reason for the dental visit, or if the examination and treatments had been completed. For example, the document listed the name, date, and time of a dental office visit, followed by a partial explanation for the visit; however, for most of the examples the statement did not fit in the space provided for this documentation and the reader could not fully determine if the appointment had been completed, rescheduled, or cancelled. Furthermore, the Facility did not provide a calendar of pending appointments for the subsequent six-month period. Summary: To help reduce missed appointments, the Facility should further evaluate the rationale for non-specified reasons, as well living area and dental office staffing issues. The Facility must enhance its process to track and trend dental office appointments. <u>Dental desensitization / programs to minimize the use of sedation and restraint</u> To assess the Facility's program to help minimize the use of sedation and restraint for dental services the Monitoring Team requested the following information: • Policy and procedure for its program to help minimize the use of sedation and restraint for dental services • Alpha list of all individuals who were provided a program to help minimize the use of sedation and restraint for dental services • Alpha list of all individuals who are unable to complete their dental visits because of challenging behaviors, and who were not currently participating in a program to help minimize the use of sedation and restraint for dental services • Program schedule of individuals participating in a program to help minimize the use of sedation and restraint for dental services • For the first ten individuals on the alpha list of individuals who were provided a program to help minimize the use of sedation and restraint for dental services: o Copy of program o Copy of data and analysis of data used to asses efficacy of the program o Copy of current ISP or other IDT document that delineates the use of a program to help minimize the use of sedation and restraint for dental services The Facility provided several documents that were not requested, such a an action plan for "dental desensitization referral process" that included 28 action steps; however, only	

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		five out of the 28 action steps indicated completion (18%), and the most recent completed action step was dated 9/13/2013. The Facility also provided a document labeled as "Goals, Behavioral objectives and Method Steps for Dental Desensitization". This document outlined many goals and objectives specific to the Facility's proposed program to help minimize the use of sedation and restraint for dental services. The Facility did not provide a specific policy for its program to help minimize the use of sedation and restraint for dental services; did not provide lists of individuals who were provided or required a program to help minimize the use of sedation and restraint for dental services, and did not provide program data or analysis of the data demonstrating efficacy of the program. Summary: The Facility had not moved forward in developing a program to help minimize the use of sedation and restraint for dental services during this reporting period, and did not have a functional program to help minimize the use of sedation and restraint for dental services. <u>Dental quality assurance:</u> To assess the Facility's process to monitor the quality of dental services, and develop strategies to enhance oral health care at the Facility, the Monitoring Team requested the following documents: • List of all dental QA indicators • All data, trends analysis, summaries, committee minutes, action plans, and follow-up to action plans for the Facility's dental QA process, for this reporting period • Policy and procedure for dental QA The Facility did not provided the requested documents but the Facility provided a written document stating that the dental database required to implement the dental QA process was non-functional. Summary: The Facility should consider developed a dental quality assurance process to assess the quality and efficacy of dental services, and to regularly assess potential adverse outcomes, such as pneumonia, behavioral exacerbation, and injuries, such as fractures, following dental procedures. <u>Pre-treatment oral sedation</u> The Facility provided document by the dental director indicating no pre-treatment oral sedation was used at the Facility during the reporting period.	

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		Total Intravenous Anesthesia (TIVA) To determine the Facility's availability of providing adequate quantity of TIVA services for dental procedures, and to assess the Facility's process for ensuring safe administration of TIVA, the Monitoring Team requested the following information: • Number of TIVA hours per month available at the Facility • Number of individuals who have been provided TIVA services each month, for the reporting period • Alpha list of all individuals who require TIVA for dental services • Alpha list of all individuals who were provided TIVA for dental services during the past 12 months • For the last five individuals who were provided TIVA anesthesia during the reporting period: o Copy of TIVA records associated with the most recent use of TIVA anesthesia o Annual dental summary o Dental treatment record, and IPNs o Copy of all nursing notes associated with post anesthesia monitoring of the individual, following general anesthesia, once back at the living area (or infirmary) • List of all individuals who were provided TIVA anesthesia during the reporting period, and who were diagnosed/treated/and or hospitalized for pneumonia (any type of pneumonia). o Date that general anesthesia was provided o Date pneumonia was diagnosed/treated/or person hospitalized • Statement by the Facility's dental director indicating that all individuals who require TIVA for their oral health care needs, are afforded TIVA services for their annual dental assessments for a minimum of two dental hygiene opportunities per year, and more if clinically indicated; and for all necessary restorative treatments, without a delay in treatment of more then 14 business days. • Facility's policy for total intravenous anesthesia (TIVA) Review of policy: The Facility provided its total intravenous anesthesia (TIVA) policy Q.3, dated 1/15/2014. The Monitoring Team noted that the policy specifies that the dental anesthesiologist would be provided a copy of the most recent annual medical assessment; however, there was no statement indicating that the anesthesiologist would be provided information on possible new medical conditions that may have occurred subsequent to the development of the annual medical assessment, and there was no statement indicating that the individual would be medically assessed by living area health care providers, such as a nurse or the medical provider, on the day of, but prior to, the scheduled TIVA appointment. It is paramount that all newly diagnosed medical	

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		conditions and the current medical status of the individual be well communicated to the dental anesthesiologist, and this should be delineated within the context of the Facility's policy for TIVA. TIVA availability: The Facility provided a document stating that a total of 75 individuals were provided TIVA anesthesia during this reporting period and that the Facility enables 32 hours of TIVA services per month (four days). TIVA Schedule: The Facility provided three sets of documents, called TIVA Comprehensive Master List, which were not in alpha format but a list of individuals by date when the individual was provided TIVA. The same list was provided for the Monitoring Team's document request for: • Alpha list of all individuals who require TIVA for dental services • Alpha list of all individuals who were provided TIVA for dental services during the past 12 months • Number of individuals who have been provided TIVA services each month, for the reporting period The Facility did not provide a specific alpha list of all individuals who require TIVA for dental services, but instead provided a list of all individuals, organized by date when they were provided TIVA; therefore the Monitoring Team could not efficiently determine who was provided TIVA, and how often an individual was provided TIVA during the reporting period. The Facility must be able to efficiently and effectively track and trend TIVA utilization at the Facility. Review of TIVA case examples (Individual #567, #159, #323, #335, and #118) found: • Anesthesia records were fully completed and documented necessary clinical parameters in five out of five examples (100%). • There was evidence of a nursing or medical examination on the day of, but prior to the administration of TIVA, to assess for acute medical changes in one out of five examples (20%). For two examples, nursing IPNs were not provided for review. • There was evidence provided documenting a post anesthesia REACT score by the nurse in one out of five examples (20%). • There was evidence of regular assessment of the individual's clinical status by the living area nurse in three out of five examples (60%). Nursing IPNs were not provided for two examples. • The dental office documented a clinically relevant IPN that informed living area staff of the treatments provided, prognosis, possible complications, specific and individualized monitoring and reporting instructions, and specific and	

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		individualized post TIVA orders in zero out of five examples (0%). The following are some specific concerns and comments for the examples reviewed: • Individual #567: Review of dental treatment record, which dated back to 6/3/2013, indicated that despite known need for dental hygiene, and multiple failed attempts to provided dental hygiene since 6/3/2013, the Facility did not conduct an IDT meeting or discussion to arrange TIVA until 1/17/2014, and did not provide dental hygiene until 3/5/2014. • Individual #159: Pre and post TIVA nursing IPNs were not provided for review; therefore, the Monitoring Team could not assess pre and post medical assessments associated with TIVA. • Individual #335: The dental treatment record indicated specific instruction following TIVA. The dental office did not document this information in the IPNs, but stated, "see dental progress record for apt details" on the IPN; there was no evidence of a specific order to "avoid NSAIDs, avoid female hormones, SBE prophylaxis". This critical information must be well communicated to the living area staff. IPNs documenting post anesthesia monitoring at the living area were only provided for 24 hours, instead of the 72 hours that nurses generally assess individuals following TIVA. • Individual #118: The dental treatment record indicated on 3/6/2014 that the "patient refused to come to the dental for post op TIVA. Sch his 3 mo recall". There was no further documentation indicating the dental office followed up with the Individual to evaluated for possible complications. The Individual was originally scheduled to have dental hygiene, and an annual dental assessment on 8/6/2013 and it was not until 3/4/2014 that the Individual was provided such services under TIVA. The anesthesia notes for 3/4/2014 indicated that the Individual was provided a pre-treatment oral sedation, prior to TIVA; it should be noted that the new dental director, in a statement dated 4/10/2014, stated "It is my understanding that during the monitored period September 1, 2013, through February 28, 2014, all anesthetic services provided at the BSSLC Dental Department were administered via an intravenous route of administration". The Monitoring Team recognizes that the administration of the pre-treatment oral sedation was administered after the stated date of February 28. 2014; however, the pre-treatment oral sedation was administered during the reporting period. Nursing IPNs documenting pre and post anesthesia assessment and follow up were not provided for review. Summary: There was evidence indicating that individuals were closely monitored during the TIVA process. There was lack of evidence to demonstrate effective pre and post TIVA	

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		monitoring by nursing staff. The dental office did not document a post procedural note in the IPNs to help ensure that living area staff were advised of the treatments provided, prognosis, possible complications, specific and individualized monitoring and reporting instructions, and specific and individualized post TIVA orders. Review of dental treatment records indicated that there was marked delay in providing TIVA when clinically necessary. Conclusion: Because the Facility did not have an effective mechanism to track and trend dental services; did not have a dental QA process; has not implemented programs to help reduce the need for dental associated sedation; and did not ensure close monitoring following TIVA, and ensure appropriate communication of issues associated with the provision of TIVA, the Monitoring Team determined that the Facility is not in compliance with Section 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 3/18/14 2. BSSLC Action Plans 3/18/14 3. Facility Section R Presentation Book 4. BSSLC Policy R.1 Communication Services 12/12/13 5. 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 6. Record Reviews of Individuals: a. Sample R.1: Individuals #131, #250, #282, 380, #408, #465, #470, #570, and #595 b. Sample R.2: Individuals #251, #297, #461, and #546 c. Sample R.3: Individuals #1, #159, #403, and #450 d. Sample R.4: Individuals #91, #492, #521, #570, and #573 e. Sample R.5: Individuals #69, #91, #343, #489, and #521 f. Sample R.6: Individuals #21, #118, #172, #189, #193, #253, #322, #337, #381, #427, #453, #457, #486, #504, and #566, 7. List of current SLPs, caseloads, and ratios 8. Copies of each SLP's current license and ASHA certification 9. Continuing education and training completed by the SLPs in the past 12 months 10. Facility list of new admissions since the last review 11. Tracking log of SLP assessments completed since the last review 12. Facility list of individuals with severe language deficits 13. Facility list of individuals with Positive Behavior Support Plans (PBSPs) and replacement behaviors related to communication 14. PBSP minutes and attendance rosters for the past six months 15. Facility list of individuals with Alternative and Augmentative Communication (AAC) devices 16. Facility AAC screening forms 17. Facility AAC-related database reports/spreadsheets 18. New Employee Orientation (NEO) Curriculum 19. Facility list of general common area AAC devices 20. 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 MS-SLP 4. Seven Direct Care Staff (Bowie, Driscoll, Childress) **Meeting Attended/Observations:**

	1. Daily activities on Driscoll, Fannin, and Childress, and Bowie 2. Mealtimes on Driscoll, Bowie, and Childress
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section R dated 3/18/14 and Action Plan dated 3/18/14. 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 substantial compliance with Provisions R.1, R.2, and R.3. This was inconsistent with the Monitoring Team's findings of noncompliance with Provisions R.3-R.4 and substantial compliance in Provisions R.1 and R.2. 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 components 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 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). ▪ 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. The Action 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. All criteria identified as part of the provisional standards were not represented as part of the self-assessment. Methods to gauge quality and not just presence should be investigated and integrated as part of the Action Plan. Additionally, many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcomes and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. The Facility should determine the priorities for action for the next six months, complete analysis of where they are now and what they need to do, and develop (and implement) a detailed

	sequential plan to accomplish the priorities.
	Summary of Monitor's Assessment: BSSLC continued to show improvement with Section R. Assessments continued to improve, especially post October 2013 when a revision was implemented. Strategies to improve communication for those who were identified as needing service were consistently identified; however, implementation and monitoring of the identified needed services were still lacking with minimal to no use of AAC as part of a 24-hour communication system/program. . **Provision R.1:** This provision was determined to be in substantial compliance. BSSLC was at full capacity with regards to Speech Pathologists and had recently filled a 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 in substantial 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. All areas of the assessments found lacking before October 2013 were addressed with the latest revision and showed presence of 100% of the areas for 100% of the sample. **Provision R.3:** This provision was determined to be not in compliance. Direct Care Professionals (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 QIDP. Staff responsible for implementing plans did not appear to be knowledgeable of the plans. Additionally, there was no way of knowing if strategies recommended by the SLP were working or being utilized in a consistent manner. **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 each device was effective and/or meaningful to the individual.

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R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience	Samples for this section are as follows: Sample R.1: Consisted of nine Individuals identified by the Facility with severe expressive or receptive language disorders with assessments completed in the last 12 months. Sample R.2: Consisted of four Individuals receiving direct speech services.	Substantial Compliance

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	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.3: Consisted of four Individuals with a PBSP and communication deficits. Sample R.4: Consisted of five Individuals with AAC systems Sample R.5 consisted of five individuals who received indirect speech supports/services. Sample R.6 consisted of 15 individuals from a list of individuals provided by BSSLC who have had their assessments completed since October 2013. Provision R.1 was found to remain in substantial compliance secondary to BSSLC having sufficient and well-trained staff to develop and implement the services needed by the individuals. The dedicated PNMT SLP began in January 2014 and should continue to allow the other therapists to improve their focus on communication. **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 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. 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 six SLPs and a Speech Pathology Assistant (SPA). The SPA provided modeling and assisted in the development of plans and programs as well as assisted with the monitoring process. As stated above, a position was filled in January 2014 for a dedicated PNMT Speech Therapist. The current staffing allowed for a caseload of approximately 58 individuals, which is reasonable to conduct the daily activities and responsibilities of the SLP. **Qualifications:** Six of six positions for SLPs (100%) were filled by licensed SLPs • Six of six SLPs (100%) were licensed to practice in the state of Texas. • Six of six SLPs (100%) had evidence of ASHA certification. **Continuing Education:** Based on a review of continuing education completed in the last 12 months, six of six SLP	

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		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: • Does your Oral Care Program need a Facelift • Outcome Based Physiological Swallowing Assessment • Just Use Your Words **<u>Facility Policy</u>** A local policy/process existed that provided clear operationalized guidelines regarding the delivery of communication supports and services and outlined minimum components of communication supports and services. BSSLC provided a set of guidelines as well as an overarching policy titled Communication Services (rev: 12/12/13) 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 • 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 supports/material • 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.	

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		Added to the policy and guidelines was information regarding how the results of monitoring will be shared with the QIDP to report in the monthly review and the need to have a clear progress note that clearly included progress towards and effectiveness of intervention. This was an added improvement and was just in the initial stages of implantation. The Monitoring Team looks forward to seeing further implementation of the new process.	
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.	This provision was found to be in "Substantial Compliance". BSSLC had a clear process in place in which individuals were receiving comprehensive assessments at a minimum of every three years and annually for those receiving supports. While the original drawn sample showed some concerns with various components of the assessment, this concern was addressed with the newly formatted assessments that occurred in October 2013. The review of assessments completed post October 2013 showed 15 of 15 (100%) compliant regarding inclusion of the components needed to make an assessment comprehensive in nature. Speech and Behavior Supports for the second consecutive visit continued to show a strong working relationship. **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. 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 report for Habilitation Therapies, all individuals have received a comprehensive assessment according the master plan. **Assessments Provided** Nine of nine 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. Twelve of 12 admitted individuals (100%) since the last review received a	Substantial Compliance

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		communication screening or assessment within 30 days of admission or readmission. For nine of nine individuals in Sample R.1 (100%), assessments/updates were dated as having been completed at least 10 working days prior to the annual ISP. Four of four individuals in Samples R.1 and R.2 (100%) provided direct or indirect communication supports and services were provided an assessment or update current within the last 12 months. **Communication Assessment:** Based on review of the sample of assessments (Samples R.1 and R.2), the comprehensiveness of the communication assessments were as follows: • Thirteen of 13 individuals' SL assessments (100%) were signed and dated by the clinician upon completion of the written report; • Thirteen of 13 individuals' SL assessments (92%) were dated as completed at least 10 working days prior to the annual ISP; • Seven of 13 individuals' SL assessments (54%) included diagnoses and relevance of impact on communication. Although this was not consistently included in the assessment, there was evidence in the ISP meetings that all relevant diagnoses and their impact on disciplines plan of care were discussed in detail. It should be noted that the reformatted Communication Assessment contained a section specific to identifying relevant diagnoses to allow for greater ease of review. • Thirteen of 13 individuals' SL assessments (100%) included individual preferences, strengths, and needs. • Ten of 13 individuals' Communication assessments (77%) included medical history and relevance to communication. While not included in the communication assessment, discussion of medications and their impact on communication was noted as part of the IRRF. It should also be noted that the reformatted communication assessment included a section specific to this issue. • Two of 13 individuals' Communication assessments (15%) listed medications and discussed side effects relevant to communication. While not included in the communication assessment, discussion of medications and their impact on communication was noted as part of the IRRF. It should also be noted that the reformatted communication assessment included a section specific to this issue. • Nine of 13 individuals' SL assessments (70%) provided documentation of how the individual's communication abilities impacted his/her risk levels. Although this information was not consistently included as part of the Communication Assessment, the ISP contained information relevant to both risk level and communication status. • Thirteen of 13 individuals' SL assessments (100%) incorporated a description of	

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		verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day; • Thirteen of 13 individuals' SL assessments (100%) provided evidence of observations by the SLPs in the individuals' natural environments (e.g., day program, home, work); • Thirteen of 13 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 13 individuals' SL assessments (100%) included discussion of the expansion of the individuals' current abilities. • Thirteen of 13 individuals' SL assessments (100%) provided a discussion of the individuals' potential to develop new communication skills. This represented an improvement of 48%. • Eleven of 13 individuals' SL assessments (85%) assessed AAC or Environmental Control (EC) needs, including clear clinical justification; and rationale as to whether or not the individual would benefit from AAC or EC. • Eight of 13 individuals' SL assessments (62%) offered a comparative analysis of health and functional status from the previous year. Although this information was not consistently included as part of the Communication Assessment, the ISP contained information regarding comparative health status and it was included as part of the IRRF review. Additionally, the revised communication assessment included a specific section devoted to this topic in an effort to provide ease of review and will be utilized moving forward. • Thirteen of 13 individuals' SL assessments (100%) gave a comparative analysis of current communication function with previous assessments • Thirteen of 13 individuals' SL assessments (100%) identified the need for direct or indirect speech language services, or justified the rationale for not providing it. This represented an improvement of 78%. • Thirteen of 13 individuals' SL assessment (100%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff. • Thirteen of 13 individuals' SL assessments (100%) had a reassessment schedule; • Eleven of 13 individuals' SL assessments (85%) supplied a monitoring schedule. • Thirteen of 13 individuals' SL assessments (100%) 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. • Thirteen of 13 individuals' SL assessments (100%) made a recommendation about the appropriateness for community transition.	

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		• Eleven of 13 individuals' SL assessments (85%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. Although sample R.1 and R.2 identified inconsistent completion of a few of the components needed to be considered a comprehensive assessment, this was not the case when considering the assessments that have been completed since the October re-formatting of the assessment. Based upon a review of 15 individuals (Sample R.6) who had their assessments completed since October 2013, all 22 of 22 (100%) components were identified as being present for 15 of 15 assessments (100%). This positive trend is felt to be reflective of the current level of service provided by BSSLC (that is, assessments being completed currently were consistently comprehensive) and therefore the standard regarding assessment comprehensiveness should be considered met as of this review. **<u>SLP and Psychology Collaboration:</u>** Based on review of individuals' records (Sample R.3) with Positive Behavior Support Plans/ Behavior Assessment and Intervention Plan (PBSPs/BAIPS) the following was noted: • Four of four communication assessments reviewed (100%) contained evidence of review of the PBSP/BAIP by the SLP. This was noted in the behavioral considerations section of the SLP assessment. • For four of four individuals (100%) communication strategies identified in the assessment were included in the PBSP/BAIP. • For four of four individuals (100%) communication strategies identified in the assessment were included in the ISP. Based on review of the Positive Behavior Support Committee meeting attendance sheets from 1/1/2014 to 3/31/2014, participation by a SLP was noted in 92% of the meetings. Per meeting attended by the Monitoring Team, the SLP had an active role in discussion and was a valued member of the team. The SLPs and psychologists continued 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 continued to use 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; this was provided in the Presentation Book for review.	
R3	Commencing within six months of the Effective Date hereof and with	**<u>Integration of Communication in the ISP</u>** Based on review of the ISPs for individuals in Sample R.1 and R.2 the following was	Noncompliance

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	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.	noted: • In 12 of 13 ISPs reviewed (92%) for individuals with communication needs an SLP attended the annual ISP planning meeting, or the IDT provided adequate justification. • Ten of 13 ISPs reviewed (77%) 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. • Communication Dictionaries for 11 individuals (100%) were reviewed at least annually by the IDT as evidenced in the ISP and ISPAs. • Two of 13 ISPs reviewed (15%) included how communication interventions were to be integrated into the individual's daily routine. Recommendations were consistently present as part of the Communication assessment but integration of these recommendations was lacking. A sample of a newly developed "Shredder: SAP" for Individual #42 showed excellent integration as did the "Sorting" SAP for Individual #380. These two examples should serve as a model for the development of future SAPS. • One of 13 ISPs reviewed (8%) contained skill acquisition programs to promote functional communication. Strategies were not integrated into existing SAPs and SAPs were not consistently developed. See bullet above. • Two of 13 ISPs reviewed (15%) included information regarding the individual's progress on goals/objectives/programs, including direct or indirect supports/interventions involving the SLP. Although the individual does not have a formal SAP, there is still a need for review of strategies contained within the assessments to ensure effectiveness. **Development And Implementation Of Functional Individual-Specific Assistive Communication Systems** For 13 of 13 individuals in Sample R.1 and R.2 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 five observations (60%) found AAC devices present in each observed setting and readily available to the individual. • AAC systems for one of five individuals (20%) were noted to be in use in each observed setting. • AAC systems for four of five individuals (80%) were portable. • AAC systems for five of five individuals (100%) were functional. • For three of five individuals (60%), staff instructions/skill acquisition plans	

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		related to the AAC system were available. **General Use AAC Devices:** Observations were completed in three homes to determine the presence and use of general use AAC devices. Findings included the following: • Three of three homes (100%) had general use AAC devices present in the common areas. • In three of three homes and other environments (100%), general use AAC devices were operational. • Seven of seven general use AAC devices (100%) noted contained clear directives on how staff should use these devices. • Seven of seven general use AAC devices (100%) noted had a clear function within that setting/situation. • Zero of seven general use AAC devices noted (0%) were used. Observations were provided in which the use of the board/devices would have been appropriate (for example: mealtimes, washing hands, oral care) but were not prompted by staff or utilized by the individuals. **Direct Communication Interventions** Review of the individuals' records from Sample R.2 showed the following: • Four of four individuals' direct intervention plans (100%) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. • For four of four individuals' records (100%) reviewed, the current SLP assessment identified the need for direct intervention with rationale. • For four of four individuals' records (100%) reviewed, there were measurable objectives related to individual functional communication outcomes included in the ISP. • For four of four individuals (100%), information was present regarding whether the individual showed progress with the stated goal. • For four of four individuals (100%), a description was found of the benefit of the device and/or goal to the individual. This represented an improvement of 100% since the last compliance review. Monthly notes were much more comprehensive and clearly identified the benefit to the individual. • For four of four individuals (100%), recommendations/revisions were made to the communication intervention plan as indicated related to the individual's progress or lack of progress. Individual #546 had his plans reviewed and his use of signs modified based on improved progress • For three of three individuals reviewed for whom intervention was terminated (100%), termination of the intervention was well justified and clearly	

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		documented in a timely manner. • For four of four individuals (100%) progress notes contained the consistency of implementation. • For four of four individuals (100%) progress notes occurred at a minimum monthly. **<u>Indirect Communication Supports:</u>** Programs for individuals in Samples R.5 who received indirect communication supports were reviewed and found: • Five of five individuals' indirect plans (100%) (i.e., SAPs) were implemented within 30 days of the plan's creation, or sooner as required by the individual's health or safety. • For five of five individuals' records (100%) reviewed, the current SLP assessment identified the need for indirect intervention with rationale. For five of five individuals in Sample R.4 (100%), staff instructions were provided for individuals' AAC devices, including written step-by-step instructions and pictures. Zero of five individuals (0%) receiving indirect Speech Services (Sample R.5) were provided with comprehensive progress notes that contained each of the indicators listed below. • Monthly documentation for two of five individuals (20%) contained information regarding whether the individual showed progress with the stated goal(s) or objectives. • Monthly documentation for one of five individuals (20%) identified the benefit of device and/or goal(s). • Monthly documentation for zero of five individuals (0%) identified consistency of implementation. • Monthly documentation for zero of five individuals (0%) identified recommendations/revisions to the program as indicated and related to the individual's progress or lack of progress. In order to obtain substantial compliance, Indirect supports (e.g., SAPS) must be reviewed on a regular basis with the detail needed to ensure implantation as well as continued relevance of goals and strategies. **<u>Staff Interviews</u>** Three of seven staff interviewed (43%) were knowledgeable of the individuals in Samples R.4 and R.5 and their communication related programs; direct support professionals had difficulty with the following questions	

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		• Stating whether the individual had an AAC system. • Whether there was a communication program. • Describing the communication program goal. • Describing the schedule for implementation of the communication program. • Identifying how communication skills in the program were addressed throughout the day. In order to obtain substantial compliance, staff must become increasingly knowledgeable regarding communication devices and how they can be integrated and implemented throughout the day. **Competency-Based Training and Performance Check-offs:** Based on review of the New Employee Orientation (NEO) training curriculum and 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 108 of 108 new employees (100%) had completed NEO core communication competencies for (i.e., foundational skills) and performance check-offs since the last review. **Individual-Specific Competency-Based Training** 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 reviewed two individuals from Sample R.4 and Sample R.5 and reviewed evidence that staff working with these individuals had received all the training related to their communication SAP. Based on that evidence the Monitoring Team determined the Facility did have a clear process in place. Four of four individuals from Sample R.4 and R.5 (100%) had evidence that staff were trained on their communication SAPs and/or AAC. The concern was that on paper the training looked appropriate but the Monitoring Team did not see an increase in the knowledge base of staff. The staff responsible for training other staff was a Speech Therapist and was competent	

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		to train other staff regarding implementation of the device. 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** 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 five of five individuals (100%), monitoring of communication supports was outlined in the assessment. • For five of five individuals (100%) 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 or consistent review to ensure devices were being implemented as expected. One of nine individuals from Sample R.1 (11%) received monthly and/or quarterly monitoring to ensure all communication supports remained effective and functional. If individuals did not have a formal program, there was no evidence of communication supports or recommendations/strategies to enhance communication being reviewed on a regular basis to ensure they were utilized or review to determine if revisions to strategies were needed. Consistent review is needed so that skills can begin to develop and enhance communication.	Noncompliance

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 (3/18/2014) 2. BSSLC Action Plan (3/18/2014) 3. BSSLC Presentation Book for Section S (4/7/2014) 4. Only three records were reviewed for Section S, as the parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample the Facility selected). This was because the Facility had recently implemented a new skill acquisition program (SAP) process and format, and requested feedback. Reviewed documents included the ISP, the Functional Skills Assessment (FSA), assessments directly related to the SAP, the SAP, and sample data sheets. All documents were reviewed in the context of the Self-Assessment and included Individuals #42, #588, and #593. **People Interviewed:** 1. Susie Johnson – Director of Residential Programs 2. Melissa Moehlmann – Director of Education and Training 3. Terry Blackmon, PhD – Director of Behavioral Services 4. Sara Bohl, MA – BCBA 5. Pam Boehnemann – QIDP Coordinator 6. Direct Support Professionals: Approximately 15 staff were interviewed in the Education and Training Center **Meeting Attended/Observations:** 1. Section S Strategy Team meeting 2. Education and Training meeting 3. Human Rights Committee meeting 4. Observations were conducted in the Education and Training Center.
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section S. 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. 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: ▪ 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 Due to the reduced review process, the monitoring tools the Facility used to conduct its self-assessment included only the Skill Acquisition Plan Checklist developed at the Facility. o This monitoring tool included adequate indicators to allow the Facility to determine compliance with the Settlement Agreement. o The monitoring tools included adequate methodologies, such as a review of all pertinent assessments, as well as the content of the SAP. o The Self-Assessment identified the sample sizes, including the number of individuals/records reviewed in comparison with the number of individuals/records in the overall population. This sample size was adequate to consider it a representative sample. o The monitoring/audit tools had adequate instructions to ensure consistency in monitoring and the validity of the results. o The following staff/positions were responsible for completing the audit tools: BCBAs, Active Treatment Coordinators, and consultants from DADS. o The staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools and were clinically and programmatically competent. o Adequate inter-rater reliability had not been established between the various Facility staff responsible for the completion of the tools. ▪ Did use other relevant data sources and/or key indicators/outcome measures. The Facility reported that, amongst other materials, reviews had included the data entailing functional engagement found in various settings across campus, enrollment data for individuals attending the public school, tracking data reflecting the timeliness of Preferences and Strengths Inventories, and data regarding the number of community outings provided per month. ▪ The Facility consistently presented data in a useful way. Specifically, the Facility's Self-Assessment: o Presented findings consistently based on specific, measurable indicators. o Consistently measured the quality as well as presence of items. o Did not distinguish data collected by the QA Department versus the program/discipline. 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 Complete, In Process, or Not started. ▪ The Facility data identified areas of need/improvement. ▪ The actions did not provide a set of steps likely to lead to compliance with the requirements of this Section. Although the steps were often adequate regarding what actions were need, they lacked specific guidelines related to how the quality of those steps would be determined.
	Summary of Monitor's Assessment: Observations, interviews, and record reviews were conducted on-site at BSSLC from 4/7/2014 through 4/11/2014. Record reviews continued off-site following the site visit. As described previously, the current site visit included reduced monitoring procedures. The Facility had recently implemented a new skill

	acquisition program (SAP) process and format, and requested feedback.. Provisions S.1, S.2, and S.3.a were reviewed only in the context of a sample of three SAPs selected by the Facility. No review was conducted of Provision S.3.b. The primary request of the Facility was that the three SAPs be reviewed to determine if the new format and development process was appropriate. Based upon the materials provided by the Facility, it was apparent that the new SAP format and procedures were a substantial improvement over previous efforts. • The new SAPs were much more integrated with the assessment and ISP process. Information from each pertinent assessment was clearly presented on the SAP cover page, as well as how that assessment was used in selecting and developing the training methodology. • The SAPs reflected a coherent approach to teaching that was based in behavior analytic principles. SAPs reviewed during previous site visits had reflected some sound teaching strategies. The SAPs reviewed during the current site visit, however, were the first to reflect an integrated methodology that was evidence-based. • The new SAPs also emphasized an approach to teaching that was practical for the staff and addressed skills that were likely to lead to greater independence. Despite the gains reflected in the new SAPs, there were some noted limitations. As was evident in the past, the new SAPs did not include an adequate number of trials, in most cases including one trial per day or less. In addition, although the new SAPs also included good examples of maintenance and generalization targets, it would have been beneficial to include at least general information about how maintenance and generalization would have be measured and tracked. Overall, the SAPs reviewed during the current site visit held the potential to improve the skill acquisition training at the Facility substantially. As the SAP process was relatively recent and included only the Education and Training Center, it was not clear how the strategy would fare when implemented campus-wide. Skill acquisition training can present numerous challenges in residential settings. The Facility must be prepared for those challenges if the new SAP process is to live up to its potential.

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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	<u>Historical Perspective</u> 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	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	information, it appeared that the supplanting of SAPs by SSOs was counterproductive concerning 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. 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. During the April 2013, BSSLC reported that revisions to both the SAP and ISP process had recently been implemented. A sample of 11 recent ISPs, as well as three SAPs that the Facility had identified as reflecting the best work were reviewed. Findings reflected minimal improvement in comparison with previous site visits. In October 2013, the Facility reported that new approaches to skill acquisition programs had only recently begun. Available information suggested that the Facility had not provided adequate assessments or used assessment information where available. <u>Current Site Visit</u> At the time of the current site visit, the Facility reported that substantial changes had again taken place regarding the development process for skill acquisition programs. Due to this, the Facility requested an abbreviated review that involved only three SAPs. These SAPs were selected by the Facility as representative of the best work completed thus far. The three individuals included in this sample of three SAPs were Individuals #42, #588, and #593. All information reported and findings described in Provision S.1 regarding the development of skill acquisition programs and the content of those programs was based upon one SAP from each of the three individuals listed above. This was not sufficient for the determination of substantial compliance. As the Facility had requested only feedback on the new skill acquisition programs and procedures, all information presented should be	

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viewed in the context of that request rather than a broader review of compliance with the Settlement Agreement.

Use of Assessment Information in Planning Skill Acquisition

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

Based upon the documentation provided by BSSLC, the use of assessments in the development of SAPs appeared to be substantially better in the latest iteration of the SAP development process.

	1/2010	10/2013	4/2014
Skill acquisition plans are implemented to address needs identified in:			
ISP	7%	10%	100%
Adaptive skill or habilitative assessment	7%	0%	100%
Psychological assessment	0%	0%	100%
Skill acquisition plans are chosen in an individualized manner.	0%	10%	100%
Skill acquisition plans are related to the individual's preferences.	0%	20%	67%

Documentation reflected that the three SAPs included a task analysis as a part of the development process. These task analyses were used, not just to define the necessary steps in the training methodology, but also to verify the validity of findings reported in the Functional Skills Assessment (FSA) for the specific targeted skill. This was a positive step, as in previous site visit reports it was indicated by the Monitoring Team that the FSA lacked sufficient rigor for use in developing SAPs and should be supplemented by assessments that were more specific.

It was also noted that each SAP included on the cover page a detailed presentation of which assessments were used in determining the need for the SAP, as well as the date of each assessment and where needed a succinct presentation of the findings. This reflected a substantial step forward and provided the foundation for the selection of the target skill.

There was also substantial evidence to support the use of preference assessments and individualization in the SAP development process. Each of the three SAPs clearly reflected a process that emphasized identifying and supporting the unique needs and preferences of

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the individual. Although only two of the three SAPs were rated successful for the use of individualization, the one SAP that was rated as not meeting that element was rated so because of incongruences in the reported information rather than a weakness in the process as a whole.

In all, the use of assessments in the development of the three SAPs represented a substantial improvement over previous efforts by the Facility.

Teaching New Skills

A review of the content of the three SAPs in the sample in general revealed improvement over previously reviewed SAPs. The ratings are presented in the table below.

	1/2010	10/2013	4/2014
Plan reflects development based upon a task analysis	0%	0%	100%
Behavioral objective(s)	0%	50%	33%
Operational definitions of target behavior	0%	60%	100%
Description of teaching conditions	0%	30%	100%
Schedule of implementation plans for sufficient trials for learning to occur	0%	0%	0%
Relevant discriminative stimuli	0%	100%	100%
Specific instructions	0%	50%	67%
Opportunity for the target behavior to occur	0%	80%	67%
Specific consequences for correct response	0%	100%	100%
Specific consequences for incorrect response	0%	100%	100%
Plan for maintenance and generalization that includes assessment and measurement methodology	0%	20%	0%
Documentation methodology	0%	80%	100%

Based upon the information gained in the review, the Facility achieved progress in five of 12 areas (42%), remained unchanged in four of 12 areas (33%), and regressed in three of 12 areas (25%). The Facility was fully successful in seven elements (58%).

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

Behavioral objectives

One of the three reviewed SAPs (33%) reflected an adequate behavioral objective. Objectives should define the conditions under which the skill will be performed, the

#	Provision	Assessment of Status	Compliance
		actions that constitute successful performance of the skill, and the criteria for measuring success. In addition, the objective should define a timeframe for success that reflects an understanding of the individual's potential, allowing adequate time for success without perpetuating training indefinitely. Limitations noted are presented below. • For Individual #42, the objective required 15 out of 20 trials per month for two consecutive months. Although training was required for this individual on Monday through Friday, the SAP stipulated that data were to be collected only once per week. It was not clear how the individual would be able to meet the requirement of 15 successful trials per month with only four to five data collection points per month. <u>Sufficient trials</u> None of the three SAPs (0%) called for more than a single trial per day. 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. A single trial per day is not usually sufficient to develop a new behavior or skill. <u>Specific instructions</u> 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. Furthermore, staff must be prepared to provide instruction under all anticipated circumstance. Only two of the three SAPs (67%) included adequate instructions for staff. An example of SAPs that did not reflect adequate descriptions of teaching conditions included the following. • The SAP for Individual #42 involved removing a full catch bag from a shredder. It was not specified how many bags the individual could fill in a single day, but the SAP required at least one training session per day. It was therefore possible that the individual might not fill a bag during a single workday. Under such circumstances, there would have been a need for staff to know how to conduct training. For example, if the end of the workday was reached without the bag being filled, was staff to implement the SAP with a less than full bag? An additional option would have been to have the individual remove bags for others who were running shredders. With no such options or instructions provided, the risk of staff making errors in training was increased.	

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		Opportunity for the target behavior to occur In order for training to be provided and learning to occur, there must be an opportunity for the behavior to be displayed within the context of a training methodology. In addition, that opportunity must include the delivery of reinforcement following the display of the target behavior. In one of the three SAPs (33%; See the example immediately above for the Specific Instructions element.), it was not evident that the individual would have the opportunity to display the targeted skill during any particular training session. Plan for maintenance and generalization Three of the three SAPs (100%) included strategies for maintenance and generalization of the targeted skill. These strategies were generally very good examples of how a skill might be maintained or generalized. None of the three SAPs (0%), however, included an assessment or measurement methodology in the otherwise suitable maintenance and generalization plans. Although it might not be possible at the onset of a new SAP to have comprehensive maintenance and generalization strategy, including assessment and measurement procedures, fully developed, it is typically beneficially to present a concept of how assessment and measurement might be approached. In that way, even if revisions become necessary, the SAP author is as prepared as possible to meet the individual's programmatic needs. Summary: Based upon the three records provided by the Facility, it was evident that the SAPs in the sample were substantially better than SAPs reviewed at previous site visits. Perhaps more important than improvement in any particular element was the indication that all three SAPs in the sample were based upon sound behavior analytic principles. If the Facility attends to the noted limitations, especially the insufficient number of trials and the lack of assessment and measurement strategies in the maintenance and generalization sections, it is likely that considerable progress can be achieved in Provision S.1. Engagement, activities, and informal skill acquisition training The Facility request for an abbreviated review included limiting engagement observations to the Education and Training Center. The reason for this request regarding engagement was that the new SAP format had only been implemented in the Education and Training Center. As the Facility was most interested in feedback regarding the new process, it appeared appropriate to limit observations to that area. The table below reflects the number and percentage of individuals who were engaged in any formal or informal activity that did not include stereotypic movement, self-stimulation, or other undesired behavior. | | Staff Present | Individuals Present | Individuals Functionally Engaged | Percent Functionally Engaged |	

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Ed & Training	2.00	4.00	1.00	25%
Ed & Training	3.00	4.00	3.00	75%
Ed & Training	1.00	3.00	2.00	67%
Ed & Training	2.00	3.00	3.00	100%
Ed & Training	3.00	8.00	7.00	88%
Ed & Training	3.00	6.00	3.00	50%
Ed & Training	1.00	6.00	3.00	50%
Ed & Training	1.00	4.00	2.00	50%
Ed & Training	2.00	4.00	3.00	75%
Ed & Training	1.00	4.00	1.00	25%
Total percentage of individuals functionally engaged				64%
Percentage of locations with 50% or greater functional engagement				80%

Observations revealed that across all settings 64% of observed individuals were functionally engaged. Furthermore, 80% of all environments observed reflected at least 50% engagement. Specific circumstances noted during observations included the following.

- In one of the shredding areas of the Education and Training Center, one staff member was rotating amongst eight individuals while two additional staff were working directly with single individuals. The staff that was floating was chanting and cheering in a loud, exuberant voice in order to maintain focus and motivation. Seven of the eight individuals in the room were engaged in their work and appeared to enjoy the actions of the staff.
- In the laundry areas of the Education and Training Center, one staff was floating amongst three individuals. The staff member was offering specific verbal prompts and pointing to pictorial examples of the steps of each individual's task.

Based upon information obtained from the Facility during observations and the review of the three records, it appeared that the actions taken by the Facility were a positive step. The Facility reported that the next phase in its efforts was to implement the new SAP format and procedures in residential areas. Despite the improvements noted during the current review and the potential benefits of the new SAPs and procedures, it should be noted that implementation of formal training procedures in residential settings is likely to present greater challenges than faced at the Education and Training Center. It would be beneficial if the Facility emphasized the importance of training and supporting those staff who will be tasked with implementation of the new SAPs.

S2	Within two years of the Effective Date hereof, each Facility shall	The parties agreed the Monitoring Team would conduct reduced monitoring (i.e., a smaller sample the Facility selected) for this subsection. This was because the Facility had recently	Noncompliance

#	Provision	Assessment of Status	Compliance
	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.	implemented a new skill acquisition program format and process, and requested feedback on three of the most recent skill acquisition programs. The noncompliance finding from the last review stands. As noted in Provision S.1, SAPs for only three individuals were reviewed: the three individuals were Individual #42, #588, and #593. It was not clear whether the documents received from the Facility for these three individuals included all assessments from the ISP or just those assessments directly related to the SAPs. Therefore, it was not possible to assess whether all necessary annual assessments had been updated from the ISP conducted one year earlier. For each individual, however, the Facility did provide a Functional Skills Assessment, a Preference and Strengths Inventory, a Vocational Assessment, and a Speech and Language Assessment. The SAP for each individual included a narrative that indicated how specific information from each of these assessments was used in developing the SAP. As reported in Provision F1c: • Assessments for the ISP were still not routinely completed on a timely basis, as evidenced by the Facility's own self-assessment and by other findings of the Monitoring Team, but there was improvement noted. • In a sample of nine recent ISPs reviewed, none (0%) had all assessments included and completed on a timely basis prior to the ISP annual meeting. Overall for this sample, the rate of timeliness was 45% based on the requirements listed in the ISP Preparation meeting documentation. Although assessments were still not routinely of sufficient quality overall to reliably identify the individual's strengths, preferences and needs, progress was noted in certain discipline specific assessment processes and outcomes.	
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	As noted in Provision S.1, the Facility requested an abbreviated review of Section S. It was requested that the Review of Section S during the current site visit be limited to the SAPs of three individuals. Those individuals were Individuals #42, #588, and #593. It is suggested that an SAP would be practical and functional if it a) could be implemented	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>practical and functional in the most integrated setting consistent with the individual's needs, and</td><td>in locations where the individual was likely to live and work, and b) was likely to strengthen the basic set of skills the individual would need to succeed. In order to obtain a measure of practical and functional qualities of the SAPs in the current sample,, those three SAPs were rated on five questions. Those questions and the ratings are presented below.

<table>
<tr><td>Practical</td><td>Percentage of SAPs</td></tr>
<tr><td>SAP does not require excessive resources, time or staff.</td><td>100%</td></tr>
<tr><td>SAP is not excessively difficult or technical.</td><td>100%</td></tr>
<tr><td>SAP can be implemented in relevant environments.</td><td>100%</td></tr>
<tr><td>Functional</td><td></td></tr>
<tr><td>SAP addresses specific needs from formal assessment.</td><td>100%</td></tr>
<tr><td>SAP targets skills useful for the individual.</td><td>100%</td></tr>
</table>

Based upon the current review, it appeared that the three SAPs were substantially more functional and practical than SAPs reviewed during previous site visits.</td><td></td></tr>
<tr><td></td><td>(b) Include to the degree practicable training opportunities in community settings.</td><td>The parties agreed the Monitoring Team would not monitor this provision because of the Facility's focus on improving SAPs. No ratings of compliance will be offered.</td><td>Noncompliance</td></tr>
</table>

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 3/18/2014 2. BSSLC Action Plans, updated: 03/18/2014 3. Brenham State Supported Living Center Presentation for April 2014 Settlement Agreement Monitoring Team Visit, Section T 4. DADS Policy 018.2: Most Integrated Setting Practices, dated 10/18/2013 5. DADS Policy 004.1: Individual Support Plan Process, dated 11/20/12 6. BSSLC Policy T.2: Most Integrated Setting Practices Discharges/Transfers, Revision 12/4/12, Implemented 3/27/2013 7. Potentially Disrupted Community Transitions Process (PDCT), revised 12/03/13 8. Timelines for Referral Process, dated October 2013 9. List of Individuals aged 18 and under 10. Permanency Plans for Individuals #155, #200, #224, #265, #279, #382 and #534 11. Since last on-site review, a list of all individuals who have requested community placement, but have not been referred for placement 12. Since last on-site review, a list of all individuals who have been referred for placement 13. 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" 14. ISPs, ISPAs, documentation of community exploration and contact notes for individuals who had a referral rescinded in the last six months: Individuals #440, #492, #501 and #590 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. Individual Support Plans (ISPs) including assessments for nine Individuals #53, #62, #102, #141, #189, #255, #379, #481 and #490 19. Community Placement Report for Meeting Dates 10/7/2013-4/7/2013, dated Monday, April 07, 2014 20. For the last twelve months, lists of all trainings/educational opportunities provided to individuals, families, and LARs to enable them to make informed choices 21. Local Authority (LA) Community Living Options Information Process (CLOIP) Worksheets for seven individuals with ISPs held in March 2014: Individuals #18, #69, #120, #318, #350, #398 and #536 22. For the last twelve months, list of all trainings/educational opportunities about community living options provided to Facility staff 23. Since last on-site review, a list of all individuals who have had a Community Living Discharge Plan (CLDP) developed

	24. Completed CLDPs for Individuals #52, #118, #303 and #468 25. Draft CLDPs for Individuals #56 and #62 26. ISP Addendums (ISPAs) documenting review of transitions that have taken longer than 180 days for Individuals #56, #273 and #335 27. ISPA documenting review of Potentially Disrupted Community Transitions for Individuals #468 28. Brenham State Supported Living Center QA/QI Council Meeting, Quarterly Quality Assurance Report, dated February 26, 2014 29. BSSLC Draft Process/Outcome Indicators as of 01/31/2014 30. For the last one year period, a list of individuals who have transitioned to the community indicating whether or not since their transition, they have: (1) had police contact, and if so the reason why, the date, and an indication of whether or not they were arrested or otherwise detained; (2) had a psychiatric hospitalization, including the date on which they were hospitalized and the length of stay; (3) had an ER visit or unexpected medical hospitalization, including the reason; (4) had an unauthorized departure, including the date and length of departure; (5) been transferred to different setting from which he/she originally transitioned, including both addresses and reason for transfer; (6) died, including the date of death and cause; and/or (7) returned to the facility, including the date of individual's transition to the community, date of return, and reason. 31. Completed Post Move Monitoring (PMM) checklists for Individuals #52, #118, #208, #252, #303 and #468 32. ISPAs documenting IDT review of PMM Checklists for Individual #208 33. Discharge Summary and assessments for Individual #289 **People Interviewed:** 1. Debra Green, Admissions and Placements Coordinator (APC) 2. Andrew Williams, Post-Move Monitor (PMM) 3. Daniel Dickson, Quality Assurance Director 4. Sharika Bingam, Placement Coordinator 5. QIDP and Lead QIDP for Individual #123 **Meeting Attended/Observations:** 1. ISP annual planning meetings for Individuals #123, #547 and #599 2. ISP Preparation Meetings for Individual #545 3. Admissions and Placement Department Weekly Meeting
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section T. In its Self-Assessment, for each provision, the Facility 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. A revised Self-Assessment template was in use that appeared to increase the focus on the use of data collected through the Facility's QA/QI system and should result in an improved process. In order to improve its Self-Assessment for use in achieving compliance, the Facility should continue to review the criteria by which it assesses that compliance. While the new template did expand upon those criteria, they still did not always fully address the noncompliant findings from the Monitoring Team. If the Facility intends to use its Self-Assessment to conclude whether it is in substantial compliance, it must identify and

	factor in all of the criteria upon which compliance is to be based. It may choose to prioritize only certain components in its Action Plan, but it should be aware that the prioritized activity may not be sufficient in achieving substantial compliance. The Facility also provided for each Section of the Settlement Agreement provisions an Action Plan listing actions to be taken to move forward toward compliance. Many of the Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcomes and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. Overall, a comprehensive strategic plan that identifies all requirements and the measurable indicators for each would allow the Facility to not only better prioritize its activities, but would also allow it to better monitor its overall progress toward substantial compliance. At least, the Facility should determine the priorities for action for the next six months, complete an analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities. Sections of the Self-Assessment could reference the specific Action Steps that would be implemented to address the reasons for noncompliance, which could tie the Self-Assessment and Action Plans together. The Facility may want to consider how it could further the integration of these two documents, such that staff could visualize the results of the self-assessment, the specific action plan to address any identified deficiencies and the measurable outcome intended to be achieved. This would also allow the Facility to appropriately update or modify its Action Steps based on an evaluation of outcome data. 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 the following Provisions: T1c1, which requires the Facility to specify actions to be taken to implement the CLDP in coordination with provider staff; 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 parties agreed the Monitoring Team would not monitor these provisions because the Facility was in substantial compliance for more than three consecutive reviews; the substantial compliance findings from the last review stand. The Facility also rated itself as substantially compliant in Provisions T1d, which requires the Facility to ensure that each individual moving to a community setting has a current comprehensive assessment of needs and supports within 45 days prior to the individual leaving the SSLC; and T1e, which requires the Facility verify, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety are in place at the transitioning individual's new home before the individual's departure from the SSLC. The Monitoring Team did not concur with these findings. The Monitoring Team did agree with the findings of noncompliance with the remaining provisions. For Provision T2, the Facility self-rated noncompliance in Provision T2a and the Monitoring Team concurred. 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. Noncompliance was also found for this provision.

	For Provision T3, no compliance rating is required. For Provision T4, the Facility indicated it was in substantial compliance with the requirement for alternate discharge planning, but the Monitoring Team did not concur.
	Summary of Monitor's Assessment: The Monitoring Team continued to find noncompliance overall for this Section. More work remained to ensure transitions were effectively planned and successfully implemented. A summary of noted progress included the continued 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. The Monitoring Team again commends the Facility for its initiative in this area. The Monitoring Team found there was continued progress in the implementation of the ISP process as it related to this Section, 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**, the parties agreed the Monitoring Team would not monitor Provisions T1c2, T1c3 and T1h because the Facility was in substantial compliance for more than three consecutive reviews. Respectively, they 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. The substantial compliance findings for these provisions from the last review stand. The parties also agreed the Monitoring Team would provide reduced or no monitoring for T1b3 and T1e because the Facility had made limited to no progress. The noncompliance findings from the last review stand for these two provisions; in addition, the remaining provisions that received a full review remained in noncompliance. Four individuals had transitioned to community living in the past six months and there were 12 active referrals. While the pace of transitions had slowed as compared to the previous two monitoring periods, many of the current referrals were close to transition dates being finalized. Overall, BSSLC still needed to improve its processes 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 into account his or her specific learning needs. Continuing deficits in assessments also translated to instances in which the IDT failed to identify in each individual's ISP the protections, services, and supports that needed to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs, or the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences and the strategies intended to overcome such obstacles. In turn, these deficits continued to be 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 remained in noncompliance with Provision T2a. The PMM Checklists

	continued to be completed in a timely and generally attentive manner; however, continued improvements were still needed to ensure a comprehensive review was taking place. Deficits in the adequate identification of needed supports, services and protections in the CLDP also continued to hamper the implementation of a post-move monitoring process that would serve to promote a safe and successful transition. The Monitoring Team continued to recommend an additional layer of formalized review and scrutiny be given to CLDPs before approval and to the subsequent PMM over the course of the next six months. Provision T2a was not rated. No Post-Move Monitoring visit was completed during this visit. **For Provision T3**, no rating is required. **For Provision T4**, the Facility indicated it was in substantial compliance, but the Monitoring Team did not concur. The Facility reported one Alternate Discharge during the past six months. A review indicated it did not provide a post-discharge plan of care sufficient to allow the receiving facility to provide all the services and supports needed by the individual.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of	<u>Transition Staffing:</u> Staffing devoted to transition included the APC, the Post-Move Monitor, a Transition Specialist funded through the state's Money Follows the Person project, a Children's Specialist and a Placement Coordinator who had been in place for about six months. The APC held a weekly departmental meeting to discuss and plan for all transition related activities, which appeared to be of value in the transition planning effort. <u>Transition Outcomes During Last Six Months:</u> • Community Transitions: The number of community transitions showed a decreasing trend. o There were four transitions to community living in the last six months. With 291 individuals currently living at BSSLC, this represents approximately 1% of the population. This figure represented a decreasing trend over the previous two monitoring periods for which nine and six individuals had transitioned during each six-month period. o The transition process took 180 days or less for one of the four (25%) individuals. • Referrals for Community Transitions: o The number of community referrals indicated an increasing trend. Twelve referrals had been made in the past six months, according to the Community Placement Report for Meeting Dates 10/7/2013-4/7/2013. This compared to seven and ten referrals made during the previous two	Noncompliance

#	Provision	Assessment of Status	Compliance
	others with developmental disabilities.	six-month periods respectively. o Fourteen individuals were on the active referral list (almost five percent of the current population at BSSLC). o It appeared that three of the 14 (21%) individuals had been on the referral list more than 180 days, but none had been on the list for more than eight months. It was noted these data were from the updated Community Placement Report, dated Monday, April 7, 2014, which may not have accurately represented the original referral dates. For example, the referral date for Individual #273 was listed as 10/1/2013, but other documentation indicated the original referral actually took place in October 2011. • Individuals requesting placement, but were not referred: There were no individuals reported to have requested placement, but were not referred. • Rescinded Referrals: o There were four rescinded referrals reported since the last review. o Of these, the reasons for the rescinding appeared to be reasonable for three (75%), in that the LAR made the choice. For Individual #590, the reason for rescinding was not clearly documented. The CPR indicated it was IDT Decision: Other Reason. It appeared the rescinding of the referral took place at the annual ISP planning meeting. The documentation in the ISP indicated the LAR was told the individual no longer qualified for IDD funding and the obstacle selected was Funding Issues. There was no explanation of why the individual no longer qualified or what the Facility intended to do to facilitate appropriate community services, particularly since the preferences of individual and LAR for community living remained. o An adequate review was conducted to determine if changes in the referral and transition planning processes were needed at the Facility for none (0%) of the rescinded referrals. For the three individuals whose reason for rescinding was LAR Choice, there was little documentation provided as to the particular concerns of the LAR or the actions the Facility had taken to address them. • Returns from Community Placement o No individuals had returned from a community placement after transition. o This number of individuals who returned to the SSLC after a failed community placement indicated a decreasing trend over the previous monitoring visit. • Deaths Following Community Placement o Two individuals who moved since 7/1/09 passed away since the last	

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		onsite review. The deaths did not occur within the 90-day post move monitoring period. The Facility did not provide documentation that reflected an adequate review had been conducted to determine whether any changes in the referral and transition planning processes at the facility should be made. • Other Adverse Outcomes • There were other unexpected or adverse outcomes occurred for three individuals who transitioned during the past six months. These included two unauthorized departures for one individual, an emergency room visit and hospitalization for one individual and an unanticipated surgery for a third individual. The Facility provided documentation of IDT review for the first individual only. <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. • The Facility had recently initiated some new approaches to obtain improved feedback about individuals' responses to community tours and pre-selection visits. See Provision T1b2. • The Facility had also held two unit-specific community education events in which providers were invited to visit and make presentations. <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) also negatively impacted the ability of the Facility to effectively assist and encourage individuals to move to the most integrated setting.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge	<u>Policies and Procedures related to transition and discharge processes</u>: 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 sections T1b1 through T1b3 would be considered stand-alone provisions that require implementation independent of Provision T1b or any of the other cells under T1b. Since the previous visit, DADS had issued DADS Policy 018.2: Most Integrated Setting Practices, dated 10/18/2013. It did not address all of the items in section T of the Settlement Agreement.	Noncompliance

#	Provision	Assessment of Status	Compliance
	processes. Such policies, procedures, and practices shall require that:	Below are comments from the Monitors: • The policy was missing a complete description of the process used to "assess" individuals for referral to the community. The ISP policy describes the process of team members making recommendations in their assessments (at III.C.5.c), but does not address having discipline members make a recommendation to the individual and LAR, followed by a full team recommendation being made. The ISP policy addresses, in very global terms, a "living options discussion," and refers the reader to the Most Integrated Setting policy for more details. T.1.b.3 states: "Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices." Neither policy, however, fully spells out how this will be done. • There was nothing requiring an individualized plan for the education of the individual and LAR. Such efforts are probably the most important aspect of addressing the primary reason for individuals not being referred (i.e., about 50% of the individuals across the state were not referred due to LAR preference). • The policy did not thoroughly address the IDT and Facility's responsibility in regard to identifying and addressing obstacles to referral and obstacles to transition. • There was no requirement that Facilities take action within their purview to overcome obstacles (e.g., working with local authority). • After referral, there was no description of expectations regarding roles of Facility staff (e.g., assessing potential community options, providing training to staff) or of potential transition activities, such as visits to potential homes, provider staff visiting Facility, etc. • The policy did not mention the Settlement Agreement requirement that action be taken prior to the individual's move if pre-move supports are not in place. • The policy did not address the quality of CLDPs. The policy listed two reviews of CLDPs to be undertaken, one at the Facility and one at State Office, but there were no requirements for any actions to be taken if needed improvements were identified. • There was no mention of need for the IDT to use the CLDP to ensure supports are in place. • There was no standard that the Facility exert its best efforts to address concerns identified through post-move monitoring. The policy did not, for example, specify any requirement for consideration of enhanced monitoring or follow-up in the event of identified issues or adverse occurrences. • The policy should draw from, and line up with, the metrics submitted by the	

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		Monitors and the content of the monitoring reports. The Facility had also recently promulgated BSSLC Policy T.2: Most Integrated Setting Practices Discharges/Transfers, Revision 12/4/12, which was reported to be in the approval process. The Monitoring Team will review this policy at the next visit.	
	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 gathers obstacle information through the ISP process, and then categorizes these using a list of DADS-approved obstacles separated into two categories as defined in Exhibit A to the statewide Policy #018.2. The first category obstacles to referral, included: • Individual's reluctance for alternate placement • LAR's reluctance for alternate placement • Medical needs requiring 24-hour nursing services/frequent physician monitoring • Behavioral health/psychiatric needs requiring frequent monitoring by psychiatric/psychology staff and/or enhanced levels of supervision maintained by direct service staff • Evaluation period (Ch55/46B only) • Court will not allow placement (Ch55/46B only) • Lack of funding The second category, obstacles to transition included: • 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 specialized mental health supports • Need for environmental modifications to support the individual • Need for meaningful employment or supported employment	Noncompliance

#	Provision	Assessment of Status	Compliance
		• Individual/LAR indecision • Medicaid/SSI funding • Need for services and supports for persons with forensic needs/backgrounds • Lack of specialized educational supports • Need for transportation modifications to support the individual Of nine sample ISPs reviewed, there were two referrals made. For the remaining seven the Monitoring Team found that all (100%) had an obstacle defined. Six indicated the only obstacle was LAR Choice and one indicated the only obstacle was Individual Choice. The Monitoring Team was concerned that the latter ISP did not accurately reflect the nature of the obstacle. It was documented in the ISP that Individual #490, who had returned from a community transition within the past year, wanted to live with a parent and that the second choice would be a group home. The facility discipline members who offered an opinion almost unanimously indicated the individual could be served in a community setting. The physician deferred an opinion to the Behavioral Team based on the individual's two previous unsuccessful transitions and challenging behaviors. No professional opinions from the psychology or psychiatry clinicians were documented. Under the obstacle heading of Individual Choice, the IDT documented the reason was unsuccessful prior community placements. Behavioral/Psychiatric Needs was not checked. See also Provisions F1a and F1e. Plans to address obstacles at the individual level were not yet adequate, but there was some progress noted during the on-site annual planning meetings attended by the Monitoring Team. For example: • For Individual #547, there was a well-managed Living Options discussion with a reluctant LAR. The Lead QIDP and QIDP had engaged the LAR in at least one conversation about community awareness and living options prior to the meeting, which resulted in a living options discussion at the meeting that was respectful and non-threatening in nature. While the LAR and another family member were very clear about their continued opposition to community transition, the discussion was open and comfortable. The IDT was able to express its opinion about what they considered an appropriate most integrated setting for the individual without discomfort on anyone's part. The LAR was not put on the defensive and agreed to allow the individual to participate in CLOIP tours on a quarterly basis. The Lead QIDP closed the discussion with an acknowledgement that he and the QIDP would have continuing discussions with the LAR over time. This was a very positive outcome. See Provision F1e for additional discussion. Otherwise, of the seven sample ISPs reviewed that did not result in a referral, none (0%)	

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		included an action plan to address/overcome obstacles identified that was adequate (i.e., individualized, measurable, and comprehensively addressed the obstacles). There was some progress noted for three of the seven (43%). For example, for Individuals #141 and #255, while the action plans themselves did not comprehensively address the obstacles, nor define measurable criteria that would be used for evaluating whether the obstacles had been resolved, they did include in the action plans a specific objective for the IDT to reconvene within six months to review information related to the obstacles. This was a step forward from previous reviews. <u>Preferences of Individuals and LARs</u> Of the nine sample ISPs, 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 the one instance in which the individual made a clear statement of preference for community living, as described above for Individual #490, the individual's affirmative response was misrepresented by the IDT as the obstacle. Preferences of LARs and families for living arrangement continued to be 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.	
	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 ten 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%) sample ISPs reviewed was there an appropriate and individualized plan for increasing awareness of community living options that took into account the learning needs of the individual. <u>An Annual Provider Fair:</u>	Noncompliance

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		The Facility had held its semiannual provider fair on January 25, 2014, with another scheduled for July 2014. 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 Authorities (LAs): BSSLC staff continued to have joint Interagency Planning Meetings with local LAs and staff from RSSLC (as the same LAs were responsible for some individuals at both facilities) to coordinate admissions and discharges. The LA Annual In-service was held at the Facility on October 18, 2013. 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 seven randomly selected CLOIP Worksheets for recent ISPs. For only one of seven (14%) was the LA Service Coordinator allowed to interview the individual. For the one individual the LA Service Coordinator met with, the documentation indicated the individual had no response to the information presented. Tours Of Community Providers: The Facility continued to work towards a consistent, formalized process to fashion provider tours as a part of an individualized community living awareness and education plan. Fifteen tours were provided between October 8, 2013 and April 8, 2014. • Opportunities to go on a tour available to all (except those individuals and/or their LARs who state that they do not want to participate in tours): In the past six months, the documentation provided by the Facility listed a total of 29 individuals, unduplicated, who had participated in CLOIP community tours. 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 291 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.:	

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		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 Facility was also arranging for providers to visit residential units on the campus for individuals who could not as easily participate in the regularly-scheduled tours due to health reasons. 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, averaging about two individuals participating in any given tour. • 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 reported it had recently begun working on improving its processes for staff documentation of individuals' responses to tours. The Monitoring Team looks forward to reviewing the progress of this initiative at the next visit. Opportunities Are Provided To Visit Friends Who Live In The Community: BSSLC indicated there continued to be some opportunities for individuals living at the Facility to visit with friends who had moved to the community, including a plan for an individual to have a weekend visit with a friend who recently moved to the community. The Monitoring Team also found supporting documentation in one of its sample ISPs for this section. A Plan For Staff To Learn More About Community Options: In response to the document request for a list of all trainings/educational opportunities provided to individuals, families, and LARs to enable them to make informed choices, the Facility provided a list of types of opportunities that included the following: • Weekly CLOIP tours on Tuesdays • Semiannual Provider's Fair, including the participation of a former resident from BSSLC who attended the Provider's Fair to share how the transition into the community was successful. • An Admissions & Placement Department Newsletter • Local group homes and ICF homes pictures accessible for BSSLC staff to view on the Facility's shared drive	

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		• Facility staff participating in on-site visits to community homes and day habilitation programs. <u>Individuals And Families Who Are Reluctant Have Opportunities To Learn About Success Stories:</u> The APC reported her department continued to publish a newsletter that highlighted success stories, with the next issue due in June 2014. <u>Conclusion:</u> 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 could 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 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.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. The noncompliance finding from the last review stands.	Noncompliance

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T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	<u>CLDP Policy and Process</u>: The Department of Admissions and Placements was responsible for coordination of the CLDP process, in collaboration with the individual's IDT. A slightly revised format for the Community Living Discharge Plan (Exhibit F to DADS Policy 018.2) had been promulgated. <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. The Monitoring Team reviewed a sample of four completed CLDPs (Individuals #52, #118, #303 and #468) and two CLDPs in progress (Individuals #56 and #62). Overall, the Monitoring Team found that documentation of ongoing implementation continued to be more frequent and detailed since the Transition Specialists were designated to maintain the referral status updates, so this appeared to be a successful modification to the process: • For six completed CLDPs and CLDPs in progress, six (100%) appeared to have been initiated in a timely manner. It was not possible to verify whether this consistently occurred within 14 days of referral as required because the Profile was undated and the CLDP material provided did not include the Living Options 14-day ISPA to provide a date. • Three of the six (50%) CLDPs reviewed, including four completed CLDPs and two in progress, included adequate documentation to show that they were updated throughout the transition planning process over the past six months. This finding is based on the lack of documentation of adequate review by the IDT of transition-related activities, as described below. • For only two of four (50%) individuals whose referrals had been rescinded in the past six months, did the Facility provide documentation which demonstrated an appropriate level of activity had been undertaken to achieve a transition during the active referral period. As an example, for Individual #501, whose referral was rescinded approximately six months after it was made, due to LAR Choice, there was no evidence provided of any related Transition Specialist activity from the time of referral to the time of rescinding. The documentation in the ISPA rescinding the referral indicated the family had worked to explore options on their own and in conjunction with the LA, but there was no indication of Facility involvement or support for the process. The ISPA to rescind the referral also provided no indication of the Facility's efforts to offer further assistance once it was notified the LAR wished to rescind the referral. • The Monitoring Team found determinations by the IDT did not consistently result in a formal referral in a timely manner. For example, for Individual #123, there was documentation in a Psychiatric Treatment Review (PTR) held on	Noncompliance

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		11/06/13 that a formal recommendation was to be made for placement in the community and for an IDT meeting to be held to discuss. The Children's Specialist had contacted the individual's mother on 11/7/13 to discuss this potential for community living. At that time, the mother agreed and the Children's Specialist indicated a Living Options meeting would need to be scheduled. A Living Options meeting was not held. No further action was documented in this regard until the ISP Preparation Meeting was held on 1/27/14. At that time, the IDT determined the individual and mother should be exposed to community living options. A Living Options meeting was not held at that time. The IDT did implement a community education plan prior to the ISP annual meeting held on 4/9/14 and there was agreement to open the referral at that time. Both the individual and mother indicated their wish to proceed and their satisfaction with the toured homes. A Living Options meeting was to be scheduled within 14 days. The Monitoring Team was concerned that a Living Options meeting was not held for nearly five months from the time of the initial agreement from the mother, which may have facilitated a timelier implementation of the community education, referral and transition. In addition, the Living Options goal set in the ISP annual meeting was for transition to occur within 12 months. No explanation for this extended time frame and further delay was discussed. The Monitoring Team reviewed an updated Community Placement Report for Meeting Dates as another measure of timeliness in implementing transitions within 180 days as policy expectations stated. • Three of the 14 (21%) current referrals had exceeded the 180 days. It was noted these data were from the updated Community Placement Report for Meeting Dates 10/7/2013-4/7/2013, dated Monday, April 7, 2014, which may not have accurately represented the original referral dates. For example, the referral date for Individual #273 was listed as 10/1/2013, but other documentation indicated the original referral actually took place in October 2011. This made it difficult to ascertain actual timeliness. • The transition process took more than 180 days for three of the four (75%) individuals who had completed transition. Exploration and development of individualized community living options can be a time-consuming process and there are situations in which the 180-day timeframe will appropriately be exceeded. DAD's Policy 018.2 that required the IDT to meet to review transition progress every 30 days once the initial 180 days has expired. The Monitoring Team requested documentation of ISPAs individuals whose transitions took more than 180 days and found these were not yet consistently being held on the required schedule. It appeared the Facility had just begun to implement this process. A single ISPA was	

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		provided for three of the three currently referred individuals whose transitions had thus far exceeded 180 days, all of which were held on March 6, 2014, but each of these should have had at least one previous meeting that was not documented. 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's office 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. <u>IDT Member Participation in Transition Process</u>: Three of the six (50%) CLDPs reviewed, including four completed CLDPs and two in progress, included adequate documentation to show that IDT members actively participated in the transition planning process. In addition to the failure to consistently meet to review transition progress for those whose transitions exceeded 180 days, as described above, the Facility did not routinely provide evidence of IDT review of each trial visit, and such review was not typically referenced in the CLDP document. The Facility should ensure that it routinely documents ongoing reviews as required. Following the visit, the Facility clarified that such documentation of reviews will be documented in an ISP; as that documentation was not provided to the Monitoring Team, it is not possible to assess whether IDT members actively participated in the planning process for the other three CLDPs reviewed. <u>Meetings Development of CLDP in coordination with the LA:</u> A review of four completed CLDPs indicated that four (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. <u>Conclusion:</u> 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 still instances in which placements did not occur within the 180-day requirement. The respective IDTs did not consistently meet to review monthly as required to the progress of these transitions. Coordination with the LA in the development of the CLDP did not appear to be of significant concern at this time. There also remained concerns related to the adequacy of the CLDPs that were developed, primarily in the failure by the IDTs to adequately identify the appropriate pre and post move supports for each individual. These deficiencies are described in more detail in Provision T1e below.	

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	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	<u>Actions to be taken by the Facility Specified:</u> Four completed CLDPs were reviewed to assess whether they clearly identified a comprehensive set of specific steps that Facility staff would take to ensure a smooth and safe transition by including documentation to show that all of the activities listed in the below six bullets occurred adequately and thoroughly. • Training of community provider staff, including staff to be trained and level of training required. • Collaboration with community clinicians (e.g., psychologists, PCP, SLP). • Assessment of settings by SSLC clinicians (e.g., OT/PT). • Collaboration between provider day and residential staff is ensured • SSLC and community provider staff activities in facilitating move (e.g., time with individual at SSLC or in community) • Collaboration between Post-Move Monitor and Local Authority staff Positive findings included: • Four of the four CLDPs reviewed (100%) did clearly identify a set of activities to occur on the day of the move and the responsible staff member. There was no documentation that the activities did indeed occur, however. • A review of completed CLDPs indicated provider staff were typically very involved throughout the CLDP process. In four of four (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. None of four CLDPs were found to have included all the necessary components. Issues of concern found in review of these activities included the following: • Collaboration between community providers and BSSLC providers was typically not addressed other than prescribed in-service. There were no specific requirements for any clinician to communicate with a counterpart in the community, such as contact between the facility physician and community physician to ensure understanding of health care concerns and any specific actions that should occur quickly. • None of four (0%) CLDPs specified the level of training that would be provided to community provider staff or the competency to be achieved by those trained. <u>Conclusion:</u> This provision was found to be not in compliance.	Noncompliance
	2. Specify the Facility staff	The parties agreed the Monitoring Team would not monitor this provision, because the	Substantial

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	responsible for these actions, and the timeframes in which such actions are to be completed.	Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	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.	<u>Timeliness of Assessments:</u> The APC tracked the timeliness of CLDP assessments. The Monitoring Team found that, for the most part, these processes 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 also continued to need to focus its attention on whether these assessments were adequately prepared, as described below. <u>Adequacy and Comprehensiveness of Assessments:</u> Assessments were still not being consistently well integrated into a comprehensive assessment in a manner that allowed for the CLDP to adequately reflect the needs and supports to be provided in the community setting. In order to be considered a current and comprehensive assessment of needs and supports, the findings and recommendations must be accurate and reflect all significant information the IDT and the community provider would need to develop an appropriate transition plan. As described in Provision T1e below, in a review of four completed CLDPs, the Monitoring Team found that the assessments did not consistently address the services and supports needed for each 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. Examples follow: • As reported in greater detail in Provision L1, for Individual #118, the Monitoring Team found there were significant issues that could impact a safe transition to community living, particularly with regard to clinical communication of health care issues, which were not adequately addressed in the assessments nor developed into appropriate pre and/or post-move supports. Examples included: o The Monitoring Team was concerned that an attempt was made to obtain a modified barium swallow study on 9/12/2012; however, because of behavioral challenges this study was not completed. There	Noncompliance

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		was no further documentation on follow-up, or clinical rationale for not completing for this unsuccessful diagnostic, and this issue was not further commented on in the CLDP. o On page three of the CLDP, there was a list of medications, and indications for the medication. The Monitoring team noted a discrepancy between this list and the list of medications, and indications on the annual medical summary, that was used for the development of the CLDP. For example, the CLDP medication list indicated that the Individual was prescribed carbamazepine for "agitation/aggression", and did not indicate that this medication was also prescribed for seizure disorder. The annual medical summary listed Vyvanase, for ADHD, and sennosides/docusate for constipation, however, neither of these two medications were listed on the CLDP medication list. The Facility must ensure that all documents used for development of a CLDP are updated and current, when developing the CLDP. o The Individual was noted to have significant behavioral challenges that resulted in failed dental appointments. It was determined that the Individual would require TIVA for dental examinations and treatments. The only recommendation stated on the CLDP for dental services was to identify a dentist that could perform TIVA. There were no specific recommendations made on the frequency and indication for TIVA. The Monitoring Team also noted that the dental professional's assessment of poor oral health, and severe plaque. Given the severity of the Individual's dental issues, and need to TVIA because of challenging behaviors, there was no evidence indicating that a dental professional attended the CLDP meeting. • Similar findings for Individual #303 related to issues that could impact a safe transition to community living, particularly with regard to clinical communication of health care issues, are described further in Provision L1. • In addition, for Individual #303, the IDT did not adequately address a new finding related to a hearing impairment. An audiological assessment dated 1/14/2014 indicated the individual had a hearing test that suggested there was a possibility of a severe or greater hearing loss in at least the better ear that negatively affected speech understanding. There was no discussion in the Speech and Language summary of how this new finding might impact the individual's needs for supports. The CLDP summary noted the new finding of a possible severe hearing impairment, but stated all other information regarding communication functioning could be found in the last speech-language assessment dated 6-17-11. The Speech and Language Discharge Summary, dated 1/31/14 had a statement under a Hearing and Vision heading that had previously read "Based on his audiology report, (the individual) presents with	

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		essentially normal hearing at least in the better ear." It had been lined out. The audiology assessment also recommended a hearing test be completed every two years or sooner "if concerns arise." In that event, it was recommended a sedated auditory brainstem response test be completed due to the individual's teeth grinding. There was no discussion of what concerns should be monitored for by the provider. <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. Specifically, to move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as an area of focus/priority for the next six months, BSSLC should redouble its efforts to develop an adequate quality assurance mechanism to ensure the adequacy, accuracy and comprehensiveness of assessments for use in the CLDP, as well as to support all other planning purposes for individuals at the Facility.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	The Facility requested that the Monitoring Team not monitor this provision, because the Facility had made limited to no progress. The Monitoring Team determined that a reduced monitoring would be more appropriate in order to provide a level of feedback regarding progress specifically in the identification of pre and post move supports. As this remained a reduced monitoring, the noncompliance finding from the last review stands. <u>Identification of Pre and Post Move Supports</u>: Four CLDPs were reviewed to determine if they identified a comprehensive set of pre and post move supports, in measurable/observable terms, to be implemented based on an evaluation of presence or absence of each of the following standards: • The list of supports should be comprehensive and inclusive, including each of these components: 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 should be addressed. o What was important to the individual should be captured in the list of Pre and Post Move supports. o The list of supports should thoroughly address the individual's need/desire for employment. o Positive reinforcement, incentives, and/or other motivating components to an individual's success should be included in the list of Pre and Post Move supports.	Noncompliance

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		o There should be Pre and Post Move supports for the teaching, maintenance, and participation in specific skills, such as in the areas of personal hygiene, domestic, community, communication, and social skills. o There should be 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 should have a corresponding Pre and Post Move support for implementation. o Any important support identified in the assessments or during the CLDP meetings should be included; for any that was not included in the list of Pre and Post Move supports, a rationale should be provided as to why it was not included. • The wording of every Pre and Post Move support should be in appropriate, measurable, and observable terms. • Every Pre and Post Move support should include 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. Significant deficiencies remained as to the above criteria in the CLDPs reviewed. None of four CLDPs (0%) reviewed fully met the criteria. Examples included: • None of four CLDPs (0%) reviewed consistently provided sufficient descriptions or adequately defined criteria as a whole. The CLDP still did not consistently specify what observation or staff interview should reveal. Sometimes this appeared to be self-evident, but in many cases it was not. For example, the CLDPs frequently indicated the provider staff were to be knowledgeable of a list of the individual's health care needs, but did not consistently provide the indicators the Post Move Monitor could use as the benchmarks for confirming staff were indeed knowledgeable. 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. See Provision T1d regarding the need for careful identification of monitoring indicators. • Examples of safety, medical, healthcare, risk, and supervision needs not being adequately addressed are described in detail in Provision L1 for Individual #118 and Individual #303. • There was no mention of employment needs for any of the four CLDPs, nor any specific day habilitation or educational needs or objectives described, other than	

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		attendance. <u>Conclusion:</u> 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.	<u>Quality Assurance Processes to Ensure Development and Implementation of CLDPs:</u> 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, and was to include an audit of two CLDPs per year from referral through the close of the PMM period. This was just beginning with a recent transition. Inter-rater reliability was not yet established. • The APC continued to track the provision of the 45-Day assessments by the various disciplines. • A Pre-Move Site Review conducted by the APC continued to provide an additional layer of scrutiny to ensure that essential supports were in place prior to an individual leaving the Facility. • In addition, the Facility continued to implement a process developed as a part of a Corrective Action Plan (CAP) during the previous monitoring period to address issues that had emerged as the result of a failed transition. The process focused on ensuring that providers notify the Facility of issues and concerns on a timely basis. • The Facility had developed Draft QA Process/Outcome Indicators as of 01/31/2014, but these were limited as they applied to Section T, and consisted only of percentages of individuals who transition within 180 days of referral and of individuals or LARs who actively participate in their annual community living options discussion. The Monitoring Team commends the Facility for this initiative overall, as it should support Facility-specific plans for improvement. The most recent Brenham State Supported Living Center QA/QI Council Meeting Quarterly Quality Assurance Report dated February 26, 2014, reported the monitoring process for Section T required revisions to adequately monitor this section. The report included some raw data, but no analysis. <u>Conclusion:</u> This provision was found to be not in compliance. The quality assurance processes for this Section continued to evolve. The Monitoring Team encourages the Facility to continue to evaluate outcome and process indicators for implementation that will address the deficiencies in Provisions T1c, T1c1, T1d and T1e. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as an area of focus/priority for the next six months:	Noncompliance

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		• Clear performance goals and outcome measures should be defined, along with appropriate methodology for obtaining the data. BSSLC should also ensure these are coordinated with quality assurance measures that address the overall quality of assessments at the Facility. • Given the concerns related to the adequacy of the CLDP as detailed above, the Monitoring Team again strongly suggests the Facility continue a focused effort within the Quality Assurance Department and in conjunction with the Department of Admissions/Placements to improve the quality of all of the processes involved in the CLDP consistent with the findings and recommendations in this report, including the continued development of outcome indicators and monitoring of CLDP assessments, the CLDP meeting, pre-move in-service training implementation, Pre-Move Site Review and PMM visits.	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance	The parties agreed the Monitoring Team would not monitor this provision, because the Facility had made limited to no progress. The noncompliance finding from the last review stands. It was noted that both the Facility and DADS, respectively, had recently issued updated Obstacle Reports. The Monitoring Team will review these at the time of the next monitoring visit.	Noncompliance

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	from other agencies or the legislature.		
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I.	The parties agreed the Monitoring Team would not monitor this provision, because the Facility was in substantial compliance for more than three consecutive reviews. The substantial compliance finding from the last review stands.	Substantial Compliance
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of	Policies and Procedures related to Post-Move Monitoring:	Noncompliance

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	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.	The Facility reported no changes in policies and procedures related to Post-Move Monitoring. A revised Post-Move Monitoring Form, dated December 2013, was in use. This version of the Checklist was condensed from a previous version. Review of PMM Checklists: The Monitoring Team reviewed PMM Checklists for six 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 six individuals, 13 reviews should have been completed since the previous review. Of the 13 required visits, 13 (100%) were conducted and completed on time. • Locations visited: For the 13 PMM visits conducted, 13 (100%) included visits to all sites at which the individual lived and worked/day activity (e.g., day program, employment, public school) • Use of Standard Assessment Tool: Thirteen (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. Assessment of Presence of Supports Called for in CLDP: The Monitoring Team also reviewed the PMM Checklists to evaluate the process for assessing the presence of supports as well as efforts undertaken by the Facility to ensure implementation of the supports. The PMM Checklists for four of four individuals (100%) 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. However, the failure of the IDTs to adequately describe the full set of supports, services and protections needed and the specific evidence required to verify their presence made it impossible to perform an accurate assessment using only the paperwork. The findings in Provisions T1e and T1d above and in Provision T2b below call into question whether supports are being accurately assessed. Facility's Efforts to Ensure Supports are Implemented: 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	

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		logs that documented follow-up and loop closure. However, there were findings that the PMM process was not consistently as vigilant as necessary. Examples included: • In the previous monitoring report, the Monitoring Team found that as a part of the 45-Day PMM for Individual #208, who had a diagnosis of legal blindness, the Habilitation Therapy Discharge Update provided conflicting information regarding the individual's mobility needs. It reported that an Orientation and Mobility Assessment had been completed on 7/7/12. This assessment indicated that the individual did not use the mobility cane functionally and was not safe walking unassisted outside on uneven surfaces and on stairs. The recommendation was that a sighted guide was needed in these situations. Elsewhere in the Habilitation Therapy Discharge Update it indicates variously that the individual's assistive devices include a mobility cane for use in an unfamiliar environment, that the individual is able to walk independently on all surfaces, and that the mobility cane is rarely used, but staff assist as needed in unfamiliar environments. The Factors for Community Placement noted that the individual should live in a one story home and that furnishings should remain in the same place consistently to prevent trips and falls due to the visual impairment. There was no specific mention of any mobility needs in environments outside the home, or clarification of the functional use of the mobility cane or the use of sighted guide. It referenced the Physical and Nutritional Management Plan, but his mobility needs were not adequately addressed in that document either. The Monitoring Team noted the IDT met to review the 45-Day results on 10/23/14, approximately two weeks later. The documentation indicated the above issue was not discussed and the IDT concluded no follow-up to the visit was needed. The Monitoring Team also reviewed the completed 45-Day Checklist and found the Post-Move Monitor stated he planned to contact the provider to re-in-service staff on the need for sighted guide. The follow-up 90-Day PMM did not address the evidence of staff re-in-service, any staff interview as to their knowledge of the need for sighted guide or mention the issue in any way. • For Individual #118, a post-move support indicated the individual would have a communication dictionary to be used to model and encourage the use of sign language. It further indicated staff should continue to encourage and model the use of pictures of specific activities and items and encouraging pointing to desired items. The Post-Move Monitor documented the presence of the communication dictionary and staff indicating the individual communicated by pointing or walking toward preferred items. He further documented the staff said they had not seen the individual use any signs. This would appear to suggest the staff were not using the Communication Dictionary to encourage and model basic sign language and use of pictures as required. The Post Move Monitor should have documented whether this was the case and, if so, should	

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		have determined whether any follow-up in-service or other assistance might be needed to ensure the individual had adequate communications supports. There was no documentation indicating the Post-Move Monitor recognized this issue or planned any follow-up. <u>ISPA meetings after each PMM visit</u>: The IDT did not routinely complete review of each PMM Checklist, which would assist the Post-Move Monitor in evaluating any emerging issues. The Monitoring Team noted that the statewide MIS Policy 018.2 did not require routine review. There was not a clear process in place to determine what might constitute a special concern that would require IDT review; this relied primarily upon the Post-Move Monitor and other departmental staff to identify such a need. It was reported that IDTs were also expected to meet at any time an individual experienced certain circumstances that had the potential to disrupt the transition, regardless of it coinciding with a PMM visit. These circumstances included: • Psychiatric hospitalization • Medical hospitalization • When there are more than three ER visits (medical) in a 12 month period • Death • Arrest or incarceration • When there are more than three contacts with law enforcement in a 12 month period • Unable to locate or left program • Provider issues – change of homes • Provider issues – closure • Provider issues –confirmed abuse, neglect and exploitation • Provider issues –change of providers • Transition return The Monitoring Team found the actual review practices at the Facility were inconsistent. The Monitoring Team requested all ISPAs related to IDT review of transitions in the past six months, with the following findings: • One of 13 (8%) PMM visits had been reviewed by the IDT. • Only one ISPA meeting was held for one of three (33%) individuals who had transitioned this past six months and were identified as having had potential disruptions. <u>Barriers to thorough PMM Review and Improvements Needed in Monitoring:</u> As described in Provisions T1d and T1e, the IDTs still did not yet provide a comprehensive assessment sufficient to prescribe needed supports, nor did they provide	

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		adequate direction to the Post-Move Monitor as to the evidence required to accurately ensure the presence of pre and post move supports. Conclusion: 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 accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	Observation of Post-Move Monitoring Visit: This provision was not rated. No Post-Move Monitoring visit was completed during this visit.	Not Rated
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		

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	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	<u>Number and Categories of Alternate Discharges:</u> The Facility reported one alternate discharge, for Individual #289, had in January 2014. This involved a transition to another SSLC, which the individual had moved from to BSSLC in September 2013. Several other alternate discharges were in process. <u>Compliance with CMS-required Discharge Planning Procedures:</u> A review was conducted of the alternate discharge to determine whether or not the Facility met the CMS requirement [42 CFR §483.440(b)(5)(ii), and W205] to provide a discharge plan "sufficient to allow the 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 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, good cause was identified in the discharge summary. The individual was reported to have expressed a preference to return to another SSLC. • 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, it would appear reasonable time was given to prepare. This impression was based on the documentation the transfer was undertaken at the behest of the individual, although the discharge packet did not explicitly state when the planning process began. • At the time of the discharge, the Facility develops a final summary of the individual's developmental, behavioral, social, health and nutritional status: The final summaries included each of these components, but the information was not consistently adequate. o The most significant deficit was in the social domain, particularly as it related to the most integrated setting. The individual had many independent living skills, no behavioral concerns and very few health care needs designated as either high or medium risk. The BSSLC IDT proceeded to include a recommendation in the Post Discharge Plan of Care that transition to a less restrictive environment be pursued; given this recommendation, it was not clear why BSSLC had not made a referral while the individual was in residence there, nor was there any indication of any barriers that existed or of any steps BSSLC may have taken to educate the individual as to community living options during the time since admission. Assessments accompanying the discharge summary indicated the professional disciplines had recommended referral for transition, but there was no documentation as to the facility's follow-up in this matter. At the same time, there were	Noncompliance

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		conflicting statements in the assessments as to the individual's preferences for community living. At least one noted the individual preferred to live in the SSLC rather than the community, but there was no information provided as to the individual's reasoning for this. Providing this information would have assisted the receiving facility to address community living needs more readily. o There was no indication in the discharge summary of any skill acquisition programs the individual was involved in, nor any documentation attached as to current ISP Action Plans except for the Integrated Health Care Plan (IHCP.) This would be important in providing continuity of care. • With the consent of the individual, parents (if the client is a minor) or legal guardian, the Facility provides a copy to authorized persons and agencies: Although it would be expected the Facility provided a copy of the discharge summary and related assessments to the receiving Facility, there was no explicit documentation to show that this had occurred. • The Facility provides a post-discharge plan of care that will assist the individual to adjust to the new living environment: Based on the narratives provided in the Referrals and/or Necessary Services Required in New Environment section, the IDT did not adequately describe the key supports that the individual would need in the new setting. Examples included: o The Post Discharge Plan of Care included a recommendation to pursue referral to less restrictive environment, but as noted above, there was no specific information provided to the receiving facility to substantiate the recommendation or to explain any barriers. o The Post Discharge Plan of Care did not include any recommendation regarding continuing support for the individual's relationships with various family members. o The discharge summary indicated the individual was very independent and was not on any formal training programs. It further stated, however, it would be beneficial for him to improve current skills if he lived in a less restrictive environment. There was no specific information provided as to what skills would benefit from improvement and the Post Discharge Plan of Care provided no additional recommendations regarding skill acquisition needs. o The Post Discharge Plan of Care recommended that "Medical may consider drawing Vit D 25 OH lab, (as of date of assessment 10/10/12 there was no result for this lab available)." Given that the date of the annual medical assessment was 11/21/13 and the discharge meeting was 1/08/14, this should have been updated with current results to	

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		ensure continuity of care and potentially avoid a need to subject the individual to duplicative treatments. o Both the Nursing and Medical assessments indicated a DEXA scan was needed, but this was not included in the recommendations for follow-up health care in the Post Discharge Plan of Care, nor was there any indication this had already been completed and/or results provided. This should have been clarified, again for continuity of care. <u>Conclusion:</u> This provision was found to be (not) in compliance.	

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Brenham State Supported Living Center (BSSLC) Self-assessment, dated 3/18/2014 2. BSSLC Action Plans, updated: 3/18/2014 3. Brenham State Supported Living Center Presentation for April 2014 Settlement Agreement Monitoring Team Visit Section U - Consent 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, Draft/Revision dated 3/26/14 7. BSSLC Draft Policy: Client Services-Advocacy, un-numbered, Draft/Revision dated 3/26/14 8. 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 Monday, March 10, 2014 9. Since the last review, a list of individuals for whom an LAR or advocate has been obtained 10. Over the six months preceding the monitoring visit, documentation that reflects the activities of the Facility to obtain LARs or advocates 11. Rights Assessment, Form 6614, dated February 2008 12. Examples of Completed Rights Assessments Selected by Facility for Individuals #1, #206, #383 and #528 13. Guardianship Committee minutes for the past six months 14. Self-Advocacy Minutes for the past six months **People Interviewed:** 1. Caitlin DiGregorio, Human Rights Officer (HRO) 2. Laqeusa Kennedy, HRO Assistant 3. Daniel Dickson, Quality Assurance Director **Meeting Attended/Observations:** 1. ISP annual planning meetings for Individuals #123, #547 and #599
	Facility Self-Assessment: The Facility submitted a Self-Assessment for Section U. 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 U, in conducting its self-assessment, the Facility reported it was not using monitoring/auditing tools at this time, and QA/QI processes for this Section were not in place at this time. In order to improve its Self-Assessment for use in achieving compliance, the Facility should review the criteria by which it assesses that compliance. The Facility's criteria did not always fully address the noncompliant findings from the Monitoring Team. As an example, for Provision U1, the Facility reported the activities engaged in for the self-assessment were a review of the State Guardianship policy, a review of

	the priority list and a reviewed of the guardianship list to determine the percentage of individuals without a guardian. Based on the findings from this self-assessment, the Facility concluded the provision was not in substantial compliance due to improvements needed to localize the state policy and not all individuals on campus having a guardian or advocate. The most significant factor affecting compliance, the lack of a standardized process, methodology, or tools to assess and prioritize the need for an LAR, an advocate or other assistance an individual might need in decision-making, was not addressed in the Self-Assessment. Substantial compliance would not be predicated on all individuals having a guardian or advocate, but rather on the ability of the Facility to accurately identify the decision-making needs of each individual and providing the appropriate supports. If the Facility intends to use its Self-Assessment to conclude whether it is in substantial compliance, it must identify and factor in all of the criteria upon which compliance is to be based. It may choose to prioritize only certain components in its Action Plan, but it should be aware that the prioritized activity may not be sufficient in achieving substantial compliance. The Facility also provided for each Section of the Settlement Agreement provisions an Action Plan listing actions to be taken to move forward toward compliance. Many (75%) of the Action Steps were listed as not yet started. Many of the proposed Action Steps appeared to be relevant to achieving compliance, but the Facility should also define the provision-specific outcomes and process improvements it hopes to achieve as a result of these Action Steps as well as how accomplishment will be measured. Overall, a comprehensive strategic plan that identifies all requirements and the measurable indicators for each would allow the Facility to not only better prioritize its activities, but would also allow it to better monitor its overall progress toward substantial compliance. The Facility should determine the priorities for action for the next six months, complete an analysis of where they are now and what they need to do, and develop (and implement) a detailed sequential plan to accomplish the priorities. Sections of the Self-Assessment could reference the specific Action Steps that would be implemented to address the reasons for noncompliance, which could tie the Self-Assessment and Action Plans together.
	Summary of Monitor's Assessment: This Section was not yet in compliance. A summary of noted progress included the Facility's renewed emphasis on self-advocacy and pending promulgation of Facility policies related to this Section, including Guardianship, Advocacy and Self-Advocacy. The Facility reported it had been working with some QIDPs toward enhancing the ability of IDTs to complete a thoughtful examination of capacity to provide informed consent; while significant progress was not yet noted in this regard, this effort could be seen as a first step in preparing IDTs for an effective capacity assessment. Specific findings for each provision are as follows: **Provision U1:** This provision was found to be not yet in compliance. The Facility did maintain a list of individuals without a guardian, but not all individuals on the list had yet been assigned a priority. The Monitoring Team remained concerned that DADS 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, process and/or methodology IDTs should use to assess and prioritize the need for an LAR, an advocate, or other assistance an individual might need in decision-making. Facility IDTs continued to rely almost solely on their own subjective assessment of capacity, with no objective standardized criteria or process. Although the Monitoring Team noted some

	recent efforts by the Facility to encourage a more thoughtful approach in the completion of the Rights Assessment, as evidenced by a small number of examples provided for review, this remained the most significant barrier to achievement of substantial compliance for this Section. As part of undertaking an effective and appropriate large-scale effort to solicit guardians, BSSLC must ensure it has an appropriate assessment process, tool and/or methodology in place to determine the actual need for guardianship. In the past several reports, it was noted that DADS State Office reportedly was developing a policy on consent to supplement the one it had issued on guardianship. This was essential, because until a process is implemented to estimate individuals' functional decision-making capacity, it is difficult to develop the prioritized list of individuals the Settlement Agreement requires. During this most recent review, Facility staff indicated that State Office had issued a draft Individual Rights Assessment that included questions related to an individual's capacity to make decisions. Since the onsite review, the Monitors jointly provided comments to State Office on the draft Individual Rights Assessment. **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 87% of the individuals living at BSSLC had previously been adjudicated incompetent. The Facility's Guardianship Committee continued to meet as called for in the DADS Policy, but the minutes did not reflect significant ongoing actions and deliberations. The Facility was to make monthly progress notes regarding the status of individuals referred to the Guardianship Committee. These data were not adequately reflected in the ongoing minutes and provided little follow-up information from one meeting to the next. This may have been due in part to a lack of continuity in the HRO position. The Facility continued to need to ensure it had 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 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	<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 had 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 process, methodology, or tools 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 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. In the past several reports, it was noted that DADS State Office reportedly was developing a policy on consent to	Noncompliance

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	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.	supplement the one it had issued on guardianship. This was essential, because until a process is implemented to estimate individuals' functional decision-making capacity, it is difficult to develop the prioritized list of individuals the Settlement Agreement requires. During this most recent review, Facility staff indicated that State Office had issued a draft Individual Rights Assessment that included questions related to an individual's capacity to make decisions. Since the onsite review, the Monitors jointly provided comments to State Office on the draft Individual Rights Assessment. A new HRO had been in the position since February 1, 2014. She had been working to develop localized policies that would accurately represent the procedures in place at BSSLC; localized versions of policies on Guardianship, Advocacy and Self-Advocacy were scheduled to be reviewed for approval during the week of the monitoring visit. The Facility provided a copy of BSSLC Policy: Client Services-Guardianship, un-numbered, Draft/Revision dated 3/26/14 that had been submitted for review and approval. It was virtually identical to the DADS policy and had not been operationalized with facility-specific details. <u>Maintenance of Prioritized List:</u> The Facility maintained a Prioritized List of certain individuals who did not have a current guardianship imposed. The list included certain other information regarding rights restrictions for each individual and provided running documentation as to activities related to guardianship and advocacy status. The Monitoring Team reviewed the provided Prioritized List for timeliness of updates to the list and the prioritization process: • <u>Timeliness of Updating Process:</u> 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 Monday, March 10, 2014. Of the 291 individuals living at the Facility, 252 were reported to have guardianship imposed. The Prioritized List included the names of 37 individuals. The Monitoring Team noted these data vary with some frequency as regular updates are made and admissions, discharges and guardianship status changes occur, so minor discrepancies are not unexpected. It was noted, however, that there had been no running documentation of any guardianship-related activity during the past six months for any of the individuals on the Prioritized List. The most recent documentation for any individual appeared to have taken place in September 2013. • <u>Prioritization Criteria</u>: The Facility continued to use the same prioritization criteria as previously reported. The list dated Monday, March 10, 2014 indicated the priority level for some, but not all, individuals was assigned. The list provided for review indicated 23 of the 37 individuals on the list (62%)	

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		individuals were assigned a priority. <u>Assessment of Functional Capacity to Render a Decision:</u> BSSLC indicated it did not yet have a standardized process, methodology, and/or tool to assess functional capacity. During the past six months, the IDTs had addressed the ability of an individual to provide informed consent using an annual Rights Assessment form dated February 2008, rather than the more recent Form 6614, dated September 2011. Section J of the latter version had required IDTs to answer a series of questions in each category of informed consent before making a determination. The Rights Assessment form currently in use had no such requirements for IDT consideration before the informed consent determinations were made. The Facility reported it had been working with some QIDPs toward enhancing the ability of IDTs to complete a thoughtful examination of capacity to provide informed consent and that a small number of promising examples were available to review. The Monitoring Team reviewed this sample of four recently completed Rights Assessments, all of whom had LARs, with the following findings: • For none of four 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 in Section J of the Rights Assessment. There was no specific basis offered for this determination in the way of an individualized assessment of the individual's decision-making capacity. Each of the four simply stated that the individual had an LAR who would provide consent. Again, it was noted this version of the Rights Assessment, dated February 2008, required even less IDT documentation of its rationale for these determinations than had been required in the September 2011 form. • Observations made by the Monitoring Team of the ISP meetings held during the site visit indicated that for none of three individuals (0%) did the IDT undertake any substantive discussion regarding decision-making capacity or strategies to enhance participation in decision-making as they pertained to the ability to provide informed consent. For example, the IDT for Individual #123 did a relatively cursory review of the individual's rights restrictions. It was noted that as a minor, the parents provided informed consent. Even though the entire IDT, including the individual and the mother, expressed support for an eventual goal of independent living, there was no assessment of the individual's needs for developing skills to make informed decisions nor any strategies discussed. In addition, the meeting facilitator noted the individual had a money management restriction, stating further that the individual had some fairly good money management skills, but that the Facility managed the money. The facilitator then asked for the IDT approval for the restriction and it was given without any further discussion of why the restriction was needed. This is provided as an	

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		example of the current lack of proficiency of the IDT in making an appropriate assessment of an individual's discrete functional capacities for decision-making, as well as an example of application of restrictions without adequate team discussion (as well as a missed opportunity to build on a strength to develop skills that would be useful for success in living in a more integrated setting). • The Human Rights Committee (HRC) review for these four Rights Assessments did not 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. There were some indicators of progress noted, however, in that the IDTs had addressed some restrictions that were related to areas of informed consent. These were not typically sufficiently detailed or well justified in the documentation reviewed, but it was an improvement that could be a beginning step toward a more comprehensive and thoughtful approach to capacity assessment. Such indicators of progress included the following positive actions taken by the Facility: • The Monitoring Team made note of some expanded documentation regarding restrictions in Section I: Manage Money and be Fairly Compensated for Work, which would bear on the provision of informed consent for financial matters, in that it required the IDT to define the reason for the restriction, less intrusive approaches attempted, risk vs. risk analysis and plan to remove restriction. • It was noted there was a subsection following the capacity determination that indicated informed consent must be provided by an adult with capacity, managing conservator or legal guardian for an individual's participation in highly intrusive or restrictive services or treatments. This subsection did require the IDT to define the reason for the restriction, less intrusive approaches attempted, risk vs. risk analysis and plan to remove restriction in any of the following circumstances: o Restrictive techniques in conjunction with a Behavior Support Plan o Use of sedation and/or restraints for dental treatments o Use of sedation and/or restraints for medical treatments o Use of postural support restraints o Use of restraint to prevent self-injury <u>Conclusion:</u> This Provision was found to be not yet in compliance. The Facility did maintain a list of individuals who did not have a guardianship imposed, but the determination of need was not predicated on any formal or standardized process or tool. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the	

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		following as an area of focus/priority for the next six months: DADS and the Facility will need to prescribe an assessment process, methodology, and/or tool rooted in objective evidence-based principles of decisional capacity, and further, require 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 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.	<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. A local policy, BSSLC Draft Policy: Client Services-Guardianship, un-numbered, Draft/Revision dated 3/26/14, had been recently submitted for review and approval. • DADS Policy 057: Self-Advocacy, dated 5/30/12, was reported to have been modified in content related to the section on Focus of Meetings, although a revision date was not indicated. A BSSLC Draft Policy: Client Services-Self-Advocacy was reported to be pending review and approval at the time of the monitoring visit. • A DADS policy on Advocacy had not yet been issued. A BSSLC Policy on Advocacy BSSLC Draft Policy: Client Services-Advocacy, un-numbered, Draft/Revision dated 3/26/14 was also pending review and approval. <u>Facility Efforts to Obtain LARs:</u> The Facility reported no new LARs had been obtained during past six months for individuals living at BSSLC, but 87% of the individuals already had a current guardianship imposed. There had not been any significant activity in this area in the last six months, as reflected in the brevity of the minutes of the Guardianship Committee as described below and the lack of any recent documentation of guardianship-related actions for any of the individuals on the Prioritized List as described in Provision U1. It was reported by the HRO that posters had been recently developed to post in various community venues to solicit guardians and advocates. She also indicated the Guardianship Committee would begin at its next meeting to strategize more active recruitment processes. It also appeared that ensuring individuals with guardians maintained a current LAR was a concern, as only 182 of the 252 (72%) individuals with guardianships imposed had current guardianship papers. It was reported that two new social work positions had been allocated to the Facility and these staff would be responsible for activities to ensure individuals with current guardians did not experience any lapses due to expiring guardianship papers or the need for a successor guardian.	Noncompliance

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		Guardianship Committee: The Facility had an established Guardianship Committee. The HRO served as the BSSLC Guardianship Coordinator as required by the statewide policy. Meetings were being held once each month. Membership appeared to be consistent with statewide policy requirements. 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 not adequately reflected in the ongoing minutes and provided little follow-up information from one meeting to the next. For example, the minutes from 10/9/2013-2/21/2014 reflected discussion regarding guardianship and advocacy needs for only four individuals (Individuals #8, #41, #360 and #417) during this period. No resolutions or updates were documented for any of the four. Two of the individuals' (Individuals #8 and #41) guardianship needs were brought up one time only, with no follow-up recorded. For the remaining two individuals (Individuals #360 and #417) the same notation was continued each month indicating that an advocate was being sought, but no details of this search were ever updated. It was particularly unclear what actions may have been taken in that there were also no recent running notes in the Prioritized List for any of these individuals. 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 Facility reported this had not yet been implemented. Advocacy Program: BSSLC continued to have an Advocacy Program as described in the previous report, although the statewide policy had not yet been issued. Recruitment and training of advocates continued to be completed by the Volunteer Services Department. The Facility provided no data as to the current number of individuals with advocates and the documentation provided for review, including the minutes of the Guardianship Committee and the running notes in the Prioritized List, indicated no new advocates had been assigned during this past six months. Self-Advocacy Program: As required by Policy 057, the HRO was responsible for providing support for the Self-Advocacy Committee. The Facility had focused some efforts on re-invigorating the self-	

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		advocacy program at BSSLC in the past six months, including obtaining some materials from a nationally known program to use at the meetings. It was reported that attendance and participation at meetings were increasing. DADS and the Facility should also 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 also 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. This had not yet been implemented; when undertaken, this would be an opportunity to disseminate such a broader vision. <u>Conclusion:</u> This Provision was found to be not yet in compliance. To move in the direction of substantial compliance, the Monitoring Team recommends that the Facility consider the following as an area of focus/priority for the next six months: DADS and the Facility need to prescribe an assessment process, methodology, and/or tool rooted in objective 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. The Guardianship Committee should be provided with training regarding the assessment process as well to facilitate their appropriate review of referrals made as a result.	

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. BSSLC Self-Assessment 3/18/14 2. BSSLC Action Plans 3/18/14 3. Presentation Book for Section V 4. Provision Action Information for Section V 5. List of new and revised policies implemented since the last compliance visit 6. DADS Policies and Procedures 7. BSSLC Policies and Procedures a. BSSLC Policy A.1 BSSLC Policy & Procedure Guidelines 1/25/12 b. BSSLC Policy V1 General Records Keeping Practices draft revision 12/5/13 and approved policy implemented 3/15/14 c. BSSLC Policy V2 Filing and Thinning of the Unified Record draft revision 12/5/13 and approved policy implemented 1/30/14 d. BSSLC Policy V3 Monitoring of the Unified Records draft revision 12/5/13 and approved policy implemented 1/30/14 e. BSSLC Policy L.1 Medical Care 10/2/13 8. Share Drive Residential Folder Site Map and Documentation Information 9. Active Record Order & Maintenance Guidelines 2/20/14 10. Individual Notebook Record Order & Maintenance Guidelines 9/2013 11. Master Record Order & Guidelines 12/8/11 12. Active Record Order & Guidelines-Definitions 4/2014 13. Guidelines for the Settlement Agreement Cross Referenced with ICF-MR Standards for Section V (Section V Monitoring Tool) 14. Record Audits conducted in February 2014 and March 2014 a. Audits forms for Active Record, All About Me book, and Master Record for Individuals #31, #58, #69, #131, #153, #163, #221, #239, #255, #312, #318, #330, #332, #443, #460, #465, #492, and #597 b. Settlement Agreement Cross Referenced with ICF-MR Standards Section V (Section V Monitoring Tool) for Individuals #69, #221, #255, #312, #492, and #597 c. Record audit tracking spreadsheet for January, February, and March 2014, with data for Individuals #26, #31, #58, #59, #69, #131, #153, #163, #206, #221, #239, #249, #250, #251, #255, #270, #312, #318, #330, #332, #361, #367, #443, #456, #460, #465, #489, #492, #548, and 597 15. 2014 February Audits Needing Corrections report for Individual #239 16. Shared Drive assessments folder for Individual #538 17. Assessments/Reported Needed for the Annual ISP Meeting for Individual #538 18. Emails from Joyce Carnagey, URC, regarding February audits needing corrections and results of

	reviews to determine completion of corrections 19. Active Record, Individual Notebook (All About Me book), and Master Record for Individuals #96 and #265 20. Trends reports for QA/QI Council, undated but with data through January 2013 through January 2014 and March 2013 through March 2014 21. Active Record Checkout blank form 9/30/13 22. Email from Joyce Carnagey regarding revision to the V4 Interview Tool and requesting response to the questions 2/11/14, completed responses, and table of responses 23. Email from Olivia Najera regarding revision to the V4 Interview Tool and requesting response to the questions 3/11/14, completed responses, and table of responses 24. Share Drive Residential Folder Site Map and Documentation Information, undated 25. Delinquent Assessments (assessments not completed as of 3/12/14 with ISP dates 1/1/14-2/28/14) and Assessment Completion report 1/1/14-2/28/14 26. Policy Manual Table of Contents 27. List of all new and revised State and Facility policies implemented since the last compliance visit 28. Minutes of the Policy-Procedure Committee 12/4/13, 12/18/13, 1/15/14, 2/19/14, 3/5/14, and 3/19/14 29. Emails from Daniel Dickson, Director of Quality Assurance (QA) notifying staff of new and revised policies 30. Policy & Procedure Approval/Review Forms documenting approvals of new and revised policies 31. Drafts (with changes tracked) and final copies of revised policies **People Interviewed:** 1. Joint interview with Joyce Carnagey and Olivia Najera, Unified Records Coordinators, Wilberta Collins CARE/CWS, and Daniel Dickson, Director of QA, regarding Unified Records 2. Daniel Dickson, Director of QA, regarding policy development 3. Pam Boehnemann, QIDP (Qualified Intellectual Disability Professional) Coordinator, Susie Johnson, Director of Residential Services, and QIDPs Marissa Camp, Leesa Donaho, Tiffanie Fritz, and Dartania Shelton **Meeting Attended/Observations:** 1. ISP annual planning meetings for Individuals #123, #547 and #599 2. ISP Preparation Meetings for Individuals #545 3. Policy Review Committee 4. Location where active records are kept at Bowie A and D, Driscoll D, and Cottage F
	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. For Section V, 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: ▪ Active Record Audit form ▪ Individual Notebook—Active Record Audit form ▪ Section V Monitoring Tool o These monitoring/audit tools included adequate indicators to allow the Facility to determine compliance with most provisions of the Settlement Agreement. For Provision V4, there was no monitoring of use of the records in meetings where planning of services, supports, and treatments is done. o The monitoring tools included adequate methodologies, such as audits of records using standardized audit tools and guidelines for scoring. The Self-Assessment did not report the use of an audit/interview with standard set of questions regarding use of records, or observation at meetings for presence of records, as had been reported in the last self-assessment. o The Self-Assessment identified the sample(s) sizes; the number appeared likely to be the entire number of audits done during the six-month period, but that was not stated explicitly. o The monitoring/audit tools had adequate instructions/guidelines to ensure consistency in monitoring and the validity of the results. o The following staff/positions were responsible for completing the audit tools: Unified Records Coordinators (URCs) o The staff responsible for conducting the audits/monitoring had been deemed competent in the use of the tools. o Adequate inter-rater reliability had been established between the various Facility staff responsible for the completion of most tools. ▪ Used other relevant data sources and/or key indicators/outcome measures. These included tracking systems for audits as well as for spot checks for corrections. The self-assessment also reported number of State policies released and operationalized into local procedure since the last assessment, and the percent of facility procedures that were updated per local procedure requirements. ▪ The Facility consistently presented data in a meaningful/useful way. Specifically, the Facility's Self Assessment: o Presented findings consistently based on specific, measurable indicators. However, the Facility continued to provide data on record audit findings as overall percentages; it would be useful to include in the assessment information about specific Appendix D requirements or areas of concentration (such as timeliness of assessments) that need to be addressed in order to establish compliance. The Facility reported on compliance of Master Records with Record Guidelines, a new practice. o Consistently measured the quality as well as presence of items. Although it was not the role of the records audits to evaluate the quality of the documents, they did evaluate the comprehensiveness of the records, whether they were current, and whether they met Appendix D requirements.

	○ All data reported in the Self-assessment were collected by the QA Department. ▪ The Facility rated itself as being in compliance with none of the four provisions of Section V. 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. ▪ Actions were reported as Completed, In Process, or Not Started ▪ The Facility data identified areas of need/improvement. For example, in Provision V1, Facility data indicated that "issues with the maintenance of the record are not yet consistent and follow components of Section D"; this conclusion was based on data reported on compliance with records guidelines. Data were also provided on corrections completed of errors identified in audits, which showed a need for improvement, but this was not referenced in the self-rating. ▪ The actions provided a set of steps likely to lead to compliance with some, but not all, requirements of this Section. For example, the actions listed for Provision V1 included training on the requirements and implementation of an Active Record Chart Checkout Procedure, both of which would address requirements of that provision. However, there was no action to improve completion of corrections of errors identified in the audits, except that Provision V3 did have an action to develop a process to confirm that corrections, such as re-training, that do not result in a change in the record itself, are made. At the time of the visit, however, spot-checks were made only at the time corrections were due, and there was no process to continue to check until corrections were completed if not done by due date.
	Summary of Monitor's Assessment: The Facility maintained a Unified Record with all required components. **Provision V1:** Records were generally accessible. The chart checkout procedure had been revised; all charts that were not present were correctly checked out. One issue was found regarding accessibility; the Individual Notebook (All About Me book) was to accompany individuals when they were away from the home; this did not occur consistently. Because the Physical and Nutritional Management Plan is found in this book, it was difficult to ensure correct positioning off site as evidence by multiple observations in which individuals were not positioned according to the PNMP. The Facility should determine how to ensure information is available where it is needed for provision of services and supports. Records were generally in order, and documents were, for the most part, present and current. Improvement continued to be needed in meeting requirements of Appendix D. **Provision V2:** Both DADS and BSSLC had developed numerous policies, and the process is ongoing. By policy, all policies are to be reviewed annually. As policies are developed and approved, the determination is made of who requires training; the determination of the kind of training is assigned to a responsible person; departments and disciplines then are to ensure training is provided. To move toward compliance, the Monitoring Team recommends the Facility establish a clear set of procedures to ensure training on policies meets the needs for implementation of those policies, and can be tracked to ensure all staff who

	need training receive it. **Provision V3:** The audit system did include random audits of more than five records (with 12 per month done routinely). There was a process to monitor all deficiencies identified in each review to identify corrective actions that need to be taken; however, this process only checked whether corrections were completed by due date and did not follow through to correction of all deficiencies nor address those corrections that required action to limit reoccurrence (such as retraining, except for the early stage of implementation of a requirement to provide evidence training had occurred) when the records themselves could not be corrected (for example, for legibility issues). There was no process to follow up and ensure corrections were completed if not done by due date. Improvements found at the last compliance visit in presence of current documents, and filing in order, remained. Improvement continued to be needed in meeting Appendix D requirements. As noted in the last report, further improvement is needed to achieve compliance. Thus, the audit process remains robust and provides the information needed about the status of records, but the corrective action process needs improvement. **Provision V4:** Most documents were present and current in the active record, and therefore available for use in decision-making; however, assessments were not consistently completed and posted in time for IDT review prior to the annual ISP planning meeting. Observation of ISP and IDT meetings found that the active record was consistently present. Documentation of data was done timely, so that it would be available. The staff interview process was revised to ask about use of the record in general rather than for an individual, and staff could report on use. Although the Facility did not have a process for quality assurance observations of meetings to assess use of information from the records, observations by the Monitoring Team indicated such information was used routinely.

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V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	<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. All three policies had been revised since the last compliance visit. Revisions were primarily for consistency in language or for clarification rather than substantive changes in process. The primary change in process was to require that the Active Record Clerk receives documents and files and thins them; the policy had specified the "File Clerk and other designated staff" but, with the revision, had centralized filing to one position. <u>The Facility Maintains a Unified Record for Each Individual</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. When documents are purged from the Active Record, they are to be sent to Central Records to be placed in the Inactive Record (the	Noncompliance

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		overflow record) or Master Record as appropriate; the Master Record also contains other documents, such as legal documents including birth certificate and guardianship papers. 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. Although this has been in place for more than a year, the inactive record format has only been revised for a small number of individuals. The Facility did change its process so that clerks provide purged documents usually weekly; they no longer use facility mail but instead provide them directly to the records staff. The Active Record was the primary document with information about the individual's current status and about the supports and services being provided. 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 All About Me book contained information needed by people providing daily service, including data sheets to record data for the Physical and Nutritional Management Plan (PNMP) and behavior data (with data for skill acquisition plans kept in data books and dining data kept in the Dining book; both are brought into the Active Record at the end of the month, and those books are not considered part of the Unified Record). The Active Record is stored at the home. In the past, and reported by the URCs in interview, the All About Me book was to accompany the individual wherever the person goes for supports and services provided by the Facility. However, observation at this visit found that these books typically remained at the home for individuals who were ambulatory and active, but did accompany the individuals who used wheelchairs. This was not addressed in the policies for recordkeeping. The Monitoring Team reviewed 18 audits conducted by the Facility during February and March 2014. Eighteen (100%) provided evidence that all three components of the Unified Record were present. The Monitoring Team audited the records for Individuals #96 and #265; both records (100%) included all three components. <u>Staffing and Responsibility for Filing in the Record</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. Active Record Clerks, also assigned to Quality Assurance, were to be given documents for filing and were to do all filing.	

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		Training of Staff on Documentation URCs reported that they continue to provide new employee orientation (NEO) to staff who document in the Unified Record. The Monitoring Team reviewed the curriculum and reported on it in the last compliance visit report. Training covered all requirements of Appendix D and included exercises that provided opportunities to practice observation and recording and a competency test that involved documentation from a video in addition to a set of questions.. The Facility reported it continued to require job-specific on the job training that involved writing a progress/observation note, locating consumer charts, and locating consumer reporting forms. The URCs reported that they had provided refresher training on correct documentation and provided a training worksheet that included guidelines for written records and a record entry that needed completion. The URCs reported that all Direct Support Professionals (DSPs), Rehabilitation Therapy Technicians, Education & Training staff, and vocational staff had been trained except a few people on long term leave who will be trained upon return; the Facility provided training rosters. Accessibility and Security of Records To assess whether records were accessible to staff for use in providing supports and in making decisions, and were secure, the Monitoring Team observed the accessibility and security of records for Individuals #26, #44, #96, #186, #239, #265, #279, and #437 at Bowie A and D, Driscoll D, and Cottage F, and reviewed data from the Section V Monitoring Tool for Individuals #69, #221, #255, #312, #492, and #597. Active Records and Individual Notebooks were accessible to staff, but names were not visible to visitors. Records were accessible or were appropriately checked out for seven of seven records checked (100%). Record audits documented that records were accessible for six of six records audited (100%). The Monitoring Team audited records for Individuals #96 and #265. Active Records were brought to the Monitoring Team for review; the Monitoring Team went to the homes to look at All About Me books and to the Medical Records office to look at the Master Record. For two of two records (100%), the Active Record was available as requested, and the All About Me book and Master Record were accessible. The Facility had revised its process for checking out Active Record charts. At the last compliance visit, the checkout system involved a checkout sheet in each chart. This had been changed so there was now a checkout clipboard hanging from each chart rack. This was found attached to the rack at four of four homes checked by the Monitoring Team (100%). Of the eight individuals for whom records were checked, all records were present for five. Of the three individuals for whom records were not present, all charts	

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		(100%) had been checked out. Additional information supported a finding that records were accessible. For example, as reported in Provision M1, there was no difficulty in accessing the records onsite. Random review of units found the All About Me Books contained Direct Support Professional Instruction Sheets. The location of the All About Me Books, Communication Notebooks, and Training Notebooks were readily accessible to the Direct Support Professionals. Interviews with the Direct Support Professionals showed they knew the location of these books. One concern, as reported in Provision V4, was that All About Me books did not consistently accompany individuals when away from the home. This made it more difficult to ensure correct positioning off site as evidence by multiple observations in which individuals were not positioned according to the PNMP. The Facility needs to ensure a process is in use to make this information readily available. In general, the records were neat, and it was usually easy to find documents. There were no examples of torn pages or missing tabs, tabs were in the correct order, and all pages were readable. <u>Accuracy and Completeness of Active Record and Individual Notebook (All About Me book)</u> To determine whether Active Records were completed in compliance with Facility expectations and Appendix D of the SA, the Monitoring Team reviewed the Active Record and All About Me book for Individuals #96 and #265. Individual #265 was selected by computer randomization from individuals admitted since the last compliance visit but more than 30 days prior to the beginning of the compliance visit. Individual #96 was selected by computer randomization from among the individuals the Facility had selected randomly for audit in April 2014. The Monitoring Team used the audit forms used by the Facility to check for the presence of current documents and whether they were in order, as well as to note issues with Appendix D requirements. These forms are described in detail in Provision V3. The Monitoring Team also 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. Completeness of Active Record and Individual Notebook: All three components of the unified record were in place for both individuals (100%). 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. The Monitoring Team used	

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		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 Active Record Order & Guidelines-Definitions provided by the Facility for the Active Record, the guidelines for the Section V Monitoring Tool, and the June 2013 internal audit notes, and the guidelines for the monitoring tool. Because many items recorded as N/A were marked that way because they were not required and were not present, including those might overstate the actual accuracy of the record (if some documents actually had been completed but not filed). Therefore, the Monitoring Team calculated percent present and current, as well as percent in order, without including the times marked N/A. The table below provides data determined by the Monitoring Team audit.	

Individual	Present/Current		In Order	
	# documents Current/Not Current/N/A	% of applicable documents	# applicable documents in order	% of applicable documents
#96				
Active Record	62/15/92	81%	70	91%
Individual Notebook	16/1/9	94%	14	82%
#265				
Active Record	58/14/97	81%	55	76%
Individual Notebook	12/1/13	92%	13	100%

These findings are relatively consistent with the findings of audits at the last compliance visit and modest improvement over audit findings from earlier visits.

The Monitoring Team also audited Master Records for Individual #96 using the Master Record Audit form. Of the applicable documents audited, seven of nine (78%) were present, and eight of nine (89%) were in order.

Consistency with Appendix D Requirements: Neither record met all requirements of Appendix D. The Monitoring Team completed the Settlement Agreement Cross-referenced with ICF/MR Standards review (the Section V monitoring tool). For Individual #96, the records met 18 of 23 requirements assessed by the Monitoring Team

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		and found applicable (75%). For Individual #265, the records met 15 of 24 requirements (63%). This was a modest increase from the findings of the last compliance visit. The Monitoring Team reviewed the audit tools completed by the Facility as part of audits in February and March 2014 and provided to the Monitoring Team for Individuals #31, #58, #69, #131, #153, #163, #221, #239, #255, #312, #318, #330, #332, #443, #460, #465, #492, and #597, including Section V Monitoring Tools for Individuals #69, #221, #255, #312, #492, and #597. For presence of current documents and for whether they are in order, the range in percent of applicable documents is presented in the following table:	

	Current	In Order
Individual Notebook	73-92%	15-100%
Active Record Chart 1 Program	53%-97%	73-100%
Active Record Chart 2 Medical	63-88%	78-98%
Master Record	67-90%	62-100%

The findings from the audit of two records done by the Monitoring Team were within these ranges.

In addition, the Monitoring Team reviewed the record audit tracking spreadsheet for January, February, and March 2014, which listed data under columns for Present, Current, and In Order for Individuals #26, #31, #56, #58, #59, #69, #111, #131, #132, #153, #163, #193, #206, #221, #239, #249, #250, #251, #255, #270, #283, #312, #318, #330, #332, #347, #361, #367, #443, #456, #460, #465, #489, #492, #548, and 597; the audits did not have a column for Present, but the date of each document that was present but not current was listed in the Comments column of the audit forms. Data for Current and In Order from the audit tools were accurately entered into the tracking spreadsheet; the Monitoring Team did not sample whether data for Present were accurate. The tracking spreadsheet provided these data both by total for each audited record and document by document. This spreadsheet gives the Facility easy access to information that can identify specific documents for which completion and filing needs to be addressed. Based on the tracking spreadsheet data (which combined the Individual Notebook and Active Record ratings), the range of Current documents (meaning they were present and current) for individuals was from 66% to 93%; for In Order, the range was from 77% to 99%.

The table below provides the averages across all records by month, as reported on the

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tracking spreadsheet.

Month	Present	Current	In Order
January	95%	83%	91%
February	95%	78%	92%
March	96%	81%	90%

These totals, along with the findings for individuals, indicate there is variation in completeness and order across records, but that nearly all documents are present, at least 80% of documents are current in most records, and at least 90% of records are in order in most records. For the two records audited by the Monitoring Team, findings were within the reported ranges; the presence of current records was somewhat better than the averages reported, but accurate order was somewhat lower than the averages reported.

Consistency with Appendix D Requirements: To assess the status of compliance with Appendix D requirements, the Monitoring Team audited records for Individuals #96 and #265, reviewed the audit findings for January through March 2014 as noted above, and reviewed the trends report for the QA/QI Council with data January 2013through January 2014 and March 2013 through March 2014.

For Individual #96, the records met 18 of 24 requirements (75%) assessed by the Monitoring Team and found applicable. For Individual #265, the records met 15 of 24 requirements (63%). This was an improvement from the findings of the last compliance visit. Specific findings included:

- Legibility had improved and was found in compliance for both individuals.
- For both individuals, gaps remained but were infrequent and primarily occurred at the bottoms of pages of orders or notes.
- Initial legends were not consistently completed for all staff who initialed.

The Monitoring Team did not review whether access to electronic records was protected, for example by passwords. This was likely the case, and a Yes would have increased the percent of compliance.

The Facility completed the Section V Monitoring Tool for two individuals each in February and March 2014. Findings for Individuals #69, #221, #255, #312, #492, and #597 were 48%, 62%, 64%, 69%, 56%, and 52% respectively. These are consistent with the findings for two monitoring tools reviewed for the last compliance visit.

The Monitoring Team also reviewed the Section V trends reports with data January 2013

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		through January 2014 and March 2013 through March 2014. These reports, combined, included graphs of the data for the period of January 2013 through March 2014. One graph in the report through January 2014 provided the percent of compliance for each requirement on the Monitoring Tool; the period of time covered was not noted on the graph (that is, whether it was for the whole 13 months, for the prior month, or for some other period). Compliances ranged from 0% for Current and Complete to 100% for several requirements. These reports also showed internal audit analysis percentages. The graphs were not labeled in a way that described what the percentages were. URCs stated during interview that the percentages were the percent of applicable items found current and found in order. Since there was one bar per month on the graph, the Monitoring Team could not determine whether that bar was for percent of current documents, percent in order, or a combination of the two. The report for March 2013 through March 2014 was broken out by Unit. All three units showed at least a small trend downward. Overall, these findings suggest that improvement is still needed in meeting Appendix D requirements. The Monitoring Team reviewed many more records in review of other Sections of the Settlement Agreement. Findings included: • The legibility for most of the nursing documentation showed some improvement but the signatures were not consistently legible. As reported in previous compliance reviews, individuals' names and demographic information printed on the records by the use of an addressograph card/machine were virtually illegible. • Several issues were noted during a review of the All About Me book for Individual #159: o The BAIP for this individual was filed in the PNMP section of the record, behind several pages of unrelated documents, rather than in the Behavior section. o The BAIP was filed with pages out of order. o The BAIP was missing pages, including at least one page that included staff instructions for addressing self-injury and aggression. o Earlier in the day, prior to reviewing the All About Me book, the Monitoring Team asked a direct support professional (DSP) about the individual's self-injury. Staff responded that the individual did not have a BAIP. Later, a different Monitoring Team member asked a different DSP, who stated the individual did have a BAIP but could not describe it accurately. This discrepancy, along with the misfiling and inaccuracy of filing of this document, indicated that the document was not used in providing services and supports.	

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		Use of Share Drive 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 working days prior to the ISP annual planning meeting, and requires IDT members to review all assessments and "be prepared for a comprehensive, integrated discussion during the PSP meeting." During an interview, QIDPs were able to access assessments due for an upcoming annual ISP meeting. Eight of 10 (80%) assessments determined to be needed for the annual ISP meeting had been completed and posted on the Share Drive; in addition, the Habilitation Therapy assessment or update was posted timely but had not been listed as required. The Facility had developed and implemented a "map" of the folders on the Share Drive. This made it more likely that posting to the Share Drive would be done in a consistent manner, and would assist new staff to navigate the folders to find information.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	Facility Process to Develop and Revise Policies A Facility process existed and was followed to develop and revise policies, protocols, and 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. This had not changed since the prior visit. The policy manual was organized by sections consistent with the 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 process made it easy to identify policies relevant to requirements of the Settlement Agreement. The last compliance report described this in detail. The Director of QA reported that all policies are to be reviewed at least annually. The Facility did not have a formal process to ensure these reviews occur. So far, it has been up to the disciplines, but the QA Director periodically reviews the dates of policies and provides reminders. Each discipline is responsible for submitting policies to the Policy and Procedure Committee; the discipline states if no changes are proposed. The Policy	Noncompliance

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		Manual Table of Contents lists when each policy was revised, approved, and implemented; it does not list the date of last review. The Monitoring Team did not request, and the Facility did not provide, information to document that policies had been reviewed and cannot assess whether that had occurred. However, the Table of Contents did document that all policies had been approved or revised in 2012 or more recently. <u>Development and Revision of</u> <u>Policies to Implement Part II of the Settlement Agreement</u> There is evidence that many protocols and procedures required to implement Part II of the Settlement Agreement have been revised as needed; however, some essential protocols and procedures remain to be developed and implemented, and others had been approved but either implemented very recently or not yet implemented. DADS policy development, revision, and implementation: DADS had continued developing and revising policies. The Facility reported the DADS Policies revised since last visit were: • DADS Policy 002 Incident Management 11/5/13 • DADS Policy 004 ISP Policy 11/21/13 • DADS Policy 008 Behavioral Health Services Department 11/5/13 • DADS Policy 018.2 Most Integrated Setting Practices 10/18/13 • DADS Policy 021.3 Protection from Harms-Abuse, Neglect, and Exploitation 11/13/13 (in BSSLC Policy as CMGMT 01A) Furthermore, there continued to be regular revisions in procedures and processes relevant to requirements of the Settlement Agreement. For example, Section M reports on several guidelines for nursing services that were implemented or revised since the last compliance visit. BSSLC Policies and Procedures: The Facility provided a list of 34 BSSLC policies that had been developed or revised since the last compliance visit. Several Sections of this report list or discuss new and revised Facility procedures, including some not reported by the Facility. The Facility did not report all new and revised policies since the last compliance visit. In addition to the policies that were reported, the following had been revised: • BSSLC Policy C.2 Restraint for Behavioral Crisis 11/2/13 • BSSLC Policy D.1 Protection from Harm-Abuse, Neglect, and Exploitation 11/5/13 • BSSLC Policy DD.1 Incident Management 11/5/13 • BSSLC Policy Q.2 Total Intravenous Anesthesia (TIVA) dated 1/15/2014	

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		The Monitoring Team observed the Policy and Procedures Committee meeting during this compliance visit and reviewed minutes of several committee meetings. The observation verified discussion was substantive and led to decisions to approve policies, to require revisions prior to approval, or to approve pending specified revisions. Meeting minutes did not provide narrative of the discussion or specifics of required revisions but simply stated whether policies were "Approved," "Approved (with) minor revisions," or "Tabled" with a recommendation for "Major Revisions." <u>Training on Policies</u> Responsibility for training staff continued to be assigned to department heads. The staff identified as responsible for the policy determines how the policy is to be trained. Training is required for all staff who are covered under the section of the policy titled "Applies To"; approval of this section would be part of the approval process by the Policy and Procedures Committee. Each discipline keeps training rosters. This would make it difficult to ensure all staff required to be trained had, in fact, received the training. As noted in past compliance reports, the Monitoring Team suggests that a centralized process be developed to track training to ensure all relevant staff receive consistent training. The Monitoring Team observed the Policy and Procedures Committee meeting during this compliance visit. As at the last visit, this committee did actually identify which staff would require training (all IDT members) and assigned the responsibility to determine the training needed and to keep documentation to the Assistant Director for Programs (ADOP). Processes for development, revision, and implementation of policies were in place. There remains a need for policies to address a few requirements of the Settlement Agreement (note, for example, the requirement reported in Section U for a policy or process to assess capacity for decision-making). The Facility needs to ensure all staff who are required to have training on new or revised policies receive consistent training.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random	<u>Audit Policy and Process</u> Policy V.3 Monitoring of the Unified Records defines the Facility process to audit records, URCs were each assigned to audit six records per month selected through computer randomization; a random list was generated of four individuals from each of the three living units. No individual will be audited twice within a six-month period; the computer randomization process does not pull those individuals. The Facility labeled these audits done by the URCs as Internal Audits. The URCs audit the Individual Notebook and each chart of the Active Record; since the	Noncompliance

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	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.	last compliance visit, the Facility began to audit the Master Record. For each of the audited records, the URCs used the Active Record Audit tool, Individual Notebook Audit tool, and Master Record Audit tool. Each tool identifies whether current documents are in the record and whether they are filed in the correct order and location. The forms for the Individual Notebook and Active Record are listed in order (per the Order & Guidelines for each), and the Master Record Audit form lists a set of basic documents that should be found in Master Records. The Order & Guidelines list 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 form grayed out the cells for N/A for documents that required a "Yes" or "No" response. 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. A document titled Active Record Order & Guidelines Definitions provided definitions for checking a document as Current and/or In Order. The URCs used the Settlement Agreement Cross-referenced with ICF/MR Standards (the Section V monitoring tool) to audit four records per month (two per URC). The Facility referred to this as the external audit. A form titled Section V: Recordkeeping and General Plan Implementation Guidelines, revised in March 2014, also provided "Guidelines to use when Scoring Y or N" next to each item on the Section V monitoring tool. Although these provided definitions and guidance, they did not indicate whether there was a limit to the number of errors permitted (for example, how many illegible documents could occur and still be rated "Y"). Review of the tracking tool for audits in January, February, and March 2014, and of the audit tool forms provided for February and March 2014, verified that 12 audits had been completed per month. Per the request for documents, the Facility provided the last 10 audits completed in February 2014 and eight audits that had been completed in March 2014. For these 18 audits: • For 18 (100%), the Facility provided the audit forms for Program and Medical Charts and the Master Record. • For 17 (94%), the Facility provided the audit form for the Individual Notebook. The audit form for Individual #332 stated the individual was in the hospital.	

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		• For six (33%), the Facility provided the Section V monitoring tool; this was consistent with the Facility's procedure of using this tool for two records per month, as it was possible that these tools would have been completed for two of the six remaining audits completed but not provided for review. <u>Interobserver Agreement/Interrater Reliability</u> The Facility had a process for evaluating interobserver agreement on audit findings for the Individual Notebook and Active Record. From the six audits assigned to each URC each month, one individual was selected for inter-rater audit. For the months of October 2013 through January 2014, the two URCs each did an inter-rater audit for one record assigned to the other; that is, there were two records audited by both URCs. In addition, a Program Compliance Monitor (PCM) audited one record from each URC. For February and March, only the inter-rater audits done by the two URCs were done, but the URCs reported the additional audits with the PCM will begin again soon. For this visit, the Facility provided a graph in the trends analysis report to the QA/QI Committee showing inter-rater agreement monthly from May 2013 through March 2014. A bar graph showed the agreement between the two URCs and the agreement for each URC with the PCM. Agreement from October 2013 on ranged from 82% to 98%. The graph did not identify whether the data were for "Current," "In Order," or both, or were for the monitoring tool. As mentioned in the report from the last compliance visit, the Facility should make sure graphs have labels that clearly identify what data are represented. 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 #96) by computer randomization from among those selected by the Facility for an audit in April 2014. No training was provided other than the Active Record Guidelines-Definitions and the guidelines for the Section V monitoring tool. The Monitoring Team audited this record on the same day with no opportunities for the charts to be updated or revised. Agreement data reflect documents for which one or both raters marked "Yes" or "No"; to establish a conservative measure, documents for which both raters marked "N/A" were not considered. Agreement on presence of current documents was 81% for both the Individual Notebook and the Active Record; agreement on whether documents were in order was 77% for the Individual Notebook and 92% for the Active Record. These demonstrated acceptable agreement on Current documents for both charts and on In Order ratings for the Active Record (and slightly below an acceptable level for the Individual Notebook). For the monitoring tool, agreement was calculated for all items checked by the Monitoring Team (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). Agreement was 75%. This was an increase from the agreement level at the last compliance visit, but did not quite achieve a level that would indicate reliable rating.	

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		Audit Findings In response to the document request from the Monitoring Team, the Facility provided copies of 10 audits completed in February 2014, and six audits completed in March 2014. The Facility also provided a tracking database for internal record audits for January, February, and March 2014. This database was extremely useful. It listed all the documents for the Individual Notebook and the charts in the Active Record (Program Chart and Medical Chart). For each record audited, it listed the name and home of the individual, the URC who did the audit, and whether each specific document was present, current, and in order (rated as yes, no, or N/A). It calculated the percent present, percent current, and percent in order. It also calculated, for each item, the percent present, current, and in order across all records audited that month; review of the database showed the percentages were based only on applicable items, an appropriate and conservative way to make these calculations. The Monitoring Team found this useful, and believes it could be extremely useful in identifying areas for which improvement is needed. Findings on presence of current documents and on whether documents are in order reported on the database and the trends reports are reported in Provision V1. Overall, they show a relatively stable trend. Findings on compliance with Appendix D requirements as rated on the Section V monitoring tool showed a need for improvement overall, with a wide variation across items. Corrective Actions for Audit Findings 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 an "Audits Needing Corrections" spreadsheet for each Unit on the S: Drive on which the URCs entered the corrections needed. This spreadsheet 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 the "Unit IDT" (with copies to the Director of Quality Assurance, Director of Residential Services, and others) notifying them that they were ready for review and correction, and providing a week to complete corrections. When the due date was reached, the URCs checked each correction in the records to ensure it was completed and sent an email to the same recipients stating the percent of corrections completed for each record. The emails for February were	

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		provided for review. They also included a copy of the "Audits Needing Correction" spreadsheet for each audited record (including for each item whether it had been found corrected) and a graph of "corrections not completed by Discipline." Unit Directors and Department heads had access to review the database at any time so they could identify any uncorrected items. 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. Furthermore, in interview, the URCs stated they do not continue to check for additional completion of corrections. Thus, no individual had responsibility to follow through until the correction was made. To achieve compliance with this provision, the Facility must have a process to ensure corrections are 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. The URCs reported they are developing processes for such instances. For example, there had been 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 URCs have begun to copy documents that need improvement, such as findings in Observation Notes, and to request the Home Managers determine how to correct those and to send an email about what they have done; if this involves training, they are to send a roster and worksheet. The Facility should develop a process to confirm that corrections that do not involve a change in the record itself, such as re-training, are made. A trends report (undated) provided bar graphs of corrections completed, by unit, from March 2013 through March 2014. The percentages since October 2013 ranged from approximately 63% to approximately 73% (estimates based on visual review of the graphs) and showed stable trends over that time. The Monitoring Team did not ask or determine whether these were measures of corrections completed by due date of audits during the specified month, or whether there was some other process to determine overall completion of corrections. These indicate that improvement is needed in correcting deficiencies found in records. To verify that spot checks accurately identified corrections made and not made, the Monitoring Team selected one record by computer randomization from the audits conducted in February 2014. One URC and Monitoring Team member checked to determine if all documented corrections to the Active Record and Individual Notebook had actually been made. The URC brought the "Audits Needing Correction" for that record and reviewed the Individual Notebook and Active Record to check each item. All items that had been marked as corrected were corrected. A few items that had been	

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		marked as not completed had, since the last spot check, been completed. A few items remained not corrected. Thus, the spot checks appeared to provide accurate information, but the lack of a process to continue following the corrections until completed resulted in the continuing incompleteness or inaccurate filing in the record. Use of Audit Information for Systemic Improvement The Monitoring Team was informed the Facility had taken one systemic action to improve accuracy of filing and compliance with Appendix D requirements: • A corrective action plan (CAP) was established to address lack of updating of skill acquisition plans (SAPs) and specific service objectives (SSOs) in data books and the Active Record. A set of actions was planned, with the first due 4/25/14. A flow sheet was created for a standardized process for updating SAP documentation when a SAP is updated. • According to the URCs, a second improvement initiative had begun for the process for filing the completed Rights Assessment. • The Facility established a tracking system for completion of assessments in January 2014. This involved a daily notice of assessments overdue. The Facility should assess progress in this area and take additional steps if timely completion does not improve. This tracking system should provide an efficient means to track progress regularly so action can be taken quickly if improvement is not evident. Additional Audit Process A second audit process continued in place. The Facility had long had a process in which Program Compliance Monitors do monthly chart audits of active records per month. This was in addition to the inter-rater reliability audits involving a PCM. PCMs 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 Skill Acquisition Programs are identified on the Action Plan 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. This additional audit could be quite valuable if the Facility performed a comprehensive monthly analysis of recordkeeping accuracy that included information from both kinds of audits. Areas in which Improvement Should be Made The Facility had a robust audit system. Conducting 12 audits per month exceeds the	

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		requirement of five random audits. The Facility tracks presence of current documents and whether they are in order, and can review this information by individual, unit, or specific document. The basis of an effective audit system is in place. However, there is not yet an indication that it is being effective at limiting reoccurrence of errors. To achieve substantial compliance, two improvements are needed. First, corrective actions should be tracked until they are completed. The audit should not be resolved until the cited corrections are done. This would include corrections that are not made directly to the record, such as training and monitoring that minimizes reoccurrence of errors. Second, the Facility should use the information to identify systemic issues to address, to initiate systemic improvements, to track the effect of those improvements, and to revise plans as needed.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	The Monitors and the parties agreed to a list of six actions that the facilities would engage in to demonstrate substantial compliance with this provision item. These actions are categorized below, with report of their status at RSSLC. <u>Records are Accessible to Staff, Clinicians, and Others</u> As reported in Provision V1, Active Records and Individual Notebooks were readily available and accessible. The Share Drive made assessments and other documents readily available to clinical staff, residential directors, QIDPs, and others who might need to refer to them. To make this easier, the Facility established a "map" of the folders for individuals so that folders would be established in a consistent manner and could be found easily. There was no difficulty in accessing the records onsite. Random review of units found the All About Me Books contained Direct Support Professional Instruction Sheets. The location of the All About Me Books, Communication Notebooks, and Training Notebooks were readily accessible to the Direct Support Professionals. Interviews with the Direct Support Professionals showed they knew the location of these books. In the past, and reported by the URCs in interview, the All About Me book was to accompany the individual wherever the person goes for supports and services provided by the Facility. However, observation at this visit found that these books typically remained at the home for individuals who were ambulatory and active, but did accompany the individuals who used wheelchairs. In some cases, this was problematic. As reported in Provision O3, Physical and Nutritional Management Plans (PNMPs) are included in the "All About Me" books. On multiple occasions, "All About Me" books that contained the PNMP were left back at the home or were not present at the point of	Noncompliance

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		service. Having the book left at home made it more difficult to ensure correct positioning off site as evidence by multiple observations in which individuals were not positioned according to the PNMP. The Facility should determine how to ensure information is available where it is needed for provision of services and supports. Examples were found, though, in which staff were able to find documents and explain them. As reported in Provision M3, the Monitoring Team interviewed DSPs for two individuals. The DSPs were able to quickly locate and show individuals' All About Me Books, Communication Notebooks, and Training Notebooks. The DSPs without hesitation were able to find the DSP Instruction Sheets and to explain their care responsibilities for these individuals. <u>Documents are Filed in the Record Timely and Accurately</u> The Section V monitoring tool for record audits checked whether documents in the record were current. Responses to that item on the reviewed audits showed zero of six records (0%) was rated as Current. That was true also for the two records audited by the Monitoring Team. For assessments to be used in the annual Individual Support Plan (ISP) process, they must be completed and posted timely to permit the entire interdisciplinary team (IDT) to review them. The Facility ISP policy requires that assessments be completed and placed on the shared drive, for the other IDT members to review, at least 10 working days prior to the annual ISP meeting. For a new admission, Facility policy requires that the assessments be completed and posted at least five working days prior to the initial ISP meeting. In the current ISP procedure, the IDT was to identify the assessments that were required for the annual ISP meeting at the ISP Preparation meeting 90 days prior to the date of the ISP. Each of the sample ISPs clearly defined the assessments that were to be completed. The Facility provided a listing, by individual ISP meeting for those that were scheduled in January and February 2014, of the assessments that were not completed as of 3/12/14, along with a summary table. The summary table reported that 426 assessments (53%) had been completed on time out of a total of 810 assessments due. Of the late assessments, 72 (9%) were one to five days late and 73 (9%) were six to ten days late (that is, were late but completed by the date of the ISP meeting. As reported in Provision F1c, of a sample of nine ISPs reviewed, none (0%) had all assessments included and completed on a timely basis prior to the ISP annual meeting; the rate of timeliness was 45% based on the requirements listed in the ISP Preparation	

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		meeting documentation. During an interview, the Monitoring Team requested the assessments available on the shared drive for Individual #538, whose ISP annual meeting was scheduled within ten working days. The QIDP provided the Assessments/Reported Needed for the Annual ISP Meeting sheet that identified which assessments were required and accessed the assessments. Eight of 10 (80%) assessments determined to be needed for the annual ISP meeting had been completed and posted on the Share Drive; in addition, the Habilitation Therapy assessment or update was posted timely but had not been listed as required. <u>Data Are Documented/Recorded Timely On Data And Tracking Sheets</u> In general, data were documented and recorded timely. There were no reports of late or missing data from the Monitoring Team in reviews of the various sections of the Settlement Agreement. Audit of two records by the Monitoring Team found data as required for two of two records (100%). <u>IPNs Indicate The Use Of The Record In Making These Decisions (Not Only That There Are Entries Made)</u> The Self-Assessment reported 61% of Section V monitoring tools indicated the records provided information that was adequate for use in routine decision-making and review. Five of six Section V monitoring tools for February and March 2014 (83%) indicated "information obtained from review of the record (integrated progress notes" provided evidence the Facility uses the records to make decision. Two of two audits conducted by the Monitoring Team (100%) indicated evidence the Facility uses the records to make decisions. <u>Staff Surveyed/Interviewed Indicate How The Unified Record Is Used</u> The Facility revised its process for surveying and interviewing staff to determine use of the Unified Record. The "V4 interview tool" and process was revised in January 2014. One interview is completed each month; the Monitoring Team did not determine how the specific individual and IDT are selected. As in the past, the URC sends an email with a copy of the interview questions to each discipline listed on the S Drive Population Report as serving the individual. Each discipline is to fill out responses to the question and return by email. The URC sends a reminder if there is no response in two weeks. The URC reviews the responses and scores the response by each clinician on each question as either + (apparently indicating the response showed use of the record) or – (apparently indicating the response did not provide evidence of use of the record). In the past, the interview tool asked for responses related to how the record was used related to the	

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		specific individual whose record was audited. That had changed. The cover emails stated "The questions are no longer specific to a particular individual, but are now in reference to how each discipline uses the Active Record." The URCs reported they usually request about eight people to fill out the interview form. For February 2014, the form was sent to nine staff (physician, psychiatrist, psychologist, QIDP, Nurse Case Manager, Occupation Therapist, Physical Therapist, Physical Therapy Assistant, and Speech Language Pathologist), and six responded, for a response rate of 67%. For March 2014, the form was sent to 10 staff from the same disciplines as in February, and six responded, for a response rate of 60%. The URCs summarized the responses on a table that included each staff to whom the form was sent and a summary of their response to each question. Based on those responses, the URC makes a determination of whether the record was being used; this determination provided a rating for the Section V monitoring tool. None of the three Section V monitoring tools provided to the Monitoring Team for February 2014 rated this question; for March 2014, the Section V monitoring tool for Individual #312 rated this "Y." The email from the URC did not identify the specific individual whose clinical team was to complete the form, but the responses to the form were consistent with a rating of "Y." The Facility did not report a process to determine inter-rater reliability on these ratings. <u>Observation At Meetings, Including ISP Meetings, Indicates The Unified Record Is Used and Data Are Reported</u> The Monitoring Team requested a copy of any monitoring form used to observe IDT/ISP meetings to audit 1) Presence and use of the records and 2) Integrated discussion and planning. The Facility responded that the URCs "no longer attend scheduled ITD (sic)/ISP meetings to monitor use of the records. The QIDP Coordinator is in the process of revising a tool that they will be using to observe IDT/ISP meetings but it is not currently in use." The Monitoring Team observed annual ISP planning meetings for Individuals #123, #546, and #599, and the ISP preparation meeting for Individual #545. The record was present at four of four meetings (100%). Information from the record was used at four of four meetings (100%). At the annual ISP planning meeting for Individual #599, the record was referenced for the date of an MBSS assessment. Information was also referenced from documentation IDT members brought to the meeting; for example, the physical therapist checked a sheet she had brought to determine whether the individual had a specific diagnostic test completed. Also, some information from assessments was on the ISP Guide form	

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		provided to the participants in the meeting.	

List of Acronyms

Brenham State Supported Living Center

April 7-11, 2014 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
BHS	Behavioral Health Specialist
BIR	Behavioral Incident Report
BMC	Behavior Management Committee
BMD	Bone Mineral Density
BP	Blood Pressure
BSC	Behavior Support Committee
BSP	Behavior Support Plan
BSPPS	Behavioral Support Program for Psychiatric Symptoms
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
CoS	Change of Status
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
DRA	Deficiencies Requiring Action
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
HPI	History of Present Illness
HRC	Human Rights Committee
HRO	Human Rights Officer
HST	Health Support Team
HT	Habilitation Therapy
IBHA	Integrated Behavioral Health Assessment
IBW	Ideal Body Weight
IC	Infection Control/Informed Consent
ICF	Infection Control Form
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
IMM	Incident Management Meeting
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
LTAC	Long Term Acute Care Facility
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
MTC	Mealtime Coordinator
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
NSI	Non-serious Injury Investigation
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
PCA	Program Compliance Auditor
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
PMR-SIB	Protective Mechanical Restraint for Self-Injurious Behavior
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)
PRP	Polypharmacy Review Panel
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
SPA	Speech Pathology Assistant
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