United States v. State of Texas

Monitoring Team Report

Brenham State Supported Living Center
January 11-15, 2010

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Submitted By: Michael J. Davis, Ph.D.
Monitoring Team: Dwan Allen, RNC, BSN,NP
James Bailey, MCD-CCC-SLP
Michael Sherer, M.D.
Douglas McDonald, Ph.D.
Scott Umbreit, M.S.
Rebecca Wright, MSW

Introduction

I. **Background** - In 2005, the United States Department of Justice (DOJ) notified the Texas Department of Aging and Disability Services (DADS) of its intent to investigate the Texas state-operated facilities serving people with developmental disabilities (State Centers) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). The Department and DOJ entered into a Settlement Agreement, effective June 26, 2009. The Settlement Agreement covers 12 State Supported Living Centers, including Abilene, Austin, Brenham, Corpus Christi, Denton, El Paso, Lubbock, Lufkin, Mexia, Richmond, San Angelo and San Antonio, as well as the ICF/MR component of Rio Grande State Center. In addition to the Settlement Agreement (SA), the parties detailed their expectations with regard to the provision of health care supports in the Health Care Guidelines (HCG).

Pursuant to the Settlement Agreement, on October 7, 2009, the parties submitted to the Court their selection of three (3) Monitors responsible for monitoring the facilities' compliance with the Settlement Agreement and related Health Care Guidelines. Each of the Monitors was assigned a group of Supported Living Centers. Each Monitor is responsible for conducting reviews of each of the facilities assigned to him/her every six (6) months, and detailing his/her findings as well as recommendations in written reports that are to be submitted to the parties.

Initial reviews conducted between January and May 2010 are considered baseline reviews. The baseline evaluations are intended to inform the parties and the Monitors of the status of compliance with the SA. This report provides a baseline status of Brenham State Supported Living Center.

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.

In order to provide a complete review and focus the expertise of the team members on the most relevant information, team members were assigned primary responsibility for specific areas of the Settlement Agreement. It is important to note that the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members shared information as needed, and various team members lent their expertise in the review of Settlement Agreement requirements outside of their primary areas of expertise. To provide a holistic review, several team members reviewed aspects of care for some of the same individuals. When relevant, the Monitor included information provided by one team member in the report for a section for which another team member had primary responsibility. For this baseline review of Corpus Christi SSLC, the following Monitoring Team members had primary responsibility for reviewing the following areas: Toni Richardson reviewed protection from harm, including restraints as well as abuse, neglect, and incident management, as well as quality assurance, and integrated protections, services, treatments and supports; Kenneth Weiss reviewed psychiatric care and services, and medical care; Victoria Lund reviewed nursing care, dental services, and pharmacy services and safe medication practices; Patrick Heick reviewed psychological care and services, and habilitation, training, education, and skill acquisition programs; Nancy Waglow reviewed minimum common elements of physical and nutritional supports as well as physical and occupational therapy, and communication supports; and Maria Laurence reviewed serving individuals in the most integrated setting, consent and record keeping. Input from all team members informed the reports for integrated clinical services, minimum common elements of clinical care, and at-risk individuals.

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 SA.

II. **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 January 11-15, 2010, the Monitoring Team visited Brenham 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. This allowed the Monitoring Team to gain some basic knowledge about facility practices prior to arriving onsite and to expand that knowledge during the week of the tour. The Monitoring Team made additional requests for documents while on site.

Throughout this report, the specific documents that were reviewed are detailed. In general, though, the Monitoring Team reviewed a wide variety of documents to assist them in understanding the expectations with regard to the delivery of protections, supports and services as well as their actual implementation. This included documents such as policies, procedures, and protocols; individual records, including but not limited to medical records, medication administration records, assessments, Personal Support Plans (PSPs), Behavior Support Plans (BSPs), documentation of plan implementation, progress notes, community living and discharge plans, and consent forms; incident reports and investigations; restraint documentation; screening and assessment tools; staff training curricula and records, including documentation of staff competence; committee meeting documentation; licensing and other external monitoring reports; internal quality improvement monitoring tools, reports and plans of correction; and staffing reports and documentation of staff qualifications.

Samples of these various documents were selected for review. 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 being implemented.

(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, PSP team 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.

(e) **Other Input** - The State and the U.S. Department of Justice also scheduled calls to which interested groups could provide input to the Monitors regarding the 13 facilities. The first of these calls occurred on Tuesday, January 5, 2010, and was focused on

Corpus Christi State Supported Living Center. The second call occurred on Tuesday, January 12, 2010, and provided an opportunity for interested groups to provide input on the remaining 12 facilities.

III. **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 and each chapter of the Health Care Guidelines.

The report begins with an Executive Summary. This section of the report is designed to provide an overview of the facility's progress in complying with the Settlement Agreement. As additional reviews are conducted of each facility, this section will highlight, as appropriate, areas in which the facility has made significant progress, as well as areas requiring particular attention and/or resources.

The report addresses each of the requirements in Section III.I of the SA regarding the Monitors' reports and includes some additional components which 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 SA and each of the chapters of the HCG, 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) **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;
(c) **Assessment of Status:** As appropriate based on the requirements of the SA, a determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement. Also included in this section are detailed descriptions of the facility's status with regard to particular components of the SA and/or HCG, including, for example, evidence of compliance or non-compliance, 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;
(d) **Facility Self-Assessment:** A description is included of the self-assessment steps the facility undertook to assess compliance and the results thereof. The facilities will begin providing the Monitoring Teams with such assessments 14 days prior to each onsite review that occurs after the baseline reviews are completed. The Monitor's reports will begin to comment on the facility self-assessments for reviews beginning in July 2010;
(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. As stated previously, it is essential to note that the SA identifies the requirements for compliance. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the SA. However, 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 SA.

Individual Numbering: Throughout this report, reference is made to specific individuals by using a numbering methodology that identifies each individual as Individual #1, Individual #2, and so on. The Monitors are using this methodology in response to a request from the parties to protect the confidentiality of each individual. A methodology using pseudonyms was considered, but was considered likely to create confusion for the readers of this report.

IV. Executive Summary

At the outset, the Monitoring Team would like to thank the management team, staff and individuals served at Brenham State Supported Living Center for their welcoming and open approach to the first monitoring visit. It was clear that the State's leadership staff and attorneys as well as the management team at BSSLC had encouraged staff to be honest with the Monitoring Team. As is reflected throughout this report, staff throughout the Facility provided the Monitoring Team with information requested, and were forthright in their assessment of the Facility's status in complying with the Settlement Agreement. This was much appreciated, and set the groundwork for an ongoing collaborative relationship between BSSLC and the Monitor's Office.

Review Process:
The baseline tour provided an opportunity to become familiar with the policies, procedures, processes, and structure of BSSLC. Team members used this time to meet and discuss with a wide range of facility staff to provide an understanding of structure and services, and to develop a collaborative approach to the review and improvement process. The team examined a great deal of documentation and carried out many observations and interviews in order to evaluate the status of the facility practices. The report describes status of provisions but does not provide decisions about compliance with provisions; that will begin at the first compliance review.

Summary of Findings:
As is illustrated throughout this report, BSSLC has a number of good practices in place, and in a number of the areas in which there is a need for improvement, the Facility has plans in place to make needed changes. In addition, BSSLC's management team and staff generally appear to be open to making additional changes as needed. The following provides some brief highlights of some of the areas in which the Facility is doing well and others in which improvements are necessary:

Positive Practices
It is clear that BSSLC is making significant efforts to improve services and meet many of the provisions of the Settlement Agreement. The monitoring team would like to recognize some positive practices and improvements. This is not an exhaustive list. Reviewing the assessments of provisions will reveal additional positive practices, and there are certainly others not mentioned in this review.

- Staff are making a serious effort to improve services and comply with the SA. They demonstrated a great interest in getting new ideas and learning from the monitoring team.
- Texas has demonstrated an understanding of the need for increased staffing and has provided support by adding a significant number in many areas, including nursing, psychiatry, and activity and vocational services.
- A great deal of data is available for quality enhancement and trending. These data can serve as the basis for an effective quality review and improvement system.
- Records indicate minimal use of restraint. For example, records indicate no individual has been restrained more than 3 times in a 30-day period.
- Staff are aware of procedures to report abuse, neglect, and exploitation as well as other serious incidents. They make those reports as needed. Investigations of these incidents by facility investigators are thorough and well-organized.
- Off-site vocational programs are well-organized. People who work at them are productive and report being happy with their jobs. Enclave sites at two community businesses provide an opportunity to enhance integration with other workers.

- Opportunities for community activity are being enhanced. For example, a shuttle is used on weekends to bring people into town for shopping and other activities. Plans are in place to increase activities directed at individuals' preferences and learning needs.
- Provider fairs are offered as a way for families, staff, and individuals living at the facility to learn about opportunities for community living.

Areas in Need of Improvement

- Planning of services and supports is not interdisciplinary. Disciplines do their own assessments. Although many people may be involved in meetings, they use that time primarily to report assessment results and their plans for intervention rather than providing that information in advance and using the meeting to make interdisciplinary and coordinated decisions.
- Facility policies in many cases simply adopt state policies. Local operational procedures are frequently unwritten. Staff may not be able to provide policies when asked and may have different interpretations of procedures.
- Quality and trend data are not routinely used to identify issues to address for systemic change.
- Although incidents are reviewed daily and following investigations, and trend data are available for systemic issues, analysis of cause of incidents and trends is rudimentary. In daily reviews, the language of "root cause" is used, but root cause analysis is not done in an organized or thorough manner.
- Assignment of risk level does not follow State policy, with many risks identified as "low" that should be identified as "medium." Furthermore, the State policy definitions do not assign risk level in a meaningful way that can guide resource allocation, frequency of monitoring and assessment, or types and level of supports.
- Functional assessments are not performed in a manner meeting current standards. As a result, replacement behaviors generally do not address the function of the problem behavior, and interventions may not be optimally effective. Although psychology staff are interested in improving their skills at functional assessment, understanding of this process needs to be developed among the entire PST.
- Skill acquisition program goals are not clear and specific. Criteria for meeting goals may actually delay progress toward independence.
- Development and implementation of physical and nutritional management plans does not meet current standards. Although the facility has made the positive steps of having an PNM team and PNMP coordinators, there is not adequate involvement of clinicians with expertise in this area to develop programs, train staff, and monitor complex cases.
- Many staff do not view community living as an outcome to plan for. If a LAR does not currently support community living, efforts in that direction often cease.
- Identification of barriers to community living focus on behavioral and medical challenges of the individual rather than on supports that are not currently available from community service providers or reluctance of LARs. Therefore, it is difficult to identify actions that can be taken to overcome barriers.
- There has not yet been an effort to prioritize need for guardians and develop a plan to seek guardians.

In Summary

BSSLC is making significant efforts, with the support of the state of Texas, to improve services. Making these improvements is a long-term process with many challenges. Based on current improvements and the commitment demonstrated by the facility, the monitoring team is optimistic.

Status of Compliance with 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:** (Note: because this was a baseline review a comprehensive set of documents was reviewed in order to determine where various subject matter-specific information may be. The list below displays documents reviewed and is relevant to Section C, D, E, and I of the Settlement Agreement. 1. PMAB Training Curriculum re: restraints 2. Trend Analysis Reports dated 9/09 and 10/09 3. Unusual Incidents Trend Report 11/09 4. UIR review log dated 1/13/10 5. Facility Quality Enhancement Plan 6. Facility Support Performance Indicators (FSPI's) schedule 7. HRC minutes 7/2/09 and 8/20/09 8. Facility Incident Map draft 9. P&P Vol 2 section 8 "Staff Supervision Levels" 10. P&P Vol 3 section 7 "Minimum Staff Training Requirements" 11. CMS 2567 survey completed 10/21/09 12. CMS 2567 survey completed 8/7/09 13. Campus Logs 12/31/09 thru 1/10/10 and 1/12/10 14. Training records for sample of 5 staff 15. Performance Improvement Council minutes Oct/Nov/Dec 09 mtgs 16. FSPI report on Consumer Monies & Personal Effects for 2nd Q FY09 17. FSPI report on Competency Training & Development for 2nd Q FY08 18. DAD's Criminal History Disclosure form 19. Curriculum for Comprehensive Investigator Training 20. UIR 09-262 case file as an example of an OIG closed case 21. DFPS case #34159592 case file as an example of a DFPS closed case 22. UIR 10-050 case file as an example of a closed case with follow-up personnel action 23. UIR 10-025 case file as an example of an allegation made to DFPS that was referred back to the Facility. 24. UIR 10-019 case file as an example of documentation of administrative follow-up. 25. "5 day reports" (ie. ICFMR compliance) for UIR's 10-015, 023, 004, 003, and 017 26. UIR 10-093 preliminary report – recent incident 27. Job description for Facility Investigator 28. Peer to Peer client injury report (Individual #1) 29. Client injury reports for Individual #14, Individual #15, and Individual #16. 30. Sample "Buddy Sheet" for newly hired DCS 31. Sample Job Specific Orientation packet (OJT) for DCS 32. Five completed Demonstration Books for DCS (OJT) 33. Training records for sample of 5 staff

	34. A/N/E Training Curriculum 35. Supt memo to all staff dated 11/9/09 re: A/N/E reporting obligations 36. P&P Volume 2 section 2b re: Unusual Incident Mgt, Allegations of A/N/E, Injuries to Persons Served, Sexual Incidents, and Unauthorized Departures 37. Working document entitled "Ideas for Corrective Actions" 38. Agenda's for Self-Advocacy group (resident council) 1/27/09, 4/28/09. and 6/30/09 39. Quality Systems Oversight Report for habilitation 2009 40. QA monitoring tools for habilitation, medical/nursing, and psychological care 41. Draft Health Status Team policy 42. Sample of documentation for 11 applications of restraint (including Individuals #2,3,4,5,6, and 7) 43. PSP minutes for Individual #17 44. Health Status List dated 1/20/10 45. Texas Department of Aging and Disability Services; State Supported Living Center Policy: Use of Restraint, Policy number: 001, Date 08/31/09, Supersedes: Essential Elements 46. BSSLC's Restraint List of individuals requiring program and emergency restraints. - July 1, 2009 through January 7, 2010 47. Draft PSP for Individual #8. **People Interviewed** (Note: because this was a baseline review people interviewed were queried on a variety of topics that touched on elements of Sections C, D, E, and I of the Settlement Agreement): 1. Director of Quality Enhancement: Kim Littleton 2. Program Specialist Cheryl Powell 3. Psychology Manager: Shawn Cureton 4. Residence Directors Jack Ross, Missy Abston, Susie Johnson, Janet Crane, and Phillip Carnagey 5. DCs 6. Facility Investigator Michael Johnson 7. J. Bret Hood, MD, Director of Medical Services 8. DFPS/APS Regional Director Ross Jackson 9. DFPS/ APS Local Office Supervisor (SD) 10. DCS Home Leader (EE) 11. DCS Home Supervisor (SJ) 12. QMRPs Ann Schrengauer, Dee Dee McWilliams, & Joyce Ward 13. Workers Compensation Coordinator Marla Sams **Meeting Attended/Observations:** 1. Individual Support Plan annual meeting for Individual #17 2. Residence daily morning meeting to review 24 hour log and other issues 3. Two of the daily Incident Management Review Team meetings convened by the Supt 4. One regularly scheduled Human Rights Committee meeting

	Facility Self-Assessment:
	Summary of Monitor's Assessment: The facility has taken a number of actions that have resulted in a significant reduction in use of restraints. That being said, there is a need to further refine policy, develop a restraint policy unique to Brenham, and ensure all staff understand and are properly trained in the policy and its attendant procedures. Review did not discover any significant gaps in the procedural aspects of the SA requirements, however, the qualitative aspects of action leading up to the need for use of restraints and of follow-up to reduce future use bears examination by the review team at the compliance review.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	There was no evidence indicating current use of prone restraints. Policy prohibits it and when queried staff interviewed provided the correct response. There is a concern that when using the side lying technique of physical restraint it could quickly, inadvertently, and unintentionally become a prone restraint with a combative client. Although this is addressed both in policy and in training, further review will be needed to determine adequacy of safeguards in place to prevent inadvertent prone restraint. A Restraint Policy specific to Brenham was not readily available. Brenham adopted the State issued policy that does meet all components of the SA. The Chief Psychologist had put together a booklet with practice guidelines and forms that he and the psychologists use as an operational tool in their work. It appeared to contain the necessary elements to ensure compliance with the State policy; however, it did not appear to have any "official" standing with respect to Brenham policies. • Summary of individuals' use for program and emergency restraints: ▪ Individual #3.: 15 episodes of program restraints ▪ Individual #9: 9 episodes of program restraints ▪ Individual #7: 6 episodes of program restraints ▪ Individual #6: 3 episodes of program restraints ▪ Individual #2: 2 episodes of program restraints ▪ Individual #10: 2 episodes of program restraints ▪ Individual #11: 1 episode of program restraints ▪ Individual #4: 4 episodes of emergency restraints ▪ Individual #12: 2 episodes of emergency restraints ▪ Individual #13: 1 episode of emergency restraints • Individual #3's Restraint Records and related Integrated Progress Notes were reviewed due the high frequency of program restraint use. The review focused on nursing performance during restraint use. Of concern was the need for 15 episodes during the 6 months reporting periods. Individual #3 has a PBSP; however, PST and psychiatrist should continue to make every effort to explore any antecedents or	

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		precipitation factors, including medical reasons for the his aggressive behavior. A review of restraint documentation indicates compliance with State Policy with respect to the key elements of use of less restrictive techniques prior to restraint, proper physician authorization, restraint monitoring, and restraint debriefing. There is a concern that the restraint debriefing (that is documented on the form) can be a bit perfunctory and may need more focus on proactive measures that can be taken to reduce/eliminate the need for restraint with the particular individual. Facility clinicians should focus additional attention on this element of the restraint process**.** It is not possible to reach even a preliminary conclusion as to whether restraints are used for the convenience of staff or as an alternative to treatment due to many issues with habilitation and behavior program design and implementation. Based upon available information, applications of restraint could not be attributed to staff convenience. Information provided in other sections of this report reflects an overall limited understanding of the principles of applied behavior analysis and a substantial lack of sophistication in behavior assessment and intervention. As a result, although it cannot be stated unequivocally at this time, it is likely that limitations in assessment, intervention and staff training contribute to the implementation of restraint procedures. There was little indication that staff members were capable of conceptualizing or applying proactive strategies of intervention that would render the undesired behaviors either ineffective or unnecessary, thereby eliminating the need for restraint. Documentation for 11 applications of restraint (including Individual #2, Individual #3, Individual #4, Individual #5, Individual #6, and Individual #7) indicates that staff lacked the skills or basic knowledge necessary to discuss or interpret behavior in terms of setting events, motivating operations, antecedents, consequences or functions. For example, in a debriefing form for a restraint involving Individual #7, the staff who applied restraint supplied conflicting statements that "there were no precursors to the behavior" and that the client was "agitated and distressed from previous restraint." These same staff later stated that the behavior may be due to the client's inability to communicate. The latter comment could have led to further review to determine what reinforcer the individual received from the problem behavior and what possible ways the person could learn to communicate and receive that reinforcer, so that a replacement behavior could be developed. Documentation did not indicate this occurred. Current intervention plans had not always been fully effective at preventing dangerous behavior, as indicated by the fact that restraint is still used in emergency situations. As a result, staff members often attempted a variety of general strategies that were at best ineffective. At times these informal strategies might actually have strengthened the undesired behavior or made the application of restraint more probable. For example, a debriefing form for a restraint for Individual #6 states staff "did everything they could due	

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		(sic)." In regard to future efforts to avoid restraint, it is reported on the debriefing form that, "Clear expectations and guidelines need to be given to … [Individual #6] and need to be enforced." During the incident, however, after the individual struck a peer, she was allowed to wander in and out of the residence until her behavior became aggressive toward staff; interventions included redirection and prompts that were not effective. As a result of the lack of proactive strategies, staff may view the application of punishment as the best approach to problem behavior. Such perspectives are more common when existing behavioral interventions are ineffective and staff are poorly trained. The development of proactive strategies and staff training in these strategies are essential steps in reducing reliance on punishment and restraint. There does appear to be extensive use of medical restraint (i.e. pretreatment sedation) that will need to be examined more closely in future visits. In informal conversations several Brenham staff members expressed surprise at the notion that it is a good idea to minimize or eliminate the need for pretreatment sedation. There are not routine and formal procedures in place for due consideration of the above matters by the interdisciplinary treatment teams. It should be noted that when reviewing the QE Trend Analysis Report (for the 12 month period ending October, 2009) the frequency of restraint use is on a downward trend. It should be noted that the report does not classify pre-treatment sedation as restraint so there is no data on the report regarding its use. Additionally, a review of HRC minutes revealed two instances of guardian approval of restraints well after the use of restraints. In one case guardian approval was noted on 6/26/09 for 3 instances of restraint that occurred in March. In another instance guardian approval for pretreatment sedation was noted four days after the event. Although it may not be possible always to predict the need for restraint, the facility needs to examine its process for obtaining guardian consent to ensure consent is obtained in a timely manner, particularly when restraint recurs.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	It is not possible to reach a conclusion as to whether a person is released from restraint "as soon as the individual is no longer a danger to him/herself or others." In the documentation reviewed, this appears to be the case, however some of the language in Safety Plans of when release should occur (e.g. "when calm") is often overly vague and not directly related to safety. Although review of the restraint documentation did not indicate any intent to use restraint longer than necessary, there need to be clearer safety-related instructions for the termination of restraint, formal and reliable definitions regarding behavior, and improvements in strategies for intervention.	

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		Staff members must be informed specifically and in detail how all elements of an intervention plan are to be implemented. When specificity and detail are lacking, staff must use their best judgment, which often differs from what the behavior analyst intended or the situation requires. When considering that the majority of PBSPs reviewed included poor definitions of intervention targets and often lacked specificity and detail, restraint may not be consistently applied or terminated.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	Based on statements in interviews and the booklet put together by the Psychology Manager, Brenham has apparently adopted the State policy. However, documentation of any formal process for policy review and approval by the executive team, or Director, or notation on documents that were described or presented as "policy" as to an approval and/or effective date was not readily available. It is imperative that documents purported to represent "policy" be appropriately labeled and include an approval and effective date. The facility needs to formulate a "Brenham Restraint Policy" that incorporates the state policy and is specific with respect to operational expectations to guide clinical and direct care staff in the proper use of restraints, and attendant monitoring, follow-up, and documentation. Through interview it was apparent that staff understanding of restraint policy varied. Staff who worked in an area where restraints (non-medical) were never an issue had only a rudimentary understanding of the restraint policy. This can be important, as staff can be "pulled" and find themselves in a situation where thorough knowledge of restraint policies and procedures is immediately necessary. One administrator, whose responsibilities included supervision of an area where many individuals had challenging behavior, could not describe for me what a Safety Plan consisted of. This lack of knowledge is of concern and should be addressed through additional training.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an	The definition of "crisis intervention" in the State policy describes three conditions that must exist for a situation to be identified as a crisis. Although this might be seen to imply that the use of restraints cannot be part of a planned program for a specific individual, it is essential that staff know procedures to be followed. The Safety Plans that have been developed provide information.	

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	individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.		
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.	A review of restraint documentation indicates this is being done. For example, documentation revealed that Individual #3's vital signs and mental status were almost always monitored at least every 30 minutes during each restraint episode. To ensure that documentation reflects implementation, a larger sample will be reviewed and interviews and observations will be conducted during the first compliance review.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury;	A review of restraint documentation indicates this is being done. Documentation for Individual #3 included opportunities to exercise restrained limbs, to eat, if near meal time, to drink and use the toilet. He was checked for injuries to restrained limbs and	

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	and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	appropriate interventions were taken when necessary. To ensure that documentation reflects implementation, a larger sample will be reviewed and interviews and observations will be conducted during the first compliance review.	
C7	Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall:	RE: C7 (a) through (g). Documentation did not identify any individual who had restraint more than 3x in a 30-day rolling time period; however, a draft PSP for Individual #8 discussed the use of a one-piece garment at night to prevent rectal digging; it was unclear whether this occurs regularly or only rarely, and therefore it is unclear whether this is recorded as restraint. To ensure that documentation reflects implementation, a larger sample will be reviewed, and interviews and observations will be conducted during the first compliance review. There is a process to complete the required actions, and it is being followed. Additional clinical review will need to occur to assess the efficacy and effectiveness of the process.	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;		
	(b) review possibly contributing environmental conditions;		
	(c) review or perform structural assessments of the behavior provoking restraints;		

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	(d) review or perform functional assessments of the behavior provoking restraints;		
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiates the use of the restraint, as well as other programs, where possible, to reduce or eliminate the use of such restraint. The type of restraint authorized, the restraint's maximum duration, the designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;		
	(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		
	(g) as necessary, assess and revise the PBSP.		
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such	There is a concern that the restraint debriefing (that is documented on the form) can be perfunctory and may need more focus on proactive measures that can be taken to reduce/eliminate the need for restraint with the particular individual. For example, review of functional assessments (see K5 and K6) indicates that effort is being made to	

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	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.	complete functional assessments, but the process, timeliness, and thoroughness do not support a finding that adequate review following restraint leads to program development and revision that may be effective in reducing future restraint use.	

Recommendations:

- Recommendation for all policies, procedures, and forms in use at Brenham: the facility needs to establish a formal mechanism for review and approval of policies, procedures, and forms, and each document should indicate an approval date, a date of last revision, and an effective date
- Develop a restraint policy unique to the facility that incorporates the state policy and is specific with respect to operational expectations to guide clinical and direct care staff in the proper use of restraints, and attendant monitoring, follow-up, and documentation.
- Staff members must be informed specifically and in detail how all elements of an intervention plan are to be implemented. The facility may need to develop guidelines for and monitoring of written safety plans to ensure instructions are clear and meet the requirements of the SA. Criteria for release from restraint should make clear that release is based on safety considerations.
- In the process of restraint debriefing and related follow-up, clinicians should focus more intensely on proactive measures that can reduce or eliminate the need for use of restraints with the individual in the future.
- Examine the process used to obtain guardian consent to ensure consent is received in a timely manner and is properly documented.
- Initiate or revise training/QA activity to ensure all staff understand restraint policy, safety plans, necessary forms, approvals, and documentation.
- If not currently in place, PST and IDT Teams and psychiatrist should track and trend, by individual frequency of restraint use.
- PSTs and psychiatrist should continue to make every effort to explore any antecedents or precipitation factors, including medical reasons for individuals who require frequent use of restraints in an effort to manage maladaptive behavior in the least restrictive manner.

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:** (Note: because this was a baseline review a comprehensive set of documents was reviewed in order to determine where various subject matter specific information may be. The list below displays documents reviewed and are relevant to Section C, D, E, and I of the Settlement Agreement. 1. PMAB Training Curriculum re: restraints 2. Trend Analysis Reports dated 9/09 and 10/09 3. Unusual Incidents Trend Report 11/09 4. UIR review log dated 1/13/10 5. Facility Quality Enhancement Plan 6. Facility Support Performance Indicators (FSPI's) schedule 7. HRC minutes 7/2/09 and 8/20/09 8. Facility Incident Map draft 9. P&P Vol 2 section 8 "Staff Supervision Levels" 10. P&P Vol 3 section 7 "Minimum Staff Training Requirements" 11. CMS 2567 survey completed 10/21/09 12. CMS 2567 survey completed 8/7/09 13. Campus Logs 12/31/09 thru 1/10/10 and 1/12/10 14. Training records for sample of 5 staff 15. Performance Improvement Council minutes Oct/Nov/Dec 09 mtgs 16. FSPI report on Consumer Monies & Personal Effects for 2nd Q FY09 17. FSPI report on Competency Training & Development for 2nd Q FY08 18. DAD's Criminal History Disclosure form 19. Curriculum for Comprehensive Investigator Training 20. UIR 09-262 case file as an example of an OIG closed case 21. DFPS case #34159592 case file as an example of a DFPS closed case 22. UIR 10-050 case file as an example of a closed case with follow-up personnel action 23. UIR 10-025 case file as an example of an allegation made to DFPS that was referred back to the Facility. 24. UIR 10-019 case file as an example of documentation of administrative follow-up. 25. "5 day reports" (ie. ICFMR compliance) for UIR's 10-015, 023, 004, 003, and 017 26. UIR 10-093 preliminary report – recent incident 27. Job description for Facility Investigator 28. Peer to Peer client injury report (Individual #1) 29. Client injury reports for Individual #14, Individual #15, and Individual #16. 30. Sample "Buddy Sheet" for newly hired DCS 31. Sample Job Specific Orientation packet (OJT) for DCS 32. Five completed Demonstration Books for DCS (OJT) 33. Training records for sample of 5 staff

	34. A/N/E Training Curriculum 35. Supt memo to all staff dated 11/9/09 re: A/N/E reporting obligations 36. P&P Volume 2 section 2b re: Unusual Incident Mgt, Allegations of A/N/E, Injuries to Persons Served, Sexual Incidents, and Unauthorized Departures 37. Working document entitled "Ideas for Corrective Actions" 38. Agenda's for Self-Advocacy group (resident council) 1/27/09, 4/28/09. and 6/30/09 39. Quality Systems Oversight Report for habilitation 2009 40. QA monitoring tools for habilitation, medical/nursing, and psychological care 41. Draft Health Status Team policy 42. Sample of documentation for 11 applications of restraint (including Individual #2, Individual #3, Individual #4, Individual #5, Individual #6, and Individual #7) 43. PSP minutes for Individual #17 44. Health Status List dated 1/20/10 45. Texas Department of Aging and Disability Services; State Supported Living Center Policy: Use of Restraint, Policy number: 001, Date 08/31/09, Supersedes: Essential Elements 46. BSSLC's Restraint List of individuals requiring program and emergency restraints. - July 1, 2009 through January 7, 2010 **People Interviewed** (Note: because this was a baseline review people interviewed were queried on a variety of topics that touched on elements of Sections C, D, E, and I of the Settlement Agreement): 1. Director of Quality Enhancement: Kim Littleton 2. Program Specialist Cheryl Powell 3. Psychology Manager: Shawn Cureton 4. Residence Directors Jack Ross, Missy Abston, Susie Johnson, Janet Crane, and Phillip Carnagey 5. DCs 6. Facility Investigator Michael Johnson 7. J. Bret Hood, MD, Director of Medical Services 8. DFPS/APS Regional Director Ross Jackson 9. DFPS/ APS Local Office Supervisor (SD) 10. DCS Home Leader (EE) 11. DCS Home Supervisor (SJ) 12. QMRPs Ann Schrengauer, Dee Dee McWilliams, & Joyce Ward 13. Workers Compensation Coordinator Marla Sams **Meeting Attended/Observations:** 1. Individual Support Plan annual meeting for Individual #17 2. Residence daily morning meeting to review 24 hour log and other issues 3. Two of the daily Incident Management Review Team meetings convened by the Supt 4. One regularly scheduled Human Rights Committee meeting

	Facility Self-Assessment:
	Summary of Monitor's Assessment: Brenham appears to have the essential policies and procedures in place for an effective client protection system; however, all the information is not necessarily clear with respect to what is actually policy and when a particular policy or practice was in effect. There is a great deal of disjointed information that needs to be pieced together into a cohesive document or manual that presents the facility's client protection system. Items 1, 2, & 3 of the SA require the facility to develop and implement policies, procedures, and practices. A document entitled Brenham State School Policy and Procedures Volume 2, section 2b, contains the policies relevant to these topics. While these policies and procedures seem comprehensive they are apparently under review for revisions to ensure SA compliance. In many cases. when team members requested policies and procedures during the review, they were directed to something other than this document.. It should be noted that during the course of ICFMR survey/incident investigation activity the State regulatory agency cited Brenham for client protection deficiencies three times in a six-month period. This was the case in August, 2009, October 2009, and the week this review team was onsite when Brenham received a Condition of Participation citation for three COP's, 1) Client Protection, 2) Healthcare Services, and 3) Governing Body.

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D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	DADS and facility policies address this and state that abuse, neglect, and exploitation are prohibited. Interviews make clear that staff understand their reporting obligations. Future reviews will probe whether staff clearly understand that there is no tolerance for abuse, neglect, and exploitation.	
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:	To confirm the findings of this provision, a larger sample will be reviewed and interviews and observations will be conducted during the first compliance review.	
	(a) Staff to immediately report serious incidents, including but	From review of documents, and from staff interview, no incidents of untimely reporting were identified.	

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	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.		
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	The facility has a practice of always, and immediately, removing an alleged perpetrator from client contact. From reviewing a sample of incident reports it is clear they also take immediate steps to protect individuals in instances of peer-to-peer abuse. The adequacy of whatever steps have been taken is reviewed at the morning unit meetings facilitated by the Residence Director and by the Incident Management Review Team at a daily meeting. Team members observed constructive discussion and modification of client protection measures if warranted.	
	(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	Training records reviewed validate that annual training is occurring. All staff received training on policy updates in December 2009. Staff interview confirmed that staff have a basic understanding of recognizing signs and symptoms of abuse/neglect and staff were able to describe events that would be considered abuse, neglect, and exploitation. It should be noted that these preliminary conclusions are drawn from a small sample and future reviews will need to include a larger, and more representative sample of staff, especially direct care staff and their immediate supervisors.	

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	completion of such training.		
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	All staff interviewed were knowledgeable of their reporting requirements. Some had reported allegations. They were also aware of consequences for not reporting, most often indicating failure to report would result in termination from employment.	
	(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.	This is a subject matter needing more emphasis. The primary method for addressing this topic with correspondents and guardians is by providing them with a pamphlet, and the primary method for addressing this topic with individuals served is through discussion at the annual PSP meeting and at meetings of the Self-Advocacy group (resident council). The facility could not produce minutes of the Self-Advocacy meetings so there was no way to tell how many individuals attend. The topic of abuse was on at least one agenda.	
	(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 required posting was noted; however it could be made more prominent, perhaps by printing it in brightly colored paper. Posting should be prominent and easily noticed. In one instance the notice of how to contact the Xerox repairman was much more prominent than the rights posting. While this was in an office area little things like this can convey the wrong message as to what is really important.	
	(g) Procedures for referring, as appropriate, allegations of	There are referrals made to law enforcement; however, the team did not find any document that set criteria for such referrals beyond the state policy which says "any	

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	abuse and/or neglect to law enforcement.	suspicion of criminal activity" be reported and the requirements of Texas Administrative Code Title 40, rule 7.508 that the head of the facility must report allegations of sexual exploitation. Since every act of physical abuse can be viewed as at least battery or aggravated battery one could take the position that every allegation be reported to law enforcement. This topic bears additional policy discussion.	
	(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.	Every staff person interviewed denied any knowledge of retaliation against reporters, only occasional"talk." DADS policy provides five possible ways to report retaliation. The team will need to probe staff awareness of this policy in future reviews.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	There was no evident process that could be construed as an audit "to determine whether significant injuries are reported for investigation." The adequacy of the definition of a "significant injury" is questionable. "Serious injuries" are defined as those requiring medical attention, however, there can be injuries that do not meet that definition but still warrant investigation for possible abuse or neglect issues. It certainly appears all injuries are reviewed and investigated (from looking at the volume of UIR's and the level of discussion at the morning residence meetings and the Incident Review Team meetings) however there is no audit function that could discover unreported injuries. Data in the Trend Analysis Report lead to a need for further review of classification of injuries as serious. The number of serious injuries (those requiring medical attention) seems extremely low for a facility with over 350 residents, at 3 in October, 2009, 8 in September, 2009, and 2 in August 2009. The average per month for the twelve months displayed on the report is 4.3. Assuming the data are correct, this could indicate extreme vigilance on the part of staff who supervise individuals. It could also indicate that individuals are not engaged in the kind of normal life experiences that inherently expose them to some level of risk of injury. It is also possible that injuries that one would think require medical attention do not get medical attention, or do get medical attention but do not get classified as a serious injury. For instance, the Trend Analysis Report indicates 3 serious injuries in October, 2009. In another section of the report it shows, among other types of injury, 72 instances of abrasion, 14 instances of bites, 57 instances of	

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		bruises/contusions, 3 puncture wounds, and 4 instances of swelling. It would certainly seem logical that all this would have led to more than 3 instances of medical intervention. This will need to be probed deeper in future reviews.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	The Department of Family and Protective Services conducts allegations of abuse. The training their investigators undergo, as described by the Regional Director, is comprehensive, periodic, and thorough. It was noted that the training includes topics related to working with people with developmental disabilities. It is also worth noting that there are specific investigators assigned to Brenham cases that should facilitate thorough investigations as these investigators, over time, become familiar with facility practices and expectations. Investigations of injuries and other incidents are conducted by one of the two facility investigators who have received special training from an outside source. There are also a number of staff, referred to as collaterals, who are available to conduct investigations if a facility investigator is not immediately available. There is no written protocol specific to the facility for investigations done by facility staff.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	Neither DFPS nor the facility investigator indicated any problem with staff cooperating with investigations. Interestingly, the DFPS Regional Administrator commented "not at this facility" noting that not to be the case at some other facilities in his jurisdiction.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	From interviews it is clear that the facility has procedures that enable law enforcement, OIG, and DFPS to conduct their investigations without interference from facility staff.	
	(d) Provide for the safeguarding of	Neither DFPS nor the facility investigator indicated any problems with the safeguarding	

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	evidence.	of evidence. Review of several investigation reports did not indicate any problems in the safeguarding of evidence. However, there is not a policy or procedure that defines safeguarding of evidence, including where evidence is kept and who has access to it, chain of custody, and how evidence is to be gathered.	
	(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.	Current policy allows for a timeline greater than 10 working days however this timeline will change to within 10 calendar days after June 1, 2010. The investigation reports reviewed complied with the timelines in current policy.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a	The DFPS reports reviewed were well organized, presented all the information required in the SA, and drew reasonable conclusions based on the evidence and facts gathered during the investigation. The reports completed by the Facility Investigators were also well organized and logical.	

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	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.		
	(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 Incident Management Review Team performs this function. In observing two of their meetings, participants spent considerable time on report typos and other edits. The process might be better served for this to occur in another smaller forum (there were about 15 people in these IMRT meetings). There was some discussion on substantive issues regarding the events in the report however to a first time observer it appeared the primary purpose of the review was to ensure the final report was well polished.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	There was a report for each unusual incident.	
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	Review of documents, and staff interviews provided evidence that this was occurring. This review did not probe the adequacy of the planned follow-up to correct the situation and/or prevent reoccurrence, whether planned actions occurred, or the actual outcome of the planned actions.	

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	(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.	Interviews did not indicate any problems in this area. At the compliance review, the procedures for access will be reviewed.	
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 Trend Analysis Report referenced earlier is designed to capture the data required in the SA. Our site review was the week of January 11th. The most current Trend Analysis Report was for the month ending October, 2009. If this report is going to be used to analyze organizational performance and as a tool to figure out what needs to improve and how, the report needs to be more timely. The report contains a great deal of potentially useful data. The facility needs to establish a timeframe for its monthly production and hold people who have to provide input data accountable for their piece of the data.	
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	These are routine for newly hired staff. The degrees to which volunteers are subject to the same screening nor whether employees are obligated to report arrests/convictions post employment were not reviewed at this time.	

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

Recommendations:

- Determine how to assemble all the policies, procedures, forms, and training materials that together represent a client protection system into a cohesive and useful document or manual.
- Examine more closely what constitutes "suspicion of criminal activity" for purposes of law enforcement referrals since every act of physical abuse, for example, could be considered as such.
- Examine the system for injury classification (section D2i)
- Establish a written protocol for facility investigations, including safeguarding of evidence.
- Develop an audit system to determine whether all significant injuries are reported
- Develop a stronger mechanism for ensuring guardians, LAR's, and clients are well trained in A/N/E policy.
- Explore an alternative mechanism for the function of editing UIR reports
- Develop a timeframe for production of the Trend Analysis Report that will allow it to be used for timely review and action planning.

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:** (Note: because this was a baseline review a comprehensive set of documents was reviewed in order to determine where various subject matter-specific information may be. The list below displays documents reviewed and is relevant to Section C, D, E, and I of the Settlement Agreement. 1. PMAB Training Curriculum re: restraints 2. Trend Analysis Reports dated 9/09 and 10/09 3. Unusual Incidents Trend Report 11/09 4. UIR review log dated 1/13/10 5. Facility Quality Enhancement Plan 6. Facility Support Performance Indicators (FSPI's) schedule 7. HRC minutes 7/2/09 and 8/20/09 8. Facility Incident Map draft 9. P&P Vol 2 section 8 "Staff Supervision Levels" 10. P&P Vol 3 section 7 "Minimum Staff Training Requirements" 11. CMS 2567 survey completed 10/21/09 12. CMS 2567 survey completed 8/7/09 13. Campus Logs 12/31/09 thru 1/10/10 and 1/12/10 14. Training records for sample of 5 staff 15. Performance Improvement Council minutes Oct/Nov/Dec 09 mtgs 16. FSPI report on Consumer Monies & Personal Effects for 2nd Q FY09 17. FSPI report on Competency Training & Development for 2nd Q FY08 18. DAD's Criminal History Disclosure form 19. Curriculum for Comprehensive Investigator Training 20. UIR 09-262 case file as an example of an OIG closed case 21. DFPS case #34159592 case file as an example of a DFPS closed case 22. UIR 10-050 case file as an example of a closed case with follow-up personnel action 23. UIR 10-025 case file as an example of an allegation made to DFPS that was referred back to the Facility. 24. UIR 10-019 case file as an example of documentation of administrative follow-up. 25. "5 day reports" (ie. ICFMR compliance) for UIR's 10-015, 023, 004, 003, and 017 26. UIR 10-093 preliminary report – recent incident 27. Job description for Facility Investigator 28. Peer to Peer client injury report (Individual #1) 29. Client injury reports for Individual #14, Individual #15, Individual #16. 30. Sample "Buddy Sheet" for newly hired DCS 31. Sample Job Specific Orientation packet (OJT) for DCS 32. Five completed Demonstration Books for DCS (OJT) 33. Training records for sample of 5 staff 34. A/N/E Training Curriculum 35. Supt memo to all staff dated 11/9/09 re: A/N/E reporting obligations 36. P&P Volume 2 section 2b re: Unusual Incident Mgt, Allegations of A/N/E, Injuries to Persons Served,

	Sexual Incidents, and Unauthorized Departures 37. Working document entitled "Ideas for Corrective Actions" 38. Agenda's for Self-Advocacy group (resident council) 1/27/09, 4/28/09. and 6/30/09 39. Quality Systems Oversight Report for habilitation 2009 40. QA monitoring tools for habilitation, medical/nursing, and psychological care 41. Draft Health Status Team policy 42. Sample of documentation for 11 applications of restraint (including Individual #2, Individual #3, Individual #4, Individual #5, Individual #6, and Individual #7) 43. PSP minutes for Individual #17 44. Health Status List dated 1/20/10 45. Texas Department of Aging and Disability Services; State Supported Living Center Policy: Use of Restraint, Policy number: 001, Date 08/31/09, Supersedes: Essential Elements 46. BSSLC's Restraint List of individuals requiring program and emergency restraints. - July 1, 2009 through January 7, 2010 47. BSSLC QA Nursing Audits November through December 2009 **People Interviewed** (Note: because this was a baseline review people interviewed were queried on a variety of topics that touched on elements of Sections C, D, E, and I of the Settlement Agreement): 1. Director of Quality Enhancement: Kim Littleton 2. Program Specialist Cheryl Powell 3. Psychology Manager: Shawn Cureton 4. Residence Directors Jack Ross, Missy Abston, Susie Johnson, Janet Crane, and Phillip Carnagey 5. DCs 6. Facility Investigator Michael Johnson 7. J. Bret Hood, MD, Director of Medical Services 8. DFPS/APS Regional Director Ross Jackson 9. DFPS/ APS Local Office Supervisor (SD) 10. DCS Home Leader (EE) 11. DCS Home Supervisor (SJ) 12. QMRPs Ann Schrengauer, Dee Dee McWilliams, & Joyce Ward 13. Workers Compensation Coordinator Marla Sams 14. Nursing Administrative and Management Staff: Debra Williams, RN, Chief Executive Nurse, Sara Colvin, RN, Nursing Operations Officer, Johanna Nelms, RN, Nursing Educator, Jill Quimby, RN, QA Nurse, Cindy Clay, RN, Nursing Recruiter, Joanne Guard, RN, Infection Control Nurse, Wendy Smith, RN, Hospital Liaison, Nancy Witt, RN, Nursing Shift Supervisor, Leona Sian, RN, Nursing Shift Supervisor, Jim Cloud, RN, Bowie Nurse Manager, Stephanie Hantizel, RN, Driscoll Nurse Manager, Ahonna Engleke, RN, Cottages Nurse Manager, Penny Foerster, RN, Health Center, Brandy Todd, LNV, LVN Manager, Kay Oschner, LVN Bowie, and Torshia Dixon, Bowie Activity Area **Meeting Attended/Observations:** 1. Individual Support Plan annual meeting for Individual #17

	2. Residence daily morning meeting to review 24 hour log and other issues 3. Two of the daily Incident Management Review Team meetings convened by the Supt 4. One regularly scheduled Human Rights Committee meeting
	Facility Self-Assessment:
	Summary of Monitor's Assessment: The facility has many elements of a quality assurance system under development, in place, and/or under review. For example, QA Nursing audits were cross-walked with the SA and HCG. The content appears to be comprehensive, inclusive of all aspects of nursing practice and consistent with compliance issues addressed in these documents. There is clear recognition that the various pieces need to be brought together into a comprehensive set of activities that can produce timely and reliable information, interpret what it means, and use it to organizational change leading to improved performance, compliance with the terms of the SA, and compliance with other regulatory requirements placed on the facility, e.g. ICFMR standards. This will require development of processes for timely production of reports, determination of effective procedures for review and action planning, and systems to ensure that actions are implemented and either effective or revised.

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E1	Track data with sufficient particularity to identify trends across, among, within and/or regarding: program areas; living units; work shifts; protections, supports and services; areas of care; individual staff; and/or individuals receiving services and supports.	There is a tremendous amount of data being collected and ending up in the QA office. The Trend Analysis Report is a good start in producing summary information (for the data items it addresses) to begin to stimulate discussion on what the data means and is telling the senior management about the organization and what might need to change. Note, however, the timeliness issue of the report discussed earlier. QA Reports related to Nursing for November and December 2009 were reviewed. The QA Audit Tools were comprehensive and encompassed all aspects of Nursing Care. They are relatively reflective of the issues identified in the SA and HCGs and in the SA Nursing Monitoring Tools. Many more than 5 audits were completed for each of these months. Items contained in the columns across the top on the page were Yes, No, NA, Comments, and Corrections that can be made. For issues marked "no" only a few contained a comment explaining rationale for the deficiency, and rarely were recommendations made for correction. It was assumed from discussion with the Chief Executive Nurse, Nursing Administrative and Management group that the Chief Executive Nurse or designee would review deficiencies and work with the QA Director to develop a POI for that section. This issue will be reviewed during future tours.	
E2	Analyze data regularly and,	The facility is in its infancy with respect to the development of a QA process including	

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	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.	how to use data to reach conclusions that can lead to corrective action plans that can address systemic issues that continue to emerge. Serious root cause analysis may help in this regard by serving as an in-depth analysis of a particular problem. The root cause analysis form used at the facility was extremely elementary and would not be adequate to fully examine a significant problem This SA Nursing Consultant did not have a copy of the QA Department's overall analysis and summary of deficiencies identified or BSSLC's POI. At the compliance review, the Nursing Consultant will review the facility QA Policy and Procedures to gain an understanding as to how and to whom deficiencies are communicated for correction.	
E3	Disseminate corrective action plans to all entities responsible for their implementation.	From initial review, corrective action plans seem limited to a specific event or action. Those that are put in place were monitored and modified when needed. It should be noted, however, that corrective action plans were not systemic in nature and were nothing complex as one might expect to flow from a comprehensive quality assurance system.	
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.	Corrective actions that are put in place were monitored and modified when needed. It should be noted, however, that corrective action plans were not systemic in nature and were nothing complex as one might expect to flow from a comprehensive quality assurance system. To determine whether systemic corrective actions are being implemented, a larger sample will be reviewed and interviews and observations will be conducted during the first compliance review.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	Corrective actions that are put in place were monitored and modified when needed. It should be noted, however, that corrective action plans were not systemic in nature and were nothing complex as one might expect to flow from a comprehensive quality assurance system. To determine whether corrective actions are effective or are modified on a timely basis, a larger sample will be reviewed and interviews and observations will be conducted during the first compliance review.	

Recommendations:

1. Implement requirements that will enable the Trend Analysis Report to be prepared in a timely manner.
2. Begin the process of establishing a mechanism to figure out what all the data means and how it can be used to drive change/improvement.

3. Explore root cause training that is more thorough and in-depth than what is currently in place. Use it as a mechanism to delve deeply into areas that the trend data suggests needs considerable improvement.
4. Develop a process for all audits, including nursing QA, that identifies items that need to be corrected or addressed, documents the rationale, and states the actions to be taken, by whom, and when. In planning actions, use root cause analysis when appropriate to identify systemic issues that need to be corrected.

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:** All Team members provided information based on their reviews and interviews. **Documents Reviewed:** 1. PSPs: Individual #7, Individual #3, Individual #18, Individual #19 2. Attended Annual PSP Meeting for Individual #20 3. Admission Meeting for Individual #21 4. PSP and Quarterly PSP, reviewed combined sample of 10, per document request, electronically transmitted: Individual #22, Individual #23, Individual #24, Individual #25, Individual #26, Individual #27, Individual #28, Individual #29, Individual #30, Individual #31, Individual #12, and Individual #32 **People Interviewed:** 1. Kori Kelm, Habilitation Therapies Director (Physical Therapist), and Occupational Therapist 2. Shawn Cureton, Psychology Manager 3. J. Bret Hood, Director of Medical Services **Meetings Attended/Observations:** PSP meeting: Individual #19, Individual #20
	Facility Self-Assessment:
	Summary of Monitor's Assessment: Interdisciplinary planning is more than the development of an annual plan at an annual meeting that involves reports from several disciplines. It requires integrated decision making in which the information provided by several disciplines serves as the basis for discussion by all members of the interdisciplinary team. It also involves integrated discussion and decision-making whenever decisions about treatment and care are being made. Although the structure of an interdisciplinary team is in place at BSSLC, most involvement is multidisciplinary, and decisions about treatment are made in a number of different forums. One of the greatest challenges for Brenham will be how it transitions to a more integrated interdisciplinary work process. On the whole, the PST members do not understand the concept of providing integrated services, the need for a comprehensive PSP that gives a good overview of the individuals' total needs, and the ability to provide quality planning that Team members can fully appreciate and implement. They do attempt to discover and meet the preferences and needs of individuals; however, they do not use a fully interdisciplinary process.

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F1	**Interdisciplinary Teams -** Commencing within six months of	Although the structure of an interdisciplinary team process is in place, most involvement is multidisciplinary. That is, different disciplines do separate assessments and decision-	

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	the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:	making, reporting information and decisions but not routinely integrating information to make joint or shared decisions.	
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 PST is facilitated for PSP development by a Team Leader who is a QMRP. However, many decisions are made during other meetings or without active PST involvement. For example, decisions about psychotropic medication are made at the PRT meetings, and the dental staff may make decisions about pre-sedation without PST involvement. It is unclear whether the PST has any process to monitor and revise these treatments and services in between annual meetings. For example, PBSP changes are not made timely based on review of data, and the need for changes does not seem to be brought routinely to the PST.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	The teams consist of the individual and/or LAR or a family member who does not have guardianship, clinicians representing the range of services, and direct care staff. However, Habilitation Therapies (PT, OT, SLP, and RD) have limited to no involvement in the PSP annuals. Per interview, Therapists stated that they only attend PSPs if they are invited however there are no criteria present to guide the QMRP in making the decision as to whether or not therapies are needed at the meeting. Observation will be done at future compliance reviews to determine the extent to which the team participation is dictated by the individual's preferences and needs.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	Some assessments are done routinely, such as DISCUS and MOSES assessments of medication side effects. Others are done annually as part of the PSP process. Others, such as formal preference assessments and functional analyses, are not done. The scheduling of assessments seems connected more to policy (such as requirements for certain assessments prior to PSP meetings) rather than to significant changes in an individual's life. As an example of lack of responsiveness to preferences: At Individual #20's PSP meeting, when asked "What's most important to the person?" Individual #20 replied she would like the Disney Channel. The Facilitator said the Facility did not have that channel. When Miss L. expressed the desire again, the Facilitator simply said "I'll note it", she or the Team made no effort to explore alternative options Individual #20. might enjoy. The Facilitator continued on down her check list and asked what else she likes to do. She said she want her bicycle from home to ride around the campus. Her mother, by phone, said no, she couldn't ride it. The Facilitator and Team made no effort to explore alternatives, perhaps, a three wheeler or a stationary bike or a referral to OT/PT for some other alternatives. There seemed to be no sensitivity expressed by the Facilitator or Team to	

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		explore age appropriate activities this young girl might like to engage in. The Facilitator and other Team members read off her "Objectives" and asked her if she agreed. It was unlikely that she understood the meaning of the word "Objective." They should have used age and intellectual appropriate language that she could understand, or at least, they could have used measures to ensure she understood. However, the Facilitator went on reading down the list. In the above example, there was no interdisciplinary discussion of alternatives or options in activities or objectives. Furthermore, there had been no formal assessments carried out prior to the PSP meeting to identify preferences.	
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.	Although data and information from assessments are regularly available at planning meetings, they frequently are not discussed; instead, they are reported, and a clinician makes a decision. The quality of behavioral and other data are questionable. As data quality improves, this information should be used to guide decisions.	
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).	As described in Section T, PSP development does not generally address barriers to movement to community living other than training or therapy needs of the individual. Goals are not selected with an eye toward the supports available from community living providers. Objections by family members and LARs to plans for movement to community living generally result in no further consideration of how training and support at BSSLC can improve the likelihood of a successful move to community living. However, it appears the PSP responds to those needs in some cases in which movement is likely. This will be monitored during compliance reviews.	
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:	The PSP document includes a plan of treatment. However, it is difficult to follow. There is no single place in which all services and supports to be provided are listed, along with goals and objectives, names of persons responsible, and data to be gathered.	
	1. Addresses, in a manner building on the individual's preferences and strengths,	There are no formal assessments of preference. Barriers are viewed as being issues the person presents (e.g., behavior problems, medical concerns) rather than supports that are currently unavailable or other issues that prevent community living.	

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	each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	By report of the Program Services Director, new vocational and activity programs are in process of development; these are intended to provide more opportunities to meet individuals' preferences and strengths.	
	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;	These are present. However, there is no single place in which all goals, treatments, and strategies are to be found. This makes it difficult to determine whether there are adequate efforts to meet preferences and needs and to overcome barriers to living in the most integrated setting.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	When planning is done, it is generally discipline by discipline rather than integrated. It is unclear that the goals, treatments, and strategies are determined in a manner that integrates them so they complement and build upon each other.	
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Methods are not written in a manner that is clear. Objectives and data to be taken are often defined in ways that do not make reliable implementation and observation likely.	
	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	Although BSSLC provides opportunities for community involvement in both work and leisure, many interventions, strategies, and supports (for example, BPSPs and health care plans) need improvement. This will be a focus of future compliance reviews.	
	6. Identifies the data to be collected and/or documentation to be	Objectives and data to be taken are often defined in ways that do not make reliable implementation and observation likely.	

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	maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the person(s) responsible for the data collection, and the person(s) responsible for the data review.		
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.	There is no single place in which all goals, treatments, and strategies are to be found. This makes it difficult to determine whether there are adequate efforts to meet preferences and needs and to overcome barriers to living in the most integrated setting. It is not clear that all decisions by clinicians (e.g., dental pretreatment sedation) are reflected in the PSP.	
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.	PSPs are accessible in the active record. However, they do not clearly specify the services and supports to be provided and who is responsible. Services are found in various sections of the active record. For example, skill acquisition/ habilitation goals are separate from PBSP goals, which limits the holistic understanding of how these relate to each other. Habilitation Therapy information is referenced in the PSP, however the rationales and descriptions of interventions regarding use and benefit are not clearly integrated into the PSP therefore resulting in an incomplete document that is difficult to understand and not functional for staff or the individual.	
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	From the information above, the lack of understanding for PST members to function in an integrated setting, limits the ability for the Team to look at the individuals in holistic manner and gauge the person's progress, or lack of progress, and make changes when needed in a meaningful way. The information contained in the PSP is too general and non specific.	

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	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.		
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	This will be monitored at a compliance review.	
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its	This will be monitored at the first compliance review.	

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	preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.		
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	Quality assurance processes to identify and remediate problems in PSPs and in the manner in which PSPs are developed and implemented are not evident.	

Recommendations:

- Revise the PSP to clarify the services and supports to be provided. One option is to add a single place in which all services and supports to be provided are listed, along with goals and objectives, names of persons responsible, and data to be gathered.
- The Facility should train or retrain all PST members in the concept of providing integrated service within a developmental disability setting.
- The Facility should make efforts to foster a culture of integrated planning and service delivery.
- Begin to develop quality assurance process to identify and remediate problems in PSPs and in the manner in which PSPs are developed and implemented. These should not focus only on the paper (that is, on the plans) but also on whether they are developed through interdisciplinary planning, whether implementation includes competency-based staff training, whether interventions are implemented regularly and accurately, whether effectiveness is being monitored, and whether revisions are made as needed.

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:** PSPs, CLDPs, and other documents reviewed by members of the monitoring team, as identified in sections below. **People Interviewed:** Interviews with various discipline staff by the members of the monitoring team, as identified in sections below. **Meetings Attended/Observations:** PSP, PRT, and other meetings attended by members of the monitoring team, as identified in sections below.
	Facility Self-Assessment:
	Summary of Monitor's Assessment: As indicated in Section F, clinical services are generally provided in a manner that meets the standards of different disciplines, but planning and monitoring of these services is not routinely done in an interdisciplinary manner. There are numerous meetings in which several disciplines participate. At those meetings, they routinely report their assessments and their plans. In some cases, the PST may have the authority to agree or disagree with those plans. In other cases, a clinician may make decisions about treatment. However, there is no process to draw together all the assessments and make treatment decisions in an interdisciplinary manner.

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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.	There are numerous meetings in which several disciplines participate. At those meetings, they routinely report their assessments and their plans. In some cases, the PST may have the authority to agree or disagree with those plans. In other cases, a clinician may make decisions about treatment. However, there is no process to draw together all the assessments and make treatment decisions in an interdisciplinary manner. For example, MOSES and DISCUS were completed by RNs and signed-off by physicians.. However, it was not clear how this information was utilized in prescribing and managing antipsychotic medications or that there was interdisciplinary involvement in making those decisions. Similarly, the psychologists are not involved in planning for programs to reduce the need for dental pretreatment sedation, although they may be involved in preparing PBSPs targeting behaviors that may lead to the need for pretreatment sedation.	

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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.	This will be monitored at the first compliance review. Based on interviews, this varies across disciplines. However, there is no formal process or guidelines to determine when to refer for PST review of recommendations.	

Recommendations:

- Begin to review both the membership of groups that meet to review status of individuals and of their process to ensure interdisciplinary discussion and decision-making. This is a long-term process. It should not result in additional meetings but instead should result in meetings that spend less time on reports and more time on planning.
- Establish a process and guidelines for referral of recommendations from non-Facility clinicians to the PST.
- Develop and implement policy and procedures for review and decisions regarding recommendations from non-Facility clinicians.

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:** PSPs, CLDPs, and other documents reviewed by members of the monitoring team, as identified in sections below. **People Interviewed:** Interviews with various discipline staff by the members of the monitoring team, as identified in sections below. **Meetings Attended/Observations:** PSP, PRT, and other meetings attended by members of the monitoring team, as identified in sections below.
	Facility Self-Assessment:
	Summary of Monitor's Assessment: Further monitoring will need to be done to determine whether clinical services meet current standards. It appears that many disciplines carry out some activities in a manner that meets current standards, but that most or all disciplines show areas in which services do not meet current standards.

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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.	In general, assessments or evaluations are performed on a regular basis. It is less clear whether they are performed in response to developments or changes in an individual's status. To determine whether they are performed in compliance with this Agreement, a larger sample will be reviewed and interviews and observations will be conducted during the first compliance review.	
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of	This was not reviewed during the baseline visit.	

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	Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.		
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	This remains variable across disciplines, as seen in the sections below. For example: The recent improvements made in the revision of the Nursing Policy and Procedure Manual and monitoring tools the Nursing Department have made and continue to improve will no doubt show improvements in future tours. PBSPs are not based on functional assessments meeting current standards. PNMPs and Dining Cards have been developed for all individuals residing at BSSLC however the PNMPs are felt to be inadequate as the risks associated with oral hygiene and oral medication are not addressed in the current format.	
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	This is variable across services and disciplines. In most cases, elements of selection of appropriate clinical indicators are present but not complete. For example, data are identified on target behaviors in PBSPs, but there is no indication that reliability and accuracy of data recording is evaluated. Also, while nursing clinical services meet professional standards of practice for an acute health care setting, e.g., hospital, emergency room, outpatient setting, practice appears to have been driven by Physician's Orders. However, recently the Nursing Administration and Management staff have been working with Statewide work groups to develop Policies and Procedures applicable to working within the framework of an integrated setting, exercising more independent clinical nursing judgment for assessments, interventions and planning in serving individuals with developmental disabilities. They are developing POI's consistent with the SA and HCG. As their Nursing Services incorporate the new changes in practice, future tours should reflect these efforts.	
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	The recent improvements made in the revision of the Nursing Policy and Procedure Manual and monitoring tools the Nursing Department have made and continue to improve will no doubt show improvements in future tours.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two	There are numerous opportunities for review and modification of interventions. There are regular PRTs, for example. It is sometimes unclear whether modifications are based on clinical indicators reported at those reviews. Monitoring of frequency and	

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	years, treatments and interventions shall be modified in response to clinical indicators.	appropriateness of modifications will be done at compliance reviews.	
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.	Although the State has developed a number of policies related to this section, that process is continuing. BSSLC needs to develop facility policies to operationalize the state policies.	

Recommendations:
Clinical staff should cross-walk the SA and HCG and continue to revise and implement policies and procedures, oversight, and training to ensure compliance.

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:** (Note: because this was a baseline review a comprehensive set of documents was reviewed in order to determine where various subject matter-specific information may be. The list below displays documents reviewed and is relevant to Section C, D, E, and I of the Settlement Agreement. 1. PMAB Training Curriculum re: restraints 2. Trend Analysis Reports dated 9/09 and 10/09 3. Unusual Incidents Trend Report 11/09 4. UIR review log dated 1/13/10 5. Facility Quality Enhancement Plan 6. Facility Support Performance Indicators (FSPI's) schedule 7. HRC minutes 7/2/09 and 8/20/09 8. Facility Incident Map draft 9. P&P Vol 2 section 8 "Staff Supervision Levels" 10. P&P Vol 3 section 7 "Minimum Staff Training Requirements" 11. CMS 2567 survey completed 10/21/09 12. CMS 2567 survey completed 8/7/09 13. Campus Logs 12/31/09 thru 1/10/10 and 1/12/10 14. Training records for sample of 5 staff 15. Performance Improvement Council minutes Oct/Nov/Dec 09 mtgs 16. FSPI report on Consumer Monies & Personal Effects for 2nd Q FY09 17. FSPI report on Competency Training & Development for 2nd Q FY08 18. DAD's Criminal History Disclosure form 19. Curriculum for Comprehensive Investigator Training 20. UIR 09-262 case file as an example of an OIG closed case 21. DFPS case #34159592 case file as an example of a DFPS closed case 22. UIR 10-050 case file as an example of a closed case with follow-up personnel action 23. UIR 10-025 case file as an example of an allegation made to DFPS that was referred back to the Facility. 24. UIR 10-019 case file as an example of documentation of administrative follow-up. 25. "5 day reports" (ie. ICFMR compliance) for UIR's 10-015, 023, 004, 003, and 017 26. UIR 10-093 preliminary report – recent incident 27. Job description for Facility Investigator 28. Peer to Peer client injury report (Individual #1) 29. Client injury reports for MD, DS, and CH. 30. Sample "Buddy Sheet" for newly hired DCS 31. Sample Job Specific Orientation packet (OJT) for DCS 32. Five completed Demonstration Books for DCS (OJT) 33. Training records for sample of 5 staff 34. A/N/E Training Curriculum 35. Supt memo to all staff dated 11/9/09 re: A/N/E reporting obligations 36. P&P Volume 2 section 2b re: Unusual Incident Mgt, Allegations of A/N/E, Injuries to Persons Served,

	Sexual Incidents, and Unauthorized Departures 37. Working document entitled "Ideas for Corrective Actions" 38. Agenda's for Self-Advocacy group (resident council) 1/27/09, 4/28/09. and 6/30/09 39. Quality Systems Oversight Report for habilitation 2009 40. QA monitoring tools for habilitation, medical/nursing, and psychological care 41. Draft Health Status Team policy 42. Sample of documentation for 11 applications of restraint (including Individual #2, Individual #3, Individual #4, Individual #5, Individual #6, and Individual #7) 43. PSP minutes for Individual #17 44. Health Status List dated 1/20/10 45. Texas Department of Aging and Disability Services; State Supported Living Center Policy: Use of Restraint, Policy number: 001, Date 08/31/09, Supersedes: Essential Elements 46. BSSLC's Restraint List of individuals requiring program and emergency restraints. - July 1, 2009 through January 7, 2010 47. BSSLC QA Nursing Audits November through December 2009 **People Interviewed** (Note: because this was a baseline review people interviewed were queried on a variety of topics that touched on elements of Sections C, D, E, and I of the Settlement Agreement): 1. Director of Quality Enhancement: Kim Littleton 2. Program Specialist Cheryl Powell 3. Psychology Manager: Shawn Cureton 4. Residence Directors Jack Ross, Missy Abston, Susie Johnson, Janet Crane, and Phillip Carnagey 5. DCs 6. Facility Investigator Michael Johnson 7. J. Bret Hood, MD, Director of Medical Services 8. DFPS/APS Regional Director Ross Jackson 9. DFPS/ APS Local Office Supervisor (SD) 10. DCS Home Leader (EE) 11. DCS Home Supervisor (SJ) 12. QMRPs Ann Schrengauer, Dee Dee McWilliams, & Joyce Ward 13. Workers Compensation Coordinator Marla Sams **Meeting Attended/Observations:** 1. Individual Support Plan annual meeting for Individual #17 2. Residence daily morning meeting to review 24 hour log and other issues 3. Two of the daily Incident Management Review Team meetings convened by the Director 4. One regularly scheduled Human Rights Committee meeting
	Facility Self-Assessment:
	Summary of Monitor's Assessment: The system for identifying individuals who are at risk and why, and to plan, implement, and monitor

	measures to put in place to reduce risk for these individuals, is rudimentary. This item was difficult to assess due to the way individuals are assessed for risk. State policy identifies people whose risk is being managed effectively as medium risk, even if significant resources are needed on a consistent basis; even so, many of these people are rated as low risk due to a perception that the expectation is to have fewer people at higher risk levels. For example, if an individual had a choking episode, the immediate risk level would be elevated to high. However, once the acute phase is resolve, according to this method, BSSLC then lowers their risk to medium or low. It seems that this is a matter of facility/staffing convenience because if the individual remained classified as high risk (as is the usual practice), the individual would require weekly monitoring. This type of risk classification system is not functional or useful to the clinicians or the individuals living at BSSLC. DADS should review and revise the risk management policy. Brenham SSLC will then need to develop facility policy to operationalize state policy. Staff will then need training and support so that appropriate risk levels and actions to address risk are appropriately identified.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	A system is in place; however it lacks criteria, relies too heavily on "clinical judgment", and results in what appears to be far too few people being identified as high risk. Thorough review of the "At Risk" policy revealed two main issues. One was that the Center was incorrectly following the policy as BSSLC was placing the majority of their individuals as being at "low risk" when they should have been placed as at "medium risk". Second, the policy as written is flawed in its ability to identify those who are at a "high risk" of physical and nutritional decline, injuries due to behavior problems, or other areas of risk. In its current state, the policy identifies individuals as being at "High Risk" if they are having an acute issue, "Medium Risk" if they require ongoing supports (i.e., a PNMP), and "Low Risk" if they do not require supports. For people with dysphagia, following the policy as written would result in BSSLC having their entire population with the exception of the 4 "High Risk" listed as "Medium Risk" since the remaining individuals have PNMPs. This type of risk classification system is not functional or useful to the clinicians or the individuals living at BSSLC. Similar concerns are found related to polypharmacy, behavior problems, and other issues. Interviews indicated that some clinicians perceive that the risk levels they identify are changed on the risk form following interdisciplinary review. Although the interdisciplinary review may appropriately result in such a change, there should be a means to document the original recommendations.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an	Because the identification of risk level is so problematic and does not adequately respond to changes in an at-risk individual's condition, review of the assessment process was not done.	

#	Provision	Assessment of Status	Compliance
	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.		
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.	Although there were many actions taken to address risks for individuals, including preventive interventions, these were not addressed through a systematic risk assessment and management process. Because the identification of risk level is so problematic and does not adequately respond to changes in an at-risk individual's condition, review plan implementation was not done.	

Recommendations:

- The Risk Policy should be reviewed and revised by the State and Facilities.
- DADS should clarify to Brenham SSLC the expectation that risk levels should be identified as dictated in policy until the policy is revised.
- The State should consider using nationally recognized standardized risk assessment tools and standards.
- After the Risk Policy is revised, an audit system should be put into place to monitor appropriateness of risk levels and of the actions taken to address higher levels of risk.

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. Review of requested tour documents 2. Policy and Procedures reviewed: Volume 4.1A General Health Care; 4.Ib Physician Health Care; 4.2 Nursing; 4.4 Pharmacy; 4.7 Dental; 4.11 Infection Control; 4.14 Medical/Dental Restraint; State Supported Living Center Policy: Use of Restraint; Informed Consent. 3. Comprehensive record reviews of 7 individuals (Individual #19, Individual #33, Individual #3, Individual #20, Individual #34, Individual #35, Individual #36) 4. Partial Record Reviews: about 20 individuals being reviewed in PTR's, Individual #37, Individual #8 5. Medication pretreatment records for procedures Individual #38, Individual #39, Individual #40, Individual #41, Individual #25, Individual #43, Individual #44, Individual #16, Individual #45, Individual #46., Individual #47, Individual #48 **People Interviewed:** 1. J. Bret Hood, Director of Medical Services 2. Psychiatrists: Victoria Morgan, Reeba Chacko, 3. Psychology Manager: Shawn Cureton 4. Psychologists: "All hands" group discussion with Department of Psychology members. 5. Informal discussions with several RNs and QMRPs. **Meeting Attended/Observations:** 1. Locations visited: Living areas in Cottages and Fanin. 2. Meetings attended: a. PTR (Dr. Reeba Chacko); PTR follow-up (Dr. Morgan); b. PSP meeting – Individual #20 3. Committee meetings attended: Human Rights Committee; Facility Behavior Support Committee
	Facility Self-Assessment:
	Summary of Monitor's Assessment: The 15 items listed in the Settlement Agreement (SA) cluster into four general areas. SA items J1, J2, J5, J6, J11 and J15 address issues which are closely linked to the work of Brenham's two psychiatrists. Brenham is fortunate to have Drs. Morgan and Chacko on the staff. Both are dedicated, energetic, and well qualified professionals. Nonetheless, the SA presents some new challenges for their work, and identifies several areas of professional responsibility that are currently receiving limited attention. The Brenham senior leadership would be well served by a review of the allocations of available psychiatric time, and the leadership needs to assure that all required areas of professional psychiatric activity receive adequate attention.

	SA items J4 and J7 address required functions that are either not currently in place (the use of the Reiss screen) or that are receiving only limited attention (the requirements around the use of pretreatment sedation). The fact that the Reiss screen has not yet been introduced offers Brenham the opportunity to consider carefully the manner in which screening for psychopathology will be used and the results integrated in a meaningful way into the PST process. More broadly, one of the greatest challenges for Brenham will be how it transitions to a more integrated interdisciplinary work process. Compared to other areas outlined below, the incorporation of the Reiss screen into the routine work of the PST is a relatively simple matter. Its introduction can serve as a pilot and model of sorts for other more complex transitions that are needed in the interdisciplinary process and success in its introduction will hopefully serve as positive catalyst toward continued improvement of the PST process. SA items J3, J10, J13, and J14 largely address the area of the use of psychotropic medications. This is an area in which there are many deficiencies in the current process at Brenham. There was little evidence of organized treatment plans for psychotropic medications. There were traces of this process, such as rudimentary consent forms and the psychiatrist's thoughts on the use of medication, embedded in the process notes. There was little evidence of substantive contributions by psychology or other disciplines, and an organized process for developing comprehensive plans for the use of psychotropic medications was not evident. The above notwithstanding, the need for medication plans is accepted, well qualified personnel are available to address those needs, and the end product is both specific and well delineated by the settlement agreement, All this provides for a clear roadmap for the path ahead. The overall process of developing, implementing, and reviewing medication needs and plans needs to be considered as a whole. Thought should be given regarding where various required elements should be embedded in the work process – see for example item J10 - since various viable options are available. SA item J8, to some extent in conjunction with SA J9 and J12, represents the most challenging – and potentially most rewarding - aspect of the process which lies ahead for Brenham: the process of transforming the nature of the work of the behavioral health team via a more integrated and combined interdisciplinary process. For example, SA item J8 is explicit in requiring that pharmacological treatments will be based on combined assessment and case formulation. This cannot be done within any given clinical discipline; it can be done only through true interdisciplinary process. In the current work process, each discipline works fairly independently, up to and including the level of annual evaluations. This leads to faulty work products, less than optimal treatment plans, and likely suboptimal treatment outcomes. As outlined in the specific notes below, the process needs to be built into the ongoing team structure (such as the PTR meetings). It is difficult to monitor the success of integration with a set of checklists. It is perhaps possible to mandate and monitor who participates in meetings, but not whether the right collegial process takes place. In the end, successful integration will be most evident in the final quality of the work product, translated out to good quality of care. Brenham would be well served by carefully considering its overall work process. It can do so via examination of the various meetings attended by the various clinical disciplines. Using the clinical process as a guideline, Brenham should identify who is needed and at which meetings, in order to provide for good interdisciplinary process. At some meetings observed by the team, it was unclear if the work process was impaired by the presence of too many people, or perhaps that the

	meeting did not bring together the best cluster of professionals. Other meetings, for example the Facility Behavioral Review Committee, seemed underutilized. Such a committee seems to be an appropriate place for final review by the senior clinical leadership, but such review was lacking. As a general matter, the senior leadership at Brenham might consider a careful review of the overall work structures and processes. One option might be to conduct parallel "bottom up" and "top down" examinations of the flow of clinical information through work structures and processes.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	The SA mandates that psychiatric services will be provided only by qualified professionals. Psychiatric services at Brenham are currently provided by Drs. Victoria Morgan and Reeba Chacko. Dr. Morgan completed her psychiatric training in 1998 and has been in clinical practice since that time. She has been board certified in adult psychiatry since 2002. Dr. Morgan has been on the staff at Brenham since November 2008, working four days per week as a staff psychiatrist (0.8 FTE). Prior to coming to Brenham Dr. Morgan worked for one year at Rusk State Hospital on a unit supporting individuals with intellectual disability. Accordingly, Dr. Morgan has about twelve years of overall clinical experience, and two years of experience working with individuals who have both an intellectual disability and mental health needs. Dr. Chacko completed her psychiatric training in 1989 and has been in clinical practice since that time. She has been board certified in adult psychiatry since 1990, and board certified in child and adolescent psychiatry since 1992. Dr. Chacko has been on the staff at Brenham since 1998, working one day per week as a consulting psychiatrist (0.2 FTE). Accordingly, Dr. Chacko has over 20 years of overall clinical experience, and twelve years of experience working with individuals who have both an intellectual disability and mental health needs. Based on review of Dr. Chacko's and Dr. Morgan's backgrounds and experience, interviews of each psychiatrist in person, and observation of each of psychiatrist in her clinical work with individuals who live at Brenham and of the work of each psychiatrist in her work with the PST, Brenham is fortunate to be supported well by the work of two hard working and well qualified psychiatrists.	
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	The SA agreement requires that the psychiatrist will have evaluated and diagnosed, in a clinically justifiable manner, all individuals receiving psychotropic medications. The SA, per item 6 below, is explicit in providing guidance for a very detailed mental status examination. As a general matter, the use of DSM IV diagnostic criteria in the diagnosis of individuals with intellectual disabilities presents additional challenges, even for	

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	psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	clinicians with sub-specialty training. In this regard, it was good to see Dr. Morgan's use of the DMID, an appropriate dual diagnosis subspecialty tool, in her clinical work. To meet the requirements of item J2, one needs the services of well qualified individual psychiatrists, and for those psychiatrists to have adequate time for clinical examinations, and time for reflection and consultation with colleagues. Perhaps for reasons of staff time availability for these functions – see item J5 below – some of the records reviewed did not contain clinical psychiatric evaluations which documented clinical evaluations and clinical diagnoses which fulfilled the requirements of this item. For example, some evaluations lacked clarity regarding the particular reasons for the assigned diagnosis or diagnoses. It would be wise for the Brenham psychiatrists to examine closely SA Appendix B and over time – perhaps over the course of a cycle of the annual examinations - to (re) examine the records of each individual supported in order to assure that the requirements of item J2 are met. The compliance review will include determining whether requirements of item J2 are observed prospectively, as admissions of new individuals to Brenham take place (see also item J7).	
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.	Reviews of clinical records for appropriate use of psychotropic medications revealed many difficulties. Generally, one looks for concordance between the diagnosis and psychotropic medication, a specific behavioral pharmacological hypotheses leading to a rationale for medication use, evidence of integration and coordination between clinicians from psychology, nursing and medicine and others, the presence of an integrated medication plan (details of which are outlined in item J13 below), and inclusion of the overall results of this process in a master problem list, which identifies the problems that are a focus for treatment. While all records reviewed contained elements of the above, few contained well articulated and comprehensive explanations for the use of the psychotropics. For example, in several records a particular medication was listed as being attributed to different diagnoses by clinicians from different clinical disciplines. In one record the informed consent form listed different behavioral targets for treatment than were discussed in by the psychiatrist in her notes. In several records there were no details regarding the planned duration of treatment with psychotropic medications, no criteria for success/failure, no documentation of progress or lack of progress toward measurable goals, and so forth. If these SA requirements are considered together, it should be possible to develop a process at Brenham which makes clear what the treatment team is expecting from medication and on what basis, what exactly will be done, how will the results will be assessed, and eventually what the results were, and the manner in which these results contributed to refinement of further treatment. Documentation regarding these issues need not be extensive, but it needs to be clear, transparent, and to contain the needed clinical elements.	

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		In 13 of 13 records reviewed (Individuals #3, 6, 9, 10, 12, 19, 20, 27, 30, 33, 50, 51, and 52), psychotropic medication was the primary emphasis of treatment regardless of the proposed cause, function or topography of the intervention target. In these 13 records, treatment review procedures consistently emphasized psychotropic medication changes in response to changes in behavior. • In 0 of 13 records reviewed was a behavioral intervention revised or replaced between annual PSP reviews as a result of changes in the intervention target. • In 13 of 13 records, the psychotropic drug regimen was altered at least once in response to changes in the intervention target between annual PSP reviews. • In 0 of 13 records reviewed, the PBSP integrated the treatment or monitoring of a diagnosed mental illness with behavioral interventions. In addition, the use of psychotropic medication was often represented in the record as based upon subjective opinion rather than empirical evidence or support in the current professional literature. • In 11 of 13 PBSPs, the use of psychotropic drugs was not clearly based upon a diagnosis of a mental illness for which psychotropic drugs are supported as being beneficial or effective. • In 0 of 13 records were behaviors targeted for intervention via psychotropic drugs provided with operational definitions or behavioral correlates. • In 0 of 13 records was there an indication of formal assessment of psychopathology using instruments designed for use with people with intellectual disabilities. • In 0 of 13 records were behavioral correlates or analogs of DSM symptoms, derived by a formal, valid and reliable assessment process, identified or used to assess psychotropic drug efficacy.	
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	The monitoring team found significant difficulties at Brenham in regard to this item. This was not limited to apparent failures to meet the requirements of the SA. In informal conversations several Brenham staff members expressed surprise at the notion that it is a good idea to minimize or eliminate the need for pretreatment sedation. The general guidance in this matter is that an individual with a disability should not, as a matter of routine, be provided different treatment for a given procedure that would be provided for non-disabled individuals. Accordingly, if an individual needs medication pretreatment for a routine procedure which typically would not require such pretreatment sedation, the appropriate clinicians on the PST should consider why this is so, and they should consider whether such an individual has an underlying psychological (or medical) difficulty which could/should be treated, so as to avoid the need for pre-treatment sedation.	

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	including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	There are no procedures in place for due consideration of the above matters by the interdisciplinary treatment teams. The psychology department may be informed that an individual should be sent for desensitization because he/she needs pre-sedation, but it did not appear that these matters were reviewed by the broader PST. In terms of current specifics, we could locate only a list of individuals referred for desensitization, verification that pro-forma informed consent for medication was being obtained, and an acknowledgment that required procedures to meet the SA requirements are lacking. The language of the SA is specific not only about coordination with various clinical services and supports via the clinical team, but also about the need for clinical monitoring and assessment of the individuals receiving pretreatment sedation. To remedy the situation, there should be a transparent process by which appropriate clinicians meaningfully discuss the needs of the individuals deemed to need pretreatment sedation in those deliberations the clinicians should jointly decide what is needed to support the individual	
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	There are currently over 230 individuals who live at Brenham who receive behavioral support services, and many of these individuals receive psychiatric medications. The combined time of the two psychiatrists at Brenham is 40 hours per week. Given the requirements of the SA, this is a heavy case load; Brenham is seeking an additional full time psychiatrist to join the staff. The current situation is a vast improvement over the situation prior to Dr. Morgan joining the staff., when Dr. Chacko supported the psychiatric needs of all Brenham residents with one day per week of service. Current improvements notwithstanding, there are deficiencies in allocation of available psychiatric time. For example, the position description for Dr. Morgan (psychiatrist III) designates the position as a lead psychiatrist, and specifies managerial duties which should include facility wide review of services. For example, facility wide reviews are needed for the monitoring of polypharmacy, for utilization of psychopathology screening tools, for the monitoring of overall rates of dyskinesia, for matters of facility wide reviews on issues such as appropriate use of laboratory testing, and for facility wide monitoring of specific medication guidelines outlined in the Health Care Guidelines. Information about the particular case loads of the two psychiatrists was not readily available. A question about who was responsible for matters of facility wide reviews was not answered clearly, and it is not clear that needed facility-wide psychiatric functions are being performed. As a general matter, psychiatric leadership will be needed as Brenham moves forward to develop the needed internal systems and procedures which will allow the facility to satisfy the requirements of the various items in the SA and Health Care Guidelines documents. Careful time management analysis of psychiatrist's caseloads and	

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		responsibilities will assure that individuals living at Brenham continue to receive excellent clinical care, while at the same time addressing the needed clinical/administrative leadership functions in a timely manner.	
J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	The SA is explicit about the need for the psychiatrist to be guided by appendix B in evaluation specifics. At the time of our visit to Brenham Dr. Morgan had not been provided with a copy of that document. To facilitate more rapid adoption of the outlined requirements, Dr. Sherer provided Dr. Morgan with a copy of that document and briefly reviewed its contents. Whether the intervention chosen is pharmacologic, behavioral or any other treatment modality, all intervention targets require operational definitions. The development of these operational definitions is a function of the formal assessment of psychopathology and behavior, and must be supported by valid and reliable data. Identification of behavioral correlates of diagnosed mental illness and of possible behavioral function was not routine, as evidenced by: • 0 of 12 individuals prescribed psychotropic medication for a diagnosed mental illness received a formal assessment of the symptoms involving functional assessment tools and psychopathology assessment instruments developed for people with intellectual disabilities. • 0 of 12 individuals prescribed psychotropic medication for a diagnosed mental illness had operational definitions of the psychopathology that included behavioral correlates or analogs for the symptoms. • 0 of 13 individuals received assessment of psychopathology and behavior in order to differentiate between biological symptoms of a mental illness and operant behavior.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility	At the present time the Reiss Screen is not in use at Brenham. Its use is mandated as a psychopathology screen for use with new admissions, and also for use in screening for individuals who do not currently receive, but might be in need of, fuller psychiatric assessment and treatment. One place where one might prioritize its use is with individuals living at Brenham who receive pre-treatment sedation, but who are not currently identified with psychopathology which could predispose those individuals to needing pre-treatment sedation. I would encourage inclusion of psychiatry in the discussions about how to use the Reiss screen results in the best manner throughout Brenham and the manner in which results will be brought, as needed, into the clinical PST process.	

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	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.		
J8	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop and implement a system to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation.	The SA is explicit in requiring integration of medication treatment through combined assessment and case formulation. In the current structure at Brenham the place where the clinical disciplines – although not medicine – come together routinely is at the PTR meeting. Elements of the needed interdisciplinary process were evident during my visits to several PTR meetings, but full collaboration per the mandate cited above was not evident. For example, at PTR meetings there was considerable discussion between the psychiatrist and psychologist, but that discussion took on the character of information gathering, rather than peer-to-peer substantive collegial discussion. Nurses participated in the meetings, but did not step forward to offer information available only to their discipline. MOSES and DISCUS screens were present in the clinical record, but the information obtained from them was not discussed by the professionals in attendance. The lack of integration was particularly evident regarding medication plans (see more detail in item J13, below). In the absence of clear medication plans there were discussions in which the psychiatrist provided clinically meaningful information about the purpose of use of medication, but the psychiatrist's description of the medication differed significantly from information in the record regarding the designated purpose of the medication. Thus, Individual #49 is diagnosed with Autistic Disorder and Bipolar Disorder. In the tracking by the pharmacy (and hence listed on the medication orders) Zyprexa is linked to autism. In the 03-25-09 Annual Medical Assessment, however Zyprexa is linked to Bipolar disorder. Both are actually reasonable, but the resulting difficulties for monitoring the efficacy of Zyprexa treatment are obvious. In a few clinical discussions I witnessed, such lack of clarity at times lead to reduction of input from psychology to simple reports of frequency/severity of broad and non-specific parameters such as aggression and self injury. In many ways, the best way to move the integration process forward may be via the development of the integration of medication use with behavioral tracking. If the psychiatrist is called upon to be clear about the rationale for medication use and the general expected result, the psychologist can then be required to provide expert advice on the particular scales/tools/items needed to best monitor progress. Success in this area can then be used to model broader collaborations.	

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J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	The SA is explicit about three required steps. First, that the PST, including the psychiatrist, will evaluate and identify the least intrusive and most positive interventions with which to treat the underlying condition. Documentation of such discussion was not found in the active records reviewed. Second, the SA requires that the PST consider and determine whether medications, behavioral interventions, or other interventions (or some combination of these) are the preferred treatment. Documentation that the PST had done so was not found in the active records reviewed. Third, the SA requires that psychotropic medications should not be used alone, and that other non-pharmacological options should be used to minimize the use of medication to the extent possible.	
J10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, before the non-emergency administration of psychotropic medication, the IDT, including the psychiatrist, primary care physician, and nurse, shall determine whether the harmful effects of the individual's mental illness outweigh the possible harmful effects of psychotropic medication and whether reasonable alternative treatment strategies are likely to be less effective or potentially more dangerous than	Documentation of a risk benefit analysis per the assessment of the PCP, psychiatrist and nurse was not found in active records. In the records reviewed, documentation could not be consistently found of determination that alternative treatment strategies were likely to be less effective or potentially more dangerous that the medications. The question of how to include (and document) these considerations in the clinical process might be undertaken alongside a similar review of requirements of item J13, below.	

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	the medications.		
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	Current procedure at Brenham is that a review of polypharmacy is done by the pharmacy department on a quarterly basis and then forwarded to the physicians for review/signature. Brenham provided lists of individuals living at Brenham who receive polypharmacy, and details of that polypharmacy. All records reviewed contained the reviews, which were quite comprehensive. The reviews lacked, however, a clear statement about the rationale for the polypharmacy.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	In the limited records reviewed on clients taking psychotropic or other medications with the potential to cause side effects, there was evidence that the validated rating instruments MOSES and DISCUS were completed by RNs and signed-off by physicians. A DISCUS was completed every three months for individuals on antipsychotics and a MOSES every six months for individuals who are on antianxiety, antipsychotic, antidepressants, stimulants, mood stabilizers, sedatives/hypnotics and/or anticonvulsants. However, the results for MOSES and DISCUS assessments were not consistently documented in individuals' Annual or Quarterly Nursing Assessments, nor are individuals' response to antipsychotic or other related medications or potential side effects listed. Physicians, nurses, and others review side effects prior to the meetings, based on clinical need. While the nurse rating scales were done consistently, discussion of the results did not regularly occur in the PTR or other clinical meeting. Information from interviews identified that responses for difficulty included dose reduction, substitution of another medication, or the use of side effect medications. There may be a discrepancy between the requirements of the SA and of the HCP relating to the frequency these assessments are to be completed. The SA, N., 5., requires, "…the Facility shall ensure quarterly monitoring and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskenesia." The HCGs, III., C., 1., g., 3), states, "Tardive dyskinesia screening to include DISCUS immediately prior to initiating therapy as a baseline and every three months during treatment and for six (6) months following discontinuation of a neuroleptic medication.	

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		The MOSES will also be completed every (6) months." In order for the SA Consultants to accurately monitor this item, there needs to be clarification as to frequency these assessments are to be completed. Nursing Care Plans (HMPs) were not consistently developed with individualized goals and interventions to meet the individuals' needs, including interventions for specific side effect monitoring by staff and referenced behavioral interventions outlined in the Behavior Plan.	
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 efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.	The SA explicitly requires that the treatment plan for psychotropic medication(s) should include several items including a specific hypothesis for treatment, the expected timeline for benefits, the objective symptoms or behavioral characteristic that will be monitored to assess treatment efficacy, and by whom, when, and how, such monitoring will occur. Such plans have yet to be developed at Brenham.	
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	Informed consent forms were typically found in the records. At minimum, consent forms should include or show that information was provided to the individual and LAR about diagnosis, purpose of the use of medication, expected benefits and side effects.	

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	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.		
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	Dr. Morgan attends scheduled neurology clinics on campus and is available to discuss cases with the neurological consultant. In many cases such reviews are particularly helpful, since many of the medications used for seizure control are also used for psychiatric indications. There are many times when several good choices of medications are available for the neurologist who is selecting an anticonvulsant, some of which might be beneficial for the psychiatric issues for which the individual is treated, and some of which might be likely to have untoward psychiatric effects, particularly in the case of vulnerable individuals. No formal arrangements are in place for Dr. Chacko to review cases with the neurologist, and it would be helpful to think about ways in which her work as a part time consultant could nonetheless benefit from collegial interactions with the neurologist, perhaps even over the telephone.	

Recommendations:

- The BSSLC position description for a lead psychiatrist specifies managerial duties, which should include facility wide oversight of psychiatric services. Among other things, facility wide monitoring is needed for the use of psychotropic medications generally and polypharmacy in particular, for the use of psychopathology screening tools, for the monitoring of overall rates of dyskinesia, and for laboratory and other physiologic monitoring of medications outlined in the Health Care Guidelines. Dr. Hood and BSSLC senior leadership should review the allocation of available psychiatric time, to assure that that psychiatric time will be available both for the person-by-person needs of the individuals who live at Brenham, and also for facility-wide clinical quality assurance and quality enhancement activities.
- Plans for psychiatric/behavioral treatments should reflect more substantive exchanges between psychiatry, psychology and other clinical disciplines. Plans for any proposed PBSP should consider whether the individual will be best served through behavioral, pharmacology or other interventions. Any treatment plans developed should include joint identification of appropriate treatment targets. Psychological and psychiatric staff should work closely together to identify appropriate measures with which to monitor treatment response(s). Clinical venues such as PTR reviews should be refocused to include more substantive communication between all participating clinical disciplines, along these lines.
- SA Appendix B should be reviewed for guidance regarding psychiatric evaluations.
- Clinical case formulations and psychiatric evaluations should be enhanced by increased use of information obtained from functional analyses and from psychopathology rating tools. Such rating tools include the Reiss Screen, mandated by the SA but not currently in use.
- Substantive psychotropic medication plans should be developed for all use of psychotropic medication. At the present, only limited clinical information is included in plans submitted to the FBRC and HRC Committees. At minimum, plans should include a specific hypothesis for treatment, the expected timeline for benefits, the objective symptoms or behavioral characteristics that will be monitored to assess treatment

- Psychiatric services should be expanded, as part of the overall interdisciplinary team, to address the potential behavioral needs of individuals requiring pre-treatment sedation.
- Medical aspects of treatment should receive more focus in the PTR process by enhancing the role of nursing in the process. Such involvement includes, but is not limited to, a greater focus on MOSES and DISCUS ratings. The unrealistically low number of individuals who live at Brenham and who are currently identified/diagnosed with dyskinesia likely reflects failures in this process. Nursing should ensure that a summary of the individual's MOSES and DISCUS findings, along with any change of status are included in their Annual and Quarterly Nursing Assessments.
- The Facility's Nursing Administration should review the SA and HCG in order to understand and develop strategies to meet compliance with: SA II. J., 9., - Psychiatric Care and services: Sections 9 (IDT integration of treatment; SA II., G., - Integrated Clinical Services: Section 1 (integrated clinical supports); SA II., H., - Minimum Common Elements of Clinical Care: Sections 1 (assessments done regularly); 4 (clinical indicators used to determine efficacy); 5 (monitoring of health status of individuals); and 6 (treatments modified in response to clinical indicators; and HCG III – Psychotropics/Positive Behavior Support

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. Brenham State Supported Living Center Policies and Procedures o Vol 2, Sec 3 Program Planning o DADS #008 Psychological and Behavioral Services o Guidelines for Counseling Process 2. Tools Used for Assessment, including o Challenging Behavior Log o FA Table o Functional Assessment Interview Template o Functional Analysis Screening Tool o Motivational Assessment Scale 3. Behavior Support Program Master List 4. Psychology Department Table of Organization 5. Minutes of Positive Behavior Support Committee meetings of June 1, 2009 to December 7, 2009, 6. Comprehensive review of 15 records (Individual #30; Individual #33; Individual #50; Individual #51; Individual #6; Individual #9; Individual #20; Individual #19; Individual #52; Individual #29; Individual #53; Individual #12; Individual #3; Individual #54; Individual #10 **People Interviewed:** 1. All Psychology Department staff 2. J. Bret Hood, Director of Medical Services 3. Psychiatrists 4. Several direct support staff **5.** Training staff **Meetings Attended/Observations:** 1. Observations in residences, training sites, classrooms and vocational sites 2. Observation of PTR, Positive Behavior Support Committee, PSP reviews
	Facility Self-Assessment:
	Summary of Monitor's Assessment: BSSLC has implemented the PBSP format and developed PBSPs for many individuals. PBSPs do not yet meet standards for adequate behavioral programs. Behavioral targets are not generally well-defined, functional assessment is rudimentary, replacement behaviors based on hypothesized functions are not typically found, data to be collected (and the procedures to collect the data) are not adequately identified and procedures to determine reliability of the data are not developed, and revisions are not made timely based on data.

	Although the facility does not employ any Board Certified Behavior Analysts (whether psychologists or other clinicians), two psychologists are in the process of working toward certification. Peer review is rudimentary. Without the availability of expertise in behavior analysis, even a thorough peer review is unlikely to identify issues of quality of programs. However, thorough peer review with clearly identified program standards may help in improving attention to the basic components required of PBSPs. Staff training to implement PBSPs is not competency-based. Staff understanding of the programs is variable. There is no process to monitor integrity of implementation. Psychological assessment does not include use of either a formal functional assessment protocol or psychopathology assessment tool currently accepted in the field of intellectual disabilities. A process for PBSP review and consent is in place. Attention should be given to ensure the process is consistently followed.

#	Provision	Assessment of Status	Compliance
K1	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall provide individuals requiring a PBSP with individualized services and comprehensive programs developed by professionals who have a Master's degree and who are demonstrably competent in applied behavior analysis to promote the growth, development, 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.	The BSSLC Psychology Department does not include any individuals who possess certification as a Behavior Analyst. Two members of the department are in the process of completing the course work and/or supervision required for certification. A third individual obtained a graduate degree from a behaviorally oriented program but has not pursued certification. During interviews with Psychology Department staff, it was mentioned on several occasions that Texas has plans to offer financial assistance to psychology staff who enroll in classes required for board certification. Details of this financial assistance plan were not available during the site visit. BSSLC is actively recruiting for psychologists. Although board certification in applied behavior analysis is indicated as desirable, it is not a requirement for hiring. Reviews of PBSPs were conducted during the site visit. These reviews revealed an overall lack of sophistication in applied behavior analysis among the psychology staff. Examples of this lack of sophistication include, but are not limited to; basic terms such as antecedent and function used incorrectly, intervention strategies did not reflect formal functional assessment and treatment targets were not operationally defined. Based upon the information obtained during the site visit, the psychology staff do not possess the skills necessary to develop effective PBSPs.	

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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.	BSSLC does not currently employ a director of psychology. Mr. Cureton is the Psychology Manager. Although he provides some guidance to the department, the way he described the role did not reflect that he had the authority or responsibility of an acting department head. He does not function as clinical supervisor of the psychology staff and is not responsible to establish policy for the department. He is motivated and focused toward improvement.	
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.	BSSLC lacks a fully functioning internal peer review process. Psychology staff report that a peer review process occurs, but there is little consensus as to what that process is or even what peer review means. In some interviews, peer review was presented as the supervision process with a senior member of the Psychology Department. In other cases, psychology staff perceived treatment monitoring meetings, such as the Positive Behavior Support Committee meetings, or meetings of the Interdisciplinary Team to be peer review. The Psychology Manager corroborated these observations and indicated that a traditional peer review process does not exist at BSSLC. Observation at the Positive Behavior Support Committee meeting indicated that it does not function as a peer review for PBSPs. The only psychologists in attendance were those who were submitting plans for review. Discussion of treatment issues was informal and anecdotal. It often appeared that the intent of the meeting was to ensure that the interventions were approved by the other committees and the PST rather than to ensure that the intervention was sound and likely to produce benefits. BSSLC currently lacks external peer review. Psychology staff acknowledged that an external peer review process was desirable, but indicated that no system for providing external peer review was under development.	
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	The data collection procedures used at BSSLC do not conform to current accepted standards and do not allow for adequate assessment of behavior and behavior change. • In 15 of 15 sampled PBSPs the data collection method involved a behavior log system. This system required staff to provide a narrative description of the undesired behavior after every occurrence, as well as indicate observed antecedent and consequent events. This system was used regardless of the parameters of the undesired behavior, such as frequency, topography or severity, and did not take into account the opportunities for occurrence in relation to the actual observed frequency. In addition, the time required for completing the behavior log inhibited observation of following behaviors. All of	

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	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.	the sampled PBSPs lacked operational definitions for the undesired behaviors and staff reported a lack of comprehensive and consistent training regarding target definitions and data collection procedures. • 0 of 15 PBSPs included procedures for collecting data on replacement behaviors. • 0 of 15 PBSPs included procedures for the assessment of reliability of observation of the measured behaviors. No staff reported that reliability assessment was being conducted. • 15 of 15 PBSPs included multiple undesired behaviors as intervention targets. Targeted behaviors were defined in a way such that a change in a single behavior would not constitute progress or regression. Also, many target behaviors are listed in a single PBSP, so that change in one behavior may not be reflected in the overall data. This makes it difficult to tell whether PBSP interventions are effective. In addition, because different problem behaviors may have different behavioral functions, it may limit the effectiveness of the interventions. • Graphs of undesired behaviors conforming to current ABA structural standards were provided for 4 of 15 PBSPs. Due to limitations in the data collection procedures, however, that data graphed were insufficient for treatment assessment. • 0 of 15 PBSPs included graphs of replacement behaviors. BSSLC has implemented some elements of a system for monitoring progress in relation to PBSPs. • In 14 of 15 PBSPs, graphs of varying quality were used in assessing the response to treatment. • In 15 of 15 PBSPs, progress review was conducted on at least a monthly basis. • Documentation reflected that input from line-of-care staff was solicited as part of the review process for 15 of 15 PBSPs. A variety of factors reflect, however, that the BSSLC system for reviewing PBSP progress is lacking in both design and implementation. • 0 of 15 PBSPs included a BCBA in the review of progress. • The progress review process in only 1 of 15 PBSPs produced decisions supported by the graphed data. • In only 1 of 15 PBSPs did the review process result in a timely change in intervention methodology as supported by the graphed data. When data suggested a need for a review of or change in the intervention, there were not changes made based on those data. Behavioral intervention plans tend to be reviewed only annually regardless of data. Psychotropic drug regimen changes are made based on subjective review rather than with documentation of data-	

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		based decisions.	
K5	Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention.	The standard psychological assessment procedures at BSSLC, although evidencing some positive elements, lack the sophistication and robustness to successfully measure the individual's abilities and limitations. • 15 of 15 records included at least a review of acceptably recent cognitive, intellectual and adaptive test results. • 15 of 15 records included a personal history and review of medical and physical status. • 0 of 15 records included a formal assessment of psychopathology using standardized instruments or an empirical approach to diagnosis. • 0 of 15 records included a functional assessment or functional analysis conforming to currently accepted practices. • 8 of 15 records did include the use of a screening tool to identify potential functions of undesired behavior. As indicated immediately above, BSSLC does attempt to identify potential behavioral functions by means of screening instruments and general observation. The behavior assessment process does not, however, advance beyond the screening stage and provides only limited information regarding the nature of undesired behavior. • 0 of 15 records included a functional assessment involving an experimental analysis of function or a currently accepted functional assessment interview protocol. • 0 of 15 records included a process to differentiate between biologically-based and environmentally-based behaviors. • 0 of 15 records identified or discussed motivating operations or setting events. • 0 of 15 records included a discussion of antecedents and consequences identified through a formal behavioral assessment process. • 0 of 15 records included replacement behaviors identified as part of a formal behavioral assessment procedure. • 0 of 15 records included a formal assessment to identify preferences and reinforcers. A document identified as a functional assessment is required by BSSLC policy to be in the record of each individual recognized as displaying substantial undesired behavior or behaviors. Although not meeting the definition of a true functional assessment, this requirement does reflect an effort on the part of BSSLC to facilitate the behavior assessment and intervention process. • 3 of 15 BSSLC functional assessments were updated or newly developed on an	

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		annual basis. The remaining 12 of 15 BSSLC functional assessments only reviewed information from previous years. • 0 of 15 BSSLC functional assessments were revised based upon the efficacy of the intervention or changes in behavior. Existing functional assessments were not revised nor new functional assessments attempted when data suggested poor response to interventions. The pattern of BSSLC functional assessment implementation suggests that said assessments are viewed as paperwork requirements rather than essential tools in the behavior change process. Interviews with psychology staff and observations during various treatment meetings indicate that most of the psychology staff lacks familiarity with the implementation and interpretation of functional assessment and functional analysis technology. Of the 15 individuals sampled, two were not prescribed psychotropic medication for psychopathology or operant behavior. Of the 13 remaining individuals, one was prescribed psychotropic medication for operant behavior with the remaining 12 prescribed psychotropic medication for at least one mental illness. The use of psychotropic medication mandates a formal assessment of psychopathology and behavior. This is done to corroborate the diagnosis or treatment target, as well as justify the use of psychotropic medication. Furthermore, whether the intervention chosen is pharmacologic, behavioral or any other treatment modality, all intervention targets require operational definitions. The development of these operational definitions is a function of the formal assessment of psychopathology and behavior, and must be supported by valid and reliable data. In the 15 records reviewed, it does not indicate that BSSLC conforms to currently accepted standards in regard to this assessment and target identification process. • 0 of 12 individuals prescribed psychotropic medication for a diagnosed mental illness received a formal assessment of the symptoms involving functional assessment tools and psychopathology assessment instruments developed for people with intellectual disabilities. • 0 of 12 individuals prescribed psychotropic medication for a diagnosed mental illness had operational definitions of the psychopathology that included behavioral correlates or analogs for the symptoms. • 0 of 13 individuals received assessment of psychopathology and behavior in order to differentiate between biological symptoms of a mental illness and operant behavior.	
K6	Commencing within six months of the Effective Date hereof and with	A useful assessment process requires that the assessment reflects current environmental, external and internal conditions. In addition to being current and	

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	full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	comprehensive, every effort must be taken to ensure that the data derived from the assessment process is valid and reliable. The records sampled during the site visit at BSSLC indicate a number of shortcomings exist in the assessment process at BSSLC. • 3 of 15 BSSLC functional assessments were updated or newly developed on an annual basis. The remaining 12 of 15 BSSLC functional assessments only reviewed information from previous years. • 0 of 15 BSSLC functional assessments were revised based upon the efficacy of the intervention or changes in behavior. Existing functional assessments were neither revised nor new functional assessments attempted when data suggested poor response to interventions. • 0 of 15 records revealed efforts to verify the validity or reliability of assessment results. • 0 of 15 records included assessments that were based upon behavioral data determined to be valid and reliable. • 0 of 15 records included a formal functional assessment protocol or psychopathology assessment tool currently accepted in the field of intellectual disabilities.	
K7	Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	BSSLC completes a psychological assessment on every individual on at least an annual basis, as well as within 30 days of admission. As indicated elsewhere in this report, however, the assessment process as defined by BSSLC does not comport with currently accepted practices in the field of applied behavior analysis or intellectual disabilities.	
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.	At the time of the site visit, BSSLC was in the process of formalizing the non-PBSP intervention process. BSSLC Policies regarding the non-PBSP intervention have been developed and appear to be adequate. Additional review will be necessary, however, during the next site visit.	
K9	By six weeks from the date of the individual's assessment, the	A process for PBSP review and consent is in place at BSSLC. The administrative element of this process, such as timelines and documentation, is the area in which BSSLC has the	

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	Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	greatest success in review and consent. Nevertheless, lapses in the process were evident. • 3 of 15 records did not include documentation that consent was obtained prior to the implementation of the PBSP. • 2 of 15 records contained consent forms that did not describe all relevant intervention procedures. • 3 of 15 records did not include documentation that a PBSP was reviewed by the Human Rights Committee and Behavior Support Review Committee prior to implementation. An area in which BSSLC demonstrates considerably less success is in ensuring that the intervention for which approval and consent is obtained comports with current best practices within applied behavior analysis. As presented elsewhere in this report, the procedures to assess behavior and psychopathology at BSSLC fall short of currently accepted best practice. Without adequate assessment there cannot be a reasonable expectation that effective interventions will be developed and implemented. A review of actual PBSPs reveals that concerns about intervention plans are well founded. • 0 of 15 PBSPs included a rationale for the proposed intervention that could be supported with valid and reliable data. • 0 of 15 PBSPs included a review of prior interventions of sufficient detail to be of use in assessing efficacy. • All PBSPs reviewed included rudimentary discussion of medical, healthcare and psychiatric issues. In 0 of 15 of these PBSPs, however, this discussion was based upon a systematic review of adequate data. • 0 of 15 PBSPs included definitions of the undesired behaviors targeted for reduction that were sufficiently robust to be considered true operational definitions. • 0 of 15 PBSPs included any definitions for replacement behaviors. • Although functions were discussed in all interventions, these proposed functions were not derived from formal assessments and lacked validity. • Due to a lack of adequate functional or reinforcer assessments, the validity or strength of reinforcers could not be supported for 15 of 15 PBSPs. • 0 of 15 PBSPs included interventions addressing antecedents or settings events based upon valid functional assessment. • Most PBSPs made reference to replacement behaviors. These references, however, were subjective or lacked validity. The general practice in the development of PBSPs involves selecting general adaptive behaviors as replacement behaviors without consideration of the functions served by either the undesired or replacement behavior.	

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		• There is little collaboration or cohesion between psychology and other disciplines such as speech pathology as it relates to PBSPs, including development of replacement behavior. For example, Individual #51 exhibits frustration by SIB, however the augmentative communication plan focuses on daily activities rather than alternate ways for this person to express frustration. • 0 of 15 PBSPs included presentation of adequate data collection procedures. • Although information described as baseline data was presented in all PBSPs, this information was not adequate to the task of identifying changes in targeted behavior. • 0 of 15 PBSPs included treatment expectations of sufficient specificity and objectivity. • 8 of 15 PBSPs were written in styles that lacked the clarity or readability necessary for effective implementation. Based upon this information, although consent and review procedures are in place and being implemented, these procedures are not effective in ensuring that intervention plans are safe, effective or reasonable.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	The most effective way to present treatment data for review is in the form of graphs. Graphic presentation of treatment data, even when using the best of graphing procedures and technologies, is insufficient when the data that are presented lack adequate validity and reliability. At the present time, BSSLC has no system in place for determining the interobserver agreement or other reliability measure for any data being collected as part of a PBSP. Therefore, 0 of 15 PBSPs reviewed could be said to be adequate for the determination of treatment efficacy. BSSLC does make use of graphing technology. 15 of 15 records included data graphs developed using Microsoft Excel. In 10 of 15 of these records, the graphs included all elements considered sufficient for data presentation in applied behavior analysis. The remaining records contained graphs lacking elements, such as axis labels or phase change lines, which could easily be addressed with additional training and review.	
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	The Psychology Department at BSSLC currently conducts observation of and interviews with direct care staff to ensure that PBSPs are being implemented as written. This represents a good initial effort to ensure that PBSPs are implemented correctly. At present, however, this process is not conducted systematically and does not involved adequate collection of staff responses and capabilities. Therefore, although this process may be effective on an ad hoc basis to correct staff errors in PBSP implementation, it does not provide a more global perspective of PBSP implementation. Additionally,	

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		current implementation of this process does not involve a majority of direct care staff being assessed on at least a monthly basis. Interviews with and observations of direct care staff revealed no direct care staff who were capable of providing an adequate demonstration of all relevant elements of a PBSP for which they were responsible. Many of the staff provided an adequate or better demonstration of parts of the PBSP, which is encouraging. This does not, however, indicate that PBSPs are regularly being implemented correctly. A factor likely to substantially impair the ability of the direct care staff to implement PBSP is the style and language used in the writing of the PBSP. Only 7 of 15 PBSPs reviewed were written in a clear and concise style likely to enhance readability and comprehension.	
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.	BSSLC provides training regarding PBSPs to all staff responsible for intervention implementation. This training is provided in a variety of modalities and is conducted both prior to implementation of the PBSP and throughout life of the intervention. This training is typically conducted by the psychology staff member who developed the PBSP or other psychology staff with direct responsibility for the PBSP. The greatest limitation noted in the PBSP training process during the site visit is the lack of a systematic and standardized approach to competency-based staff training on individuals' PBSPs for staff responsible for implementing the PBSPs. As a result, there are numerous inconsistencies both within and across residences and programmatic sites.	
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	BSSLC does not employ any staff credentialed as a BCBA. There is currently approximate 1 psychologist per 28 individuals served in the facility. There is approximately one psychology assistant for every two psychologists.	

Recommendations:	**Recommenda**
• It is recommended that BSSLC aggressively pursue training and certification for the members of the Psychology Department. Mastery of applied behavior analysis is essential to meeting the stipulations of the settlement agreement, and achieving certification as a behavior analyst is the only currently-recognized indication of mastery. Reimbursement for certification training expenses is helpful, paying for rather than reimbursing training expenses should be explored.	

- It is insufficient, however, to wait for all staff to achieve certification as that process can require years. It is therefore recommended that BSSLC develop or obtain a training curriculum that can be implemented immediately. This training curriculum, which would be mandatory for all psychology staff, should mesh with the core principles of certification training while being geared towards application of services. In addition, the BSSLC training curriculum should combine classroom and applied teaching strategies. Training could be combined with a process for regularly-scheduled literature review, including books on behavior analysis, seminal and current articles, and training materials available on electronic media.
- BSSLC should aggressively recruit for a Director of Psychology. It is strongly recommended that requirements for the position include doctoral training based upon the scientist-practitioner model and certification as a behavior analyst, as well as experience working with people who have intellectual disabilities.
- It is recommended that BSSLC develop and implement a peer review process that encapsulates the intent of peer review and extends beyond the cursory review typical of the interdisciplinary team and administrative processes. In order to achieve this, it will be essential that BSSLC solicit and obtain the participation of experts relevant to the goals of the committee, such as Board Certified Behavior Analysts with experience in working with individuals diagnosed with intellectual disability. The combination of an internal and an external peer review process would appear to be vital, especially as BSSLC strives to develop mastery amongst its own psychology staff. Even once mastery is achieved by the BSSLC psychology staff, external peer review is strongly recommended for especially severe, problematic or resistive conditions are presented.
- Comprehensive training of psychology staff in basic scientific and applied behavior analytic principles will be beneficial in correcting current weaknesses in the collection and interpretation of data. In addition, however, it is recommended that BSSLC establish clear and specific requirements for all aspects of data collection and interpretation. These requirements should included minimum validity and reliability parameters, and require that data collection methodologies be encompassed within the identification of and operational definitions for all treatment targets.
- It is also recommended that BSSLC enhance the capabilities of the psychology staff in the use of graphing technology as well as the intent and purpose of graphically presented data in the intervention development and monitoring process. Several of the staff members are currently able to develop and embed a graph in a word processing document. It is not clear, however, that there is broad comprehension of how those graphs are to be used and the components essential to that use. Training, peer review and enhanced quality enhancement procedures include effective use of graphical data.
- As an element of the training curriculum presented above, it is vital that the psychology staff become competent in the scientific method and the empirical approach to treatment. Too often, assessment reports and other documents reflect only a cursory review of previous assessments with no focus upon understanding behaviors or psychopathology in the current environment. BSSLC must go beyond providing a simple format for the assessment documents. It is vital that BSSLC establish clear and specific requirements, reflecting a scientific and empirical approach, for how assessments are to be conducted as well as minimum standards for acceptable findings.
- A key element of this process will be staff training and peer review. In addition, however, BSSLC must implement guidelines within the Interdisciplinary Team process to ensure that assessment and treatment integrity is not sacrificed for expediency or due to misunderstanding on the part of other staff. It is recommended that all members of the Interdisciplinary Team be provided with the training necessary to recognize and foster a data-based decision process for reviewing the effectiveness of intervention as well as an understanding of function-based treatment planning.
- Additionally, it is recommended that BSSLC conduct a comprehensive review of all assessment instruments, protocols and procedures relating to behavior disorders and psychopathology in people with intellectual disability. The goal of this review is to identify those instruments best suited to the needs of BSSLC and to require the use of those instruments in the assessment process. BSSLC must initiate use of the Reiss Screen as one component of this assessment.
- As with assessment, it is crucial that BSSLC establish clear and specific standards for behavioral and psychopharmacologic interventions. At present, the majority of these interventions lack scientific integrity and cannot be demonstrated as beneficial – or non-harmful – to the people

living at the facility. It is recommended that these intervention standards require comprehensive adherence to empirically based treatment models, as well as current best practice with the field of intellectual disabilities. Included within these parameters should be, but not limited to, the adequate identification of behavioral functions and replacement behaviors, methodologies to strengthen desired behavior while weakening undesired behavior, and the integration of pharmacologic and behavioral strategies. • It is recommended that BSSLC also formalize and strengthen the process of training staff on the implementation of behavioral interventions. All staff responsible for implementing a PBSP should be required to demonstrate competence concerning the PBSP before being allowed to implement that intervention plan. Additionally, formal treatment integrity checks requiring a demonstration of competence by all responsible staff should be implemented. This training and ongoing assessment should be implemented in a standardized manner using specific tools and procedures. There must also be procedures in place to ensure that staff members who cannot demonstrate competence are not allowed to implement the PBSP until adequately trained.	

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: **Documents Reviewed:** **1.** Reviewed the requirements of the separate monitoring plan, identified as Health Care Guidelines 2. Review of requested tour documents 3. Policy and Procedures reviewed: Volume 4.1A General Health Care; 4.Ib Physician Health Care; 4.2 Nursing: 4.4 Pharmacy; 4.7 Dental; 4.11 Infection Control; 4.14 Medical/Dental Restraint; BSSLC Nursing Policy, Emergency Equipment, Volume 4, Section 2, Revised: November 2009 4. BSSLC Mock Emergency Drill Procedures 5. BSSLC Mock Emergency Drill Reports July through November 2009 6. BSSLC Hospital ER Visit Reports – June through December 2008 and January through October 2009 7. BSSLC Pneumonia Type List – September 2, 2008 through November 21, 2009 8. Records reviewed: Comprehensive record reviews of 6 individuals (Individual #19, Individual #33, Individual #3, Individual #20, Individual #34, Individual #35) 9. Injury reports: Individual #55, Individual #51, Individual #56, Individual #57, Individual #58, Individual #59, Individual #60, Individual #61, Individual #24, Individual #75, Individual #63 10. Injury Reports and Associated Documents (Unusual Incident Investigations, Integrated Progress Notes and Neurological Assessment for Head Injury Records), as provided through document request on: Individual #62, Individual #76, Individual #64, Individual #65 11. Review of complete seizure records: Individual #66, Individual #67, Individual #68, Individual #69, Individual #70 12. Review of seizure type and medication regimen: 125 individuals 13. Restraint injury review: Individual #71, Individual #7, Individual #72, Individual #12, Individual #6, Individual #3 14. TIVA (10 individuals) and oral sedation 10 (individuals) listings 15. Review of medication pretreatment for procedures: Individual #38, Individual #39, Individual #40, Individual #41, Individual #42, Individual #25, Individual #43, Individual #44, Individual #16, Individual #45, Individual #46, Individual #47, Individual #48 16. Death investigation report : Individual #73, Individual #74 17. Committee minutes: Pharmacy and Therapeutic Committee minutes, (7/30/09 and 10/30/ **People Interviewed:** 1. J. Bret Hood, MD, Director of Medical Services 2. Victoria Morgan, MD, Psychiatrist 3. Dr. Reeba Chacko MD, Psychiatrist 4. Joe Williams, Pharmacist 5. Dental Clinic staff 6. Several RN's **Meetings Attended/Observations:** Locations visited: Health Center, Dental Clinic, Pharmacy Toured Units: Bowie, Driscoll, Childress, Cottages A and C, observed location and storage of emergency equipment in each Unit

	Meetings attended: Quarterly Medical and Health Status Reviews, Medical Department daily review
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: Dr. Sherer used this baseline visit as an opportunity to meet with the facility physicians, dentist and pharmacist, and also with several nurses and additional medical personnel. He and Dr. Hood discussed the upcoming need to commit to specifics in terms of medical quality assurance and quality improvement processes. Routine care is provided. The process for Medical quality improvement, including tracking and trending medical conditions, is limited and should be a focus of facility efforts. Medical policies and procedures are not all found in one place. These should be gathered so they are readily available. Emergency response drills and emergency equipment checks should be more thorough and should lead to corrective actions as needed. Some equipment was not ready or available rapidly for use.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Specific areas of routine care and preventive medical care as outlined in Health Care Guidelines (HCG) include infection control, immunizations, health care screening (including laboratory, BP, cholesterol, cardiac, weight, bowel care, smoking status, vision, hearing), cancer screening (including mammography), colonoscopy/rectal exams, PSA tests for men and pap smears for women), and bone health care including diagnostic scanning for persons at risk. Rapid identification, timely and appropriate treatment are identified by the HCG as key to management of acute episodes, and guidelines are provided for several key areas, including head injury, temperature, vomiting or diarrhea, choking, respiratory distress. Dr. Hood reviewed Brenham practices for routine, preventive and emergency medical care. Brenham Nursing Record Audit and Brenham Medical Record Audit forms provided further guidance. Standardized protocols for individuals with intellectual disabilities include those developed by the Massachusetts Department of Mental Retardation via its Health Screening Recommendations (2003), the Massachusetts Department of Mental Retardation Annual Health Screening Recommendations (revised 2007) and the Preventive Health Screening Recommendations of the Ohio Department of Mental Retardation and Developmental Disabilities. Texas may also have recommendations regarding the specifics of care for children and adults with mental retardation/intellectual disabilities, but if so these were not located. We will further review local procedure and practice at the next visit.	

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		Emergency Response Review • During a tour of the Units, a major concern was the observation of limited Emergency Equipment and it's storage on the Units. Each Unit has a different storage area; within the general storage area the equipment is not stored together on a crash cart. Typically, oxygen cylinders are stored in one room, the AED on a wall in another area, suction machines in yet another area, emergency drugs in the Medication Room. In Cottage C some, if not all, Emergency Equipment is located in the Social Workers Office. The only exception was in Bowie where all necessary Emergency equipment is stored in a suitcase/backpack for ready and quick access. • BSSLC's Policy and Procedures for Mock Emergency Drills meets acceptable professional standards of practice. Review and cross-check of Mock Emergency Schedules and Monthly Mock Drill Reports indicated that Drills are carried out quarterly according to policy. In future compliance reviews, the findings of the drills will be examined to determine any trends that indicate a need for action. • Review of the Mock Drill Reports indicated that all drills conducted between 7/09 and 11/09 "passed" except for two; related to significant delay in response time. However, only one of the failed drills indicated a plan of correction. Two of the "passed" drills indicated that staff need for retraining in CPR, however, no plan of correction was indicated. In two other "passed" drills there was a problem related to locating the AED, e.g., Cottage C, "[Staff] unsure as to where AED located on PS, able to locate list of AED's and obtain in reasonable amount of time." On Cottage A, "AED was a little late because it was in a locked area on Cottage C but it got there". A plan of correction was indicated in one of these two reports. Although these were only drills, it is imperative that staff know where all emergency equipment is located without having to locate a list; the equipment should not be locked up and inaccessible to staff. This could have been a real Code Blue; the delay in responding with all necessary equipment could have caused loss of life. Further, one-way mask were either not brought to the drill or the staff could not locate. Although this item is listed as "optional", it a personal protective devise used to cover the victim's mouth to prevent the back flow of secretions from entering the rescuers mouth, thus preventing infections, e.g., prevents the transmission of over 99% of the bacteria and viruses that are known to cause such diseases as HIV, Tuberculosis and Hepatitis. It is important that the one-way masks are brought to the drills to ensure they are available and used during a Code Blue to protect the staff. Review of December 2009 Employees Delinquent in CPR Training Report, indicated that 7 employees were delinquent in CPR re-certification. • All Emergency Equipment are to be checked daily by a designated nurse. Samples of the December 2009 Emergency Equipment Checklist for Driscoll, Childress and Fannin were reviewed for compliance. Fannin's Emergency Equipment Checklist was	

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		not completely checked for 7 of 31 days. Items most frequently not checked were the oxygen tanks (psi availability), sterile nasal canula/non rebreather masks, Ambu bag AED/battery/pads, suction machine, and yanker catheter. <u>Review of Hospital and Emergency Visits</u>: • BSSLC's Pneumonia Type List – September 2, 2008 through November 21, 2009 Identified: o 17 incidents of Aspiration Pneumonia involving 11 individuals; 6 receive enteral nourishment, 4 receive Pureed Diets; and 1 Ground Diet o Individuals diagnosed with episodes of Aspiration Pneumonia and other types of Pneumonia include: ▪ Individual #77: 3 Aspiration; 1 Bacteria ▪ Individual #78: 3 Aspiration; 2 Viral ▪ Individual #79: 2 Aspiration ▪ Individual #80: 2 Aspiration ▪ Individual #81: 1 Aspiration; 2 Bacterial ▪ Individual #82: 1 Aspiration; 1 Bacterial ▪ Individual #83: 1 Aspiration ▪ Individual #84: 1 Aspiration ▪ Individual #85: 1 Aspiration ▪ Individual #54: 1 Aspiration ▪ Individual #86: 1 Aspiration o Since hospitals do not consistently diagnose or often misdiagnose types of pneumonias it is plausible to wonder, of the individuals above with repeated episodes of pneumonia diagnosed as bacterial or viral, if some of these pneumonia might not have been misdiagnosed aspiration pneumonias. Considering the Facility's method of ranking "levels of risk" it is important that the PST, if they have not done so, reassess the above individuals "level of risk" for aspiration/dysphagia and implement Nursing (HMP) Care Plans to prevent or reduce the potential of reoccurring pneumonias. • A cursory review and analysis was completed on Emergency Room visits from the available data for June through December 2008 and January through October 2009 to identify the most frequent causes for visits. The findings indicated: o In 2008: 21 or 38% of 55 visits were for lacerations; 6 or 11% of 55 visits were for injuries w/o fractures or lacerations; 2 or 4% of 55 visits were due to fractures; combined injuries accounted for 29 or 53% of all visits. o In 2009: 38 or 26% of 147 visits were for lacerations; 25 or 17% of 147 visits were for injuries w/o fractures or lacerations; 6 or 4% of 147 visits were due to factures; combined injuries accounted for 61 or 41% of all visits. **<u>Review of BSSLC's Incident's of Fractures and Injuries Requiring Sutures</u>:**	

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		• A cursory review and analysis of TX-BR-1001-III.10a – Fractures since July/1/2009, indicated: 4 caused by: Slip/Trip/Fall – self induced; 44% 4 caused by: Hit – self induced; 44% 1 Caused by Push/Shove – peer induced; 11% • A cursory review and analysis of TX-BR-1001-III.10b – Sutures since July/1/2009, indicated: 12 caused by Slip/Trip/Fall –self induced; 44% 6 caused by Head Banging/Hitting/Behavior – self induced; 22% 3 caused by Bump Into – self induced; 11% 1 caused by Seizure – self induced; 4% 1 caused by Foreign Object – self induced; 4% 1 caused by Push/Shove – peer induced; 4% 3 Caused by Other (Unknown) – other induced; 11% **Review of BSSLC's Serious Medical Incidents:** • A cursory review and analysis of ten (10) sampled BSSLC Client Injury Reports and Associated Documents (Unusual Incident Investigations, Integrated Progress Notes, and Neurological Assessment for Head Injury Records), as provided through document request on: Individual #62, Individual #76, Individual #64, Individual #65 o Summary of injuries (all injuries reviewed resulted in lacerations requiring repair: ▪ 8 of 10 or 80% were related to falls: 1 related to sedation; 4 related to loss of balance; 3 related to falls during a maladaptive behavior episode; 1 related to trip over peer; and 1 fall unknown/not witnessed. ▪ 2 of 10 or 20% were related to head banging during a maladaptive behavior episode. ▪ 8 of the 10 or 80% injuries were lacerations to the head (2 to eyebrows, 1 to chin; 2 to forehead; and 3 to scalp): 2 of the 10 or 20% were to forearms. ▪ 9 of 10 or 90% of individuals had a history of serious injuries reported since admission to BSSLC. o Trends identified related to staffs' response to injuries: ▪ Injuries were promptly reported to nurses. Nurses timely completed Client Injury Reports; nursing assessments and monitoring of injuries (except for one individual, described below in discussion of the Unusual Incident Reports); applied emergency treatments to wounds; promptly notified physicians; and individuals were sent to the emergency room for evaluation and treatment. Upon return individuals were assessed, physicians notified of their return; Physicians' Orders were carried out and the individuals monitored according to professional standards of care. In the limited associated documentation reviewed a few Acute Nursing Care Plans for the	

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		management of Head Injuries and Infection were included. The Nursing Care Plans met professional standards of care. When indicated for head injuries, neuro checks were completed according to professional standards of care. Families/guardians were consistently notified by nurses of individuals' injuries. ▪ Of the limited information available for review the following documentation was consistently missing: A complete set of vital signs before and after emergency room visits; modes of transportation to and from the emergency room; and upon return communication with direct care staff and other PST members regarding individuals' health care status and plans for follow-up care. Documentation was consistently illegible on the Client Injury Reports and associated Integrated Progress Notes. Integrated Progress Notes were not consistently entered chronologically, blank spaces were left in the notes, and documentation errors were not corrected according to professional standards of practice. Additionally, of the 10 Client Injury Reports reviewed, physicians failed to complete the Examination/Assessment/Treatment Section on three (3) of the reports, physicians did not complete this section on two (2) reports for > than 24 hours, and on three (3) reports for >than 2 to 8 hours ▪ The Unusual Incident Reports (UIRs) associated with the Client Injury Reports were completed timely and thorough with relatively good recommendations for follow-up and prevention, except for two (2) individuals: o The UIR, Chronology of the Incident/Injury for Individual #62, nursing progress note written on 07/10/09 indicated that Individual #62 received 2mg of Ativan at approximately 6:15 a.m. as pre-sedation for an appointment with the eye doctor at 8:30 a.m. Individual #62.'s Integrated Progress Notes did not indicate that she was monitored by a nurse after the 6:15 a.m. dose of Ativan. The next entry in the notes was at 8:30 a.m. noting her injury. UIR's Recommendations for Current/Future Actions did not include the need for frequent nursing monitoring of individuals who are sedated. o According to the information supplied on the Client Incident Report, Individual #64 apparently became frustrated and agitated after attempting to communicate his needs, e.g., "Geet, Geet", to staff who could not understand him. Consequently, he engaged in maladaptive behavior, throwing off his protective helmet throwing it on the floor, running into the dining room area, banging his head on the door sustaining a one inch laceration to the scalp. By history on the UIR, he has sustained twenty head injuries since May 2003. He has sustained ten injuries this year (2009). He is sustaining at least one head injury	

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		per month as a result of head banging on door frames. He does have a Behavior Support Plan for SIB. The UIR, Recommendations for Current/Future Actions for Individual #64 failed to consider a recommendation for Speech and Language evaluation in addition to the recommendation for his PST to discuss his ongoing SIBs. It is plausible that his inability to effectively communication his needs may be a precipitating factor contributing to his SIB.	
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.	Dr. Hood discussed the requirement for ongoing medical review, including the requirement in the SA for non-facility physician case review and assistance. Dr Hood reviewed the current availability at Brenham of such reviews. Due to limitations on availability, such reviews at Brenham are currently conducted primarily for mortality review.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	Dr. Hood discussed the requirement for a medical quality improvement process. There is a need to have complementary medical quality assurance and quality improvement process which can build from existing Brenham nursing quality assurance processes	
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	Some medical department procedure manuals, which may or may not be complete, could be located. A more complete review of existing policy and procedure will be carried out at the time of the next visit.	

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	compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.		

Recommendations:

- It would be helpful to collect all current Medical Policies and Procedures in a place that will be convenient for Brenham medical staff to review as necessary. At the next visit , review will be conducted of the specifics with which Brenham will follow the SA guidelines regarding Medical QA and QI processes during the next visit.
- If not in place, the Facility should implement a system for analyzing, tracking acute illness and injuries, e.g., using information from Hospital and Emergency Room visits, Client Injury Reports, Infection Control Reports, including antibiotic usage, etc., in an effort to identify causal relationship and develop plans (systemically and/or individually) to prevent and/or reduce the incidents of reoccurrence. This is particularly important for individuals for repeated episodes of aspiration pneumonia.
- The Facility should ensure that their emergency equipment, supplies and medication are sufficient to provide Basic Life Support according to standards required by ICF-MR Regulations and/or other regulatory authorities.
- The Emergency Equipment Check list should include all items used, including medications and other supplies. The Emergency Equipment Check List should also be completed after each time such equipment/medication/supplies are used.
- The optional use of one-way masks should be made a requirement for both Mock Emergency Drills and for actual Code Blue response.

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. Settlement Agreement and Health Care Guidelines **:** (Listed below are the primary documents reviewed. However, other electronically transmitted documents, relevant to this SA Consultant's area of responsibility (C., F., G., H., I., L., M., N., and Q.; HCG Sections: I., II., (II.C.2,) III. (III.C.2), IV., VII., IX., and Appendix. Pharmacy/Therapeutics.), were reviewed prior to the tour but are not included on this list.) 2. BSSLC Organizational Record, Campus Map, POR-MR Index (Split Records), Facility Abbreviations. Client Roster 3. Nursing Staffing Information: a. Current Patterns for Nurses [Staffing], Revised: January, 2010 b. *Direct Care Nursing Minimums* c. Temporary/Short Term Reassignment, BSSLC Policy and Procedure, Nursing Policy, Vol4, Sec. 2, Revised: June, 2009 d. Nursing Call-In Logs and Graphs, June through November, 2009 4. Nursing Job Descriptions: a. Debbie Williams, RN: Chief Executive Nurse b. Sara Colvin, RN: Nursing Operations Officer c. Johanna Nelms, RN: Nurse Educator d. Wendy Smith, RN: Hospital Liaison e. Cindy Clay, RN: Nurse Recruiter f. Joanne Guard, RN: Infection Control Nurse g. Jill Quimby, RN: QA Nurse h. Brandy Todd, RN: LVN Manager 5. Nursing Meeting Minutes: a. Nursing Administration Meetings: 7/24/09 and 10/12/09 b. Nursing Case Manager Meetings: 7/29/09 and 10/16/09 c. Nurse Manager Meetings: 7/28/09, 10/20/09 and 11/16/09 d. Cottage Nursing Meeting: 11/24/09 e. Childress Nursing Meetings: 10/20/09 and 11/17/09 f. Bowie Nursing Meeting: 10/14/09 g. Driscoll Nursing Meetings: 7/09, 8/09, 9/09, 9/14/09, 9/29/09, 10/20/09, 10/21/09, 10/29/09; 11/30/09 and e-mails to nursing staff from Stephanie Liescheski, Driscoll Nurse Manager h. LVN Meetings: 10/15/09 and 12/9/09 6. Medication Error Committee Meeting Minutes: 8/14/09, 9/30/09, 10/29/09, and 11/24/09 7. Pharmacy and Therapeutics Committee Meeting Minutes: 7/30/09 and 10/30/09 8. Texas Department of Aging and Disability Services, State Supported Living Centers Policy: Nurse Competency Based Training Curriculum – August 2009 and Agency Nurses Competency Agreement and Date/Signature Sheet 9. BSSLC RNs Competency Check-Off Sheet , Completed for 2009

	10. BSSLC Competency Fair: 2010 Check-Off Sheet (not filled in) 11. Competency Exams 2010 Study Guide, including Curriculum content, competency checks and testing materials 12. BSSLC Policy and Procedures: Nursing policy, Volume 4, Section 2, Revised November, 2009 13. Sample Acute and Chronic (generic) Nursing Care Plans (NCPs): a. Acute NCP – Related to Shingles; Influenza; Cellulitis; G.I. Integrity; Viral Infection; H-Pylori; Potential for Skin Integrity; Urinary Tract Infection; Blepharitis; Clostridium Difficile/C-Diff; Decubitus Ulcer; Conjunctivitis; Ear Infection; Fungal Infection; Herpes Simplex; Potential for infection related to abdominal incision; Pneumonia; and Sinusitis b. Chronic NCP – Potential for Impaired Skin Integrity 14. Texas Department of Aging and Disability Services, State Supported Living Centers Policy: Self Administration of Medication (SAMS), Date: August 2009 15. Texas Department of Aging and Disability Services, State Supported Living Centers Policy: Nursing Services, Policy Number, Date: Draft 16. Texas Department of Aging and Disability Services, State Supported Living Centers Policy: Guidelines for Comprehensive Nursing Assessment, Date: October 2009 17. Texas Department of Aging and Disability Services, State Supported Living Centers , Weight Management Guidelines – Team Roles, Date: August 2009 18. Texas Department of Aging and Disability Services, State Supported Living Centers, Procedure: Weight Management, August 2009 19. BSSLC Medication Pass Times; Enteral Medication Pass Times 20. Medication Administration [Oral] Observation Pass Form: Enteral Feeding/Enteral Medication Administration Observation Form 21. Texas Department of Aging and Disability Services, State Supported Living Centers, Procedure: Date: Medication Error, Date: November 2009 22. BSSCL Policy and Procedures: Infection Control, Volume 4, Section 11, Revised July 2008; 23. Texas Department of Aging and Disability Services, State Supported Living Centers Procedure: Communication with Hospitals and other Acute Care Facilities, Date: August 2009 24. Texas Department of Aging and Disability Services, State Supported Living Centers Procedure: Care Plan Development, Date: August 2009 25. BSSLC Policy and Procedures: Dental, Volume 4, Section 7, Revised: May 2008 26. Texas Department of Aging and Disability Services, State Supported Living Centers Policy: Use of Restraints, Policy Number, 001, Date: 8/31/09 and Restrain Documentation Guidelines for State Supported Living Centers, Date: November 2008 27. BSSLC List of Restraint Use: 7/09 through 12/09 28. Texas Department of Aging and Disability Services, State Supported Living Centers Procedure: Neurological Assessment, Date: November 2009 29. BSSLC Mock Medical Emergency Drills Procedures, Revised: 2/07BSSLC Policy and Procedures: Pharmacy Services, Volume 4, Section 4 30. Infection Control Information: Infection Control Committee Meeting Minutes: 5/25/09 and 9/30/09; Decubitus Spreadsheet, 1/7/09 through 11/30/09;Infection Control Spreadsheet – to date; IC-1 Weekly Infection Report: October through December 2009; and Texas Department of Aging and

	Disability Services, State Supported Living Centers Procedure: Infection Control Training and Competency Testing Materials 31. QA Nurse Audit Reports for Medical and Nursing – November and December, 2009 32. Seizure Records and associated documentation – sample of 10 copies reviewed per document request 33. TX-BR-1001-III.10.a., Fractures Since 7/1/09 34. TX-BR-1001-III.10.b., Sutures Since 7/1/2009 35. BSSLC Monthly Mock Emergency Drill Policy and Procedures and Monthly Mock Drill Schedules and Reports 7/09 through 11/09 36. Partial record reviews of 22 records (includes onsite records and records obtained from document request) on the following individuals, with focus limited to issues related to C., F., G., H., I., L., M., N., and Q.; HCG Sections: I., II., (II.C.2,) III. (III.C.2), IV., VII., IX., and Appendix. A. a. Individual #19, Individual #33, Individual #3, Individual #20, Individual #37, Individual #8, b. BSSLC Client Injury Reports and Associated Documents (sample of 10 reviewed): 7/09 through 12/09: Individual #62, Individual #76, Individual #64, Individual #65 c. BSSLC PSP and Quarterly PSP, reviewed combined sample of 10, sample of 10 copies reviewed per document request, electronically transmitted: Individual #22, Individual #23, Individual #24, Individual #25, Individual #26, Individual #27, Individual #28, Individual #29, Individual #30, Individual #31, Individual #12, and Individual #32 d. Sample Seizure Reports and associated documentation supplied through document request: 37. BSSL Hospital ER Visit Report-June through December 2008, and January through December, 2009 **People Interviewed:** 1. Debra Williams, RN, Chief Executive Nurse, Sara Colvin, RN, Nursing Operations Officer, Johanna Nelms, RN, Nursing Educator, Jill Quimby, RN, QA Nurse, Cindy Clay, RN, Nursing Recruiter, 2. Joanne Guard, RN, Infection Control Nurse, Wendy Smith, RN, Hospital Liaison, Nancy Witt, RN, Nursing Shift Supervisor, Leona Sian, RN, Nursing Shift Supervisor, Jim Cloud, RN, Bowie Nurse Manager, Stephanie Hintzel, RN, Driscoll Nurse Manager, Ahonna Engleke, RN, Cottages Nurse Manager, Penny Foerster, RN, Health Center, Brandy Todd, LNV, LVN Manager, Kay Oschner, LVN Bowie, Torshia Dixon, Bowie Activity, and multiple Unit RNs and LVNs and Direct Care Staff 3. J. Bret Hood, MD, Director of Medical Services **Meetings Attended/Observations:** 1. Facility Entrance Meeting 2. Annual PSP Meeting for Individual #20 3. Admission Meeting for Individual #21 4. Medical Daily Meeting 5. Facility Exit Meeting 6. Tour of Living Units Driscoll, Bowie, Fannin, Childress, and Cottages A and C 7. Medication Administration via Enteral Route, (Individual #37, administered by Della S., LVN)

	8. Enteral Nourishment via bolus, (Individual #37, administered by Della S., LVN 9. Childress 2-10 Nursing Shift Report
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: **Note:** Because this was a baseline review the majority of monitor's time was spent with formal and informal staff interviews/meetings/tours related to assigned monitoring areas. This was done in an effort to understand BSSLC's organizational and functional structure, identify systemic issues, and concerns. Future tour will focus more on record reviews and compliance issues. **Staffing:** There are no dedicated nurses routinely scheduled in the Cottages on the 10-6 shift. When nurses are needed the Shift Supervisor or Unit nurses are called. While the nursing staff ratios have not fallen below minimum staffing needs since June of 2009, coverage is challenging particularly on the weekends, often resulting in pulling staff and using Agency nurses. Recruitment of nurses is difficult in rural areas and/or where there are hospitals with higher nursing salaries. The Nursing Department now has a full complement of administrative and management level nurses: Chief Executive Nurse, Nursing Operations Officer, Nurse Educator, Hospital Liaison Nurse, Nurse Recruiter, Infection Control Nurse, nurse Case Managers, Nurse Managers, LVN Manager. The QA Nurse that reports to the QA Director works closely with the Nursing Department. **Nursing Policies and Procedures:** There needs to be a continuing effort to emphasize practices that more specifically meet the unique needs of individuals with Developmental Disabilities, particularly those individual with co-morbid chronic conditions. The Nursing Policy and Procedures Manual have recently been revised. While it meets basic professional standards of nursing practice, this must be incorporated into the Nursing Competency-based training curriculum. Facility's tour scheduled for six months hence will focus more on record reviews and compliance issues. The development and implementation of an internal Peer Review System is needed to assist the nursing staff self-monitor their practices. Such a system is needed to accurately reflect the quality of nursing care provided in an effort to quickly identify problematic trends and implement timely plans of correction. The Nursing Department needs to continue to improve and strengthen their practices regarding Nursing Assessments, Nursing (HMP) Care Plans, working in an interdisciplinary team setting, and documentation. There was an increase of medication errors/omission reported during August and September, 2009. Most of the errors were related to omissions in administering medication. Many corrective actions have been put in place to monitor all aspects of medication administration to prevent/reduce medication administration errors/omissions. This issue will be reviewed in the upcoming compliance review of the Facility, in order to

	assess the effectiveness of their corrective actions in preventing/reducing the incidents of medication errors/omissions. **Other Concerns**: Medication Rooms are very small and are overcrowded, particularly in the Cottages (A and C), Bowie and Driscoll where two large medicine carts were needed. Maintaining privacy for medication administration is challenging because of lack of space. Plastic spoons are primarily used for medication administration when medication is mix with food stuff. This is a concern because of the possible hazard of breaking and causing mouth injury or choking, particularly for clients with an involuntary bite response. One of the Medication Rooms in Driscoll does not self-lock when closed. This presents a safety and security breach. Of major concern was the observation of limited Emergency Equipment and its storage on the Units. Each Unit has a different storage area; within the general storage area the equipment is not stored together on a crash cart. Typically, oxygen cylinders are stored in one room, the AED on a wall in another area, suction machines in yet another area, and emergency drugs are in the Medication Room. In Cottage C some, if not all, Emergency Equipment is located in the Social Workers Office. The only exception was in Bowie where all necessary Emergency equipment is stored in a suitcase/backpack for ready and quick access.

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M1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, nurses shall document nursing assessments, identify health care problems, notify physicians of health care problems, monitor, intervene, and keep appropriate records of the individuals' health care status sufficient to readily identify changes in status.	Ms. Williams, CEN, gave an in depth overview of BSSCL Nursing Services' organizational and functional structure. Over the past two years she has done an outstanding job; personally interviewing, selecting/hiring and orienting highly qualified and experienced nurses for the Nursing Administrative/Management group. There is a lack of understanding and/or implementation of integrated services at the Facility. Each discipline seems to function predominantly within its own respective discipline without collaboration or coordination of services. At the same time, nurses seem limited in their ability to exercise independent judgment related to nursing assessments, planning and integration of services with other disciplines. Nursing Services appears to still operate much like a "Medical Model," with physicians dictating medical care, and the nurses caring out Physician Order's. With the revision to the Nursing Policies they are moving toward comprehensive nursing assessments, care planning and enhanced communication with relevant disciplines. Presently, the Chief Executive Nurse reports to the Program Director, who reports to the Facility Director. Today, in most DD facilities the CEN functions at the level of a Program Director and/or as part of the Executive Staff because of the level of responsibility required by the Nursing Department. When CENs' have a higher level of designation within the organization they have more leverage in the decision making processes of the facility. Although structure of the organization is at the discretion of the organization, it is essential that the structure support both establishment and implement high standards of	

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		care and integration of nursing within the interdisciplinary process. The Nursing Department does not have an internal Nursing Peer Review System to monitor nursing practices. Nursing audits are completed by the QA Nurse. An internal Peer Review System can serve to improve quality of services and enhance skill and practices of nurses. The group did not seem to have a clear understanding of the SA and HCG requirements, although they were working on their section of BSSLC's Plan of Improvement (POI). Cross-walking the Draft SA Monitoring Tools with the SA and HCG will help the nursing staff better understand the expectations for compliance and will be helpful in revising and/or developing their own audit tools. The nurses do not have a process to review their practices and performance against the SA and HCG, The Nursing Department needs to develop and implement an effective internal peer review process. The Lippincott Manual of Nursing Practice, is used as their primary reference in developing nursing policies and procedures. Professional standards of nursing practice should be adapted to meet the unique needs inherent in the DD population. In an effort to strengthen the nursing staff' knowledge and skills in the specialized field of Developmental Disability Nursing, they should consider joining and participating in the Developmental Disability Nursing Association (DDNA). While the Team is relatively new to the field of Developmental Disability, they are a very cohesive group and are diligently striving to improve Nursing Services. This work, combined with their work with the various Statewide Workgroups, will no doubt result in comprehensive improvements in BSSLC's Nursing Services as well as provide continuity across the state. Some of the improvements include, new and revised local and State policies and procedures: End of Life Planning, Emergency Equipment, At Risk Individual's, Self Administration of Medication(SAMS), Nursing Competencies, Care Plan Development, Weight Management, Nursing Services, Conscious Sedation, PEG Tube Feeding, Medication Errors, and other revised BSSLC Policy and Procedures: Nursing Policy, Volume 4, Section 2, Revised: November 2009. The upcoming tour and review will determine Nursing's compliance with these standards. The Nursing Department has a dedicated Hospital Liaison Nurse. This nurse's responsibilities include: Conducting daily hospital rounds to promote continuity of care for individuals served at BSSLC, assessment of hospitalized individuals, communication with hospital nurses, documentation of progress notes, communication of the findings with relevant PST members, assistance with discharge planning, and identification of staff training needs. It was not possible to review currently hospitalized individuals' documentation related to the Hospital Liaison Nurse's activities because the chart goes to the hospital with the individual and remains there until discharge,. This item will be further reviewed on the next Tour.	

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		The State's policy requiring that RNs be considered professional staff and thus not receive overtime pay is causing staffing problems on weekends which then necessitates the call-in of Agency Nurses. RNs can only accrue compensatory time of which they are unable to take off because it would cause further shortage of staffing. Hiring and retention of nurses is further confounded because the State system has no parity in salary. A newly hired nurse or one with limited experience can be hired at a salary equal to or greater than the nurses who have long tenure with excellent performance. Reportedly, since June 1, 2009, nursing staff ratios have not fallen below minimum staffing needs. In the event a call-in occurs, an Agency Nurse, the nursing shift manager, or the RN on-call provides coverage to assure minimum ratios. The CEN stated that the State has approved 1,160 new positions throughout the L.S.L.C. for DCs, nursing and professional staff. It is difficult to find RNs in rural areas because many nurses move to bigger cities to work in large hospitals, or for better paying positions. While it may be absolutely necessary to use Agency Nurses to meet the minimum staffing ratios, it is important to limit their use, because Agency Nurses may not be as familiar with the individuals as full-time staff. Review of the Nursing Department's Staffing Patterns indicated that there are no nurses routinely scheduled on the 10-6 shift in Childress, Fannin and Cottages. The Nursing Shift Supervisors or "pulled" nurses cover these buildings when the need arises. Review of staffing patterns also indicated that an RN is not consistently available everyday in all Units on the 6-2 and 6-10 shifts. Although, minimum staffing ratios are met with LVNs, it is of concern in the Units where clients reside with complex health care needs that RNs are not consistently available. While LVNs play an important role in the delivery of health care, their education/training, skills, knowledge, and scope of practice are limited. Reportedly, the number of nursing staff for the Units is based on the number of medication passes per shift. This is a concern because it is obvious that in Units with greater numbers of residents, in addition to individuals with complex medical issues requiring more medications, that more nurses are needed than in Units of lesser size with less medically complex clients. There is no formalized acuity rating system in place to assist with making decisions regarding staffing allocations. If BSSLC's Nursing Department is to meet compliance with the SA and HCG there must be adequate staffing and resources to meet the requirements as well as sound policies and procedure/protocols to meet the health care need of the individuals who live there. Nursing needs to consider developing and implementing an acuity rating system for staffing. Nursing should consider staffing with at least one dedicated RN for the Cottages on the 10-6 shift and at least one RN available everyday in all Units on the 6-2 and 6-10 shifts. A number of possibilities for resources to improve work flow were identified: o More LVNs are needed to assist with direct client care.	

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		○ More computers for the Nursing Department. Presently, they must share with other disciplines. Because of the increasing demand for computerized reports, assessments, plans, etc, particularly for the Case Managers, the inability to have access to computer slows down their work, causing delays in getting required documents completed or they have to rush through the reports, shortening them such that they are not as thorough as they should be. Failure to have access to computer also causes problems with receiving and sending communication over the e-mail. Additionally, LVNs do not have access to computers. ○ Units need large bulletin boards to write on that require immediate attention, especially for the LVNs. ○ Office space is needed, especially for privacy when discussing HIPAA related information with individuals, families/guardians, etc. ○ Facility telephones are antiquated and additional phone lines are needed. Bowie's Doctor's Office needs a telephone. ○ There is only one mobile phone for the Nursing Department, used by the Nursing Shift Supervisor. Other nurses must rely on their own personal cell phones when out of the building or making ground rounds. This is a serious problem if there is an urgent/emergency need for Unit staff to contact a nurse when in another home or out on the grounds or when a call has to be made to an outside doctor and the nurse goes off shift before the doctor returns the call. The nurse cannot reasonably be expected to give out a personal cell phone number. This is a barrier to care. There is no reimbursement for use of their personal cell phones. ○ The printer used by the Nursing Department is also used by the Education Department. Because of the high volume of printing required by the Education Department, it is difficult for the nursing staff and Nurse Educator to gain access to the printer. ○ Blood pressure cuffs and other assessment tools are of poor quality (drug store variety because they can easily be purchased with Pro Card), their accuracy is questionable, and they have to be replaced frequently. Professional equipment should be purchased. ○ Each home needs a set of professional scales for weights. ○ Current professional literature is needed in order for nurses to stay current in their nursing practice. The CEN should discuss the identified need for additional resources with the Facility Administration if an effort to procure resources she deems necessary to enhance nursing practices.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update	In the limited records reviewed only trends related to nursing assessment are reported: • Nursing Quarterly Assessments were completed timely by a RN as scheduled. However, they did not consistently contain an evaluation of the effectiveness of ongoing treatments, nor were there evaluations of response to treatments that do	

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	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.	not have potential for serious complications such as sunscreens, shampoos etc. The exacerbations of chronic conditions that required weekly monitoring for a minimum of one month were not consistently documented. It could not be ascertained if the completion of a course of treatments were documented the Integrated Progress Notes. • All actual and potential health problems were not consistently identified and nursing diagnoses formulated. • Health risk and actual problems were not consistently addressed using a comprehensive Nursing (HMP) Care Plan.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	Annual and Quarterly Nursing Assessments documented a head to toe assessment by use of a form that recorded assessments in a check box. Although a Comment section was available, documentation failed to consistently describe the findings in detail in the Comment section of the Nursing Assessment form. Consequently, it was difficult to discern if the findings required further intervention or change of the Nursing (HMP) Care Plans. Nurses completing the Annual and Quarterly Nursing Assessment should consistently summarize any health status variance in the Comment Section of the form and develop and implement (if not previously addressed) Nursing (HMP) Care Plans for intervention. Evaluations should carefully assess the issues presented by the individuals. As an example: • At the PSP meeting for Individual #20, the Nurse Case Manager stated that she did not have any health care issues and did not need a Nursing Care Plan. Concerns this SA Nursing Consultant identified by only reviewing the limited Nursing Section indicated that Individual #20 definitively needed a Nursing (HMP) Care Plan. Health issues requiring a Nursing (HMP) Care Plan include, but may not be limited to: A weight gain of 18 pounds in the last 6 month or 15% unplanned weight gain, diagnosis of hypothyroidism; taking Levothyroxine, folic acid deficiency, psychiatric/behavioral issue; taking Zyprexa, and receiving Medroxyprogesterone (Depo Provera) injection. Additionally, her favorite foods are pizza and she enjoys going to the vending machines for snacks. She is on a Regular 2000 Cal Diet. All these factors contribute to weight gain. Although she remains within her DWR, she needs some weight management assessments by Nursing, Nutritionist and OT/PT (for increased activity). In addition to weight management issues she needs a Nursing (HMP) Care Plan for health maintenance as well as to monitor the therapeutic effects of her medications. She is taking Depo Provera for "fertility control." A sexuality assessment and need for training was not contained ISP; nor was a sexual history or the rationale for the birth control medication. All these issue should have been included in her ISP.	

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M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	The recently revised Nursing and Policies and Procedures and nursing improvements in providing oversight and competency based training as put into practice, and will no doubt show improved compliance with the SA and HCG requirements.	
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.	There is a lack of specific/clear criteria for determining risk levels. As a result, identification of low risk may not accurately represent the individual's true need for increased assessment or care. This is true for many areas of possible risk. It is appropriate for nurses to participate in assessment of risk in many areas, including falls, diabetes, cardiac conditions, and other health care conditions. Nurses are required to complete some Risk Assessments that should be done by another discipline, e.g., OT/PT. The Risk Assessment procedure should be reviewed by the Facility and/or other relevant staff to evaluate the appropriateness as to which discipline is best qualified to complete the various components of the assessment. The Risk Assessment procedure should be evaluated by the appropriate State and/or Facility staff for clear criteria for determining risk to eliminate subjectivity. For example, nurses have no documentation or follow-up procedures when observing clients who experience swallowing difficulties ("trigger") during oral intake. Further, there are no "triggers", e.g., signs and/or symptoms indicating that the individual is having difficulty swallowing/breathing, etc., listed on the PNMP. Nurse should receive additional training in Physical, Nutritional, and Management, particularly related to Mealtime Challenges. Signs and symptoms of swallowing difficulties ("trigger") needs to be noted on the PNMP and MAR. (See Section O for further information and recommendations.) The nurses cannot directly notify the Therapist of PNMP concerns; they must go through the Physician for a referral to a Therapist. A better communication process needs to be established between Physicians, Therapists and Nurses in ordered that all care providers are aware of the individual's needs. Results of assessments and decisions on action need to be consistently included in the PSP process. The MARs do not contain a copy of individuals' PNMP. This would be helpful to ensure that special techniques for swallowing, positioning and adaptive equipment were carried out during medication administration to prevent aspiration, choking, etc. Nurses cannot directly notify the Therapist of PNMP concerns; they must go through the physician for a referral to a Therapist. They were asked if the nurses observed a client experiencing	

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		"triggers" during oral intake what would they do. They explained there in nothing formally in place for follow-up. Further, it was discussed there are no "triggers", e.g., signs and/or symptoms indicating the client is having difficulty swallowing/breathing, etc., listed on the PNMP.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	• Review of the Medication Errors/Omission Reports indicated in August and September, 2009, there had been an increase of medication errors, primarily related to omissions. The Medication Error/Omission Committee and Nursing administrative staff indicated there were several contributing factors, such as, employment of new nurses, changing reporting form, better nursing oversight of medication administration by Nurse Managers. Efforts to reduce medication errors were evident in discussion and review of Medication Error Committee Minutes. Nursing Meeting Minutes, and Pharmacy and Therapeutic Committee. Below are identified areas of procedural changes occurring at the time of the baseline tour. Compliance regarding these changes and required standards of practice will be evaluated during the upcoming compliance review. o The Nurse Educator provides all new nurses with competency based orientation, mentors all aspect of their nursing practice for the first six months of employment, then the Nurse Recruiter continues to monitor for an additional six months. All nurses receive annual competency based training. Reviewed Competency Based Training. o Nurse Managers are responsible for making sure MARS are transcribed and updated correctly. Additionally, Nurse Managers are to perform random med cart counts and ensure that all narcotics are counted with another nurse before and after each shift. (If the narcotic count is off, no one is allowed to leave the Unit until the count is resolved.) o Nurses are to perform medication cart checks daily. o Nurse Managers are to use a tracking tool to spot check 10 individual medication drawers a week. o Case Managers are to perform MARS audits weekly and initial at the bottom of the MARS the date the audits were performed. o Due to changes on the Medication Error Form and classification of serious medication error (e.g., Category E through I), if a Category E through I error is committed, the nurse is taken out of the nursing role and re-educated and retested on medication administration. Then, the nurse will have a monitored medication pass before they can pass medications independently. o When transcribing orders, two nurses must sign off on the order to help prevent transcription errors. o Efforts are being made to ensure individuals' privacy with each treatment and/or medication pass., as well as with calling the of individuals' name.	

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		• The QA Nurse is responsible for reporting medication errors/omissions. A computerized Access Program is used and generates reports. The number and types of errors/omission are reported monthly to the State Office. Presently, there is no formal tracking and trending process in place; however, raw data reports are reviewed and used to assist with identifying type and severity of the errors and corrective measures. A more comprehensive analysis is useful in pinpointing issues to assist with management of resources and problem solving. For example, it is possible some of the medication errors/omissions could be related to lack of nursing staff to safely and timely pass medication in Units/Homes with heavy medication passes. Such an analysis could identify that more nurses are needed in Units with heavy medication passed. The QA Nurse should consider working with the staff who manages the Access database, to use more of the data from the Medication Error Report, e.g., Possible Cause of Error, to develop a tracking and trending report using a "Root Cause Analysis" approach. • The Medication Error/Omission Policy lists only the nursing discipline. Physicians and pharmacists also have the potential for committing medication errors. The Medication Errors/Omissions Policy should be changed to a Medication Variance Policy that encompasses all aspects of medication administration and all relevant disciplines. • Review of BSSLC Policy and Procedures: Medication Administration, Nursing Policy, Volume4, Section 2, Revised: November 2009, appears to meet professional standards of general nursing practice in an acute setting, except it does not include in the "Purpose Section", "when indicated for individuals who have PNMP needs for special oral intake (texture, consistency, and bite size), adaptive equipment and positioning." It does not include a procedure for administering medication/nourishment via enteral route for both G and J tubes. This should be included in the Medication Administration Policy. The Medication Administration Error/Omission Policy and Procedure should be revised to include in the purpose, when indicated for individuals who have PNMP needs for special oral intake needs As well as a procedure for administering medication/nourishment via enteral route for both G and J tubes. • Review of limited Medication Review Records (MAR) reflected that therapeutic responses to PRN medications are not consistently documented either on the MARs or in the Integrated Progress Notes. Medication was not always initialed as given, there were no accompanying documentation explaining the omissions in either the MARs or in the Integrated Progress Notes. The nurses monitoring/auditing Medication Errors/Omissions should continue to review MARs/Integrated Progress Notes for documentation of therapeutic response to PRN medications and for omissions in initialing the MARs. • While observing medication administration onsite for an Individual #37 that	

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		received medications via G-tube the following significant issues were identified. Specifically, the nurse failed to check the tube for placement and to flush the tube before and after administering medication with the prescribed amount of water. The staff nurse checked each medication before administering the medication against the MAR. While checking the medications it was discovered that the prescribed dose of $FeSO_4$ on the MAR did not contain the number of mgs. to be administered. The available $FeSO_4$ package contained a 350mg pill. When the staff nurse was asked what she must do to verify the correct dose she checked the Physician's Order. The MAR was corrected before administering. The Pharmacy was to be notified of the error, as the MARs are generated by the Pharmacy. Then, the staff nurse proceeded to administer the medications. Further review of the MAR revealed that Individual #37 received a PRN dose of Tylenol administered on 1/6/10 for pain. The MAR did not contain documentation specifying the nature of the pain or the therapeutic response to the Tylenol; nor was it documented in the Integrated Progress Notes. Fortunately, the CEN, QA Nurse, Nurse Educator, and Nurse Manager were present during the observation and corrective action was taken. According to the CEN there has been some controversy regarding checking tube placement by checking residual stomach contents verses checking by auscultation. She said the nursing literature is not specific but they have decided to check placement by both methods. It was also agreed that the reason for, and the therapeutic response to a PRN medication must be documented on the MAR and in the Integrated Progress Notes in accordance with their Medication Administration Policy and Procedures. The nurses monitoring/auditing Medication Errors/Omissions should continue to review MARs/Integrated Progress Notes for documentation of therapeutic response to PRN medications. They should also monitor medication/nourishment administered via enteral to ensure that nurses follow correct procedures when administering medication/nourishment, particularly checking for tube placement prior to administration, and flushing tubing before and after with prescribed amount of water.	

Recommendations:

- Nursing Administration should review the SA and HCG to ensure they have a thorough understanding of compliance requirements. SA and HCG should use the SA and HCG guide as they make improvement in their policies and procedures and develop an internal Nursing Peer Review System.
- Nursing Administration should continue to strengthen their role within the interdisciplinary treatment team process to ensure that treatment plans for individuals are comprehensive.
- Nursing Assessment forms and procedures should be revised to ensure that a comprehensive nursing assessment is completed. The form presently used is a checklist with a comment section that does not always provide a detailed summary of information regarding the individual's current health status. Providing a more detailed explanation of the individual's health status is necessary to analyze and plan interventions necessary to prevent or eliminate or minimized negative health outcomes.

- Nursing staff should receive competency-based training on: Completing Nursing Assessments specific to individuals with developmental disabilities, and Nursing Care Plan development, monitoring and evaluating effectiveness of plans.
- In an effort to strengthen the nursing staffs' knowledge and skills in the specialized field of Developmental Disability Nursing, they should consider Joining and participating in the Developmental Disability Nursing Association (DDNA). DDNA can provide an excellent resource for development of procedures and standards of practice of nursing with this population.
- Nursing (HMP) Care Plans should be revised to ensure that individual specific plans are developed to meet the individual's unique health care needs. Nursing (HMP) Care Plans should also include health maintenance issues as well as disease specific interventions. Plans should establish reasonable, observable and measurable health outcome goals, timeframes for accomplishment, staff responsible for implementing planned interventions, and who, how and where interventions are to be documented.
- Nursing needs to develop and implement an acuity rating system to use for basing nursing staffing ratios.
- Nursing should consider staffing with at least one dedicated RN for the Cottages on the 10-6 shift and at least one RN available everyday in all Units on the 6-2 and 6-10 shifts.
- While it may be absolutely necessary to use Agency Nurses to meet the minimum staffing ratio, it is important to limit their use because Agency nurses may not be as familiar with the individuals as full-time staff. A cost to benefit analysis should be conducted by the Facility to determine the cost of Agency Nurses as compared to hiring more Facility Nurses
- The Facility should provide the Nursing Department with the needed resources to provide services safely and effectively, such as: professional quality diagnostic equipment e.g., Blood Pressure cuffs, scales for weights, and other assessment tools; current professional nursing literature; computers for nurse managers, printer for the nurse educator, large bulletin boards to post information pertinent to LVN's since they do not have ready access to computers; telephone in physician's office in Bowie; private office for nurse to provide privacy when meeting with individuals; and families/guardians; mobile telephone or walkie talkies for nurses to enhance communication within the facility as well as outside physicians, hospitals, families/guardians, etc.
- The Nursing Administration should develop and implement an internal Nursing Peer Review System for self-monitoring all aspect of nursing services. The System should ensure that the following issues are included:
    - Nursing Assessment are comprehensive, timely, and meet professional standards of nursing care.
    - Nursing Care Plans meet the individual's health care needs as identified in the Nursing Assessment or through other interdisciplinary assessments, and are reviewed at least quarterly and/or when the individual's health status changes.
- Nurses completing the Annual and Quarterly Nursing Assessment should consistently summarize any health status variance in the Comment Section of the form and develop and implement (if not previously addressed) Nursing (HMP) Care Plans for intervention.
- The Nursing Medication Administration Policy and Procedures should include instruction for administering medication through enteral; route, including specific instructions for G-tubes and J-tubes. Consideration should be given to changing the policy to a Medication Variance Policy that would also include capturing unexpected adverse drug reactions.
- The nurses monitoring/auditing Medication Errors/Omissions should continue to review MARs/Integrated Progress Notes for documentation of therapeutic response to PRN medications. They should also monitor medication/nourishment administration via enteral to ensure that nurses follow correct procedures when administering medication/nourishment, particularly checking for tube placement prior to administration and, flushing tubing before and after with prescribed amount of water.
- The nurses should receive competency-based training in Physical and Nutritional Management, particularly as related to Mealtime Challenges.
- The QA Nurse should consider working with the staff who manages the Access database, to use more of the data from the Medication Error Report, e.g., Possible Cause of Error, to develop a tracking and trending report using a "Root Cause Analysis" approach.
- Since errors may also be committed by physicians and pharmacist, they should attend and actively participate with the nursing staff to reduce medication errors/omissions and identify other areas of improvement for safe administration of medication practices. A copy of each individual's PNMP should be placed in front of each MAR for the nurses to follow when special techniques are required for administering medication.

- The Nursing Staff should work with the Physical and Nutritional Management staff to identify individuals that might be at risk for involuntary biting into a plastic spoon while receiving medication. For these individuals the Facility should consider use of hard plastic spoons for their administration of medication, like a "maroon spoon".
- The Facility should evaluate the location and proximity for Emergency Equipment in all locations and consider the use of a crash cart or suitcase/backpack to store equipment for ready access in the event of an emergency.
- One of the Medication Rooms in Driscoll that does not self-lock when closed should be immediately repaired.
- The CEN with the Facility Administration should evaluate available physical plant space to determine the possibility of making more space available for medication rooms.
- Although structure of the organization is at the discretion of the organization, it is essential that the structure support both establishment and implement high standards of care and integration of nursing within the interdisciplinary process.

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:** • Health Care Guidelines Appendix A: Pharmacy and Therapeutics Guidelines • Pharmacy and Therapeutic Committee Meeting Minutes • Medication Error Committee Meeting Minutes • Various Nursing Meeting Minutes in relation to Pharmacy issues • Pharmacy and Therapeutics Committee Minutes **People Interviewed:** **1.** Joe Williams, RP, Pharmacy Director **2.** Pharmacy staff during tour **Meetings Attended/Observations:** Toured the Pharmacy area and met Pharmacy staff.
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: The Pharmacy is not presently tracking polypharmacy according to the SA, e.g., DUE list. Polypharmacy usage is reviewed and tracked for psychotropic medications and sent to the respective physician, however, seizure medications are not included. Pharmacists reviewed new medication orders and completed prospective reviews with substantive comments/recommendations for prescribing physicians. Of the records reviewed, no disagreements by the physicians were found. Quarterly Medication reviews were completed with comments/recommendations, when indicated. Pharmacy has discussed the POI. The facility is awaiting instructions and training from DADS. The facility is beginning to draft policy changes regarding the role of the Medication Error Committee. Medication errors have increased. Review of the errors revealed, a high percentage of them are "meds not given", based on having meds left on the cart on refill day or via a spot check count by nursing staff. Often these were not considered real errors, rather failures to document such things as refusals, out on ATV or even doses held for various reasons. The facility is taking aggressive efforts to reduce medication errors.

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N1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature.	In the limited records reviewed there was evidence that the Pharmacists reviewed new medication orders and completed prospective reviews with substantive comments/recommendations for prescribing physicians. Of the records reviewed, no disagreements by the physicians were found. (See SA Medical Consultant's comments regarding is issue.)	
N2	Within six months of the Effective Date hereof, in Quarterly Drug Regimen Reviews, a pharmacist shall consider, note and address, as appropriate, laboratory results, and identify abnormal or sub-therapeutic medication values.	There was evidence that client Quarterly Medication reviews were completed with comments/recommendations, when indicated. (See SA Medical Consultant's comments for medical appropriateness of comments/recommendations.)	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics,	Pharmacy is not presently tracking polypharmacy according to the SA, e.g., DUE list. Polypharmacy usage is reviewed and tracked for psychotropic medications and sent to the respective physician, however, seizure medications are not included. He related the indication for prescribing was the responsibility of the physician. (See SA Medical Consultant's comments regarding is issue.)	

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	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.		
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.	In the limited records reviewed there was evidence that the Pharmacists reviewed new medication orders and completed prospective reviews with substantive comments/recommendations for prescribing physicians. Of the records reviewed, no disagreements by the physicians were found. (See SA Medical Consultant's comments regarding is issue.)	
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	In the limited records reviewed on clients taking psychotropic or other medications with the potential to cause side effects, there was evidence that the validated rating instruments MOSES and DISCUS were completed by RNs and signed-off by physicians. A DISCUS was completed every three months for individuals on antipsychotics and a MOSES every six months for individuals for individuals who are on antianxiety, antipsychotic, antidepressants, stimulants, mood stabilizers, sedatives/hypnotics and/or anticonvulsants. The SA, N., 5., requires, "…the Facility shall ensure quarterly monitoring and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia." The HCGs, III., C., 1., g., 3), states, "Tardive dyskinesia screening to include DISCUS immediately prior to initiating therapy as a baseline and every three months during treatment and for six (6) months following discontinuation of a neuroleptic medication. The MOSES will also be completed every (6) months." The Facility's Nursing Policy, Volume 4, Section 2, Revised: November 2009, Procedure for MOSES and DISCUS, appears to follow the HCG. However, there is a discrepancy between the requirements in the SA and the HCG relating to the frequency these assessments are to be completed. In order for the SA Consultants to accurately monitor this item, there needs to be clarification as to frequency these assessments are to be completed. In the limited records and other associated information reviewed on individuals taking	

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		psychotropic or other medications with the potential to cause side effects only trends are of non-compliance are identified: • The results of MOSES and DISCUS assessments were not consistently documented in clients' Annual or Quarterly Nursing Assessments, nor are individuals' responses to antipsychotic or other related medications or potential side effects listed. • Nursing Care Plans (HMPs) were not consistently developed with individualized goals and interventions to meet the individuals' needs related to interventions for specific side effect monitoring by staff and referenced behavioral interventions outlined in the Behavior Plan. • Documentation was not found in the Integrated Progress Note validating that the individual, family/guardian and PST were educated about signs and symptoms, causes and associated health problems (e.g., swallowing problems, risk of falls, etc.) related to psychotropic medications. Perhaps, this information is contained in other documents not reviewed. • A more in depth review of documentation related to PST quarterly reviews, data collected, and integrated PST discussion related to planning, implementing and evaluating programs and other activities that impact upon the individual's behavior and use of medications will be carried out during future compliance reviews.	
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.	This will be reviewed at the first compliance review.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of	Pharmacy is not presently tracking polypharmacy according to the SA, e.g., DUE list. Polypharmacy usage is reviewed and tracked for psychotropic medications and sent to the respective physician, however, seizure medications are not included. He related the indication for prescribing was the responsibility of the physician.	

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	care with regard to this provision in a separate monitoring plan.		
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 10/30/09 Pharmacy and Therapeutics Committee minutes reflected that Mr. Williams will be sending a draft to review of changes in the policy concerning the roles and responsibilities of the committee in relation to the POI. Draft changes in policy or the Pharmacy's POI were not available for review. This should be followed-up on the next review tour. Consideration should be given to changing the Medication Errors/Omissions Policy to a Medication Variance Policy that would encompass all aspects of medication administration and all relevant disciplines. Reportedly, there has been an increase of medication errors reported, primarily related to omissions. A summary of medication errors showed the following 2009 medication error data: July, 67 total errors of which 57 were omissions, August, 91 total errors or 62 were omissions, and September, total 92 of which 71 were omissions. However, no trends in errors were identified nor were recommendation for corrective action offered. The QA Nurse is responsible for reporting medication errors/omissions. A computerized Access Program is used and generates reports. The number and types of errors/omission are reported monthly to the State Office. Presently, there is no formal tracking and trending process in place; however, raw data reports are reviewed and used to assist with identifying type and severity of the errors and corrective measures. Aggressive efforts to reduce medication errors were evident through discussion and review of Medication Error Committee Minutes, all levels of Nursing Meeting Minutes, and Pharmacy and Therapeutic Committee Minutes. The QA Nurse, pharmacist, and staff who manages the Access database should work together to use more of the data from the Medication Error Report, e.g., Possible Cause of Error, to develop a tracking and trending report using a "Root Cause Analysis" approach. A more comprehensive analysis may be useful in pinpointing issues to assist with management of resources and problem solving. Additionally, when reviewing the Medication Error/Omission Policy, nursing is the only discipline listed; physicians and pharmacists also have the potential for committed medication errors. Review of BSSLC Policy and Procedures: Medication Error Committee, Nursing Policy, Volume 4, Section 2, Revised: November 2009, states that the policy applies to RNs, LVNs, Physicians, and Pharmacists. Review of Medication Error Committee Minutes, 8/14/09, 9/30/09, 10/29/09, and 11/24/09, only include the attendance of a pharmacist at one meeting; physicians were absent at all meeting. The purpose of this committee is to, "Track and analyze errors and develop strategies to reduce errors. Minutes reflect that the nurse participants actively analyze errors and develop strategies to reduce errors." However, since errors may also be committed by physicians and pharmacist, it is	

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		important that they attend and actively participate with the nursing staff to reduce medication errors/omissions and identify other areas of improvement for safe administration of medication practices.	

Recommendations:

- Pharmacy should begin tracking polypharmacy according to the SA.
- Pharmacists should participate in a documented way in the Medication Error Committee, either through attendance and direct participation or through another effective process to be determined by the facility.
- In order for the SA Consultants to accurately monitor this item, the disparity between N., 5., and HCG, III., C., 1., g., 3 should be clarified regarding the frequency MOSES and DISCUS assessments are to be completed
- Nursing Administration should review the SA and HCG in order to understand and develop strategies to meet compliance with: SA II. J., 9., - Psychiatric Care and services: Sections 9 (IDT integration of treatment; SA II., G., - Integrated Clinical Services: Section 1 (integrated clinical supports); SA II., H., - Minimum Common Elements of Clinical Care: Sections 1 (assessments done regularly); 4 (clinical indicators used to determine efficacy); 5 (monitoring of health status of individuals); and 6 (treatments modified in response to clinical indicators; and HCG III – Psychotropics/Positive Behavior Support.
- The Medication Error database should be expanded to include tracking and trending possible causes by unit, home, and nurse. This information should be available to the Medication Error Committee. The pharmacist and physicians should participate in the process of reviewing medication errors to identify and prioritize issues for improvement.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Comprehensive record reviews of 6 individuals (Individual #19, Individual #33, Individual #3, Individual #20, Individual #34, Individual #35) 2. Partial record reviews of 20 individuals (Individual #85, Individual #87, Individual #88, Individual #89, Individual #60, Individual #90, Individual #91, Individual #77, Individual #92, Individual #93, Individual #94, Individual #95, Individual #96, Individual #97, Individual #79, Individual #86, Individual #51, Individual #50, Individual #98, Individual #99) 3. Review of requested tour documents **People Interviewed:** 1. Kori Kelm, Habilitation Therapies Director 2. Occupational Therapist 3. Speech Pathologist 4. Dentist, Dental Hygienist 5. Chief Executive Nurse 6. PNMP Coordinator 7. Residence Director 8. RN Case Manager 9. Hospital Liaison 10. Nurse Educator 11. Multiple Direct Support Staff and Unit Nurses **Meetings Attended/Observations:** 1. Observations of living areas, dining rooms, oral care, positioning, enteral nutrition, and medication administration 2. Attended morning unit meeting, HST quarterly, and shift change
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: BSSLC Has the beginnings of a physical and nutritional management system; however the system is severely fragmented in that all professionals are working on a common goal but are not fully aware of their role in the process or how it relates to the other professionals. Staff is unsure of how the system works or how it will truly improve the individuals' quality of life.

	Individuals who are at a "high risk" are not being identified and therefore may not be receiving the care and treatment required to prevent future illness. While everyone has a PNMP, the PNMPs are not considered to be appropriate due to oral hygiene and medication administration not being included as part of the document. Additionally, the assessment process involved in the development of the PNMPS is flawed secondary to little input being provided by therapy regarding positioning for GERD management, oral hygiene techniques, and presentation of medications. Overall, there needs to be more of a proactive, cooperative, collaborative, systemic approach to address physical and nutritional support issues.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and	Although Brenham State Supported Living Center (BSSLC) has a Nutritional Management Team, the team's scope is too limited and narrow; it does not proactively and comprehensively address the wide ranging needs of the individuals. The team consists of an occupational therapist, physical therapist, dietitian, house lead, nurse, and physician however the team meets as part of the Medical quarterly which focuses primarily as a medication and medical health status review and does not address the individualized physical and nutritional needs and concerns of the individuals. Per review, active involvement by the speech pathologist in the quarterly meetings was not routine nor was it apparent that team members had participated in any form of specialized training regarding physical and nutritional management. The meeting this reviewer attended did not appear to be a meeting in which active collaboration of all involved parties was facilitated. Simply having a limited nutritional management team is not enough. More needs to be done to minimize individuals' risk and maximize their skill acquisition. BSSLC does have physical and nutritional management plans (PNMP) in place for all individuals however the PNMP is lacking information concerning oral care strategies and medication administration and the information provided regarding head of bed elevation is not individualized. Additionally, the PNMP is not integrated into the individual's Personal Support Plan (PSP) other than being referenced in the dining section.	

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	nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.		
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	Many BSSLC individuals have medical conditions that seriously complicate the swallowing and digestion of their food and beverages as well as increase their difficulty in being able to safely manage their oral secretions. Aspiration Pneumonia is often a preventable condition that results from the accumulation of foreign materials (usually food, liquid, or reflux) in the lungs. BSSLC lists only 4 individuals as at "high risk" yet several individuals who are not on the center's high risk list were hospitalized for aspiration or choking related events. Based upon observation, there were a significant number of individuals who were observed to be at "high risk" but were listed as being at "low risk" according to their screening forms. Currently BSSLC's aspiration and choking risk lists has 323 listed as at "low risk", 31 listed as at "medium risk" and 4 at "high risk". In addition, 5/6 records reviewed had inaccuracies with scoring and inconsistencies between various risk screenings. For example: • Individual #33's behavior risk form states that he is at risk for PICA however the aspiration/choking screenings states that he is not. • Individual #33's aspiration/choking risk screening states that he has good oral hygiene when the dental report states that he has poor oral hygiene. • Individual #100's Aspiration risk screening states that individual eats by mouth when he actually receives only enteral nutrition. It also states that he has good oral	

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		hygiene when the dental report states that he has poor oral hygiene • Individual #86's Aspiration risk screening states that individual does not steal food however the behavior risk screening states that she steals food. • Individual #86 has a diagnosis of choking and aspiration pneumonia within the last 18 months. A MBSS conducted at St Josephs stated that she was at a "high" risk of aspiration however, at BSSLC is "Low Risk" • Individual #60 engages in PICA, is on a modified diet, has a diagnosis of dysphagia and has had pneumonia in the past 12 months yet is listed as being at a "low risk" for aspiration and/or choking. • Individual #34's risk screening states that he has good oral hygiene when the dental report states that he has poor oral hygiene Thorough review of the "At Risk" policy revealed two main issues. One was that the center was incorrectly following the policy as BSSLC was placing the majority of their individuals as being at "low risk" when they should have been placed as at "medium risk." Second, the policy as written is flawed in its ability to identify those who are at a "high risk" of physical and nutritional decline. In its current state, the policy identifies individuals as being at "High Risk" if they are having an acute issue, "Medium Risk" if they require ongoing supports (i.e., a PNMP), and "Low Risk" if they do not require supports. Following the policy as written would result in BSSLC having their entire population with the exception of the 4 "High Risk" listed as "Medium Risk" since the remaining individuals have PNMPs. This type of risk classification system is not functional or useful to the clinicians or the individuals living at BSSLC. A decubitis ulcer or skin breakdown is another preventable condition given appropriate care. As with other conditions, BSSLC is failing to identify all those individuals truly at risk and this hampers or eliminates the possibility of providing proper preventative services and supports. For example, two individuals had multiple skin breakdowns over the course of 12 months but are listed as being at "medium risk." The issues noted above results in questioning whether or not BSSLC is accurately identifying and treating all those individuals at risk. Assessments have been or will be provided for all individuals living at BSSLC however the assessments provided, contained vague terminology and were incomplete with regards to all pnm issues. 16 of 27 OT/PT assessments reviewed contained vague terminology (i.e., fair and good) without providing a definition of the descriptor. "Fair" and "good" are very difficult terms to measure and result in the decreased ability to compare and contrast assessments between clinicians and from year to year. This same issue was noted throughout all therapy assessments including nutritional and speech.	

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		Issues related to the risk of aspiration outside of mealtime (i.e., oral hygiene, HOB elevation, and medication administration) were not included as part of the assessment process. While the Dietitian is involved in quarterly meetings, Nutritional Assessments are not completed on a consistent basis and are frequently listed as outdated on the PSP. Additionally, 27 of 27 records reviewed indicated findings of the assessments were not adequately integrated into the PSP.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	PNMPs and Dining Cards have been developed for all individuals residing at BSSLC however the PNMPs are felt to be inadequate as the risks associated with oral hygiene and oral medication are not addressed in the current format. Currently, therapy has no role in developing oral hygiene plans or input into the method in which oral medication is provided. Oral management as well as positioning of person and staff associated with these two activities is essential to minimizing the risk of aspiration. Therapy should play an integral role in determining the methods to be utilized during these activities as well as determining head of bed elevation for individuals who receive enteral nutrition or have a diagnosis of GERD. In its current form, this information is provided by only the physician and is based mostly on the standard protocols and is not individualized. PT/OT should play a vital role in determining these issues as they are the ones who are most familiar with the individuals' positioning and skeletal structure.	
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.	Based upon observations, it was noted that implementation of the dining cards and PNMPs are sporadic at best. These observations revealed little to no staff response to potential signs of aspiration or difficulty swallowing (i.e., poor positioning, coughing, watery eyes). 9 of 12 individuals observed during dining were not provided with cues or strategies as outlined in the PNMPs or dining cards and individuals receiving enteral nutrition and oral intake were not consistently well positioned. For example: • Individual #92's plan states that she should be upright in wheelchair but was observed to be leaning significantly to her right during the meal. • Individual #77 receiving enteral nutrition when elevated less than the 30 degree physician order • Individual #91 was observed sideways in his bed when receiving enteral nutrition. • Individual #93 requires ¼ to ½ teaspoon bite sizes but was observed receiving large full teaspoons bites • Individual #60 requires cues to alternate bites with liquids but this was not prompted by staff • Individual #94 requires ½ teaspoon bite sizes but was observed receiving large	

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		full teaspoons bites • Individual #90 requires bread be chopped into dime size pieces however bread was only torn in half. • Individual #97 should be provided with nectar like liquids but was provided with pudding like liquids • Individual #95 was provided with liquids not thickened to recommended honey consistency Oral Care observations revealed minimal to no carryover of safe swallow strategies. Staff was observed providing thin liquids to individuals who required thickened liquids, individuals who utilize wheelchairs were consistently observed hyper-extending their neck due to poor self positioning and staff positioning thus increasing the opening of their airway and their risk of aspiration, and staff was routinely observed standing over the individuals during the activity. Individuals who are on modified diets (i.e., pureed and honey thick fluids) are provided at times with whole medications and are consistently without the adaptive equipment specified in their PNMPs and dining cards for oral intake thus placing the individual at an increased risk during these activities. Once again, Kori Kelm, Habilitation Therapies should become a more active member in determining the positioning of the individual and staff during these activities and assist in determining the best method for presenting these two activities.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing.	Based upon multiple discussions and observations, staff are not very knowledgeable regarding physical and nutritional management. Staff were unaware of the individual's level of risk or the rationale behind the recommendations listed on the PNMPs and dining cards and how not following these recommendations may increase the individual's level of risk. Per document review and interview, all staff participate in a foundational class called "Optimal Dining" during orientation however this course is not renewed or recertified on an annual basis. Many staff interviewed mentioned that it is difficult to remember all the information, especially if they have been long time employees. Additionally, the training primarily focuses on mealtime issues and does not fully address the more holistic approach of physical and nutritional management. Person-specific training is provided to staff who routinely work at a specific unit; however there is no process in place to provide this additional training should a unit have to utilize floating or pull staff from another area. It is essential that PNM supports	

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		for individuals who are determined to be at an increased level of risk are only provided by staff who have successfully completed competency-based training specific to the individual. Much training relevant to the PNMPs is conducted by the PNMP coordinators who do not have the training or the expertise to appropriately provide this type of training in detail or provide the rationale for the use of the strategies and/or equipment. This results in poor staff knowledge as they may know that they need to use a specific strategy or piece of equipment but do not have the understanding of why it is so important to the individuals' level of care.	
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.	Monitoring is conducted by professionals and PNMP coordinators, however there is not a clear process in place that outlines the frequency in which individuals will be monitored (i.e., high risk vs. low risk) or the response if a deficiency is noted. Additionally, many staff who conduct monitors state that they have received little to no additional training on how to complete the form, what signs or symptoms they should be monitoring and what happens to the forms once they are completed. This was evident by a mealtime this reviewer observed as well as a PNMP coordinator. This reviewer found five deficiencies associated with the mealtime and the PNMP coordinator found only one. In order to be an effective monitor, one must have the skills necessary to identify potential early warning signs associated with physical and nutritional decline. Currently, there are seven PNM monitoring forms being utilized by multiple professionals and staff. This results in confusion, and the inability to analyze data between dates and between monitors as well as establish trends over time. BSSLC should consider reviewing the entire monitoring process so that it is streamlined and clearly defined.	
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.	The current monitoring system focuses primarily on whether or not equipment is available and staff are implementing the strategies as listed in the PNMP and dining plan. The effectiveness of the plan is not clearly monitored. The determination of whether a plan is effective or not requires clinical decision making and therefore should only be completed by individuals who have expanded experience with physical and nutritional issues. Findings of the current monitoring forms are filed with the Residence Director and Habilitation Therapies but there is not a clear system in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with physical and nutritional risk.	

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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.	As of 1/15/2010, there are 46 individuals receiving enteral nutrition which is approximately 12% of the BSSLC population. There was no evidence that an individual's continued need to receive enteral nutrition or possible return to oral intake is assessed and reviewed annually by the physical and nutritional management team or PST. Comprehensive evaluation should be utilized to determine their feasibility of returning to oral intake and to allow for comparison of swallow function from year to year. Identified in these evaluations should also be strategies that have been developed to transition an individual to oral intake, if appropriate.	

Recommendations:

- BSSLC should review their entire PNM system to ensure that the PNM team is a therapy driven collaborative team that focuses on proactive preventative care. Individuals who are at a high risk are not being identified due to the criteria set forth by the "At Risk" policy as well as inadequate follow through of said policy. Therefore, BSSLC in coordination with other state centers and the state of Texas should revisit the policy and redesign so that is identifies those who are at risk. Individuals who are completing the screening forms should be the ones who contain the most knowledge of the individual's physical and nutritional status. For example, the Aspiration/Choking screening should be completed by the swallowing expert.
- Assessments should be reviewed and revised so that all aspects of physical and nutritional management are addressed. This includes assessing oral care, medication administration and positioning for these activities as well as positioning for improved GERD management and stomach emptying. BSSLC should also focus on improving the use of measurable terminology and consistency between assessments and clinicians.
- PNMPs should be revised to contain the strategies identified via the assessments. PNMPs and dining plans should be reviewed to eliminate vague terminology with regards to the listed strategies in an effort to increase consistency of implementation by staff.
- A training system should be considered that ensures all staff are regularly trained on all aspects of physical and nutritional management. The training curriculum needs to be expanded with specific learning objectives and competencies to provided foundational knowledge and skills related to: mealtime position and alignment, diet texture and consistency, presentation techniques to enhance nutritional intake and hydration, care and use of adaptive equipment, aspiration and choking precautions, purpose of a swallow study, strategies to support independence during PNM activities, presentation and alignment to support safety during oral care, bathing, and medication administration. This should include orientation training as well as regular updates. Care should also be taken to ensure that all staff are provided with individualized competency based training prior to working with an individual who is considered to be at an increased risk.
- A monitoring system should be implemented that focuses on plan effectiveness rather than just presence and implementation. All staff conducting the monitoring for plan effectiveness should have the clinical knowledge to make such determinations and those monitoring for implementation and presence should have additional training as well to ensure consistency and accuracy. The system should be data driven to allow proper analysis and tracking of trends. Multiple mealtime monitoring forms were presented to the reviewer but there was not a standardized system.
- Ensure the policy and procedure for monitoring defines the process of analysis of monitoring reports to formulate corrective strategies to address specific and/or systemic areas of deficiency.
- Individuals who receive enteral nourishment should be assessed annually to determine appropriateness of continued enteral status and the possible return to oral intake.

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. Comprehensive record reviews of 6 individuals (Individual #19, Individual #33, Individual #3, Individual #20, Individual #34, Individual #35) 2. Partial record reviews of 20 individuals (Individual #85, Individual #87, Individual #88, Individual #89, Individual #60, Individual #90, Individual #91, Individual #77, Individual #92, Individual #93, Individual #94, Individual #95, Individual #96, Individual #97, Individual #79, Individual #86, Individual #51, Individual #50, Individual #98, Individual #99) 3. Review of requested tour documents **People Interviewed:** 1. Kori Kelm, Habilitation Therapies Director (Physical Therapist) 2. Occupational Therapist **Meetings Attended/Observations:** 1. Observations of living areas, dining rooms, program services, oral care, positioning, enteral nutrition, and medication administration 2. Attended morning unit meeting, HST quarterly, and shift change
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: Habilitation Therapies have and continue to provide assessments for the individuals living at BSSLC. While the assessments are clinically sound as it relates to areas of functional mobility and adaptive positioning equipment, they are lacking in detail relevant to an individual's physical and nutritional concerns. This includes oral management and positioning during medication administration and oral hygiene as well as positioning for GERD management and stomach emptying. The rationale and justification behind a therapists' recommendation is also lacking in detail and does not provide a clear picture of how the interventions benefit the person. Individuals who have plans in place (positioning, alternative positioning, and/or mealtime) are not consistently provided with supports, and there is not an effective monitoring system in place that provides reliable data and tracking. Staffing concerns exist within the disciplines that provide health care and physical supports to BSSLC individuals. Currently, BSSLC may not have enough clinicians to provide adequate physical and occupational therapy to meet the needs of individuals who require these services.

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	BSSLC has on staff, 2 full time physical therapists, 2 physical therapy assistants, 3 full time occupational therapists, and 1 certified occupational therapy assistant. There is currently one opening for an additional physical therapist. This results in an average caseload of 180 for the physical therapists and 120 for the occupational therapists. Carrying a caseload this large makes it increasingly difficult to provide proactive care as most of the clinician's time will be spent in wheelchair clinic or completing other annual assessments. On the topic of assessments, the therapists have done well in collaborating and providing PT/OT assessments in a timely manner and follow up with more comprehensive assessments as applicable. The primary concerns regarding the assessments are as follows: • Appropriate bed positioning regarding GERD management, oral care, and medication administration are lacking and/or missing. • The use of vague terminology (i.e., good or fair) which is not measurable and is difficult to analyze and track trends over time. • Lack of justification and functional rationale for proposed strategies and interventions. For example: Adaptive equipment is recommended and described but why it is appropriate and how it will address the identified concerns is not available.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	While the PT/OT assessments have been completed, they are not adequately integrated into the PSP. Upon review of the PSP, the assessments are mentioned but are not integrated as part of the summary of the individual and do not clearly provide information on the individual's strengths and weaknesses and how the proposed interventions provided in the PT/OT assessment will benefit the individual in living a more independent and functional life. Per interview and documentation review, there is limited to no therapy involvement in the PSP which results in a fragmented interdisciplinary approach and may be a factor in the issue just mentioned. Plans developed by the PT/OT assessments include positioning, dining cards, and PNMPs. Once again vague terminology is present throughout the plans resulting in multiple interpretations of what is required for the individual. For example: • Individual #51's plan states "Encourage eating at a slow pace". Upon interview with multiple staff, this reviewer received multiple ways on how staff slows the individual's pace down instead of a single cohesive approach.	

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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.	Staff has received foundational training during orientation but like physical and nutritional management, the trainings are only provided once and there is no annual update or recertification. Per interview, staff was mostly aware of the interventions but is not knowledgeable regarding the rationale for such interventions and how this improves the individual's quality of life. For example: • Staff was asked about repositioning an individual. They stated that it needed to be done every two hours but were unable to articulate why this practice was important. Per observations, 5 of 7 individuals observed and followed were not provided with positioning interventions outlined in the PNMPS. For example: • Individual #91 was laying sideways in bed when plan call for 30 degree HOB elevation • Individual #77 was not provided with a pillow between his legs as indicated in the PNMP. • Individual #88 was not elevated to 45 degrees per physician's order • Individual #93 was leaning to her right and hyperextending her neck throughout her meal • Individual #96 was hyperextending her neck during meal and oral care	
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	The current monitoring system focuses primarily on whether or not equipment is available and staff are implementing the strategies as listed in the PNMP and dining plan. The effectiveness of the plan is not clearly monitored. The determination of whether a plan is effective or not requires clinical decision making and therefore should only be completed by individuals who have expanded experience with physical and nutritional issues. Findings of the current monitoring forms are filed with the Residence Director and Habilitation Therapies but there is not a clear system in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with physical and nutritional risk. Person-specific training is provided to staff who routinely work at a specific unit however there is no process in place to provide this additional training should a unit have to utilize floating or pull staff from another area. It is essential that supports for individuals who are determined to be at an increased level of risk or are receiving PT/OT interventions are only provided by staff that have successfully completed	

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	of these interventions.	competency-based training specific to the individual.	

Recommendations:

- BSSLC and state of Texas should review the caseload and job duties of Habilitation Therapies to ensure that current staffing levels are appropriate to meet the demanding need of physical and nutritional supports.
- The current assessment format needs to be reviewed to determine if the current assessment format is sufficiently comprehensive to identify the needs of the individuals at BSSLC. Special care should be given to the areas of oral care and medication administration as well to improving overall detail.
- Habilitation Therapies should participate more actively in the annual PSP process. Systems and procedures should be developed to integrate PT and OT assessments into the PSP. When screening and assessment indicate need for services directly provided or developed and monitored by PT or OT staff, Habilitation Therapies should participate throughout the PSP process.
- A training system should be considered that ensures all staff is regularly trained (See SA O recommendation)
- A monitoring system should be implemented that focuses on plan effectiveness rather than just presence and implementation (See SA O recommendation)

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: **Documents Reviewed:** **1.** BSSLC's Policy and Procedures: Dental, Volume 4, Section 14, Revised: May 2008 2. BSSLC's Policy and Procedures: Conscious Sedation Treatment, Nursing Policy, Volume 4, Section 2, Revised: November 2009 **People Interviewed:** 1. Interview with Dental Staff: Gary Johnston, DDS, Dental Director, Julie Weidemann, RDH, and Jennifer Pampell, RDH **2.** Shawn Cureton, Psychology Manager **Meetings Attended/Observations:**
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: • Because of the recently hired full time Dentist and Dental Hygienist BSSLC is able to expand dental services to the individuals that reside at Brenham. The Dental Hygienist has started using suction toothbrushes and teaching the staff in the home in its use. • The facility used Conscious Sedation for a number of individuals. When asked how individuals are selected for this form of sedation, no set criteria for its use were provided. Given the lack of criteria for use of Conscious Sedation, it appears the PST is not involved in making those decisions. Rather, it is decided by the dental and medical staff based on the individual's reaction to dental treatment. When asked who writes the Dental Pre-sedation and Desensitization Plans for such procedure, it was explained that the QMRP wrote the plan. • Development of desensitization programs does not adequately involve interdisciplinary team planning. Psychologists are not involved in developing these programs.

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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	• It could not be determined if the use of Conscious Sedation by a contracted Anesthetist meets the, Texas Occupation Code: Dental Practice Act, ADA guideline, and ICF-MR regulations. There was a lengthy discussion regarding the recent use of Conscious Sedation. They explained how its use is implemented using a contracted Anesthetist that comes to the Facility twice a month. Reportedly, all State Facilities are providing Conscious Sedation. When the safety of the use of Conscious Sedation via intravenous route was questioned, Dr. Johnston strongly insisted this was the safest method of delivery. Individuals recover from the sedation quickly and safely. The Anesthetist brings all the emergency equipment and an assistant. However, because of the use of Conscious Sedation the facility is required to have nurses trained in ACLS. The Nursing Department has developed a Conscious Sedation Policy.	

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	guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	Two nurses are trained (whether they are certified was not reviewed) in ACLS and are on site when Conscious Sedation is administered. It is of concern that staff physicians are not trained in ACLS. While the Anesthetist and his assistant may be able to respond to an emergency while on site, it was not clear what resource would be available when they leave. Of further concern is the fact that nurses are trained in ACLS, but it is not clear what happens if an individual has a cardio-respiratory compromise after they leave the Dental Office or when the Anesthetist leaves. Nurses are held to their highest level to skill/knowledge, so this may mean they would be expected to carry out ACLS level of resuscitation.	
Q2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement policies and procedures that require: comprehensive, timely provision of assessments and dental services; provision to the IDT of current dental records sufficient to inform the IDT of the specific condition of the resident's teeth and necessary dental supports and interventions; use of interventions, such as desensitization programs, to minimize use of sedating medications and restraints; interdisciplinary teams to review, assess, develop, and implement strategies to overcome individuals' refusals to participate in dental appointments; and tracking and assessment of the use of sedating medications and dental restraints.	• Dental Policy and Procedures have not been revised to include the use of Conscious Sedation Procedures. Reportedly, the policy is in the process of being updated and reviewed. The Dental Department does not have a flow record as to procedure regarding this restraint, but a record will be created and implemented. • Presently, 21 individuals have Dental Pre-sedation Plans; of those, 8 individuals have Desensitization Plans while 13 do not have a Plan. Reportedly, the Facility has no method for tracking and summarizing data pertaining to pre-sedation. There is no Facility wide review of dental data. On an individual basis PST's are required to review the use of pre-treatment sedation and develop plans to minimize its use. The outcome of the PST's review could not be determined. The possibility of including the psychologist/behavioral analysis in the assessment and planning process for pre-treatment sedation and desensitization plans was discussed. The Dental staff seemed receptive to the idea. Failure to include the Psychology Department staff to assist with assessing and planning for the least restrictive method for delivery of dental service, points out the lack of integrated services. • Shawn Cureton, Psychology Manager, discussed the involvement of the Psychology Department with Dental Department regarding pre-treatment sedation and Desensitization Plans. Mr. Cureton related his department was not involved in these plans but thought they should be in an effort to develop a more comprehensive and effective plan to use the least restrictive measures possible in aiding individuals with dental care.	

Recommendations:

- The Dental and Nursing staff should ensure that individuals that have had Conscious Sedation for dental care are fully awake, responsive and have complete return of the "gag reflex" before returning to their home and/or receiving oral intake.
- PSTs should be involved in decisions regarding use of sedation, including Conscious Sedation, and in development of desensitization plans.
- See HCG Section V Prevention for information leading to this recommendation: The Infection Control Nurse should conduct infection control inspections of Dental Services equipment for all potential causes for increased oral infections.

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.** Review of requested tour documents 2. Comprehensive record reviews of 6 individuals (Individual #19, Individual #33, Individual #3, Individual #20, Individual #34, Individual #35) 3. Partial record reviews of 20 individuals (Individual #85, Individual #87, Individual #88, Individual #89, Individual #60, Individual #90, Individual #91, Individual #77, Individual #92, Individual #93, Individual #94, Individual #95, Individual #96, Individual #97, Individual #79, Individual #86, Individual #51, Individual #50, Individual #98, Individual #99) **People Interviewed:** 1. Kori Kelm, Habilitation Therapies Director 2. Speech Pathologist 3. Residence Director 4. House Leads and unit staff **Meetings Attended/Observations:** Observation of living areas, dining rooms, and program services
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: BSSLC's approach to augmentative communication and assistive technology is fragmented and not team-oriented. BSSLC lacks sufficient coordination and collaboration between and among the various disciplines, especially with regard to the need for proper communication devices on wheelchairs and to address aspects of communication associated with targeted problem behaviors. In addition, the center fails to provide sufficient assistive communication systems to all individuals who would benefit from such supports. Although it is positive that communication plaques were placed in many common areas, and all individuals have at least a communication dictionary, these were not observed to be used nor was the staff knowledgeable of the dictionaries. Finally, as is true on other areas, staffing concerns exist within the disciplines that provide health care and physical supports to BSSLC individuals. Currently, BSSLC does not have enough clinicians to provide adequate speech therapy to meet the needs of individuals who require these services.

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R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	There are currently 3 full time Speech Pathologists with 1 Speech Tech on staff at BSSLC. As with PT and OT this is resulting in a very large caseload of approximately 120 individuals per therapist. Carrying a caseload this large makes it increasingly difficult to provide proactive involvement as most of the clinician's time is spent completing assessments and provides little time for continued supports to be provided by the Speech Pathologist. With the current numbers, the therapists are passing many duties on to other professionals which should be completed within the department. An example of this is the passing of communication goals to program services. It is considered appropriate to have program services work on a communication goal but the author and monitor of that goal should be the Speech Pathologist as these goals are essential to future language and speech development. As it is now, there is limited to no follow through being provided by the Speech Pathologist as it relates to these goals.	
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.	As with other therapy reports, the Speech assessment contains vague terminology that is difficult to measure. Assessments are narrative in format and vary from therapist to therapist and areas focused on from assessment to assessment. Individuals identified with therapy needs are in the process of receiving assessments; however the assessments do not adequately address verbal and nonverbal skills, expansion of current abilities or the development of new skills. There is little collaboration or cohesion between psychology and speech pathology as it relates to PBSPs and the development of augmentative communication plans. For example: • Individual #51 exhibits frustration by SIB, however the augmentative communication plan focuses on daily activities rather than alternate ways for this person to express frustration. The majority of individuals at BSSLC have been provided with communication dictionaries; however, out of 173 individuals who are primarily non verbal , fewer than a quarter are provided with another form of low, mid, or high tech devices. Additionally, throughout the survey, there was no evidence of the existing devices being utilized by an individual or encouraged to be used by staff. Per interview and document review, there is no clear policy or process that defines the schedule or criteria regarding whether an individual receives a speech update or full assessment.	

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R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	Results from the speech assessment are only mentioned in the PSP. Rationales and descriptions of communication interventions regarding use and benefit are not clearly integrated into the PSP. Other than mention the device and or assessment, the PSP does not contain information regarding how the individual communicates and strategies that staff may utilize to enhance communication. Per informal discussions, direct support staff was not knowledgeable of the content listed individuals' communication dictionaries. AAC devices have been placed in many common areas, however these devices were not observed to be utilized during the course of the tour. Additionally, individuals with communication wallets, or other AAC were not observed utilizing the devices and there was no observed staff prompting to do so.	
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.	BSSLC does have a monitoring system that tracks the presence and working condition of the AAC equipment however the implementation and effectiveness piece is missing. Monitoring should cover all areas in which the use of the device is applicable (which should be all the time). As mentioned in section O-7 and P-4, effectiveness of the device may only be determined by a professional with expertise in that related area therefore the implementation of the plans should be followed by the Speech Pathologist. Progress with all communication goals should be consistently reviewed by the Speech Pathologist so that modifications to the plan are timely and appropriate for future language and speech development.	

Recommendations:

- BSSLC and state of Texas should review the caseload and job duties of Habilitation Therapies to ensure that current staffing levels are appropriate to meet the demanding need of physical and nutritional supports.
- An increased presence and utilization of communication devices is needed at BSSLC. To BSSLC's credit, they have implemented multiple communication boards in common areas, but these are not being utilized. More attention should be provided to those individuals who find it difficult to communicate basic wants and needs.
- Currently, speech and language goals that are not directly treated by an SLP are passed on to program services to work on prerequisite skills. The goals then developed are done so by the QMRP who does not have experience writing speech or language objectives. Goals that do not build upon each other often result in little to no progress. A process should be developed through which the SLP collaborates in development of goals and programs for communication skill development, including writing and monitoring goals and training staff.

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. Review of all requested documents 2. Observation of PTR, BSRC, PSP reviews 3. Comprehensive review of 15 records (Individual #30; Individual #33; Individual #50; Individual #51; Individual #6; Individual #9; Individual #20; Individual #19; Individual #52; Individual #29; Individual #53.; Individual #12; Individual #3; Individual #54; Individual #10) and review of PSP for Individual #18) **People Interviewed:** Interviews with training supervisors, residence managers, teachers, direct care staff, vocational staff **Meetings Attended/Observations:** 1. Residences, including afternoon/evening leisure times at Cottage D and Fannin D 2. Training sites, classrooms and vocational sites, including 3. Adult Program Services (APS) A (shredding), C, D, Money Management 4. Brenham Production Services (BPS) 5. Enclave at Blue Bell
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: Skill acquisition programs are consistently found in records. They cover a broad array of skill areas. However, the programs do not contain all the components that would be needed to effectively teach or strengthen behavior. Task analyses and preference or reinforce assessments are not evident. Objectives are not clear and well-defined. Criteria are written in a manner that may delay movement to more independence. Vocational and leisure programming is a mix of excellent programs (some with at least limited community integration) versus programs and activities that are irrelevant to individuals' skill and preferences, community-integrated leisure versus time spent doing little activity, household activities versus no training in household living.

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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	BSSLC provides an adequate number of skill acquisition training programs. In 15 of 15 records reviewed there were skill acquisition programs that reflected identified personal needs. These plans cover a broad array of skills and are provided for training in a variety of settings.	

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	individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	Based upon information gathered during the site visit, however, the ability of the reviewed skill acquisition programs to effectively teach or strengthen a behavior is doubtful. In a review of 15 records the following weaknesses were consistently evident. • Training was not based upon a valid and individualized task analysis. • Objectives lacked specificity • Training targets were not operationally defined • Teaching conditions and procedures were lacking in specificity • The number of trials was not sufficient to ensure that learning was likely to occur • There was no indication of a formal and valid reinforcer assessment • It was not clear that consequences were adequate to strengthen the desired responses and weaken undesired responses • Plans for generalization lacked foresight and detail • Data collection did not evidence standards currently accepted in the field of applied behavior analysis Observations and interviews strongly suggest that the emphasis of the skill acquisition process at BSSLC is upon the administrative elements of teaching; ensuring that time frames are met and the required documents are available in the record. Although individuals living at BSSLC undoubtedly develop skills, it is not apparent that this skill acquisition is due to the content or implementation of skill acquisition programs. Vocational training programming is a mix of excellent programs and activities that are irrelevant to the individuals' skills and preferences. The workshop located in Brenham provides excellent vocational opportunities; individuals were almost all active and productive. People working at the enclave at Blue Bell were also productive and expressed enjoyment of their work. Staff indicated that Blue Bell employees did come by frequently, but the work area is isolated. The day program at Adult Program Services included a relatively new and productive shredding program, but in C and D most individuals were assigned to areas that did not provide productive or relevant activity. People who appeared not to recognize numbers or letters were assigned to a bingo game in which staff placed all the pieces (sometimes by using hand over hand assistance). An individual in a "sensory" program was to put dowels with materials of different textures into holes with the matching textures; the staff guided his hand and praised him, but he never touched the textures on the rods or in the holes. A "greenhouse" room did not involve people in doing any work with plants, dirt, or any other greenhouse activity. However, the Program Services Director was aware of these concerns and is planning to change this area. Brenham is preparing a building for an on-campus vocational workshop. Staffing in Adult Program Services has	

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		increased from about 78 FTEs to about 112. The Program Services Director described planning that is going on now to increase activities in the evenings and weekends; a shuttle service has been developed to take people into the community for activities and shopping on some weekends, and a catalog of activity options is being developed.	
S2	Within two years of the Effective Date hereof, each Facility shall conduct annual assessments of individuals' preferences, strengths, skills, needs, and barriers to community integration, in the areas of living, working, and engaging in leisure activities.	The sequences of many objectives do not lead to increases in skill or independence. Many sequences of objectives (in both skill acquisition programs and PBSPs) change only by the frequency of occurrence or the number of prompts allowed for a daily "plus" data point (for example, a behavior will occur "with no more than 4 verbal prompts for 2 consecutive months" and then, when that is met, "with no more than 2 verbal prompts for 2 consecutive months.") When the number of prompts defines the criterion for a plus, it is possible that fewer prompts are required than even in the next objective (e.g., although an objective is defined so that a plus requires no more than 4 prompts, a person completes the required activity in only 2 prompts, which would meet the next objective). Nevertheless, the person would be required to continue the same objective, with the reduced number of prompts, for another period (often, two consecutive months). This may delay progress toward objectives that will teach or increase more skilled behaviors or greater independence. In 15 of 15 records reviewed, the records contained a variety of skill assessment instruments. It was frequently the case, however, that these assessments were inadequate to the task of assessing skills and personal characteristics. • No formal preference or reinforcer assessments were noted that would meet current accepted practices of applied behavior analysis. • Assessments did not include personal strengths and limitations as measured by individualized and formally presented task analyses. • There was no indication that the validity and reliability of assessment included in the record were assessed. • Although nearly all skill acquisition programs use a total task training approach, there is no evidence of task analysis being done to establish the steps to be trained.	
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	A number of limitations were noted in the implementation of skill acquisition training programs. • Observations of training in C Side and D Side revealed a chaotic environment in which little structured teaching was taking place. Staff members tasked with teaching were often unable to provide effective instruction or training. When interviewed, staff members often reported being provided with minimal instruction and support, and described the general strategy as, "keep people	

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	individual's needs. Such programs shall:	busy." • The implementation of training in the homes was equally lacking. Staff members were often ill-prepared and unable to adequately describe the purpose of or skills taught by the activities in which they were engaged. In numerous homes, teaching consisted of playing dominos or board games. • For individuals with the greatest physical and cognitive disabilities, the apparent approach to training was to provide stimulation and ensure that everyone was happy. No observations revealed any teaching of basic personal care, vocational or academic skills although individuals were observed to demonstrate the capacity to learn such skills. • During observations of teaching sessions across a wide variety of homes, academic classrooms, workshops and other settings, no staff member was observed to record any data regarding skill acquisition programs. • The only consequences observed that could be construed as reinforcement were verbal praise and tactile attention. During no observations was any potential form of reinforcement observed being used in a formal or systematic manner likely to strengthen a behavior	
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	As noted above, strategies are not yet adequately individualized, may not involve training designed to be effective, and have limited data on effectiveness, they could not yet be considered practical and functional for a more integrated setting. This will be a focus of compliance reviews when the timeline in the SA approaches.	
	(b) Include to the degree practicable training opportunities in community settings.	Vocational training opportunities have been developed in community settings, but there is room for continued growth. The workshop located in Brenham provides excellent vocational opportunities; individuals were almost all active and productive. People working at the enclave at Blue Bell were also productive and expressed enjoyment of their work. Staff indicated that Blue Bell employees did come by frequently, but the work area is isolated. Furthermore, the workshop, although located in the community, is not integrated into the community; because of its location and well-established program, opportunities for community integration could be explored. Community recreation is available but could be expanded. The recently-established shuttle service to take people into town is an excellent example of the kind of process that can be developed so that individuals and small groups can participate in community-integrated learning activities. During compliance reviews, training plans will be	

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		reviewed and actual training activities observed.	

Recommendations:

- It is critical that the BSSLC staff tasked with developing skill acquisition programs attain competence in the skills necessary to effectively perform those tasks. These staff members require comprehensive, competence-based training on all aspects of skill assessment, task analysis, and reinforcer and preference assessment, as well as behavior analytic principles essential to understanding and strengthening behavior. Although applied behavior analysis is often mistakenly considered to be only within the domain of psychologists and behavior analysts, it is in fact critical to the skill acquisition process as well. Therefore, these staff members should receive comprehensive training in applied behavior analysis.
- In addition to adequate skill acquisition training programs, skill development requires an environment that facilitates learning. Included within that requirement are such factors as:
  - Environmental stimulation (auditory, visuals, activity, structure, etc.) that neither suppresses nor interrupts the teaching process
  - Adequate access to stimulating and functional training materials
  - Employees with competence in the teaching process, including teaching delivery and learning documentation
  - Employees who recognize the teaching requirements of the people they serve, as well as the potential ability of each person
  - Administrative support and guidance for the teaching process
- It is recommended that BSSLC conduct a comprehensive evaluation of all teaching settings to identify those factors that inhibit the skill acquisition process. The findings of this assessment process should then be used to offer the remediation necessary to each environment in order to strengthen the teaching process.
- BSSLC should continue to expand its efforts to develop opportunities for learning that include integration into community settings.

Recommenda

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. PSPs for Individual #19, Individual #59, Individual #101, Individual #53 2. PSP Drafts distributed for PSP Meetings for Individual #8 and Individual #102 3. CLDPs for Individual #103, Individual #103, Individual #105, Individual #22 4. CLOIP Worksheets for Individual #33, Individual #19 and Individual #8 5. Post Move Monitoring Reports for Individual #103, Individual #103, Individual #103 6. Permanency Planning for Individual #3, Individual #20, Individual #21 7. Pre-Admission materials for Individual #21 8. Brenham State School Policy And Procedures (Volume 2, Section 1 Revised: February 2006 Continuity of Services) 9. DADS State Supported Living Center Policy Number 018: Most Integrated Setting Practices, October 30, 2009 10. Full Record Reviews: a. Individual #8, Individual #20, Individual #19, Individual #3, Individual #103, Individual #103 **People Interviewed:** 1. Parents of Individual #21 2. Individual #20 (consumer) 3. Two Facilitators 4. QMRPs Ann Schrengauer, Dee Dee McWilliams, & Joyce Ward 5. Admissions/Placement Coordinator (APC) Debra Green 6. Assistant Director of Programs Debra Kollman 7. QMRP Coordinator Sharon Whitmire 8. QMRP/Social Worker (Post Move Monitor) 9. Team Psychologist for Individual #20 **Meetings Attended/Observations:** 1. PSP for Individual #8 2. PSP for Individual #102 3. Community Living Discharge Plan (CLDP) for Individual #22 4. Admission Meeting for Individual #21 5. Post Move -Monitoring Visit for Individual #103 **6.** Post Move -Monitoring Visit for Individual #103
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.

	Summary of Monitor's Assessment: The Settlement Agreement calls for the Facility to develop and implement policies, procedures and practices related to Planning for Movement, Transition, and Discharge and for Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs. State-level (DADS State Supported Living Center Policy Number 018: Most Integrated Setting Practices) and Facility-specific {(Brenham State School Policy And Procedures (Volume 2, Section 1 Revised: February 2006 Continuity of Services)} policies exist, but the BSSLC policies could bear additional review and revision to ensure consistency with as well as further operationalize DADS policy. There is a lack of clarity across all levels of staff about their roles in assisting and, especially, encouraging individuals to move to the most integrated setting consistent with their needs, as required in the Settlement Agreement. As is common in many facilities when a new emphasis is placed on movement to community living, some staff have ambivalent, even negative, feelings and opinions about such movement. This is reflected in PST assessment of the appropriateness for Community Living, the identification of barriers and consequent strategies to address those barriers, and interactions with family members. PSPs attended and reviewed during the site visit indicated that during the Community Living Options portion of the PSP, the PST is routinely discussing the protections, supports and services an individual will need in a community placement, as required. The process was individualized to the person, although the supports identified seemed to typically reflect what the person is currently receiving at the Facility and did not go beyond that to include additional opportunities that might be available in a community setting. Increasing staff awareness of community living options over time is likely to enhance the teams' expertise in this regard. There appears to be a less consistent approach to the identification of obstacles and barriers, and particularly to the identification and implementation of strategies to overcome those obstacles. Many of the obstacles identified were related to a perceived deficit of the person, such as a behavioral issue. Teams rarely, if at all, focused on resource barriers, such as an available home that accepts someone and works well with a specific behavioral issue. As a result, there is no avenue to brainstorm and develop strategies to address those resource obstacles. In a similar vein, teams did not, as a rule, identify family or LAR opposition to placement as an obstacle that should also be addressed with a formal strategy. Such opposition is often understood by staff as a stopping place. Confusion exists, at least in part, because both the Settlement Agreement and State policy either seem to suggest, or state outright, that individual/family/LAR opposition to community placement means that no move will occur. While there is also specific instruction in DADS policy that such opposition should be considered a barrier requiring a formal strategy, many staff, including some Facilitators, will need additional training and clarification on how to reconcile these requirements. The assessment process for community placement is not well defined in either State-level or Facility-

	specific policy or procedure. Teams would benefit from some additional guidance in this area. The Facility should also consider how it prioritizes the implementation of placement processes following the assessment. Once a person has been identified as someone who could be appropriately placed in the community, the Community Living Discharge Plan (CLDP) process uses the State-level prescribed format as required. However, it seems to be being implemented in a somewhat haphazard manner, with the potential for important information to be overlooked. In particular, the 45-day comprehensive assessment could not be confirmed to have been completed as required, with no written assessments provided during the meeting itself. In some areas, such as Health Care, the discussion was unfocused and left out essential information regarding needed adaptive equipment and other supports. The Post Move-Monitoring process, to the extent that it was observed during the site visit, was characterized by very good interaction among the APC, the Post-Move Monitor and the Designated MRA. It was clear the group regularly collaborates in post-move activities. The Facility uses the Post Move Monitoring Checklist as prescribed by State Policy 018. As in the CLDP process, however, the actual practice of using the tool is very informal and may not lend itself to careful tracking of the provision of needed supports.

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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	The Settlement Agreement requires the State to take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. As is common in many facilities when a new emphasis is placed on movement to community living, some staff have ambivalent, even negative, feelings and opinions about such movement, hampering their ability to encourage it. One PSP (Individual #102) observed exemplified this conflict and the difficulty teams have in reconciling their roles with their feelings and concerns. In this meeting, a Facility physician arrived about ½ hour into the meeting and requested that the team move to the Community Living Options discussion as that was her purpose for attending. In fact, she stated that she planned to begin attending all of the Community Living Options discussions, although she did not say why. During this discussion, the mother, who participated by phone, indicated that she preferred that her son remain at the Facility, saying that she wanted her son to stay at the Facility. The RN Case Manager replied by saying, "we want him to	

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	account the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities.	stay here too." The Community Living Options discussion that followed was couched as "something we have to discuss and document." The Facilitator explained that the discussion would include the supports and services that would be needed in a community setting and the team physician added "if that ever happened." At one point while the mother was briefly on hold, the team physician remarked that "we don't have any intention of doing anything" about placement. In the second of the 2 PSPs observed (Individual #8), the PST determined that there were no real barriers to community placement for him. Because the Designated MRA was not present at the meeting, the team agreed to schedule a CLO meeting within 2 weeks. However, one staff person suggested that perhaps they should first notify the mother to see if she or another family member wanted to pursue guardianship. The team then decided to do community exploration as an Action Plan instead of scheduling a CLO meeting, with the express purpose of giving the mother or family member time to become an LAR. The Facilitator stated the team would then not "have to have a CLO meeting." When questioned following the meeting, the Facilitator acknowledged that there was an assumption that the LAR would not want community placement and that would be the end of it, if that was the LAR's decision. The Facility has taken some initial steps since July 2009 to raise the awareness of and educate staff in this area. In July, 2009, the Facility hosted the Brenham State School 3rd Annual Provider Fair. Fifty (50) community providers were represented. It was attended by 150 staff and 97 individuals living at BSSLC. In November 2009, an inservice was held on "Community Exposure: Providing Information for Residents, Staff and Families to Enhance the Understanding of the Mental Retardation Authorities' Role in the Community Exploration Process." It was open to all staff, to individuals living at BSSLC and to family members. According to the attendance sheets provided, 68 staff attended. A few staff have also had the opportunity to visit provider programs. A Staff Record of Community Interaction tracking form was provided in response to the document request that listed 7 staff who have visited community programs. The Facility will need to provide substantially more such opportunities to staff to create the level of awareness needed to allow them to assist individuals and families with the realistic information they require to make truly informed choices.	
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	The Settlement Agreement requires each Facility to review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. The Facility provided the DADS State Supported Living Center Policy Number 018: Most Integrated Setting Practices, October 30, 2009 in response to the document request in this area. However, upon request of the consultant, the Facility was able to provide additional relevant Facility-specific Brenham State School Policy And Procedures (Volume 2, Section 1 Revised: February 2006 Continuity of Services). There are 3	

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	processes. Such policies, procedures, and practices shall require that: 1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles. 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. 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	specific sub-items to this requirement, as described below. 1) The Settlement Agreement requires the PST to identify in each individual's PSP 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. It also requires the PST to 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 identify, and implement, strategies intended to overcome such obstacles. Observation of 2 PSPs and record review of 9 additional PSPs would suggest that the PSTs at the Facility are proficient in identifying the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation if the person were to move to a more integrated appropriate setting. These protections, services and supports are individualized according to the assessed needs of each individual. They also tend to mirror those protections, services, and supports being provided by the Facility, suggesting that teams may benefit from some additional training about opportunities that may be available in home and community based services beyond those available in a large congregate setting. PSTs seem to have more difficulty in the identification of major obstacles to the individual's movement to the most integrated setting and the identification and implementation of strategies intended to overcome such obstacles. DADS State Supported Living Center Policy Number 018: Most Integrated Setting Practices describes, in Section V. Procedures for Identification of Obstacles to Movement to a More Integrated Setting, and assigns responsibility to the QMRP for completing the prescribed form, Identified Obstacles to Individual's Movement. The Policy does not provide additional guidance to teams as to the types of obstacles that might be identified nor discuss the teams' role in resolving those barriers. Brenham State School Policy And Procedures (Volume 2, Section 1 Revised: February 2006 Continuity of Services addresses the identification of barriers and strategies to address them as follows: "When the PST is considering whether to recommend that an individual move to the community consistent with the Texas Health and Safety Code, Section 594.011. issues which could constitute barriers to a successful transition must be evaluated and possible responses recommended. The PST's evaluation and recommendations regarding such issues will be documented in the PST report." This is consistent with the Settlement Agreement and DADS State Supported Living Center Policy Number 018: Most Integrated Setting Practices. The policy goes on to say, " (a)lthough not an exhaustive list, the following issues could prevent the individual from successfully adapting to community living: a) individual's ability to provide legally adequate consent; and, b) lack of effective community supports and services to address	

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	remaining individuals for placement pursuant to such policies, procedures, and practices.	behavioral services." No further guidance as to the identification of and response to barriers is provided. Many of the obstacles the PSTs were able to identify in the observed and reviewed PSPs were related to a perceived deficit of the person, such as a behavioral issue. The teams observed rarely, if at all, focused on resource barriers, such as an available home that accepts someone and works well with a specific behavioral issue. As a result, there is no avenue to brainstorm and develop strategies to address those resource obstacles. In a similar vein, observations and PSP reviews revealed that teams did not, as a rule, identify family or LAR opposition to placement as an obstacle that should be addressed with a formal strategy. Such opposition is often understood as a stopping place. Confusion exists, in part, because both the Settlement Agreement and State policy either seem to suggest, or state outright, that individual/family/LAR opposition to community placement means that no move will occur. However, there is also specific instruction in DADS policy that such opposition should be considered a barrier requiring a formal strategy. DADS State Supported Living Center Policy Number 018: Most Integrated Setting Practices, October 30, 2009, Section III B. 5 states that "if an individual or LAR has indicated a preference to remain at the State Center, then no move will occur. The opportunity to participate in community exposure opportunities should continue to be afforded to the individual and their LAR. The individual's and LAR (if applicable) choice should be documented as an obstacle to placement which will require identification and implementation of strategies to attempt to overcome." In the 2 PSPs observed, there was discussion related to barriers. In one (Individual #8), the Facilitator had made a presumption in the draft PSP that the person was not appropriate for community placement. The behavior of occasional rectal digging and the need to wear a one-piece garment during sleeping hours was assumed to be a barrier. However, the team decided that his did not represent a barrier, as it could be managed in a community setting and, further, that no other barriers existed. Because the Designated MRA was not present at the meeting, the team agreed to schedule a CLO meeting within 2 weeks. However, one staff person suggested that perhaps they should first notify the mother to see if she or another family member wanted to pursue guardianship. The team then decided to do community exploration as an Action Plan instead of scheduling a CLO meeting, with the express purpose of giving the mother or family member time to become an LAR. The Facilitator stated the team would then not "have to have a CLO meeting." When questioned following the meeting, the Facilitator acknowledged that there was an assumption that the LAR would not want community placement and that would be the end of it, if that was the LAR's decision. So, not only did the PST not address the potential barrier of family opposition with a strategy, it actually identified an opportunity for family opposition to become a barrier and developed a strategy to	

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		facilitate that. In the second PSP Community Living Options discussion (Individual #102), the team physician suggested possible barriers to placement that could be cited, including, for example, the individual's lack of communication skills or whether he might be an elopement risk., although the team denied that either of these would be barriers in his case. The physician also stated that she had been trying to get some guidance from the State in the form of a list of "acceptable" barriers. This appeared to assume that the identification of a barrier was an end that would result in the deferment of community placement, rather than a starting place for development and implementation of strategies to resolve the barrier. The mother, who participated by phone, stated that she wanted her son to stay at BSSLC. Since no other barriers were identified, the Facilitator in this instance continued to press the team to identify the noted family opposition to placement as a barrier that should be addressed. While this was accomplished, no specific Action Plan was spelled out during the meeting that would address the barrier. There was also no further discussion with the mother at this time about her statement that, if her son were to be placed in the community, she would want him to live with her. The team did not discuss what supports and services would be needed by the mother in this circumstance. Many staff, including some Facilitators, will need additional training and clarification on how to identify and address barriers, most particularly in the area of family opposition. QMRPs and Facilitators have been provided with updated Person-Directed Planning training, which was reviewed following the on-site visit. There is a segment on the identification and resolution of barriers contained in slides 124-127, including some emphasis on approaching the barrier of family opposition. Continuing training and opportunities to debrief and share their experiences in working with teams around these issues is recommended, combined with increased opportunities to visit community programs by all team members. It is noted, in particular, that Facilitators have not yet been afforded the opportunity to visit community programs, according to an interview with the Assistant Director of Programs. This is of significance because Facilitators are responsible for conducting all meetings that contain a Living Options component, and according to the Assistant Director of Programs, are expected to assist the teams with their expertise and knowledge of community living options. Even though the Facilitators themselves stated during interview that they are not team members, their attitudes and opinions are very likely to have an impact on the process and on the other team members. 2) The Settlement Agreement calls for the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices.	

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		Much of the responsibility for fulfilling this requirement for adults is delegated by statute to the MRA contracted to provide the CLOIP, in this case the Brazos Valley MRA. CLOIP staff make a visit with each adult individual prior to his/her annual PSP, review community living options with the person and complete the CLOIP Worksheet. This is known as the CLOIP assessment. The completion and receipt by the Facility of the CLOIP assessments are tracked on a monthly basis by the APC. Referrals are also made to CLOIP staff to arrange tours of community programs for individuals living at BSSLC to allow them a first-hand of the experience of community living. Documentation provided by the Facility indicates that requests were made for community tours for 26 people and that community tours were completed for 23. In most instances, the tours were completed within 4-6 weeks. DADS State Supported Living Center Policy Number 018: Most Integrated Setting Practices, October 30, 2009, Section III.A.4 states that "**Each** individual will be afforded the opportunity to participate in tours of community provider homes, day programs, and employment opportunities" (emphasis added). The Facility did not describe its plan to ensure that each person living at BSSLC has such opportunities. This will be examined further at the next site visit. CLOIP staff also contact family and/or guardians to provide information about community living options. Their responses are also documented on the CLOIP Worksheet. This Worksheet, in turn, is provided to the Facilitator and QMRP in advance of the PSP meeting and is used during the meeting to facilitate discussion about community living options. The contracted CLOIP staff typically attend the PSP meeting and participate in this discussion. Three (3) CLOIP Worksheets were reviewed, including the worksheet completed in December 2009 for Individual #8 in preparation for his January 2010 PSP. All 3 of the Worksheets indicate that the family was mailed a letter regarding CLOIP program services, a copy of the Long Term Care Services and Supports publication and a copy of the Making Informed Choices booklet. They also noted that the family did not have any questions or concerns regarding community living, nor did the person have any expectations about living in the community. There was no information provided about how these determinations were arrived at, nor any recommendations about strategies the CLOIP staff may undertake in the future to enhance awareness of individuals and families. The CLOIP assessment process will require further examination at a future site visit. The roles and responsibilities of the Facility and its staff in providing adequate education for individuals and families should also be more carefully considered. As one QMRP	

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		noted during an interview, families tend to be "afraid" of the CLOIP staff. This makes sense. Families are familiar with Facility staff and have come to rely on them for information. The CLOIP staff typically have contact with the family once a year, and thus may not have the relationship and trust needed to discuss what may be a subject that causes concern and fear for the future. Facility staff must also be prepared to speak knowledgably with family about community living options in a manner that does not provoke unwarranted concern. The QMRP interview also indicated that there is some sharing of "horror stories" about community placement by staff that needs to be curtailed. As noted above in Section T1a, the Facility has taken some initial steps to educate staff, but more will be called for to change attitudes. In addition, the Facility may want to consider what other educational opportunities it can provide, as a trusted source, to families. Families were invited to the Provider Fair and MRA in-service described above, but it was reported that only "3 or 4" attended. The Facility will need to evaluate other potential venues and methods that will be more accessible to families. These same observations hold true for the individuals living at BSSLC, in terms of the trusting relationships that exist with staff and the role that staff must play in assisting individuals to understand their community living choices. Facility staff communicate with family on both formal and informal bases. One of the things that may have complicated the Facility's ability to maintain a consistent standard and approach in this communication in the area of community placement is the availability of a Social Worker. Staff report that this position, which historically and appropriately is the primary link between Facility and family, was eliminated for a period of time in the recent past. During that time, QMRPs were reported to have borne primary responsibility for family communication, in addition to their QMRP responsibilities. Social Work positions have recently been re-instated, but not all positions have been filled. Given the important roles the Facility needs to play in educating and informing both individuals and families about community living options, it will be essential to devote the resources necessary to do it well. For children, under the age of 22, the vehicle for discussion of community living options is the Permanency Planning Meeting, which is to be conducted semi-annually by the Designated MRA. The Permanency Plan document is transmitted to the QMRP and is also reviewed during the PSP. Three (3) Permanency Plans were reviewed during the site visit. It is noted that the allowable goals for the Permanency Plans using Form 2260 (1/08) reflect the generally accepted standard of practice that children are best served in family home settings rather than institutions. Remaining at the Facility is not one of the goals; only 2 Family-Based Options are available. Form 2261 (10/08), however, adds 2 additional goals that may or not be Family-Based, including moving to another living	

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		arrangement or remaining in the current residence as determined by the individual and LAR. Brenham State School Policy And Procedures (Volume 2, Section 1 Revised: February 2006 Continuity of Services) reinforces the Family-Based standard of practice by defining Permanency Planning as "(a) philosophy and planning process that focuses on the outcome of family support by facilitating a permanent living arrangement with the primary feature of an enduring and nurturing parental relationship." It is not clear that this philosophy is put in to practice by the Facility. First, it is unusual to see a large number of children in a state-operated Facility at this point in time due to the family home setting standard of practice, but BSSLC reports having over 30 children in residence. During the site visit, a pre-admission meeting was held for a child (Individual #21). It is not clear what the ostensible reason for admission was, but it was reported by the APC that the primary reason was that the parents felt the Facility provided opportunity for peer interaction that they had been unable to find at home. According to Brenham State School Policy And Procedures (Volume 2, Section 1 Revised: February 2006 Continuity of Services), no person shall be committed to a residential care facility unless: 1. The person is mentally retarded. 2. Evidence is presented showing that because of retardation, the person represents a substantial risk of physical impairment or injury to himself or others, or he is unable to provide for, and is not providing for, his most basic physical needs. 3. The person cannot be adequately and appropriately habilitated in an available less restrictive setting. 4. The residential care facility does provide habilitative services, care, training and treatment appropriate to the individual's needs. The information available for and presented at the pre-admission meeting for Individual #21 did not indicate that she represented a substantial risk of physical impairment to herself or others, or that her parents were unable to provide for her most basic physical needs. It was also not shown that Individual #21 could not be adequately and appropriately habilitated in an available less restrictive setting. The desire for enhanced peer interaction would not typically be considered to meet either of those criteria. This is not to say that the parents' estimation of this need is incorrect, but simply that it does not rise to the level of the criteria stated in the policy or general standard of practice for admission to an ICF/MR, particularly in the case of a child. Individual #21 did have a Permanency Plan, but long-term plans beyond placement at BSSLC were not discussed in any depth during the meeting. Second, a Permanency Plan dated 7-16-09 for another child (Individual #20) indicated	

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		that her Permanency Plan goal is "bringing the child home with access to needed services." However, Monitoring Team staff present at her PSP during the site visit reported that the individual stated she wanted to live in a group home and that some team members felt this should be considered. The Facilitator provided no real response as to options for placement, citing only the parents' unspecified objections. In an interview with the team Psychologist at a later time, this staff person stated that she was very concerned about not only this child, but others that she felt could do well in the community, but who were not being provided with these options. She further said she had brought this to the attention of the Facility Director. A review of this child's previous PSP revealed that it called for her to have visits to community options, but no such visits were documented from 12/08 through 12/09. It is noted that Brenham State School Policy And Procedures (Volume 2, Section 1 Revised: February 2006 Continuity of Services), in compliance with DADS rule, 40 TAC, Chapter 9, Subchapter E, Sec.9.250(6), indicates in at least two separate places that "(f)or individuals under 22 years of age, the PST, Personal Support Team, discussion of Living Options is to include the option of the individual remaining at the facility if the individual has not met their Permanency Planning goals. If these goals have not been met an approval for the individual's continued residence must be approved by the Commissioner of the Department." Interviews with the APC and Assistant Director of Programs indicated they were not aware of this stated requirement, and that the Facility did not seek the approval of the Commissioner in such circumstances. This section of the Policy should be reviewed to determine if it is, in fact, a requirement. If not, the policy should be corrected. 3) The Settlement Agreement and DADS State Supported Living Center Policy Number 018: Most Integrated Setting Practices require that within eighteen months of the Effective Date, the 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. Further, within two years of the Effective Date, the Facility is required to assess all remaining individuals for placement pursuant to such policies, procedures, and practices. In response to the document request, the Facility provided a list of 182 people it considered to have been assessed for community placement as of 12/12/09. This would represent approximately 48% of the Facility population (182/377). It is not clear what comprises the assessment for placement at this time. There is not a clear set of criteria nor a specific process defined in policy or procedure, either at the State-level or the Facility-level. Neither the DADS Policy nor the Brenham State School Policy And Procedures (Volume 2, Section 1 Revised: February 2006 Continuity of Services) provide guidance as to the details of this assessment process. The list provided	

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		in response to the document request was reported to reflect those people who had had a PSP meeting since 7/1/09 and therefore a Community Living Options discussion. Of the 182 people considered to be assessed as a part of the PSP since 7/1/09, 26 had been recommended for placement. Of the 10 people reported to have been placed since 7/1/09, only 3 were also represented in the 26 on the Recommended for Placement List. Twenty-nine (29) people were reported to have requested placement, yet only 2 of them were also on the Recommended for Placement List and were the only 2 who had requested placement that had been placed in the community. This all suggests that there is not a clear sense of priority in place as to how a person moves through the process, or how the assessment process figures in. For example, one might expect that individuals actually requesting placement would receive a timely assessment for needed supports and services, be referred to the MRA and achieve placement fairly quickly. Yet, only 4 of these individuals were included on the list of people for whom CLOIP community tour requests have been made since 7/1/09 and, as noted above, only two had been placed. When asked why 27 individuals who had requested placement had not yet been placed, the APC indicated that it was because they still had time within their 180-day window.	
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: 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. 2. Specify the Facility staff responsible for these actions, and the timeframes in which	The Facility uses the basic format and forms for the Community Living Discharge Plan (CLDP) as prescribed in the State Policy on Most Integrated Setting 018. The Facility specific policy on Continuity of Services with a revision date of February 2006 does not refer to the Most Integrated Setting policy and requires updating to ensure consistency with the requirements of the Settlement Agreement and DADS Policy 018. Observation of the actual CLDP meeting (Individual #22) indicated that it was implemented as a somewhat informal process that did not follow a set agenda. Facility staff did not provide written assessments to the provider, and there was ample opportunity for important information to be lost in the shuffle. One such example was the individual's AFO, which was mentioned on several occasions, but Facility staff did not offer specifics on the use, maintenance or provider for the equipment. The meeting was almost over before the provider asked for more information about the AFO. It was clear that the information was not going to be offered at the initiative of the Facility staff. In each of the 4 CLDPs reviewed, the Facility did specify certain actions that need to be taken by the Facility and designated the staff responsible, such as designating the APC to ensure a person's trust fund was established. They also defined certain responsibilities and assistance requested in the Community Living Monitoring Activities and Agreement sections, but these tended to be boilerplate. Additional examination may reveal opportunities to use the CLDP in a more formalized and individualized way to ensure that all supports are identified and provided as needed.	

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	such actions are to be completed. 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.	In only one of the 4 CLDPs was it clear that it had been reviewed with the individual, documented by his signature. None of the 4 had documentation of review by the family or LAR included with the CLDP. Other documentation may exist of such contact, but this was not observed from the material the Facility made available.	
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.	Brenham State School Policy And Procedures (Volume 2, Section 1 Revised: February 2006 Continuity of Services) does not specifically address the 45-day comprehensive assessment requirement, either in terms of what would constitute a comprehensive assessment or the 45- day timeline. It does state that the community living profile will be completed by the QMRP and describes, in part, "the individual's medical, psychiatric and behavioral needs." In addition, it states, that "(t)he findings and observations are described by the facility and include: (1)thorough medical and behavioral information, which will be communicated to the physician who will be providing care in the community; (2) all current physician orders and treatments, including rationale for all medications prescribed and dispensed by the facility which will be continued after the move; and, (3) a brief summary of findings, events and progress during the period the individual resided in the facility." Facility practices could not be confirmed at this time. According to the APC, the CLDP meeting is considered to be the 45-day assessment and should include assessments from a number of disciplines. However, at the CLDP observed during this site visit, one of the first team members to report was the RN. She began the process by opening the individual's record and asking "What do you need to know?" A written assessment was not provided to the team or the provider staff at that time, nor was any other written discipline-specific documents provided. According to an interview with the APC at a later time, the Facility is trying to make more of the required pieces of the CLDP available at the time of the meeting, but she reported this is a work in progress. She acknowledged the disciplines should have provided a written assessment. She did state that all of the assessments would be available and included with the CLDP at the time of actual discharge. Brenham State School Policy And Procedures (Volume 2, Section 1 Revised: February 2006 Continuity of Services) does not specifically require that the assessments will be provided on the date of departure to the community-based provider. A review of 3 CLDPs confirmed that they do uniformly reference attachments of specific assessment documents. However, when requests were made to review the CLDP for these 3 individuals, the assessment documents were not included. A request was also made to review, post-visit, the CLDP and specifically the full placement packet for Individual #22 in order to confirm the APC's statement that all assessment materials	

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		were included in the completed packet at the time of discharge. The only material received in response to this request was the completed CLDP form, such that it is not possible to confirm the assessments were actually completed as required. This also calls into question whether the assessments are considered to be an integral and essential component of the CLDP process at the Facility. This will require additional follow-up during the next site visit.	
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.	DADS State Supported Living Center Policy Number 018: Most Integrated Setting Practices describes procedure for the Facility to follow in 1) identifying essential supports as a function of the prescribed CLDP format and 2) expectations of the Facility and MRA in ensuring that all essential supports are in place at the time of the individual's departure to the community program. Brenham State School Policy And Procedures (Volume 2, Section 1 Revised: February 2006 Continuity of Services has an extensive section on the Community Living Discharge Plan, but it does not include information on identifying the "essential" supports and would benefit from review and modification to comport with DADS policy and the Settlement Agreement. The discussion surrounding essential v. non-essential supports in the observed CLDP for Individual #22 seemed appropriate. This portion of the CLDP meeting more closely followed the CLDP format than other portions and was concluded with signatures of the participants confirming their mutual understanding of the requirements. A review of 3 other completed CLDPs also had identified the essential supports and these were also confirmed by signatures of the Facility, MRA and provider representative. However, 7-day post-monitoring visit records for three individuals documented that the essential supports were not always in place for 2 of the individuals at the time of the post-move monitoring visit, as described in Section T2a below.	
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.	DADS State Supported Living Center Policy Number 018: Most Integrated Setting Practices, October 30, 2009 requires that "an assessment will be conducted to identify the effectiveness of the living option process. A ten percent (10%) random sample will be conducted monthly to evaluate policies, procedures and practices related to the transition/discharge process." This policy does not provide further detail as to how this evaluation will be conducted. Brenham State School Policy And Procedures (Volume 2, Section 1 Revised: February 2006 Continuity of Services does not provide any quality assurance procedures for monitoring the implementation of the discharge plan. Facility quality assurance practices, as far as they could be discerned during this baseline review, consist of the APC tracking the implementation of the CLDP process, including referral date, a projected 180 target date, the date of any pre-visit to a selected provider, the date of the CLDP meeting and the move date. This process was completed, from referral date to move date, for 11 people on the provided tracking form. In 9 of these, the	

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		process exceeded the 180 days. It is not clear whether the 180 day timeframe is a state requirement or simply a target, which will need to be further researched. However, since it is on the tracking form, it is assumed that it is at least a goal and that the Facility intends to achieve it. No information was provided as to the documentation or corrective action made in any of the instances in which the 180 day timeframe was exceeded. The quality assurance procedures will be further examined during the next site visit.	
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	DADS State Supported Living Center Policy Number 018: Most Integrated Setting Practices, October 30, 2009, Section V.D., requires the State Center's Quality Enhancement Department to submit an assessment of identified obstacles to the Director on a quarterly basis, and to DADS State Office on a yearly basis (by September 1 of each year). No analysis was provided in response to the document request. As described in Section T1b above, PST members at the Facility do not have a consistent understanding of the need and/or process for identifying barriers to movement. This will seriously compromise the Facility's ability to produce an analysis that will be a useful and meaningful tool for its own purposes or that of DADS at the State-level.	
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	The most recent Community Placement Report, provided by the Facility in response to the document request, is not dated. It is a listing of 10 names of people who have been placed in the community since September 2009. The average time from referral date to placement date was 10.7 months. The Report does not reference those individuals who the PST has determined may be appropriately placed in the community, although the	

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	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.	Facility does have this information and may provide it as a supplement to the form entitled Community Placement Report. Follow-up will be conducted at the next site visit to verify practice in this area.	
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the	DADS State Supported Living Center Policy Number 018: Most Integrated Setting Practices, Section VI, lists Procedures for Post-Move Monitoring and Reporting. Brenham State School Policy And Procedures (Volume 2, Section 1 Revised: February 2006 Continuity of Services) only addresses the Post-Move Monitoring process as a component of developing the CLDP. Seven, 45, and 90 day Post-Move Monitoring visits are routinely tracked and appear to be implemented in a timely manner. The Facility uses the prescribed format, the Post-Move	

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	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.	Monitoring Checklist, as found in Appendix C of the Settlement Agreement and in DADS policy. Its implementation, however, was informal in the 2 post move monitoring site visits observed as well as in the historical CDLP reviewed for 3 individuals, potentially resulting in a failure to identify supports that were not being provided as needed and/or required follow-up. The CLDPs for two individuals (Individual #103, Individual #103), transferred to the same provider on the same date, identified a Primary Care Physician as an essential support that must be in place at the time of move. The 7-day Post-Move Monitoring Checklists for both individuals indicated that this support was not in place, but did not have any notation of Action/Follow-Up for Items Marked "No." One of the individuals (Individual #103) was reported to have first seen the physician on 12/16/09, followed by an emergency room visit for dehydration on 12/21/09. It was not clear if the initial visit to the physician was as a result of a health issue or was the planned initial, albeit delayed, visit. The other individual transferred on the same date was reported not to have seen the physician until 1/9/10. The 7-day Post-Move Monitoring Checklists for both individuals also indicated that their personal belongings were not "in the home and available to the individual." Again, there was no notation regarding follow-up, although it was noted that the item was marked "yes" for both individuals in the 45-day Post-Move Monitoring Checklists. The 45-Day Post-Move Monitoring Checklists reviewed for these two individuals were copies of the handwritten notes of the Post-Move Monitor, as they had just occurred. It is not clear, however, whether these notes are to be transcribed, and perhaps more importantly, entered into a tracking database that could be used to monitor corrective action in the short term and used as a quality improvement tool over time. Such a process would be recommended. This would allow the Facility to track provider performance in establishing and maintaining supports. It might also be used to identify categories of supports that are the more difficult for providers to obtain, which, in turn, could be used to develop and implement systemic resource development strategies.	
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	A 45-day post move monitoring visit for two individuals was scheduled during the Facility site visit and was attended by this Monitoring Team member. Both of these meetings were held in conjunction with the 30-day provider meeting and therefore took place at the provider's office rather than in the home and work sites. The latter visits were to be made by the Post-Move Monitor at a later time. Observations are described in Section T2a above.	

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	accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.		
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.	DADS State Supported Living Center Policy Number 018: Most Integrated Setting Practices is consistent with the Settlement Agreement in that it specifies that the provisions of the Policy 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; and that the provisions of the policy do apply to individuals committed to the Facility following the court-ordered evaluations. No Facility-specific policy and procedure related to Most Integrated Setting for alleged offenders was provided in response to the document request. According to the APC, the facility does not admit alleged offenders. Therefore there is no basis for evaluation of practice in this area of the Settlement Agreement at this time.	
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe;	The Settlement Agreement and DADS State Supported Living Center Policy Number 018: Most Integrated Setting Practices requires the Facility to follow CMS required discharge processes for certain categories of individuals rather than the discharge processes prescribed in that policy and by the Settlement Agreement. These are known as "alternate discharges." The State-level policy does not provide any additional guidance to the Facility. Brenham State School Policy And Procedures (Volume 2, Section 1 Revised: February 2006 Continuity of Services) prescribes specific discharge procedures for individuals due to ineligibility for services and for individuals voluntarily withdrawing from services that would appear to be consistent with CMS requirements under the ICF/MR regulations. The policy does not specifically address the other categories of alternative discharges, including individuals who move out of state; individuals discharged at the expiration of an emergency admission; individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; individuals receiving respite services at the Facility for a maximum period of 60 days; individuals discharged pursuant to a court order vacating the commitment order.	

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	(d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.	In response to the document request, the Facility reported no alternate discharges since July 2009, therefore there is no basis for evaluation of practice in this area of the Settlement Agreement at this time. This will bear further examination at the time of the next site visit.	

Recommendations: As a baseline review, these initial recommendations will tend to be in the form of suggesting broad direction. • PST members would benefit from intensive and ongoing training related to the general identification of barriers and the consequent design and implementation of strategies to reduce those barriers. The training should also focus specifically on the role and responsibilities of the team in the identification of family/LAR opposition as a barrier and in the development of strategies to resolve that barrier. Additional guidance from DADS at the State-level would also be useful. • PST members in all disciplines would benefit from opportunities to visit community programs on a regular and ongoing basis. Facilitators, in particular, should begin visiting community programs immediately. • PST members should receive some additional guidance/training on their roles and responsibilities in assisting and encouraging individuals, and their families, to move to the most integrated setting. This process will certainly take some time, and staff will need the opportunity to resolve some of their own concerns and ambivalence; however, the Facility will need to take planned action to ensure that staff are acting in concert with the intent of the Settlement Agreement. • Develop a Facility plan to increase opportunities for more individuals to take community tours and experience community living options, in accordance with State policy that each individual is afforded these opportunities. This will also likely enhance the formal CLOIP assessment process, as individuals at the Facility will have a better foundation to understand its meaning. • Develop a Facility plan to increase opportunities for families/LARs to learn more about community living options, to complement the MRA CLOIP activities. The Facility will want to consider talking with the parents' group to help identify what kinds of opportunities would be most accessible and helpful to families. Clearly this plan should also be undertaken with sensitivity to the concerns of families/LARs, and crafted to help alleviate those concerns over time. • Ensure that Facility Policy and Procedure on Continuity of Services is comprehensively reviewed and updated as needed to comport with requirements of Settlement Agreement and State-level DADS Policy 018 on Most Integrated Setting Practices. • Evaluate and define the process used to assess a person for community placement, including prioritization criteria. • Formalize the implementation of the CLDP meeting such that all written assessments are available at the meeting, if this is considered to be the 45-day comprehensive assessment. Also ensure that there is a formal agenda based on the CLDP such that all needs are covered. Current practices may lead to important items falling through the cracks. • Formalize the implementation of the Post-Move Monitoring Checklist to ensure its use as a meaningful tracking tool for both essential and non-essential services and supports. The Facility should consider entering the data from each visit in an electronic format that will allow for data	**Recommenda**

tracking, data manipulation, reporting and analysis. This will enable the Facility to track corrective action in the short-term, but will also be useful for identifying quality improvement needs across, for example, provider compliance rates or supports availability. • Evaluate, and incorporate into Facility policy, the quality assurance procedures for transition and discharge, including specifically the 10% monthly random sample as required by DADS Policy 018 on Most Integrated Setting Practices. • Develop a methodology for the DADS- required assessment of barriers such that it can be used as a quality assurance tool, and one that can inform the development of Facility plans for raising awareness of staff, individuals living at BSSLC and their families/LARs. In the long-term, it should also be useful in formulating regional resource development strategies with providers and other stakeholders.	

SECTION U: Consent	
	Steps Taken to Assess Compliance: **Documents Reviewed:** 1. Brenham State School Policy And Procedures (Volume 2, Section 2A Revised: February 2006 Human Rights 2A-14) 2. PSPs for Individual #19, Individual #59, Individual #101, Individual #53 3. PSP Drafts distributed for PSP Meetings for Individual #8 and Individual #102 **People Interviewed:** 1. Two Facilitators 2. Three QMRPs 3. Admissions/Placement Coordinator (APC) 4. Assistant Director of Programs 5. QMRP Coordinator **Meetings Attended/Observations:** 1. PSP for Individual #8 2. PSP for Individual #102
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: Much of this requirement has not yet been fully implemented. State policy and procedure for implementation of this Section have not been completed, nor have Facility level policies and procedures been promulgated. Specific staff responsibilities for implementation have not yet been assigned. While the Facility does have a list of individuals it identifies as being in need of an LAR, the only criterion cited for being placed on the list is that a person does not currently have an LAR. This seems to assume that each person living at the Facility requires an LAR, which would mean that no one has capacity to make decisions about their health and welfare; however, the Facility is not using a prescribed process or set of criteria to individually assess such capacity, nor does it have a current plan in place for the implementation of such a process. The Settlement Agreement also calls for the list to be prioritized using, at minimum, a set of criteria defined in the Settlement Agreement document. The current list is not prioritized, nor does the facility currently have a process identified for prioritization. The Settlement Agreement requires the Facility to use the prioritized list to make reasonable efforts to obtain LARs for individuals. Current efforts to obtain LARs is limited to contacting parents on an ill-defined "as –needed" basis, although the Admissions/Placement Coordinator reports she does provide some assistance to parents with meeting paperwork requirements.

	Perhaps the most troubling finding in this area is the sense that some team members perceive guardianship as primarily a means to delay or prevent community placement. While it is not possible from a limited baseline review to characterize this as a pervasive viewpoint, the Facility should take pains to evaluate this situation and take needed action to educate all concerned about the true purposes of guardianship prior to undertaking a comprehensive outreach program to solicit guardians for people living at BSSLC.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	State Policy to implement this section of the Settlement Agreement has not yet been promulgated. BSSLC did not provide policy and procedure addressing their processes for developing the list, including how it would assess whether a person lacks functional capacity to render health and welfare decisions. According to an interview with the APC, the list provided in response to the Document Request has 119 names and was developed simply by using the criterion that the individuals did not currently have an LAR. In response to the document request regarding assessment procedures for guardianship, the Facility provided the current PALS assessment tool, but it does not address the ability to give informed consent in any specific manner. Alternatively, the APC suggested that the Rights Assessment (Form 6614, February 2008) completed as a part of the PSP would serve as the assessment process. The Rights Assessment does indicate whether a person has an LAR and whether or not a person needs assistance from an advocate. The ability to Give or Withdraw Informed Consent is one of the rights addressed in the Rights Assessment in Section J. Section J defines Informed Consent as consent that is obtained from a person who understands the basic nature, the reason he or she is being asked to provide the consent and the potential effect(s) and consequences of giving or withholding consent. It goes on to state that "(b)ased on assessments and the annual review process, the PST has determined that he or she is **unable** to give informed consent in the areas noted below." The areas noted include the following: Medical; Programmatic; Financial; Restrictive/Intrusive Practices; Media/Photo; Release of Records. In the 2 PSPs attended, the Rights Assessment was reviewed. All of the areas for giving and withdrawing informed consent were checked, indicating the person was unable to give consent in each category. There was no reference to the assessments used to make this determination, nor any team discussion about relative strengths and abilities in any of the areas or any strategies to enhance the person's ability to participate in decision-making in any of the areas. In each of the PSPs reviewed, all of the areas were also checked. Neither the development of the list nor the 2 teams observed demonstrated an understanding of the responsibility to make a careful assessment of the ability to provide informed consent as a precursor to identifying a need for an LAR. However, Brenham State School Policy And Procedures (Volume 2, Section 2A Revised: February 2006	

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		Human Rights 2A-14 lays a good foundation for consideration of these issues. The Policy requires the following (bold/italic emphasis added): When proposed services or treatments require specific, written, informed consent, the **individual's Personal Support Team must first assess the individual's capabilities in *each aspect* of the decision-making process based on the individual's experiences**. People must have sufficient experience and knowledge that is based on exposure, interactions, instruction, or personal response to make an informed decision. A real choice can only be made when there is adequate awareness of the alternatives and the consequences of the options available. In some instances, a true assessment of consent cannot be made by the Personal Support Team due to the individual's lack of experience with decision-making. In these situations, the Personal Support Team's responsibilities shift to education, instruction, and support. It is not uncommon for individuals to need assistance with decision-making. **Personal Support Teams do not readily assume that the individuals we serve cannot make decisions, cannot learn to make decisions, or need guardianship because they need assistance with decision-making. Personal Support Team discussions focus on what resources are available to assist the individual and how the individual can be supported to expand his or her experience and knowledge.** **..."Positive expectations and assumptions about people are important to respecting individual rights. We believe that with support and intervention in the form of instruction, environmental modification, and opportunities, every individual can experience some measure of rights expression regardless of the degree of disability. Personal Support Teams begin with the assumption that the individuals we serve will exercise their rights as citizens with the needed supports and interventions. Team discussions focus on determining the particular supports and interventions needed by the individual."** The Settlement Agreement further requires the Facility to prioritize its list of people in need of an LAR by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources. There is no State-level or BSSLC policy and procedure for implementation of this component at this time. When	

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		asked, both the APC and Assistant Director of Programs acknowledged there is no current plan for how this prioritization will be accomplished.	
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.	Interviews were held with the APC and the Assistant Director of Programs to inquire about the processes or plans the Facility has in place to obtain LARs for individuals on the list. There are no current processes or plans in place for this purpose, other than notifying current LARs of upcoming expirations and providing some paperwork assistance to family members who have indicated an interest in becoming an LAR. The Assistant Director of Programs suggested that State-level guidance is required and that the Facility needs assistance from experts in this area. Both the APC and Assistant Director of Programs were asked about how LARs or potential LARs were prepared for their responsibilities in assisting individuals to make decisions about health and welfare issues. Both were unaware of any educational opportunities outside of instruction from the courts. Both agreed that the Facility does not typically engage in any sort of orientation or training for LARs, although it was noted that an attorney was scheduled to speak with the Parents' Association on this issue in the near future. However, Brenham State School Policy And Procedures (Volume 2, Section 2A Revised: February 2006 Human Rights 2A-14 has a section related to Obtaining Personal Advocates for Individuals which provides a solid rationale for the responsibility of the Facility in ensuring that advocates are selected and oriented carefully. It may be useful as a model as the Facility examines its next steps in this area. The policy states (bold/italic emphasis added): When an individual requests assistance from a personal advocate or when an individual's Personal Support Team determines the individual would benefit from assistance from a personal advocate, the individual's QMRP first attempts to secure an advocate for the individual from the individual's family support network. When a family member of the individual agrees to assist the individual as an advocate, **the QMRP communicates the role and responsibilities of an advocate to the person, as/if needed.** If the QMRP is unable to secure a personal advocate from the individual's family support network, the QMRP will refer the individual's need for an advocate to the facility's Community Relations Coordinator who will obtain an advocate. **Efforts to secure advocates may include informing community members.** **When a personal advocate is identified, the Coordinator of Community Relations and the Advocacy Coordinator work together to *orient the***	

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		advocate to the role and responsibilities of an advocate. Finally, in practice, there is an appearance that guardianship is viewed by at least some teams as primarily a means to delay or prevent placement. See Provision T1.b for an example involving Individual #8 Interviews with the APC, the QMRP Coordinator and three QMRPs confirmed that there are team members who view guardianship as a means to delay or prevent placement. While it is not possible to characterize this as a pervasive view from the baseline study, it is a matter of concern. As the Facility develops it approach to the implementation of the Consent section of the Settlement Agreement, it will need to begin with an examination of the purposes of guardianship and provide comprehensive training to staff on these purposes.	

Recommendations:

- State-level guidance is needed in the area of guardianship and should address, at a minimum, a) the State's philosophy as to the purposes, including roles and responsibilities, of guardianship; b) the assessment process for determining the need, and level of need, for guardianship; c) the process and criteria for prioritization; d) development of orientation materials for LARs and potential LARS.
- The Facility should develop facility-specific policy and procedure to implement the State-level guidances once received. Brenham State School Policy And Procedures (Volume 2, Section 2A Revised: February 2006 Human Rights 2A-14) can be used as a starting point
- The Facility should make a specific assignment of responsibility, with timelines, for implementation of each of the requirements in this Section of the Settlement Agreement.
- Training should be designed and undertaken for QMRPs and Facilitators as to the content of the State-level guidances and Facility policies and procedures once completed. Given the sense some team members seem to have that guardianship can be sought to delay or prevent placement, it may be prudent to provide some immediate training for QMRPs and Facilitators, as team leaders, on how to convey the purposes of guardianship to the team.
- Training should be designed and undertaken for PST members to ensure they understand the purposes of guardianship and their roles in the assessment of need and development of strategies to enhance the ability of individuals to participate in health and welfare decision-making.
- An overall outreach plan to potential LARs should be developed by the Facility in keeping with any State-level guidances that are promulgated. Training and orientation for LARs and potential as to their roles and responsibilities should be developed as a part of this outreach plan.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: **Documents Reviewed:** (In addition to the documents noted below, all team members provided information about the status of records; please note records identified in sections above.) 1. DADS Recordkeeping Policy #020 dated 9/28/09 2. Active Records (Program and Medical Books): Individual #7, Individual #18, Individual #19, Individual #3 3. Several Individual Notebooks **People Interviewed:** Night shift home staff Keri J. **Meetings Attended/Observations:** 1. PSP: Individual #19 2. CLDP: Individual #22
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: State policy and required format for the record is being revised; local policies are needed to operationalize those state policies for implementation at the facility. The formats and order of active records and individual notebooks are consistent. Some departments keep information needed to make decisions separate from the active records for convenience; the review did not check for consistency of those separate records with the active record. In many cases, information within the records was not legible, including both content and signatures. Some records are in poor repair, which makes some information difficult to read. Use of records to make decisions on care, treatment, and training both for services and supports for individuals and for system change is variable. Chronic (ongoing) Nursing Care Plans are filed in the Program Record. Acute Nursing Care Plans are filed chronologically (by date) in the Interdisciplinary Progress Notes, in the Medical Record. This makes them difficult to locate, leading to fragmentation of information. The Annual and Quarterly Nursing Assessment are also filed chronologically in the Medical Record. Recommendation: All Nursing Care Plans should be filed in the Medical Records. Annual and Quarterly Nursing Assessment should be tabbed filed together, as should all the Nursing Care Plan. Documentation of all disciplines is sometimes illegible, such that content is difficult to read but signatures and titles of the author of entries are virtually impossible to discern. Documentation errors are not always corrected according to professional standards for correction.

	Typically, the individuals' records are sent to the hospital and remain with the individual throughout their hospital stay. This is not standard practice and has the potential for loss of control of records.

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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.	All active records reviewed had sections and documents in the same order. For each individual checked, an active record and individual Notebook was available. Additional records were kept by departments in order to maintain information needed for decisions; for example, the medical department kept additional records of health care, including information that had been purged from the active record. Chronic (ongoing) Nursing Care Plans are filed in the Program Record. Acute Nursing Care Plans and Annual and Quarterly Nursing Assessments are filed chronologically (by date) in the Interdisciplinary Progress Notes, in the Medical Record. This separation may lead to fragmentation of information. The State is in the process of revising the Table of Contents for the unified record, and has asked the Monitoring Panel for input regarding the new format before it is finalized. During future reviews, the Monitoring Team will review records that are in the new format.	
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.	State policies are in place or in process of development. However, there is a lack of locally developed policies that were operationally oriented to use in implementing the State policies. In some cases, facility policy specific to this facility does exist; this visit did not include enough review to determine how completely locally developed policies and procedures operationalize state policies and provide guidance to staff. Because DADS is in process of revising policies, a thorough review of policies was not conducted.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement additional quality assurance procedures to ensure a unified record for each individual consistent with the guidelines in Appendix D. The quality assurance procedures shall include random review of the unified record of at least 5 individuals every month; and	The facility reported that at least 5 records are checked by the facility monthly. During this tour, information on these checks was not reviewed to determine comprehensiveness. Information was not gathered on tracking of information on findings or identification of trends. At the compliance review, a check will be made of the records that have been reviewed. Some of the record binders were in poor condition, with torn or loose pages. Documentation of all disciplines is sometimes illegible, such that content is difficult to read but signatures and titles of the author of entries are virtually impossible to discern. Documentation errors are not always corrected according to professional standards for correction.	

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	the Facility shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.		
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.	Use of records in making care, medical treatment, and training decisions is variable. For example, in some meetings, data are presented during the meeting in the form of a report, but discussion of the data and their impact on decisions are limited. For example, during PTR meetings, data were presented by psychologists, and information from side effects rating scales was presented by nurses, but there was little discussion of that information. Home staff are aware of the Individual Notebooks and 1:1 books, which are readily accessible.	

Recommendations:

- Continue development of the new policy. Prior to implementation, ensure that SSLCs develop local policies to operationalize the state policy. Implementation should include provisions for competency-based training of all staff who will use the records.
- Ensure that data are gathered on reviews of records to identify trends and to plan corrective actions.
- Develop a plan to ensure that discussion of information from records, including data, during meetings is used to influence decisions.
- When checking the unified record, the facility should ensure the record binder is in good condition.
- The Chronic Nursing Care Plans should be filed in the Medical Record.
- The Facility should evaluate the practice taking and leaving individuals' at the hospital during the stay.

Health Care Guidelines

SECTION I: Documentation	
	Steps Taken to Assess Compliance: • Partial record reviews of 22 records (includes onsite records and records obtained from document request) on the following individuals, with focus limited to issues related to C., F., G., H., I., L., M., N., and Q.; HCG Sections: I., II., (II.C.2,) III. (III.C.2), IV., VII., IX., and Appendix. A. o Individual #19, Individual #33, Individual #3, Individual #20, Individual #37, Individual #8, o BSSLC Client Injury Reports and Associated Documents (sample of 10 reviewed): 7/09 through 12/09: Individual #62, Individual #76, Individual #64, Individual #65 o BSSLC PSP and Quarterly PSP, reviewed combined sample of 10, sample of 10 copies reviewed per document request, electronically transmitted: Individual #22, Individual #23, Individual #24, Individual #25, Individual #26, Individual #27, Individual #28, Individual #29, Clara Individual #30, Individual #31, Individual #12, and Individual #32
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: Partial review with a focus on documentation revealed the follow trends: • Documentation was not consistently recorded in a manner consistent with applicable legal standards, required by BSSLC and DADS policies and procedures and professional standards. • Entries were not consistently legible and clearly written to facilitate effective interdisciplinary communication and as a means of assessing and evaluating individual care. • Entries did not consistently include date, time and full professional signature and title of the writer. • Health care issues indentified in the integrated progress notes did not consistently include follow-up documentation to reflecting status of the problems, actions taken and the response to treatment through to resolution. • Nursing staff did not consistently document communication with interdisciplinary team members. • Late entry notes were not clearly labeled according to acceptable legal standards of practice. • The SOAP and DAP format was generally followed when applicable for substantive content. • As well as could be ascertained, nursing actions and interventions were documented. • With the limited documents reviewed it could no be ascertained if the initiation of new treatments were document. When treatments were noted, expected outcomes, and therapeutic responses were rarely documented. Documentation of instruction to direct care staff was consistently missing in the Integrated Progress Notes. • Of the limited records reviewed, consistently missing was the first of the month summaries of treatments (e.g., psychotropic medications, antihypertensives, antiepileptics, etc.), efficacy of treatment, side effects experienced, and instructions to the individual and/or staff. • Nursing Quarterly Reviews were consistently completed. However, they did not consistently contain an

	evaluation of the effectiveness of ongoing treatments, nor were there evaluations of response to treatments that do not have potential for serious complications such as sunscreens, shampoos etc. The exacerbations of chronic conditions that required weekly monitoring for a minimum of one month were not consistently completed. Could not ascertain if the completion of a course of treatments were documented the Integrated Progress Notes. • Nursing Reviews (Quarterly and Annually) were scheduled and completed timely by RNs. ▪ All actual and potential health problems were not consistently identified and nursing diagnoses formulated. ▪ Health risk and actual problems were not consistently addressed using a comprehensive Nursing (HMP) Care Plan. ▪ Annual and Quarterly Nursing Assessments documented a head to toe assessment by use of a form that recorded assessments in a check box. Although a Comment section was available, documentation failed to consistently describe the findings in detail in the Comment section of the Nursing Assessment form. Consequently, it was difficult to discern if the findings required further intervention or change of the Nursing (HMP) Care Plans. Nurses completing the Annual and Quarterly Nursing Assessment should consistently summarize any health status variance in the Comment Section of the form and develop and implement (if not previously addressed) Nursing (HMP) Care Plans for intervention. • Skin Integrity Assessments: The BRADEN Scale evaluations were consistently completed quarterly. None of the individuals in the records reviewed had skin integrity issues.

Recommendations: The Nursing Administration, Management and QA Nurse should review the HCG to ensure that measures are taken to improve the quality of documentation and compliance with the SA and HCG.

SECTION II: Seizure Management	
	Steps Taken to Assess Compliance: • Review of Complete seizure records - Individual #66, Individual #67, Individual #68, Individual #69, Individual #70. Review of seizure type and medication regimen – 125 individuals • Reviewed BSSLC Policy and Procedures: Nursing: Seizure Management, Volume4, Section 2, Revised: November, 2009 • Reviewed sample of 6 Seizure Records and associated documentation supplied per onsite document request for: Individual #66, Individual #67, Individual #68, Individual #69
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: Key elements of seizure monitoring and treatment (diagnostic testing and neurologist monitoring,

	pharmacy involvement in reviewing polypharmacy, propriety of selected anticonvulsant medications, appropriate seizure classification, therapeutic anticonvulsant drug level monitoring) were reviewed. Documentation was detailed, laboratories for drug levels were present and neurological consultations were appropriately scheduled. Review of overall ER visits demonstrated that for the period of 06-01-08 through 12- 31-2008, 4/55 (9%) of the visits were for seizures, and for the period of 01-01-09 through 01-31-09 the 9/147 (6%) were for that indication. BSSLC's Nursing Policy for Seizure Management is fairly comprehensive, except it does not clearly state: When nurses are to be notified regarding seizure activity, nor does it spell out when a nursing assessment is to be completed in relation to seizure activity. According to the HCG, II, C. 2., Seizure Management, "1) The RN will be informed of **all** seizure activity either directly or indirectly through clinical documentation. 2) A clinical assessment by a RN will occur in all situations where seizure activity is atypical for the individual, lasts more than three minutes, and/or an injury or other secondary complication is suspected or apparent. 3) Licensed nursing staff will collect and record objective and subjective data that is clinically appropriate and significant to seizure activity. 4) Data will be recorded on the Seizure Record in a clinically useful manner." Further, the role and responsibilities of the support staff is not included in the policy. This policy did not include instruction to the support staff when to notify the nurse, how to report and record seizure activity on the Seizure Record. Perhaps, this is contained in another BSSLC policy for support staff that was not available for review. This points out the lack of integrated services at BSSLC. Review of the Seizure Records revealed numerous items on the records that were **not** consistently documented, they include: o The time seizures occurred and/or duration, often the time the seizures ended were documented as opposed to recording the duration. o Description of the seizure activity was often missing o Notification of nurses by support staff of all seizure o When nurses were notified, often only their first name was documented o Notification of the physician before administering Ativan or Diastat o Nurses often failed to document the time and route of administration of Ativan and Diastat and their signature and title. o Nurses failed consistently to document the individuals' therapeutic response to Ativan or Diastat o Nursing clinical assessments were often missing or inadequate, particularly when Ativan or Diastat were administered o Communication with the physicians was not documented o If the individual was sent to the Emergency Room for prolonged or complicated seizure activity, this information was not documented on the Seizure Record o Most documentation of content, signatures, and titles were illegible o The Seizure Record does not contain a place for the physicians to classify the seizure type There seems to be a lack of understanding by the support staff as to how to fill out the time and duration of seizures and the requirement to consistently notify nurses of all seizure activity. The nurses also seem to have a lack of understanding as to when it is necessary to complete a clinical nursing assessment. In

	general, the nursing assessments when completed were not in keeping with professional standards of practice for seizure management. It is important to note that only the Seizures Records were reviewed, some of the nursing documentation may have been contained in the individuals' Integrated Progress Notes that were not available for review. A more comprehensive review of all documents associated with Seizure Management will be reviewed on future tours

Recommendations:

- It would be helpful to have specific departmental procedures (in particular, guidelines regarding status epilepticus and serial seizures, and the rectal use of benzodiazapines) available in a central medical location, for staff review as is needed.
- The Nursing Administrative staff should review and revise BSSLC's Seizure Management Policy and Procedures with the HCG to ensure that the guidelines are followed. Seizure Management training should be required annually and when staff are not performing according to standards of practice.
- All nursing and support staff should be retrained on the Seizure Management Policy and Procedures (once they are revised) to ensure that Seizure Records are completed correctly and that the staff understand when the nurse is to be notified, how to record seizure activity. Nurses must understand when a clinical nursing assess is needs and to accurately and completely record findings on the Seizure Records. When medications are administered the date, time, dose, route and therapeutic response must be documented. Efforts should be made for all documentation to be written legibly, including signature and title.
- If not in place, the QA Nurse should develop an audit to ensure compliance with HCG Seizure Management requirements.

SECTION III: Psychotropics/Positive Behavior Support	
	Steps Taken to Assess Compliance: • Comprehensive record reviews of 6 individuals (Individual #19, Individual #33, Individual #3, Individual #20, Individual #35, Individual #36) • Partial record reviews; about 20 individuals being reviewed in PTRs • Partial record reviews of Individual #19, Individual #33, Individual #3, Individual #20, Individual #37, Individual #8,
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: This baseline visit to Brenham provided the opportunity to become familiar with the tracking of relevant data in the medical records. Many observations overlap with issues noted in SA section J. There are some difficulties in the area of identification of target behaviors and symptoms, charting regarding r/o of medical etiologies, and review of psychiatric differential diagnosis that is pertinent to the selection/monitoring of psychotropics and positive behavioral support. The Healthcare Guidelines (HCG) document is explicit in its guidance for labs (blood tests, EKG etc), as well as ophthalmological exam (e.g. Quetiapine) and other

	general medical tests to guide use of medications. Institutional oversight of the use of psychotropics is extensive, and there are many requirements for review and approval by the PST, by guardians and by committees such as the Human Rights Committee and Facility Behavioral Review Board. For Brenham staff to provide care which will comply with the requirements of the SA and HCG, explicit procedures for the routine and emergency use of psychotropic medications need to be developed and readily available for guidance. It is possible that such documents exist at Brenham, but those were not reviewed. In addition, the complexities of tracking the labs needed for the various psychotropics make it advisable to have internal reference guidelines that will allow for prospective planning and for standard-of-care review of these issues. In the limited records reviewed on clients taking psychotropic or other medications with the potential to cause side effects, there was evidence that the validated rating instruments MOSES and DISCUS were completed by RNs and signed-off by physicians. A DISCUS was completed every three months for individuals on antipsychotics and a MOSES every six months for individuals for individuals who are on antianxiety, antipsychotic, antidepressant, stimulant, mood stabilizer, sedatives/hypnotic and/or anticonvulsant medications. However, there may be a discrepancy between the requirements in the SA and the HCG relating to the frequency these assessments are to be completed. In order for the SA Consultants to accurately monitor this item, there needs to be clarification as to frequency these assessments are to be completed. The results of MOSES and DISCUS assessments were not consistently documented in clients' Annual or Quarterly Nursing Assessments, nor are individual's response to antipsychotic or other related medications or potential side effects listed.

Recommendations:

- Collect available procedures for routine and emergency use of psychotropic medications and place in a convenient location for staff review. If such procedures have not been developed to date, it would be wise to do so.
- The Nursing Department should review the SA and HCG for nursing responsibilities regarding the administration and management of psychotropic medication and retrain the nursing staff to ensure compliance.

SECTION IV: Management of Acute Illness and Injury	
	Steps Taken to Assess Compliance: See Section L
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: Only injuries reviewed through Client Injury Report and Hospital ER Visits are reported in this report. More

	in depth reviews will be completed in future tours

Recommendations:

SECTION V: Prevention	
	Steps Taken to Assess Compliance: • Reviewed BSSLC's Nursing Policy and Procedures,Volume4, Section2 • Partial record reviews of Individual #19, Individual #33, Individual #3, Individual #20, Individual #37, Individual #8 • Observation of 2-10 shift report in Childress • Infection Control Information: Infection Control Committee Meeting Minutes: 5/25/09 and 9/30/09; Decubitus Spreadsheet, 1/7/09 through 11/30/09;Infection Control Spreadsheet – to date; IC-1 Weekly Infection Report: October through December 2009; and Texas Department of Aging and Disability Services, State Supported Living Centers Procedure: Infection Control Training and Competency Testing Materials
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: • Initial, Annual and Quarterly Nursing Assessments are completed and Nursing Care Plans are developed from findings identified in the assessments or when there is a change in the individuals' health care status. However, in the limited record review of the individuals listed above, the Assessments and Nursing Care Plans appeared to be based more on a "Medical Model" as oppose to exercising independent nursing judgment and developing proactive/preventative interventions applicable to caring for individuals with developmental disabilities. The Nursing Administration and Management team recognizes the need to exercise more independent nursing judgment with a focus on managing care for individuals with developmental disabilities and are making efforts to remedy this issue as well as work within the framework of an integrated setting. • At observation of the 2-10 Shift Report in Childress, the off-going nurse gave an excellent report of each individual's status and nursing activities to be follow-up. While the verbal report was excellent the written report was virtually illegible. This was discussed and suggestions were made to improve the quality of the documentation to ensure that nurses following-up on activities could clearly and accurately understand what needed to be completed. • Infection Control documentation obtained from onsite document request was reviewed. The Facility uses the training material supplied by Texas Department of Aging and Disability Services, State

	Supported Living Centers Procedure: Infection Control Training and Competency Testing Materials. Contained within the training material are instructions for Hand Washing and Standard Precautions in accordance with the Center for Disease Control and Prevention recommendations. Training records were supplied to validate training. Infection Control Training is required for all new employees, however, it could not be ascertained if refresher training is required annually. This will be followed-up on future tours. • Joanne Guard, RN, Infection Control Nurse, explained her role and function and the reports she generates, as listed above and reviewed. The Infection Control Committee meets quarterly. Minutes were review for June and September, 2009. The majority of the discussion centered on planning for the seasonal flu and H1N1 flu. The IC-1 Weekly Reports and Monthly Infection Reports, report types and sites of infections and antibiotic usage. However, the data is not analyzed, tracked and trended. This is necessary to identify most frequently occurring infections, where they are clustered and to put this information into use by preventing and/or reducing the incidents of infections. • An ongoing Infection Control Spreadsheet is maintained for: MRSA, Hepatitis B, Hepatitis C, Positive PPD, TB Converters, H1N1, C-Diff and STDS. It could not be determined how this information is communicated or used. Immunization status for residents as well as employees is tracked by the Infection Control Nurse. Ms. Guard and the Nursing Administrative and Management staff are concerned about the requirement for annual chest rays on individuals/staff that have a converted TB Skin Tests. They have attempted to research CDC guidelines for current standards of practice for follow-up and management of converted TB Skin Tests. However, the information received has been conflicting with no specific recommendation. • A Decubitis Spreadsheet is maintained tracking the status of wound healing. Presently, the Facility reports 2 Stage II and 2 Stage I decubitis. The PUSH method is use to measure and assess decubitis. Nurses complete a BRADEN skin assessment on each individual quarterly. This was validated through the limited record review. A more in depth review of this program will be completed on future tours for individuals with skin integrity Issues. • Ms. Guard related that recently there had been an increase in oral infections but she did not know why. She was asked if she had completed any trend data to identify potential causes. This has not been done. She was asked if the increase could be related to the fact that the Facility has a full time Dentist, with the ability for more individuals to access dental care. She did not think this was the case since the Dentist has been on contract and seeing the same number of individuals. She was asked if she had completed an Infection Control inspection of the dental equipment, instruments, staff compliance with infection control measure, etc. This has not been done. It was suggested that she meet with the Dental staff to further explore this concern along with conducting infection control inspections for all potential causes for increased oral infections. Future tours will focus on a more in depth review of performance related to preventative health issues. • The Facility has gone through many changes to the Self Administration of Medication System (SAMS) Program guidelines and forms. They now have a nurse serving as the SAMS Coordinator. She will be responsible for implementing and following through with all individuals on this program. The policy for the SAMS Program was not obtained and review. A more in depth review of this program will be completed on future tours.

Recommendations:

- Nursing Administration should review the HCG, Section V, and revise Nursing's Prevention Policies and Procedures to ensure that they reflect the conditions set forth in these guidelines.
- Nursing Administration should work with the Systems staff to develop a program for analyzing, tracking and trending Infection Control data into a meaningful format to use to identify types of infection, frequency of occurrence by location and person. This data should be used to prevent and/or reduce the incidents of infection.
- When problematic trends are identified, root cause analysis should be instituted to determine possible causes and lead to actions to correct or improve.
- The Facility Director of Medical Services should determine the frequency and follow-up treatment for individuals that have a converted TB Skin Test.
- The Infection Control Nurse should conduct infection control inspections of Dental Services equipment for all potential causes for increased oral infections

SECTION VI: Nutritional Management Planning	
	Steps Taken to Assess Compliance: • Interviews with: o Kori Kelm, Habilitation Therapies Director o Occupational Therapist o Speech Pathologist o Dentist Gary Johnston, DDS o Dental Hygienist o Chief Nurse Executive Debbie Williams, RN o PNMP Coordinator o Residence Director Susie Johnson o RN Case Manager o Johanna Nelms, RN: Nurse Educator o Wendy Smith, RN: Hospital Liaison o Multiple Direct Support Staff and Unit Nurses • Comprehensive record reviews of 6 individuals • Partial record reviews of 21 individuals Review of requested tour documents • Observations of living areas, dining rooms, oral care, positioning, enteral nutrition, and medication administration • Attended morning unit meeting, HST quarterly, and shift change
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.

	Summary of Monitor's Assessment: Individuals residing at BSSLC have been assessed for nutritional risk however the identified risk levels are not felt to be accurate due to inaccuracies in completing the risk screening forms as well as a policy which is flawed in its ability to identify those who are at an increased risk. Refer to SA O2 for details. Individuals are not consistently provided with assessments or referrals in response to risk factors. These include behavioral challenges, medical problems, medication side effects, and physical clinical indicators. For example: • Individual #88 was noted by nursing to have increased lethargy. Physician was notified but no involvement by habilitation therapies to address how this lethargy may have an impact on their daily functioning or safety. • Individual #33having increased residuals with gurgly voice and wheezing. Physician notified but no involvement by habilitation therapies or NMT to address positioning. Individuals with enteral tubes are evaluated on an annual basis regarding type, rate and frequency of enteral feedings however the appropriateness of continued enteral support or the return to oral intake is not identified or addressed. Refer to SA O8. Dining Plans are present for all individuals however the dining plans contain vague terminology resulting in various strategies being attempted by staff. Refer to SA P2. Review of Hospital and Emergency Visits indicates by the number of incidents of aspiration pneumonia that physical and nutritional management needs improvement. Since hospitals do not consistently diagnose or often misdiagnose types of pneumonias it is plausible to wonder, of the individuals with repeated episodes of pneumonia diagnosed as bacterial or viral might not have misdiagnosed aspiration pneumonias. Considering the Facility's method of ranking "levels of risk" it is important that the PST, if they have not done so, reassess "level of risk" for aspiration/dysphagia for individuals who have diagnosed pneumonias and implement Nursing (HMP) Care Plans to prevent or reduce the potential of reoccurring pneumonias.

Recommendations:
- Refer to SA O & P recommendations
- The PNMP Team and physician should track and trend incidents of pneumonias, and use data to provide a comprehensive assessment of those individual with high frequency prevent and/or reduce the reoccurrence.

SECTION VII: Management of Chronic	

Conditions	
	Steps Taken to Assess Compliance: During this baseline review, the team members did not focus specifically on this issue. Please see sections above that address Sections L and M of the Settlement Agreement.
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment:

Recommendations:

SECTION VIII: Physical Management	
	Steps Taken to Assess Compliance: • Interviews with Kori Kelm, Habilitation Therapies Director, Occupational Therapist, Speech Pathologist, Dentist, Dental Hygienist, Chief Executive Nurse, PNMP Coordinator, Residence Director, RN Case Manager, Hospital Liaison, Nurse Educator, and multiple Direct Support Staff and Unit Nurses • Comprehensive record reviews of 6 individuals • Partial record reviews of 21 individuals • Review of requested tour documents • Observations of living areas, dining rooms, oral care, positioning, enteral nutrition, and medication administration • Attended morning unit meeting, HST quarterly, and shift change A cursory review and analysis was completed on Emergency Room visits from the available data for June through December 2008 and January through October 2009 to identify the most frequent causes for visits. The findings indicated: o In 2008: 21 or 38% of 55 visits were for lacerations; 6 or 11% of 55 visits were for injuries w/o fractures or lacerations; 2 or 4% of 55 visits were due to fractures; combined injuries accounted for 29 or 53% of all visits. o In 2009: 38 or 26% of 147 visits were for lacerations; 25 or 17% of 147 visits were for injuries w/o fractures or lacerations; 6 or 4% of 147 visits were due to factures; combined injuries accounted for 61 or 41% of all visits. <u>Review of BSSLC's Incident's of Fractures and Injuries Requiring Sutures</u>:

	• A cursory review and analysis of TX-BR-1001-III.10a – Fractures since July/1/2009, indicated: 4 caused by: Slip/Trip/Fall – self induced; 44% 4 caused by: Hit – self induced; 44% 1 Caused by Push/Shove – peer induced; 11% • A cursory review and analysis of TX-BR-1001-III.10b – Sutures since July/1/2009, indicated: 12 caused by Slip/Trip/Fall –self induced; 44% 6 caused by Head Banging/Hitting/Behavior – self induced; 22% 3 caused by Bump Into – self induced; 11% 1 caused by Seizure – self induced; 4% 1 caused by Foreign Object – self induced; 4% 1 caused by Push/Shove – peer induced; 4% 3 Caused by Other (Unknown) – other induced; 11%
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: All individuals at BSSLC have been provided with a document called the PNMP however the PNMP is not considered to be comprehensive due to the document lacking information on oral care and medication administration. Individuals are receiving PNM assessments however the assessments are lacking information regarding oral care, medication administration and positioning requirements during these activities as well as when in bed. Currently the elevation of the head of the bed is provided solely by the physician and is based primarily on general standards rather than being individualized with input from the PT. Many BSSLC individuals have medical conditions that seriously complicate the swallowing and digestion of their food and beverages as well as increase their difficulty in being able to safely manage their oral secretions. Aspiration Pneumonia is typically a preventable condition that results from the accumulation of foreign materials (usually food, liquid, or reflux) in the lungs. BSSLC lists only 4 individuals as at "high risk" yet several individuals were hospitalized for aspiration or choking related events who do not appear on the center's high risk list. Based upon observation, there were a significant number of individuals who were observed to be at "high risk" but were listed as being at "low risk" according to their screening forms. Currently BSSLC's aspiration and choking risk lists has 323 listed as at "low risk", 31 listed as at "medium risk" and 4 at "high risk". In addition, 5/6 records reviewed had inaccuracies with scoring and inconsistencies between various risk screenings. Thorough review of the "At Risk" policy revealed two main issues. One was that the center was incorrectly following the policy as BSSLC was placing the majority of their individuals as being at "low risk" when they

	should have been placed as at "medium risk". Secondly, the policy as written is flawed in its ability to identify those who are at a "high risk" of physical and nutritional decline. In its current state, the policy identifies individuals as being at "High Risk" if they are having an acute issue, "Medium Risk" if they require ongoing supports (i.e., a PNMP), and "Low Risk" if they do not require supports. Following the policy as written would result in BSSLC having their entire population with the exception of the 4 "High Risk" listed as "Medium Risk" since the remaining individuals have PNMPs. This type of risk classification system is not functional or useful to the clinicians or the individuals living at BSSLC. A decubitis ulcer or skin breakdown is another preventable condition given appropriate care. As with other conditions, BSSLC is failing to identify all those individuals truly at risk and this hampers or eliminates the possibility of providing proper preventative services and supports. The issues noted above results in questioning whether or not BSSLC is accurately identifying and treating all those individuals at risk. Monitoring is conducted by professionals and PNMP coordinators, however there is not a clear process in place that outlines the frequency in which individuals will be monitored (i.e., high risk vs. low risk) or the response if a deficiency is noted. Additionally, many staff who conduct monitors state that they have received little to no additional training on how to complete the form, what signs or symptoms they should be monitoring and what happens to the forms once they are completed. This was evident by a mealtime this reviewer observed as well as a PNMP coordinator. This reviewer found five deficiencies associated with the mealtime and the PNMP coordinator found only one. In order to be an effective monitor, one must have the skills necessary to identify potential early warning signs associated with physical and nutritional decline. Currently, there are seven PNM monitoring forms being utilized by multiple professionals and staff. This results in confusion, and the inability to analyze data between dates and between monitors as well as establish trends over time. BSSLC should consider reviewing the entire monitoring process so that it is streamlined and clearly defined.

Recommendations:

- Refer to SA O & P recommendations
- The IDT Team and physician should track and trend incidents of falls, fracture and injuries requiring sutures, and use data to provide a comprehensive assessment of those individual with high frequency prevent and/or reduce the reoccurrence.

SECTION IX: Pain Management	

	Steps Taken to Assess Compliance: • Reviewed BSSLC's Policy and Procedures: Nursing: Pain Management, Volume 4, Section 2 • Partial review of: Individual #19, Individual #33, Individual #3, Individual #20, Individual #37, Individual #8
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: • Review of BSSLC's Nursing Pain management policy is very general and non-specific. It does not incorporate the requirements included in the HCG for Nursing Management. The policy does not use a nationally standardized assessment to for assessment of pain. While it list signs and symptoms of pain and interventions. It does not include the requirement for nursing to provide training to direct care staff on recognizing signs and symptoms of pain, how to report and record such findings. Nor does it require that each person have a Pain Assessment and Nursing Care Plan to meet the individual unique expression of pain. For individuals with chronic pain it is essential that the nurses along with the PST assess individuals for their unique expressions of pain. Often maladapted behaviors are an expression of pain or discomfort, e.g., an individual having a toothache may engage in slapping their face or banging their head or an individual with GERD my hand-mouth or ruminate to gain relieve. If the individual's unique manifestation of pain is known, when maladaptive behaviors occur, having this insight might mean the difference in treating pain as oppose to treating behavior. • A partial record review of the individuals listed above included a cursory review of MARs and Integrated Progress Notes looking at documentation of PRN medications. Often when PRN pain medication was documented on the MAR, there was no accompanying note written on the MAR stating the purpose or therapeutic response. In cross-walking the MAR with the Integrated Progress Notes rarely was there a note written about the administration of pain medication. If a corresponding note was written it usually stated something like, "Tylenol given for headache as ordered." There was no in dept assessment of pain or therapeutic response to the pain medication administered.

Recommendations:

- Nursing Administration should review the HCG and revise their Pain Management Policy to comply with these guidelines
- If not in place, the Nurse Educator should develop a training module for direct care staff on recognizing, reporting and recording signs and symptoms of pain.
- The Nurse Case Managers or designee should work with the PST to assess individuals for their unique expression of pain and develop an individualized Nursing (HMP) Care Plan. This plan should be included in the individual's PSP. Pain interventions and response should be summarized in Quarterly Nursing Assessments.

List of Acronyms Used in This Report
Brenham SSLC
January, 2010 Baseline Tour

Acronym	Meaning
AED	Anti-Epileptic Drug/Automated External Defibrillator
AIMS	Abnormal Involuntary Movement Scale
A/N/E	Abuse/Neglect/Exploitation
APC	Admissions/Placement Coordinator
APS	Adult Protective Services
BCBA	Board Certified Behavior Analyst
BP	Blood Pressure
BSP	Behavior Support Plan
BSRC	Behavior Support Review Committee
BSSLC	Brenham State Supported Living Center
CDC	Centers for Disease Control and Prevention
CLDP	Community Living Discharge Plan
CLO	Community Living Options
CLOIP	Community Living Options Information Process
CMS	Centers for Medicare and Medicaid Services
CEN	Certified Executive Nurse
COP	ICF/MR Condition of Participation
CPR	Cardiopulmonary Resuscitation
CRIPA	Civil Rights of Institutionalized Persons Act
DADS	Texas Department of Aging and Disability Services
DCS	Direct Care Staff
DD	Developmentally Delayed
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DOJ	U.S. Department of Justice
DMID	Diagnostic Manual-Intellectual Disability
DRO	Differential Reinforcement of Other Behavior
DSM	Diagnostic and Statistical Manual of the American Psychiatric Association
DUE	Drug Utilization Evaluation
EKG	Electrocardiogram
ER	Emergency Room
FA	Functional Analysis or Functional Assessment
FSPI	Facility Support Performance Indicator
FTE	Full Time Equivalent
FY	Fiscal Year
GERD	Gastroesophageal reflux disease

HCG	Health Care Guidelines
HCP	Health Care Plan
HIPAA	Health Information Portability and Accountability Act
HMP	Health Maintenance Plan
HOB	Head of Bed
HRC	Human rights committee
HST	Health Status Team
ICF/MR	Intermediate Care Facility for the Mentally Retarded
IDT	Interdisciplinary Team
IMRT	Incident Management Review Team
ISP	Individual Support Plan
LAR	Legally Authorized Representative
LVN	Licensed Vocational Nurse
MAR	Medication Administration Record
MBSS	Modified Barium Swallow Study
MD/M.D.	Medical Doctor
MOSES	Monitoring of Side Effects Scale
MRA	Mental Retardation Authority
NCP	Nursing Care Plan
NMT	Nutritional Management Team
NP	Nurse Practitioner
OIG	Office of the Inspector General
OJT	On the Job Training
OT	Occupational Therapy
OTR	Occupational Therapist, Registered
PALS	Positive Adaptive Living Survey
P&P	Policies and Procedures
PBSP	Positive Behavior Support Plan
PCP	Primary Care Physician
PDP	Personal Development Plan
PMAB	Physical Management of Aggressive Behavior
PRN	Pro Re Nata (as needed)
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
POC	Plan of Correction
POI	Plan of Improvement
PRN	Pro Re Nata (as needed)
PSA	Prostate Specific Antigen
PSP	Personal Support Plan
PST	Personal Support Team
PT	Physical Therapy

PTR	Psychiatric Treatment Review
QA	Quality Assurance
QE	Quality Enhancement
QI	Quality Improvement
QMRP	Qualified Mental Retardation Professional
RD	Registered Dietician
RN	Registered Nurse
r/o	Rule out
SA	Settlement Agreement
SAM	Self-Administration of Medication
SIB	Self-injurious Behavior
SLP	Speech and Language Pathologist
SSLC	State Supported Living Center
SPO	Specific Program Objective
TB	Tuberculosis
UIR	Unusual Incident Review or Unusual Incident Report