United States v. State of Texas

Monitoring Team Report

Corpus Christi State Supported Living Center

Dates of Review: July 12 through 16, 2010

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Submitted By: Maria Laurence, MPA

Monitoring Team: Patrick Heick, Ph.D., BCBA-D
Victoria Lund, Ph.D., MSN, ARNP, BC
Edwin J. Mikkelsen, MD
Antoinette Richardson, MA, JD
Nancy Waglow, MS, MEd
Wayne Zwick, MD

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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 Intermediate Care Facility for Persons with Mental Retardation (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 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 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 were considered baseline reviews. Compliance reviews began in July 2010, are intended to inform the parties of the Facilities' status of compliance with the SA. This report provides the results of a compliance review of Corpus Christi State Supported Living Center (CCSSLC).

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, 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 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 a section of the report for which another team member had primary responsibility. For this compliance review of Corpus Christi State Supported Living, the following Monitoring Team

members had primary responsibility for reviewing the following areas: Antoinette Richardson reviewed protection from harm, including restraints as well as abuse, neglect, and incident management, integrated protections, services, and supports, as well as quality assurance; Edwin Mikkelsen reviewed psychiatric care and services; Wayne Zwick reviewed, medical care, dental services, and pharmacy services; Victoria Lund reviewed nursing care, restraint, and safe medication practices; Patrick Heick reviewed psychological care and services, restraint, 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 integrated protections, services, treatments and supports, and 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 might 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 July 12 through 16, 2010, the Monitoring Team visited Corpus Christi 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), Positive Behavior Support Plans (PBSPs), 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.

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, the report includes the following sub-sections:

(a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;
(b) **Facility's Self-Assessment:** No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the SA. This section describes the self-assessment steps the Facility took to assess compliance, and the results, thereof.
(c) **Summary of Monitor's Assessment:** Although not required by the SA, a summary of the Facility's status is included to facilitate the reader's understanding of the major strengths as well as areas of need that the Facility has with regard to compliance with the particular section;
(d) **Assessment of Status:** 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;
(e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") is stated for reviews beginning in July 2010; 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 according to randomly assigned numbers (for example, Individual #45, Individual #101, etc.). 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 entire Monitoring Team would like to thank the management team, individuals served, and staff of Corpus Christi State Supported Living Center for their willingness to share information and their time to assist the Monitoring Team in conducting its review. During the July 2010 review, as during the baseline review, the Corpus Christi team's willingness to provide honest assessments of the status of compliance was appreciated. In addition, when during the course of the review issues were brought to the management team, it responded by addressing them immediately, and developing reasonable plans to correct identified concerns. The Monitoring Team also would like to thank the State Office staff who were on-site during the review for their contributions, as well. They were instrumental in assisting the Facility to address some of the issues raised, as well as providing invaluable assistance with regard to the logistics of the review.

As is illustrated throughout this report, CCSSLC had a number of good practices in place, and in a number of the areas in which there was a need for improvement, the Facility had plans in place to make needed changes. The following provides some brief highlights of some of the areas in which the Facility was doing well and others in which improvements were necessary:

Positive Practices: The following is a brief summary of some of the positive practices that the Monitoring Team identified at CCSSLC:

<u>Restraints</u>

- As during the baseline review, the clear commitment from the top-level management at CCSSLC to prohibit the use of most mechanical restraints and to reduce the use of all restraints was still in evidence.
- According to reports reviewed, restraint checklists were being filed, restraint monitors were on site within minutes, and psychology staff and nurses were notified and arrived to perform their responsibilities. Staff remained with the person being restrained, explained the restraint.

<u>Abuse, Neglect and Incident Management</u>

- There were processes in place to report abuse, neglect, and other incidents, and staff members appeared to know their responsibilities in this regard.
- Since the last review, a number of policy revisions had been made, particularly by the Facility to address a number of elements that previously had been missing with regard to the conduct of investigations.
- Both DFPS and the Facility were utilizing investigation report formats that included the components required by the Settlement Agreement.

Quality Assurance

- The quality enhancement activities at CCSSLC were moving out of the initial stages of development and into the testing stage of development. New policies were being implemented, committees activated, and new information linkages formed between disciplines. A Quality Enhancement Plan had been put in place.
- Trends were being reported quarterly for some key issues, such as abuse allegations, incidents, injuries and hospitalizations. Information was available to show some specific characteristics of incidents, such as where incidents were occurring, what time of day, and on which living units. Breakdowns of data were now available by unit and by residence, making it possible for units and residences to use the data as a tool in analyzing and addressing undesirable trends.

Integrated Protections, Services, Treatments and Supports

- Some of the positive aspects of the Person Centered Plans (PSPs) reviewed included efforts to identify the preferences and achievements of individuals served through use of the Personal Focus Worksheet (PFW) Meetings preceding the annual team meeting; inclusion of Legally Authorized Representatives (LARs) in team meetings, including offering options such as telephone participation; and updating PSPs at least annually.

Psychiatric Care and Services

- CCSSLC had implemented a monthly meeting to address polypharmacy with psychotropic medication. The minutes of these meetings also tracked the progress of the Psychiatry Department in meeting the provisions of the Settlement Agreement.
- There had been a great deal of progress in meeting the requirements of the Settlement Agreement related to the periodic assessment of the MOSES/DISCUS side effect monitoring instruments and the administration of the Reiss Screen to individuals who were not currently receiving psychotropic medication.

Psychological Care and Services

- CCSSLC had made progress by developing and approving formal Psychological and Behavioral Services Policies. As staff members within psychological and behavioral services move forward, they will need to work out the details of implementing these new policies and procedures.
- CCSSLC had successfully developed and begun to implement a policy targeting the recruitment of and/or training of BCBA-level professionals. This included the recent hiring of a Board Certified Behavior Analyst as a consultant to provide peer review and supervision to psychology staff members who have committed to starting (or continuing) graduate coursework in Applied Behavior Analysis (ABA). This consultant had also begun to attend Behavior Support Committee (BSC) meetings at which peer review of Positive Behavior Support Plans occurred.
- Progress also had been made in the area of data collection and monitoring of PBSPs. Improved access to computers appeared to have facilitated the use of data management systems as well as graphic displays, including both target and replacement behaviors, that ultimately will promote more efficient and effective monthly reviews.

- A newly revised Structural and Functional Behavior Assessment (SFBA) format had been introduced. This new format appeared to support a more comprehensive assessment process (i.e., using direct assessment methods) and, subsequently, is likely to promote more assessment-linked interventions. At the time of the review, this process was still relatively new.

Medical Care

- Generally, it appeared that seizure management was adequate. Individuals were followed closely by neurologists.
- As an important but separate component providing external review, a contract had been recently signed with a patient safety organization. They will be conducting mortality reviews of CCSSLC death cases. This is an important step in meeting the requirements of the SA.

Nursing Care

- Although many of the systems were not in place addressing the requirement of the SA to meet substantial compliance, the Nursing Department had made significant progress in moving forward.
- CCSSLC's QE Nurse and Nursing Department had begun using the Monitoring Teams' review/monitoring tools in a number of areas. Although some data was generated from the auditing, this process continued to be in the initial stages of implementation.
- The Nursing Department had implemented a peer review process focused on individuals with acute illness and requiring hospitalization. They were in the process of using the monitoring tools when assessing the care and documentation, which should lead to the implementation of plans of correction to address the identified deficiencies.
- Since the baseline review, the Nursing Department had implemented a number of interventions associated with the medication administration system. The Medication Observation tool was appropriately revised to include all the basic elements of medication administration orally, by injection or via tube, and was implemented in February 2010. In addition, the frequency of the medication observations for nurses was changed from annually to at least quarterly, and more often, if necessary.

Pharmacy Services and Safe Medication Practices

- Quarterly Drug Regimen Reviews (DRRs) appeared to be being completed for individuals receiving psychoactive medications. These reviews were thorough, and provided prescribing physicians with valuable information.

Dental Services

- One of the essential steps in providing quality dental care is having an adequate complement of dental personnel. In this regard, the dental department had made great strides over the past several months. At the time of the review, they had two full-time dentists, and two full-time dental hygienists. One of the dental hygienists was working directly with individuals and staff in the homes on dental hygiene. This is a positive step in providing preventative care.

- Since the baseline visit, thorough policies had been developed and implemented with regard to the use of Total Intravenous Anesthesia (TIVA), particularly with regard to the completion of dental work. Based on a review of records, the preparation for the use of TIVA, monitoring during the procedure, and post-operative care were thorough and well documented. This represents a valuable addition to the spectrum of dental services provided through the dental department to allow for the provision of quality dental care. Policies allowed for TIVA to be used both to address individuals' behavior (e.g., refusal) to have dental work completed, as well as to allow the completion of extensive dental work that would be painful. Concerns related to the need to improve desensitization plans and other strategies to reduce the need for the use of sedation are discussed with regard to Section Q of the SA.

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

- Since the baseline review, CCSSLC had made progress by developing several draft polices, revising assessment and skill acquisition formats, and by initiating new quality improvement systems, including the development of two oversight committees.
- Progress also had been made in the area of data collection. Graphing of skill acquisition data had recently been introduced. The use of visual analysis to examine performance over time will hopefully assist PST members in evaluating interventions and recommending modifications. The adequate recording of weekly data and summary of monthly data, however, continued to be inconsistently observed.
- During the baseline visit, concerns were raised about the adequacy of the vocational assessment as well as the limited opportunities for some individuals to access day or vocational programming both on and off campus. Since then, a new more comprehensive vocational assessment had been developed, and was being piloted.

<u>Most Integrated Setting</u>

- Post-move monitoring had been completed in a timely manner for most of the individuals who had transitioned to the community. With regard to the content of the checklists, the checklists all utilized the format attached to the SA as Appendix C. Each of the items on the checklists had been addressed.
- The post-move monitoring identified some issues with regard to the provision of services at the community sites, and these items appeared to be addressed appropriately with provider agencies.

<u>Recordkeeping and General Plan Implementation</u>

- Since the baseline visit, the State issued the new Table of Contents (TOC) for the active records. At the time of the review, 125 records had been converted, representing approximately 43 percent of the records at the Facility. This was a substantial accomplishment in a short time.
- Another positive development at CCSSLC since the baseline visit was the development and implementation of the CCSSLC Policy and Procedure Guidelines policy. This policy set forth a process for the development and review of policies and procedures. It required that the Policy and Procedure Committee review and approve all draft policies.

Areas in Need of Improvement: The following identifies some of the areas in which improvements are needed at CCSSLC:

Restraints

- Because the documentation for use of alternative measures prior to the restraint was a checklist, there was no way to determine if the staff used the appropriate methods and strategies that were included in the individual's Behavior Support or Safety Plans. This would make it difficult, if not impossible, to determine the overall effectiveness of the interventions in the plans, or to help clinical staff identify when interventions needed to be modified.

Abuse, Neglect and Incident Management

- Based on the sample reviewed, Department of Family and Protective Services (DFPS) as well as Facility investigations were not consistently being completed within the timeframes required by the Settlement Agreement. Based on the SA requirement that the provisions in D.3.e needed to be fully implemented within one year, Adult Protective Services (APS) policy did not require investigations be completed in 10 days until June 2010.
- Some of the investigations completed, particularly by the Facility, did not thoroughly ask and answer all of the relevant questions surrounding the incident. As a result, conclusions of the investigations were not always substantiated fully.
- Trend analysis of incidents and allegations was underway. One of the challenges with analyzing such data will be ensuring that issues that are identified are addressed.

Quality Assurance

- Quality monitoring tools had been adopted based on the tools used by the SA monitors. At the time of the review, these tools had not yet been modified for use by the Facility's quality monitors, but they had begun to use them in the field. It is positive that the Facility is making use of the tools developed by the Monitoring teams. However, while on site, the Monitoring Team discussed with Facility staff some of the modifications and/or enhancements that would be necessary for these tools to be useful to the Facility. These include, but are not limited to:
    - The monitoring tools do not currently include instruction sheets or guidelines. These would need to be developed to:
        - Ensure that various facility staff implementing the tools are using the same methodologies to rate indicators, thereby increasing the likelihood of inter-rater reliability; and
        - Provide adequate guidance to reviewers who do not have specific subject-matter expertise to ensure accurate rating of the tools. Again, these tools were developed by and for the use of Monitoring Team members with substantial subject matter knowledge. If they are going to be used by, for example, QE staff, who have more limited subject matter expertise, it will be essential that specific, written

guidance is available to assist in rating indicators, as well as training, and ongoing technical assistance by subject-matter experts.

- There was some discussion that these tools would be used to generate a cumulative score with regard to compliance. The items on the tools have not been weighted, but would need to be if they were going to be used in this manner.
- Some of the indicators on the tool are specifically designed for a team approach to monitoring. For example, some indicators reference gathering information from other team members who have specific expertise. Particularly if the Quality Enhancement Department is going to use these tools, such indicators will need to be modified, and more specific methodologies identified to evaluate such indicators.
- At times, it may be beneficial for separate scoring sheets to be developed to assist with the data collection necessary to score some of the indicators. Not all of the current monitoring tools facilitate this process because they track very closely the requirements of the Settlement Agreement that calls for, for example, policy development, as well as policy implementation. As a result, they are not necessarily formatted to allow easy review of only individual records or only policy. A separate sheet(s) likely would assist in this process.

- Trending of some basic quality indicators was being conducted. Additional indicators will need to be developed to better enable the Facility to identify problems with regard to protections, services, and supports provided to individuals served by CCSSLC. This is important for a few reasons, including providing the Facility with the ability to identify objectively the individuals who require additional attention to ensure they are safe and are receiving the supports and services they require, as well as to identify proactively homes, day programs, and/or departments that require improvement, and to identify a wide array of potential systemic issues. At the time of the review, the Facility did not have a system such as this in place. Throughout this report, there are references made to data that should be incorporated into such a system.
- The next step will need to be responding to the identified trends with analyses of potential causes, and the development of action plans to address issues identified. Follow-up will also need to occur to ensure that actions are taken that effectively address the trends.

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

- As was identified in the baseline report, the biggest challenge for CCSSLC with regard to PSPs appeared to be ensuring that team meetings included interdisciplinary discussions that resulted in one comprehensive, integrated treatment plan for each individual. This also included the need to incorporate individuals' preferences and desired outcomes into the planning process in a meaningful way.
- As is noted throughout this report, issues with regard to adequate assessments impacted teams' ability to identify strengths, as well as needs of individuals. As assessment processes improve, teams will have better tools on which to base their discussions and the resulting integrated plans.

At-Risk Individuals

- There had been some initial attempts at developing risk assessment tools, such as the health risk assessment domains. However, these tools, including the severity ratings, were subjective, making consistency across teams problematic. Precise criteria reflective of each level need to be developed as guidance for all the teams. Then, those individuals at risk can be identified, and a plan of care implemented. None of these steps had been completed.

Psychiatric Care and Services

- There was not adequate psychiatric staffing to provide for the needs of the individuals at the Facility. The Facility was engaging in a number of activities to bring the staffing to acceptable levels. However, at the time of the review, CCSSLC employed two part-time psychiatrists to provide psychiatric services to the 150 individuals who were prescribed psychotropic medications. One of the two psychiatrists was expected to be leaving in the near future.
- The analysis of the medical records of individuals served by CCSSLC identified three fundamental problems, including: 1) the identification of the specific symptoms that support the psychiatric diagnosis was absent; 2) in every record, the behaviors that were described as "targets" of the psychotropic medication were also referred to in the Behavior Plan and Functional Analysis as being present on a learned-operant basis and/or a response to environmental factors; and 3) there was a lack of documentation to confirm that the psychotropic medication had been useful in reducing the frequency and severity of the behaviors they were prescribed to address.

Psychological Care and Services

- Challenges continued to exist in ensuring that each individual residing at CCSSLC had a current psychological evaluation, as well as with the ongoing monitoring of approvals, consents, and/or trainings associated with PBSPs.
- Counseling services continued to lack measurable objectives.
- Improvement in the area of PBSPs was noted since the baseline review. This included the inclusion of data graphs as well as replacement behaviors. However, areas for improvement included ensuring adequate operational definitions for replacement behaviors, prescribing meaningful antecedent strategies, and defining functionally equivalent replacement behaviors.
- Timely and reliable data collection continued to be an area of concern.

Medical Care

- Adequate medical staffing necessary to provide needed medical supports to individuals residing at CCSSLC was not in place at the time of the review. The CCSSLC Medical Director carried a caseload that was too large to allow her time to complete the duties of Medical Director. In addition, the Facility had been using contract physicians who were there for short periods of time, making training and supervision difficult. The DADS SSLC Medical Services Coordinator had taken a number of steps to help recruit physicians, including increasing base

salaries, and advertising on a local as well as national level. At the time of the review, several candidates were being considered to fill open physician positions.

- Based on a review of five mortalities that occurred during the past year, and the finding that all of these deaths were attributed to aspiration pneumonia or pneumonia, there is concern about the standard of care being provided to medically complex individuals with respiratory complications. This should be an area of urgent review by the medical department.
- The clinical death review process was generally not adequate to identify areas requiring attention, and the reviews generally did not result in recommendations that would be helpful in making improvements to the supports and treatment offered at the Facility.
- A medical review system that consisted of a non-Facility physician case review had not begun. There had been some informal discussion concerning recruiting and choosing the physicians who would best meet the needs of the Facility and the requirements of the SA. However, at the time of the review, there had been no contract created or signed to begin this process.
- A comprehensive set of policies, procedures, and clinical pathways/guidelines still need to be developed. Clinical pathways should set forth standardized expectations concerning diagnosis and treatment, including time lines for moving to the next clinical step. Areas of priority for the development of policies, procedures, and clinical pathways include ones to address: pneumonia, chronic constipation, gastroesophogeal reflux disease GERD, dysphagia, enteral nutrition, rumination, pica, diabetes insipidus, and osteoporosis.

<u>Nursing Care</u>

- Consistent with the findings from the baseline review, there continued to be a number of significant problematic issues that were found regarding complete and adequate nursing assessments of symptoms for acute changes in status. There were problems noted regarding the lack of adequate documentation when the individual began showing symptoms of a status change, and of assessments prior to the transfer to an off-site medical center as well as upon return to the Facility.
- Consistent with the baseline findings, significant problems were found regarding the quality of the Nursing Assessments and Nursing Care Plans. Since the baseline review, in July 2010, the State Office had modified the procedure Guidelines for Comprehensive Nursing Assessment, as well as the Comprehensive Nursing Assessment form. The implementation of the modified Comprehensive Assessment was reported to begin 8/1/10.

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

- Facility policy required that Quarterly Drug Regimen Reviews only be completed for individuals prescribed psychoactive medications. They should be conducted for all individuals receiving any medication(s).
- A system needs to be instituted to ensure that physicians and/or nurse practitioners respond to recommendations included in the quarterly DRRs.

- A policy and procedure had been created to assist in tracking and resolving medication errors and variances. However, according to the Medication Error Committee minutes, there were a number of problems associated with the medication administration system, medication errors were not being reported consistently, and, even when issues were identified, systems were not being improved.

Physical and Nutritional Supports

- Since the baseline review, the Physical and Nutritional Management Team (PNMT) had not meet regularly to address changes in status, assess clinical data, and/or review monitoring results. During the week of the review, a corrective action plan was developed to address this issue. The plan included the identification of a dedicated PNMT.
- CCSSLC did not have a process in place that identified individuals with physical and nutritional management (PNM) concerns, and referred these individuals to the PNMT. Individuals identified as being at an increased risk level were not provided with a proactive comprehensive assessment, and treatment/intervention strategies and plans were not developed and implemented. Analysis and review of documentation and monitoring to determine the efficacy of supports provided at both the individual-specific and systemic levels was not being conducted.
- A review of Facility reports (Quality Improvement/Quality Enhancement, HST minutes, and Mortality Review Committee) did not show that a mechanism was in place that ensured timely data was provided to the PNM (NMT) that could be analyzed to identify and ensure the provision of supports to individuals with the most complex physical and nutritional support needs. The PNMT should establish thresholds to trigger further evaluation based on degree of and/or frequency of certain types of incidents, and/or key health care indicators. Individual-specific outcomes and criteria must be clearly recorded, utilized for monitoring, and analyzed to determine efficacy of the supports provided at both the individual-specific and systemic level. This information should be integrated into the Facility's Quality Assurance/Enhancement, Incident Management and Risk Management systems.
- The Facility did not evaluate individuals who were enterally nourished to ensure that the continued use of the tube was medically necessary. There was no Facility policy that addressed the assessment process of individuals receiving enteral nutrition to provide justification to support the appropriateness of receiving and continuing enteral nutrition, and/or strategies to transition an individual to oral intake, if appropriate.

Physical and Occupational Therapy

- The current caseloads for occupational and physical therapists will not allow therapists to be active members of the individuals' Personal Support Teams (PSTs), and will present significant challenges in meeting the standards set forth in the SA and HCG.
- Although requested, Occupational Therapy (OT) and Physical Therapy (PT) comprehensive evaluations were not submitted. As a result, the Monitoring Team was not able to determine if OT/PT comprehensive evaluations had been completed as required. Many of the individuals reviewed had documented needs related to movement,

mobility, range-of-motion, independence, and regression of functional skills, but active OT/PT treatment or participation in an OT/PT program was not documented.

- Likewise, individuals for whom OT/PT screening results identified potential needs for therapy were not consistently provided with comprehensive assessments.
- Per report, PNMP Coordinators had been provided competency-based training, but observations identified concerns with regard to their competency. PNMP Coordinators should be required to successfully complete competency-based physical assistance and mealtime supports training with specific learning objectives and identified competencies. It is essential that PNMP Coordinators are competent in the performance of their duties, because these staff are responsible for service delivery, as well as monitoring of direct support professionals.

Dental Services

- Based on the data provided, during the past year, 60 individuals (approximately 20 percent of the individuals residing at CCSSLC) received no dental care and/or no annual dental exam. They were either unable to cooperate with treatment or did not show for the appointment.
- Missed appointments were a significant issue with approximately 20 to 30 percent of appointments being missed. Although a policy had been developed to address this issue, there was not yet a systematic approach to identifying the underlying issues impacting this complex problem using a team approach, and developing and implementing plans to address the potential causes. When plans to address underlying issues are implemented, there should be improvement over time, and eventually the missed appointment rate would be expected to improve.
- An area still requiring attention was with regard to the development of desensitization plans and other strategies to overcome individuals' refusals to allow dental care to be completed, and/or for it to be completed with the least amount of sedation necessary. It did not appear that the Dental Department and Psychology Department had begun to collaborate with individuals and their teams to develop such plans.

Communication

- The current caseloads for Speech Language Pathologists (SLPs) and Speech Assistants will not allow therapists to be active members of the individual's PST, or provide functional communication supports.
- Although SLP evaluations, updates and screenings had been completed, these evaluations were not sufficient to identify individuals who would benefit from the use of alternative or augmentative communication systems. Per observation and record review, there were many individuals who would benefit from the use of alternative or augmentative communication systems, including systems that could be integrated with behavioral supports or interventions.
- There were only three individuals on campus with electronic AAC devices. When, the Speech Assistant and a member of the Monitoring Team went to observe these three individuals, their devices were broken, not working, and/or not available.

Habilitation, Training, Education, and Skill Acquisition Programs

- At the time of the review, residents typically had multiple skill acquisition programs developed to address identified needs and, ultimately, to promote and maintain adaptive behavior. The current format of these plans had not changed significantly over the past six months and, as a result, many of the concerns identified then continued to be problematic.
- Training of staff continued to be an area of great concern. Baseline reviews and more recent observations continued to produce mixed findings regarding staff knowledge of and competencies in implementing skill acquisition plans.

Most Integrated Setting

- The Facility continued to be at the initial stages of identifying obstacles to movement to the most integrated setting appropriate to the individual's needs and preferences, as well as strategies to overcome such obstacles.
- The CLDPs reviewed included essential and non-essential supports. However, it appeared that the Facility continued to be at the beginning stages of refining this process. Teams did not consistently identify all the essential supports that the individual needed to transition safely to the community, nor did teams adequately define the essential supports in measurable ways.

Consent

- CCSSLC had identified a list of 215 individuals who did not have the support of guardians, but had not yet prioritized the list. Facility staff recognized that this was an area in which they needed to make additional efforts.
- Some of the concerns related to the current process included the following: 1) the process that teams were using to determine an individual's ability to provide informed consent was vague and did not appear to be based on specific assessment tools; and 2) identification of concerns related to an individual's ability to make informed decisions did not result consistently in recommendations for either supports and services to increase the individual's decision-making capacity or to pursue guardianship.

Recordkeeping and General Plan Implementation

- As is discussed throughout this report, policies and procedures necessary to implement the SA were in various stages of development.
- CCSSLC was conducting reviews of at least five records each month. The system for doing this, and particularly the processes for identifying trends that needed to be addressed and putting plans in place to address problematic trends, were in the beginning stages of development.
- There continued to be issues related to missing documents, and/or the quality of information included in individuals' records. These will need to be corrected in order to ensure that records can be adequately used for making treatment decisions.

V. 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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS Policy #002.1: Protection from Harm – Abuse, Neglect, and Incident Management, dated 11/06/09; o DADS Policy #001: Use of Restraint, dated 8/31/09; o CCSSLC Plan of Improvement, dated 5/17/10; o CCSSLC Corrective Action Plan, undated; o CCSSLC Supplemental Plan of Improvement (POI), dated 5/19/10; o CCSSLC Policy #C001: Use of Restraint, dated 5/10/10; o CCSSLC Policy Section J: Behavioral Services, as of 1/25/09; o CCSSLC Restraints Monthly Trending Report from 4/1/10 to 4/30/10, dated 5/4/10; o CCSSLC Restraints Monthly Trending Report from 6/1/10 to 6/30/10, dated 7/13/10 o CCSSLC Restraints Quarterly Trending Report from 3/1/10 to 5/31/10, dated 7/7/10; o Minutes of Restraint Reduction Team meeting for 12/2/09, 3/10/10 and 5/10/10; o Restraint Reduction Weekly Minutes, dated 7/7/10; o Minutes of Incident Management Review Team Meeting, dated 713/10; o Restraint Checklist, revised 12/09/08; o List of Individuals Restrained from 1/1/10 through 7/1/10; o Restraint Checklist (401200BR); o Face-to-Face Assessment, Debriefing and Reviews for Crisis Intervention Restraint 11/24/08; o Twenty-five (25) Restraint Report Forms involving: Individual #7, Individual #20, Individual #26, Individual #95, Individual #172, Individual #186, Individual #191, Individual #218, Individual #246, Individual #268, Individual #275, Individual #297, Individual #300, and Individual #325; o FY 2010 Restraint Monthly Tracking Log; and o Personal Support Plans (PSP), PSP Addendums (PSPAs), Psychological Assessment, Structured Functional Behavior Assessments (SFBAs), Positive Behavior Support Plans (PBSPs), Safety Plans for Crisis Intervention (SPCI), and Monthly PSP Reviews, as available, for: Individual #172, #191, #7, and #246 ▪ **Interviews with:** o Iva Benson, Director o Everett Bush, Associate Psychologist V, and o Robert C. Cramer, Director of Behavioral Services, Chief Psychologist ▪ **Observation of:** o Restraint Reduction Committee Meeting, on 7/13/10; and o Incident Management Review Team Meeting, on 7/13/10

	Facility Self-Assessment: CCSSLC did not find substantial compliance for any subsection within Section C of the SA. However, they noted progress on policy development, reported issues that presented challenges to substantial compliance, and described actions and timeframes for achieving substantial compliance. The Facility Corrective Action Plan displayed the actions that the Facility will take to monitor the corrective actions to be taken to assure the Facility comes into substantial compliance with the Settlement Agreement. Though not yet in use, the plan provides a means for following the action steps needed. The Facility was in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Although the POI reviewed for CCSSLC did not include this component, the POI, the self-assessment with regard to Section C appeared to be an honest representation of the Facility's level of achievement to date.
	Summary of Monitor's Assessment: As during the baseline review, the clear commitment from the top-level management at CCSSLC to prohibit the use of most mechanical restraints and to reduce the use of all restraints was still in evidence. Staff interviewed appeared to know which mechanical restraints were prohibited. During the last review, a member of the Monitoring Team attended a Personal Support Plan meeting during which the Personal Support Team (PST) filled out the form for restraint use that still contained a list of mechanical restraints. The team filled out the form as if mechanical restraints were still an option. During this review, no such references to mechanical restraints were found. However, the State and companion Facility policies still referred to permissible mechanical restraints. According to reports reviewed, restraint checklists were being filed, restraint monitors were on site within minutes, and psychology staff and nurses were notified and arrived to perform their responsibilities. Staff remained with the person being restrained, explained the restraint, and promptly removed the restraint when the person no longer presented a danger. The trending data showed that use of personal restraints had been rising since the last review. The Facility noted the trend and took action. The Restraint Reduction Committee had been reorganized, and its focus reformed to provide renewed attention on the use of restraint and how to reduce it. Trending reports were now available by residential unit and by home. This focused report was expected to be available to unit directors and home managers to permit further analysis of restraint use. The Facility was at the beginning stages of developing individualized plans that included strategies to reduce the need for pre-treatment sedation for medical and dental procedures. It appeared that the Facility was focusing its efforts initially on individuals for whom tolerating dental care was an issue. Because the documentation for use of alternative measures prior to the restraint was a checklist, there was no way to determine if the staff used the appropriate methods and strategies that were included in the individual's Behavior Support or Safety Plans. This would make it difficult, if not impossible, to determine the overall effectiveness of the interventions in the plans, or to help clinical staff identify when

	interventions needed to be modified.

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C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.	The Department of Aging and Disability Services' (DADS) policy on restraint was completed on August 31, 2009. Review by the Monitoring Team found that the policy was congruent with and addressed relevant components of the Settlement Agreement (SA). CCSSLC Policy #C001, dated 5/10/10, was an adoption of the DADS policy by the Facility. It was essentially the same as the DADS policy, with minor edits to insert the Facility name. While the Facility limited mechanical restraints to mitts, helmets and waist ties, the policy retained references to additional mechanical restraints at C001.I.B. There were further procedures related to restraints in the CCSSLC policy and procedure manual in Section J. All policies stated that prone restraint was not permitted. Generally, there were no indications in the materials reviewed related to restraint or in interviews that staff used restraint for convenience or punishment. The 25 restraint reports reviewed for this section indicated that the individual restrained was posing a serious risk to himself or others, most often aggression toward staff or self-injurious behavior (SIB). Restraint reports showed a graduated range of less restrictive measures were being attempted prior to using restraint, including verbal redirection and prompting alternate behaviors. However, as discussed below with regard to Section C.8, this was a checklist, making it difficult to determine if individualized approaches as outlined in individuals' Behavior Support Plans had been implemented. The Restraint Checklist provided checkboxes for common, less restrictive measures and space to comment on use of less restrictive measures prior to using restraint, but staff generally did not provide substantive comments. The Plan of Improvement noted a need for a policy revision and an addition to the tracking tool to follow the key elements of this provision more closely. The POI also noted a need for better documentation in home shift logs of the time of restraints. Video surveillance was in use in common areas throughout the campus to verify locations of individuals and actions of both staff and individuals related to reports of abuse, neglect and exploitation, as well as unusual incident reports in which restraint was used. This was evident in the review of incidents of restraint and in review of abuse and neglect allegations. There was one incident that involved Individual #186 that resulted in the possible use of prone restraint, as CCSSLC self-identified in their Plan of Implementation. The individual was involved in an aggressive behavior episode. When two staff attempted to redirect his	Noncompliance

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		behavior, he tried to break away resulting in the individual and staff falling to the ground. In an effort to extricate themselves, staff held the individual by the feet and arms at points in the struggle. Since the individual was face down, they tried to get him to turn onto his side, but he did not respond immediately. The incident was investigated and the determination was that no prone restraint was used. However, there was some disagreement among those who watched the video of the event as to whether prone restraint occurred. Given the dangers that it presents, it is essential that staff be trained on alternatives in a situation such as the one involving Individual #186, including letting go until a safe hold could be implemented. While it was clear in the reports of this event that staff knew that prone restraint was prohibited and tried to move out of what apparently looked like prone restraint, they were not sufficiently prepared to deal with this event. Therefore, the Facility is not in substantial compliance on this subsection. In addition, as discussed below, with regard to Section C.7 and Section K of the Settlement Agreement, issues continued to exist with regard to behavioral supports provided to individuals. This is a key component to ensuring that restraint is not used in the absence of adequate behavioral supports.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The CCSSLC policy #C001.II provided for immediate removal of restraints when the person was no longer a danger to him/herself or others. The Restraint Checklist contained spaces to record the status of the individual in restraint, actions taken and release information. There were two sets of boxes: "Event Codes and "Action Release Codes." Event codes include number 7: "calm and quiet." This is not necessarily the same as no longer presenting a danger to self or others as required by the Settlement Agreement. Action/release included a code J that meant "meets the Safety Plan definition for release," and Code L that meant "no longer a danger to himself or others." The standard for release should be "no longer a danger to him/herself or others. It is important that staff understand they must release the individual from restraint when he/she is no longer a danger, not necessarily when "calm and quiet." In the sample of 25 restraint records, the reviewer noted that in 12 records (48%) the code for no longer a danger was entered, sometimes in combination with other codes. In six records (24%), the code J was used to indicate the requirements of the individual's safety plan was met. In the remaining records the code was recorded as A to indicate the restraint stopped and started at the same time. For substantial compliance to be achieved, individuals need to be released from restraint when they are no longer a danger to themselves or others, and to provide accurate documentation of this, the coding on Restraint forms likely needs to be revised. Criteria	Noncompliance

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		for release from restraint should make it clear to staff that release is based on safety considerations, not on an individual being calm and quiet.	
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.	CCSSLC Policy #C001.II set forth standards of use for restraints, and generally conformed to the requirements of the Settlement Agreement. Where it failed to conform to the requirements, this is noted in the corresponding report sections. Section III.A-C of the policy addressed staff training for staff applying restraints. While the policy spelled out types of restraints that were permitted, it had been CCSSLC practice to encourage staff to avoid the use of restraint, whenever possible, and to approve a more limited list including only wrist bands, mitts and waist ties. The Behavioral Services section J of the policy manual continued to allow a more restricted list of restraints than required in the C001 Policy. ▪ During the January 2010 review, the Personal Support Plan format still included a form that listed mechanical restraints that could be considered by the team for use with the individual. That form was not found in the sample of PSPs reviewed for this report. ▪ Checklists on the restraint evaluation form still referred to four-point restraint and arm splints, and the method of restraint sections the DADS and Facility policy still referred to mechanical restraints that reportedly had been discontinued at CCSSLC. ▪ The State and Facility policies had references to types of physical restraint that could be used, but there was not a clear list of the approved protective holds as required by the SA. However, the Facility specified that training on restraint use included the Prevention and Management of Aggressive Behavior (PMAB) curriculum and that curriculum did contain protective holds. ▪ Section II.C. 1 of CCSSLC Policy #C001 dated 5/10/10 addressed a graduated range of less restrictive measures to be tried prior to use of restraint, and the form for reporting restraint use included a list of many of the less restrictive measures. It was clear in Section III.A-C of the Facility policy that staff applying restraint must have training in the use of the restraints they apply, in verbal intervention and redirection techniques, and in supervision of the individual in restraint. The POI noted that CCSSLC restraint training occurred in the third week rather than the second week of new employee training, and did not conform to the state policy or the Settlement Agreement. If this practice results in staff potentially performing restraints prior to training, the practice needs to be corrected. A review of the staff training delinquency report revealed that at least six out of	Noncompliance

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		approximately 1000 staff or less than one percent of total staff had not been retrained in RES0115, Supporting the Prevention and Safe Use of Restraint. At least nine, or less than one percent, had not been retrained in the Prevention and Management of Aggressive Behavior (PMAB) series or some portion of that training. However a slightly larger number, 24 staff or 2.5 percent had not received training on applying restraints. These are relatively small numbers and most of the missed training was by less than six weeks. These low numbers are probably achieved in part by the sending of delinquency data to supervisors/managers on a regular basis to promote sending staff to needed 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 individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	CCSSLC Policy C001 limited use of restraints to crisis interventions. The CCSSLC Policy Manual, Section J.2, Step 2 required that restraint be used only in crisis situations. In addition, conversations with staff suggested that they understood that restraint was to be used only as crisis intervention. Based on review of 25 restraint records, documentation was present to substantiate that on seven out of the 25 (28%) reports the box for "crisis intervention" was checked. In the remaining, the box for support plan was checked. A check of the PSP for Individual #275 who experienced restraint as part of a safety plan indicated that the plan was in place. CCSSLC had a plan for reducing the use of programmatic restraint. While implementation of this plan resulted in progress as evidenced by the FY10 First Quarter Trend Analysis report, the reduction did not hold for the second and third quarters. According to the Monthly Trending Report for Restraints (Total Personal Restraints by Type) as of 5/4/10, the combined chemical and personal restraints for the first quarter of FY2010 was 75. The second quarter was 168 and the third was 236 without including the data for the month of June. As a result, at the time of the review, the Restraint Reduction Team Committee had been reorganized and was meeting weekly to take a fresh look at restraint use and what the alternatives might be to reduce it in a sustainable way. The reviewer attended the second meeting of the reconstituted group where discussion revolved around how to analyze data more effectively. The Committee identified some ideas on restraint reduction. The Facility should be commended for its commitment to reduce the use of restraint, and for its action in revising a process that was not producing the desired results. The Restraint Reduction Team meeting minutes should include information regarding the analysis the team has conducted, the trends identified, clinical findings, and descriptions of the plans of correction implemented, including expected outcomes, dates of completion, and responsible persons. It will be important to maintain a record of the team's findings and recommendations, which action steps were successful, as well as which methodologies had to be modified and which, if any, did not have the desired impact.	Noncompliance

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		As is discussed in further detail below with regard to Sections J.4, and Q.2 of the Settlement Agreement, the Facility was at the very initial stages of developing and implementing desensitization plans and/or other strategies to reduce the need for restraints, including chemical restraint, used with individuals who do not easily tolerate dental or medical procedures. The Psychology Department was just beginning to work on such plans, and had prioritized this for individuals for whom dental care was an issue. It will be essential for an interdisciplinary approach to be used in the development and implementation of such plans. Additional discussion regarding the use of chemical restraint to control individuals' behavior is included below with regard to Section N.3 of the SA.	
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	With regard to the existing policies and procedures: ▪ The November 2008 restraint documentation guidelines required a face-to-face assessment of the person in restraint by a trained staff member within 15 minutes of application of the restraint, and the restraint form called for recording of the assessment. In addition, the form for the nurse required the nurse to check on the status of the individual in restraint at least every 30 minutes. ▪ CCSSLC Policy #C001 at M.4 specifies that in extraordinary circumstances with clinical justification the Director may order an alternative to enhanced level of supervision. This did not appear to be in accordance with the Settlement Agreement that required a physician to order an alternative monitoring schedule. ▪ In policy #C001 at II.E.7, there were specific requirements for reporting restraint used in the community. Requirements included reporting the use to a licensed health care professional as soon as reasonably possible, but not within the 30 minutes of return as specified in the Settlement Agreement. In nearly every Restraint Checklist reviewed, a restraint monitor was available within 15 minutes and usually more quickly. However, in three instances of restraint reviewed out of 25 (12%), (Individual #297, Individual #218 and Individual #186) the restraint monitor was also one of the people applying the restraint. This appeared to be a conflict that needed to be avoided. A review of 19 episodes of physical restraint, and four episodes of chemical restraint for 14 individuals (Individual #172, Individual #191, Individual #7, Individual #300, Individual #246, Individual #297, Individual #218, Individual #186, Individual #26, Individual #275, Individual #95, Individual #268, Individual #20, Individual #325) found that in 22 episodes the vital signs were documented within 30 minutes of the initiation of the	Noncompliance

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	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.	restraint and one episode did not have documentation that the vital signs were taken at all. However, there were five episodes where the mental status section and/or respirations were marked as "refused" by the nurse. These areas do not require the individual's cooperation to be able to make observations and document the findings in the appropriate section. The Facility Plan of Improvement indicated that the Facility was not in substantial compliance with the requirements of this subsection, and needed to revise CCSSLC policies and provide templates for doctor's orders. Some of that work was accomplished with the adoption of policy #C001 on 5/10/10. However, the templates for MD orders were not available for review.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one supervision. In extraordinary circumstances, with clinical justification, the Facility Superintendent may authorize an alternate level of supervision. Every use of restraint shall be documented consistent with Appendix A.	State and CCSSLC Policy at 001.II.H and Procedure at Section J.2, Steps 6 and 8 required that an individual in restraint be checked for injury by a licensed health care professional. From a nursing perspective, a review of 23 episodes of restraint for 14 individuals showed documentation indicating that the individual was checked for injury following the restraint episode. In the 25 records reviewed, a number of restraints, 11 out of 25, or 44%, lasted less than 10 minutes. Only one may have exceeded one hour. The documentation for an episode on 4/7/10, at 7:45 a.m. involving Individual # 218 was unclear as to whether the release time was 7:45 a.m. or 9:45 a.m. Except for the one with unclear documentation, when restraints lasted more than a few minutes, there was documentation in these records that comfort was provided and drinks offered. In one record of physical restraint, involving Individual #297 on 3/26/10, at 11:30 a.m., the staffing level was checked as enhanced rather than 1:1 as required. This appeared to be a documentation error, since the individual was being restrained in a hand-over-hand restraint. No reports of alternate levels of supervision during restraint were noted in the reviewed reports. Generally the reports reviewed contained the required information, signatures, dates and times. In some reports, information was missing, for example: ▪ On 4/7/10, in a restraint involving Individual #186, the restraint monitor did not sign the restraint documentation forms. ▪ In a restraint involving Individual #246 on 5/24/10, the report form was not	Noncompliance

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		entirely legible. ▪ For Individual #7 for a restraint on 6/2/10, there was no restraint checklist. ▪ For a restraint involving Individual #246 on 6/5/10, the documentation included an injury report that was incomplete concerning a tooth detachment. ▪ For a restraint involving Individual #95 on 4/28/10, there was an order for a chemical restraint but no doctor's signature on the form.	
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:	DADS Policy #001 at II.K addressed situations in which an individual is placed in restraint more than three times in any thirty-day period. The CCSSLC Policy #C001 was the same. According to the FY2010 Restraint Monthly Tracking Log, approximately 14 individuals had more than 3 restraints in a 30-day period from January 1, 2010 to June 9 2010. Of this group, four individuals were selected for review (i.e., reflecting a sample of 29% of total individuals who met criteria) and included, Individual #172, Individual #191, Individual #7, and Individual #246. Of these four individuals, three were identified as having the most restraints since January 1, 2010, three were listed as at risk for causing harm to self or others, and two were identified as having some of the highest number of injuries. The PSP, PSP addendum, psychological assessment, SFBA, PBSP, SPCI, and PSP Monthly reviews (for the last six months or less), as available, were reviewed for each individual sampled. The following is a summary for each individual selected: ▪ Individual #172 had more than three restraints in a rolling thirty-day period for the months of January, February, and April 2010. At the time of these restraints, he appeared to have had a PBSP and SPCI implemented to address his challenging behavior including self-injurious (SIB) (including threats of suicide), physical and verbal aggression, inappropriate sexual behavior, and spurious allegations. Review of provided PSP Monthly Reviews, in general, indicated that data on target behaviors was collected and summarized monthly. However, summary data for February 2010 was not provided in these documents. This is unfortunate as February was the month with the most restraints during this time period. Data on replacement behaviors only began in April 2010. Review of PSP and PSP addendums suggested that the team met frequently (approximately 11 times over the course of four months) due to concerns about his behavior. Throughout this time period, his level of supervision was increased, his psychotropic medications were changed, and he was hospitalized due to his behavior. It was unclear when his PBSP was last revised, because dates on provided documentation were inconsistent. That is, dates listed within his PSP, PSP monthly review, BSC tracking grid, and on provided sampled documentation indicated that the PBSP was revised (or projected to be updated) on 3/1/10, 2/10/10, 8/31/09, and 6/1/09, respectively. Based on the display of replacement data in PSP Monthly Reviews, the best estimate of PBSP revision	

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		was March or April 2010. Sampled documentation also indicated that the psychological assessment and SPCI were revised on 9/15/09, and 5/25/10, respectively. At the time of the Monitoring Team's reivew, an SFBA had not been completed. ▪ Individual #191 was restrained more than three times in a 3- day period in the months of January and February 2010. At the time, a PBSP and SPCI were in place to address aggression, program refusals, spurious allegations, and unauthorized departures. Available PSP Monthly Reviews indicated that data on target and replacement behaviors were collected and summarized monthly during this time period. However, restraint information recorded in the data table for monthly reviews (i.e., March, April, and May 2010 PSP Monthly Reviews) was not consistent with data presented in the Restraint Tracking Log. The PSP and PSP Addendums reflected frequent meetings (i.e., five meetings across a five month period) during which his behavior and current supports (medication, supervision, PBSP, and SPCI) were discussed and recommendations were made. It appeared that his PBSP was revised and implemented on 1/27/10, just prior to his PSP meeting on 2/22/10. Curiously, his psychological assessment was revised on 2/24/10, following both the PSP and revision of his PBSP. At the time of the Monitoring Team's review, a SFBA had not been completed. ▪ Individual #7 was restrained more than three times in a 30-day period in the months of April, May, and June 2010. At the time of these restraints, a PBSP and SPCI were in place targeting aggression, property destruction, SIB, unauthorized departures, and pica (attempts and ingestion). Available PSP Monthly reviews indicated that data on target behaviors and replacement behaviors were collected and summarized monthly during this time period. However, data on the use of restraints in the monthly review documentation did not appear to be consistent (e.g., April and May data indicated on data table) with information on the Restraint Tracking Log. PSP addendums and PSP Monthly Reviews indicated that, over the past six months, she had had multiple inpatient and outpatient hospitalizations for pica behavior and psychiatric stabilization. According to PSP addendums, the PST appeared to have met regularly (at least two times per week over the past three months) since the increase in challenging behaviors and restraints and various treatment recommendations had been implemented (e.g., medication changes, use of mitts, hospitalizations, enhanced supervision, including 2:1 staffing, PBSP and skill acquisition program, including reinforcement schedule revisions). It appeared that, based on the Behavior Support Committee (BSC) tracking grid, a psychological assessment, dated 8/10/09, and an SFBA, dated 2/10/10, were completed, although these were unavailable for review. In addition, it appeared that the PBSP was revised at least twice in the last six months.	

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		▪ Individual #246 experienced more than three restraints in a 30-day period in the months of January, February, May, and June 2010. At the time of these restraints, he had a PBSP and SPCI that were recently revised and implemented (on 2/10/10) to address aggression and spurious allegations. Language on the PBSP suggested that the plan was revised concurrent with his annual PSP meeting. PSP Monthly reviews reflected ongoing data collection on target and replacement behaviors. However, restraint information listed within data tables appeared inconsistent with data summarized on the Restraint Tracking Log (e.g., PSP Monthly reviews for March 2010). PSP Addendum meeting minutes indicated that the PST met frequently, approximately 10 times over a period of six months, to discuss ongoing behavioral issues and recommended supports (e.g., increased level of supervision, move to another residence, etc.). A psychological assessment was completed, dated 11/09. At the time of the Monitoring Team's review, a SBFA had not been completed.	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	In general, documentation reflected frequent meetings with members of the PST to discuss ongoing concerns and problem-solve for all four individuals sampled. These reviews, however, were incomplete without SFBAs having been completed to assess psychosocial factors. This is discussed below with regard to Section C.7.c of the SA. ▪ According to available documentation, the PST for Individual #172 met repeatedly, 11 times in four months, due to concerns regarding his behavior. It appeared that the team responded through medication changes, increases in supervision, psychiatric consultation (although the psychiatric consultation listed in his PSP was outdated), hospitalization, and changes in his residence. ▪ According to available documentation, the PST for Individual #191 met approximately monthly (five meetings over a five-month period). Meeting notes indicated review of specific restraints, medication adherence, environmental factors and other issues and necessary supports related to his behavior. ▪ According to available documentation, the PST for Individual #7 met approximately twice a week (or more) between April and June 2010 (note – meetings may have occurred previous to this time period, but documentation was not provided). These frequent meetings appeared to be due to concerns regarding her serious life-threatening behavior. During this time, the team reviewed all aspects of her behavior, including potential etiology and functions as well as discussed and recommended a variety of different interventions (e.g., changes in medication, inpatient psychiatric assessment, nutritional assessments, revision in PBSPs, use of restrictive mitts, increases in level of supervision, etc.). ▪ Available documentation for Individual #246 reflected multiple meetings of the PST (at least 10 meetings over six months) in an effort to address ongoing behavioral issues (e.g., provision of PBSP, schedule change, PBSP and SCIP	Noncompliance

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		training, etc).	
	(b) review possibly contributing environmental conditions;	As presented above, ongoing efforts to address the challenging behavior of sampled individuals appeared consistent across all four sampled individuals. These reviews, however, were incomplete without SFBAs having been completed. This is discussed below with regard to Section C.7.c of the SA. ▪ The PST met frequently to discuss the ongoing behavioral issues for Individual #127. ▪ The PST also met frequently for Individual #191 in response to ongoing challenging behavior, as well as the number of restraints. It appeared that discussions included potential contributing factors of his challenging behavior. ▪ It appeared that the PST for Individual #7 had been quite comprehensive in their review of potential environmental variables associated with her challenging behaviors. ▪ Frequent PST meetings were held for Individual #246 across a six-month period to address his ongoing challenging behaviors and restraint.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	Overall, all individuals sampled had a psychological assessments that had been completed within the current year. However, only one of the four assessments (25%) was completed after these reported restraints. One psychological assessment was completed within 30 days of a significant increase in restraints for Individual #191. Only one of the four (25%) had a completed SFBA. ▪ Although a psychological assessment was in place, an SFBA was not completed for Individual #172, Individual #191, or Individual #246. ▪ It appears that both a psychological assessment (in 8/09) and an SFBA (on 2/10/10) were completed for Individual #7 (as indicated on the BSC Tracking grid); however, both documents were currently unavailable for review (i.e., not provided as part of the sample requested).	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	See Section C.7.c above.	Noncompliance
	(e) develop (if one does not exist) and implement a PBSP based on that individual's particular strengths, specifying: the objectively defined behavior to be treated that leads to the use of the restraint; alternative, positive adaptive behaviors to	In general, all individuals had a current PBSP and SPCI that appeared to identify target and replacement behaviors. However, for only one of the four individuals (Individual #7) had a SFBA been completed. Without adequate assessments informing the development of the PBSPs, it was unclear if the plans adequately met individuals' needs. ▪ A PBSP (date unknown) and SPCI, dated 9/15/09, were in place for Individual #172. However, it was unclear when these plans were revised more recently. The PBSP identified target behaviors that were likely those leading to restraint,	Noncompliance

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	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;	as well as contained replacement behaviors and strategies aimed at encouraging more positive adaptive behavior. As noted above, no SFBA had been completed to inform this process. ▪ A PBSP, dated 1/27/10, and SPCI, dated 3/19/09, were currently in place for Individual #191. The PBSP identified target behavior that was likely to lead to restraint, as well as replacement behaviors and strategies aimed at encouraging more positive behavior. As noted above, no SFBA had been completed to inform this process. ▪ PBSPs, dated 3/18/10 and 7/8/10, and SPCI, dated 3/17/10 and 4/16/10) were currently in place for Individual #7. Indeed, it appears that several revisions of the PBSP and SPCI were implemented during this time period. Both plans appeared to be developed using the results of a recently completed SFBA. ▪ A PBSP and SPCI, both dated 2/10/10, were currently in place for Individual #246. The PBSP identified target and replacement behaviors aimed at encouraging more adaptive behavior. As noted above, no SFBA had been completed to inform this process.	
	(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	In general, there is no evidence that treatment integrity was systematically measured for any of these individuals during this time period.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	In general, it was difficult to determine if PBSPs were revised due to increases in restraint or because annual revision coincided with the PSP meeting. There was some indication to suggest that the PBSP for Individual #7 was revised due to increased behavioral challenges. ▪ As presented above, it was unclear when the PBSP for Individual #172 was revised and implemented. From available documentation it appeared likely that the plan was revised following the PSP that was held on 2/1/10, in March or April 2010. ▪ The PBSP was revised and implemented just prior to the PSP meeting for Individual #191. Language in the PBSP indicated that the plan was developed at his last PSP meeting on 2/25/09. Subsequently, it was unclear if the plan was revised in response to the frequent use of restraint. ▪ It appeared that the PBSP was recently revised on 3/18/10 and 6/21/10, for Individual #7 due to the severity of her challenging behaviors. ▪ It appeared that a PBSP was revised for Individual #246 on 2/10/10, following	Noncompliance

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		his PSP meeting, on 11/19/09. It seems likely that this revision was completed, although a bit delayed, to coincide with his annual PSP meeting. The PSP did not indicate that the PBSP was revised to address increasing behavioral challenges or restraint use.	
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	The CCSSLC Plan of Improvement indicated that it was not in substantial compliance with this subsection, but that the restraint review process included reviews by the Restraint Monitor, psychologist, unit team and Incident Management Review Team. However, review of the records indicated: ▪ Because the documentation for use of alternative measures prior to the restraint was a checklist, it could not be determined if the staff used the appropriate methods and strategies that were included in the individual's Behavior Support or Safety Plans. The Restraint Checklist provided checkboxes for common, less restrictive measures and space to comment on use of less restrictive measures prior to using restraint, but staff generally did not provide substantive comments. This would make it difficult, if not impossible, to determine the overall effectiveness of the interventions in the plans, or to help clinical staff identify when interventions needed to be modified. The current checklist does not lend itself to performing a critical clinical analysis. Modifying the form so that there is an expectation that specific, individualized alternative measures should be documented would provide pertinent clinical information for review and analysis. ▪ The descriptions of antecedent behaviors on the restraint report forms did not provide much detail. For example: o Individual #297 experienced episodes of hand-over-hand restraint on 3/16/10 and 3/26/10, because she wanted Tylenol with codeine for a toothache. What was not clear was whether she truly had a toothache and perhaps needed to see the doctor about additional pain medication, or whether she just wanted more medications. Her true condition with respect to pain might provide insight that would allow her team to devise a plan to deal with future pain episodes that avoid the need for restraint. ▪ In some cases, the debriefing did provide the needed explanation of antecedent behaviors: o On the Restraint Report for Individual #7, she was reported to have entered the door of the apartment with a sharp piece of wood, threatening staff and biting her hand. In the debriefing section of the face-to-face form, the individual was reported to have been upset at having been redirected from another home she wished to visit.	Noncompliance

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

1. The Facility's efforts to decrease the use of restraints should continue.
2. The Restraint Reduction Team meeting format for minutes has been restructured to include information regarding the analysis the team has conducted, the trends identified, clinical findings, and descriptions of the plans of correction implemented, including expected outcomes, dates of completion, and responsible persons. The Restraint Reduction Team should use this format to guide discussion and provide a clear record of efforts that are implemented and whether they succeed or fail.
3. Additional training should be provided to staff on how to avoid prone restraint and how to respond if an individual lands and/or positions him/herself in a prone position.
4. Consideration should be given to updating the policy statement that prefaces Section J of the CCSSLC Policy Manual on Behavior Supports to emphasize that behavior interventions must always begin with the least restrictive means, that restraint is used only when other methods have failed, and that only limited methods of restraint are permitted, including a clear list of permitted holds.
5. Facility policy should be amended to define what chemical restraints, if any, might be used, under what circumstances, and with what protections in place.
6. References to the use of mechanical restraints that are now prohibited should be removed from the policy manual.
7. PSPs should be monitored to ensure that if they include medical restraints, there are strategies to minimize and/or eliminate the use of the restraint, and that the team weighed the risks and benefits of the use of restraints.
8. It should be established in policy that physicians document the extraordinary circumstances when they order an alternative monitoring schedule.
9. Plans to track and analyze key elements of restraint use should continue.
10. Individuals experiencing more than three restraints in a 30-day period should be prioritized for the completion of Structured Functional Behavior Assessments and, once completed, the PST should determine whether or not a PBSP is subsequently developed or revised.
11. SFBAs and PBSPs should clearly identify the dates of revisions, and the reason for the revision.
12. Some language in State policy gives directions to the Facility to assure certain actions are taken. When adopting State policy as its own, the Facility needs to modify that language to show that the Facility will take the required actions.
13. In order to ensure that pertinent clinical information is available for review and analysis, the section of the Restraint Checklist on alternative measures that were attempted prior to the use of restraint should be modified to require more specific information, particularly with regard to implementation of the individual's BSP or Safety Plan.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS Policy #021: Protection from Harm – Abuse, Neglect, and Incident Management, dated 6/18/10; o DADS Policy #002.2: Incident Management; o CCSSLC Policy #021: Protection from Harm-Abuse, Neglect and Incident Management dated 6/18/10, with procedures D.1 –D.12; o CCSSLC Policy #C.002.2: Incident Management with procedures DD.1-DD.15.1; o CCSSLC Plan of Improvement, dated 5/17/10; o CCSSLC Corrective Action Plan, undated; o CCSSLC Supplemental Plan of Improvement, dated 5/19/10; o Mental Health and Mental Retardation (MH&MR) Investigations: Training Information – Department of Family and Protective Services (DFPS) Investigators at Corpus Christi SSLC: Regional Information (on employees); o Minutes of Incident Management Review Team Meeting, dated 7/13/10; o Trend Analysis Report FY10 for the 3rd Quarter (March 2010 through May 2010) for Unusual Incidents, Abuse/Neglect/Exploitation, and Injuries, dated 7/7/10; o Incident Log from January 2010 through June 2010; o Incident report forms on individuals who experienced incidents or abuse/neglect allegations during the six (6) months preceding the review; and o Investigation records maintained by the Facility of 70 allegations of abuse and/or neglect; o File provided in response to request for most recent investigation completed with involvement of law enforcement (Section III.25 of the request for documents: Individual #337, now discharged); o Abuse/Neglect/Exploitation reports from the six months preceding the review involving the following: Individual #3, Individual #7, Individual #30, Individual #38, Individual #44, Individual #46, Individual #48, Individual #51, Individual #66, Individual #75, Individual #88, Individual #89, Individual #94, Individual #114, Individual #116, Individual #118, Individual #133, Individual #144, Individual #172, Individual #183, Individual #186, Individual #191, Individual #206, Individual #211, Individual #218, Individual #246, Individual #254, Individual #256, Individual #267, Individual #275, Individual #282, Individual #289, Individual #299, Individual #302, Individual #315, Individual #325, Individual #335, Individual #336, Individual #337, Individual #351, Individual #357, Individual #363, Individual #365, and Individual #366; o Unusual Incident reports from the six months preceding the review involving the following individuals: Individual #140, Individual #144, Individual #235, Individual #267, Individual #326, and Individual #337

	▪ **Interviews with**: o Iva Benson, Director; o Cheryl Huff, Incident Management Coordinator; o Daniel Dickson. Quality Enhancement Director; o Javier Luna, Investigator; and o Judy Palmer, Coordinator of Comprehensive Staff Training ▪ **Observations of**: o Various homes and day/vocational programs throughout campus; and o Incident Management Meeting led by the Director on 7/13/10
	Facility Self-Assessment: CCSSLC completed a Plan of Improvement, showing most subsections of D to be in substantial compliance. Each subsection of the plan had two parts: one describing the SA requirements and a second describing criterion for substantial compliance. The POI was not clear however, about the size of the samples used to reach determinations of substantial compliance. For example: D.A.2 of the POI indicated that "100% of records reviewed show that all staff have been trained on abuse and neglect policies," and specified the training rosters as the source of evidence, but did not indicated for what period. In interview it was clear that considerable work has gone into this section and that the incident manager had assembled some supporting data in her presentation book. However, there is still work to be done in conducting thorough reviews of the sections and assembling evidence, based on reasonable samples.
	Summary of Monitor's Assessment: Over the past six months, CCSSLC had achieved substantial compliance on one of the subsections in D, and on five of the elements in D2, and two (2) of the elements within D3. A number of other actions had been taken, and others continued to need to be refined and/or implemented. There were processes in place to report abuse, neglect, and other incidents, and staff members appeared to know their responsibilities in this regard. As an illustration of their understanding of their responsibilities, staff consistently pointed to the back of their badges on which there was a sticker that explained how to report abuse or neglect to the Department of Family and Protective Services. Since the last review, a number of policy revisions had been made, particularly by the Facility, to address a number of elements that previously had been missing with regard to the conduct of investigations. Staff appeared to understand that the Facility Director intended to protect them from retaliation. She had demonstrated her intent by making referrals to the Inspector General on two occasions to investigate allegations of retaliation. However, there were some indications in abuse/neglect/exploitation (A/N/E) reports that staff feared retaliation. Incident reports that were submitted generally appeared to be timely. Based on the sample reviewed, Department of Family and Protective Services (DFPS) as well as Facility

	investigations were not consistently being completed within the timeframes required by the Settlement Agreement. Based on the SA requirement that the provisions in D.3.e needed to be fully implemented within one year, APS policy did not require investigations be completed in 10 days until June 2010. Both DFPS and the Facility were utilizing investigation report formats that included the components required by the Settlement Agreement. Some of the investigations completed, particularly by the Facility, did not thoroughly ask and answer all of the relevant questions surrounding the incident. As a result, conclusions of the investigations were not always substantiated fully. Trend analysis of incidents was underway and that will produce additional data as the process evolves. One of the challenges with analyzing such data will be ensuring that issues that are identified are addressed. This is an area that will be reviewed in further detail in future reviews as the process develops.

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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.	The DADS policy on abuse, neglect and incident management was revised on June 18, 2010. The revision separated the Abuse/Neglect/Exploitation policy, DADS Policy #021 from the Incident Management Policy which now appeared as DADS Policy #002.0 These policies were reviewed and found to correspond in most respects to what is required under the Settlement Agreement. Any variations from the SA are noted under the corresponding sections below. The Facility's Corrective Action Plan at D.1 to D.5 step 2 indicated that a Policy Notebook was under development that includes Section I for State Office policies and Section II for CCSSLC policies, protocols and procedures. This was not available for review. The Corrective Action Plan also contemplated revisions to Facility policies to be done by August 1, 2010. The DADS abuse, neglect and exploitation rules and incident management policy stated that abuse, neglect, and exploitation were prohibited. The SSLCs were required to comply with these State policies and rules. CCSSLC had revised its policies and procedures on abuse, neglect and incident management since the last monitoring. The policy on abuse/neglect/exploitation had become Policy and Procedure Manual Section D, adopted June 18, 2010. Section D.1-15 of the manual contained procedural information about abuse, neglect, and exploitation. Sections DD.1-15 contained procedural information on incident management. There were also guidelines and forms that were in use at the Facility, and these provided the basis for some of the analysis below.	Substantial Compliance

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		Both the DADS and CCSSLC policies clearly stated a commitment to not tolerate abuse/neglect/exploitation of individuals served by the Facility. Zero tolerance posters were prominently displayed in residences, the administration building, and other campus locations. In speaking with staff, it was clear that staff had been trained on reporting abuse and neglect. When the reviewer inquired of staff what should be done if abuse or neglect is suspected, they consistently said they needed to protect the individual and report the abuse/neglect immediately. When the reviewer asked where they must report, staff consistently flipped over their identification badges and showed the reviewer where the instructions and phone number was always available. During an interview, the reviewer asked ten staff members if they had ever reported abuse. At least five had. The volume of allegations (195 in the March, April, May 2010 quarter) suggested vigilance in reporting of abuse/neglect/exploitation. The Facility's Plan of Implementation indicated that CCSSLC was in substantial compliance with this section of the Settlement Agreement. Based on the policies reviewed, the posting of Zero Tolerance posters, and the response of staff to questions about reporting, it appeared there was substantial compliance with this subsection.	
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:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as	According to Section C002.2.IV of the Facility policy manual, staff were required to immediately (or within one hour) report abuse, neglect or exploitation to the Texas Department of Family and Protective Services (DFPS) by calling an 800 number. Based on the 70 investigation reports reviewed, reporting appeared to be timely. Policy required that this number be posted in work areas, and each employee's ID badge included the number as well. Policy stated that other incidents such as deaths must be reported to the unit supervisor, campus coordinator and nurse, and the Director must be notified. The timeframe for this appeared to be within 24 hours. In the 13 Unusual Incident reports reviewed,	Substantial Compliance

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	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.	investigations were begun timely and the required notifications were made. The CCSSLC Incident Management Review Team met each weekday to discuss serious injuries and incidents, and to assure that the appropriate reporting procedures were being followed. The reviewer attended one of these meetings. The Director led the meeting. Each member had a printout of the incidents and issues being followed, and reported on any important additional information. The procedure appeared efficient and well run. Standard forms were in use for the reporting of abuse, neglect, exploitation and serious injuries and incidents.	
	(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.	In CCSSLC Policy #002.2 III.A, and in D.2 a staff member who discovered or learned about abuse/neglect/exploitation must stop the abuse/neglect/exploitation; arrange for a nurse to assess the individual for injuries, and preserve the physical evidence. In Section D.7 of the manual, the Director or her designee must take measures to assure the safety of the alleged victim, including reassigning the alleged perpetrator away from direct contact with the alleged victim. Specifically, the alleged perpetrator would be placed and monitored on temporary work assignments that would not allow contact with individuals served by the Facility. Based on the reports reviewed, it appeared that these steps were being taken. The reviewer did not find evidence in the reviewed files to indicate these steps were not being carried out. The IMRT reviewed reports of abuse, neglect, exploitation and serious injury on a regular basis, reviewing actions taken and instructing staff on additional actions to take when appropriate. In the case of individuals with histories of making spurious reports of A/N/E, a protocol was in place at the Facility to avoid removing the staff member. Under the protocol, the staff member who was the alleged perpetrator was not automatically removed from the home. Instead, the staff member remained at their work station until a physical assessment by the nurse was completed, and the Director or her designee decided whether reassignment was necessary or whether alternatives were needed such as switching staff assignments, or requiring direct monitoring by the home team leader when the staff member was working with the individual. Four individuals (Individual #172, Individual #246, Individual #206 and Individual #125, who has transferred to the community) were assigned streamlined investigations by DFPS. These four individuals out of 293 individuals in residence represented approximately 1% of the 293 individuals living at CCSSLC. In each case, notice was sent to CCSSLC in advance of the use of streamlined procedures. For Individual #172, the notice specified that not all allegations would be streamlined, only those that met certain criteria. The Incident Management Coordinator pointed out that she investigated such	Substantial Compliance

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		allegations as incidents and could refer them back to DFPS in the event she found evidence of abuse. In reviewing three allegations of A/N/E made by Individual #172, the use of a streamlined process was not apparent, and it appeared that full investigations had been completed. In one of the cases, police were notified, although abuse was unconfirmed, as it was in the other two. It appeared that in addition to putting processes in place to review these individuals' allegations carefully by involving nursing staff, and the Director or her designee, as well as having a full incident investigation completed, CCSSLC also was approaching this from a behavioral perspective. For example, one of these individuals had made repeated 911 calls to police, and a behavior plan was implemented that involved removing his cell phone and attempting to teach him alternative ways to express dissatisfaction. While it is important to attend to all abuse allegations made by individuals at CCSSLC, it is as important to find ways to address false reporting. When individuals have long histories of making false allegations, community transition becomes more difficult. An Incident Management Coordinator (IMC) was in place to review incidents, assure that they were being addressed properly, and analyze incident reports to identify and assess series of incidents in one location for contributing factors.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	According to Section D.1 of the Facility Policy Manual, all staff received initial competency-based training on reporting and investigation of A/N/E, and the retraining was to occur annually (Course #ABU0100). According to the data report on staff training, known as a delinquency report, only three staff out of the total 1000 staff (less than 1%) did not appear to have received training or annual retraining on A/N/E. Staff received initial and annual training on signs and symptoms of abuse. It was not clear whether signs and symptoms are taught as part of Course #ABU0100 or in a separate course.	Substantial Compliance
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility	DADS policy #021 required staff be trained on A/N/E at the commencement of employment and annually thereafter. The policy included a requirement that staff sign a statement acknowledging their responsibilities at the time of employment and every year thereafter. Section D.1 of the CCSSLC Policy and Procedure Manual outlined the requirements for training staff on reporting abuse, neglect and exploitation, including initial and annual training. On interview with the Comprehensive Training Department head, it was learned that	Not Rated

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	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.	training records were kept in her office and that a signed statement by each employee was maintained, showing their understanding of their obligations. Of 10 files reviewed, all had the required signed statement. A larger sample will be requested during the next review. Documentation of personnel actions for failure to report were to be included in the unusual incident review file. None of the investigations reviewed documented a failure to report.	
	(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.	A resource guide for individuals, primary correspondents, and Legally Authorized Representatives (LARs) was required in DADS Policy #021.1.M. The Facility's POI indicated that this was an area in which they were not in compliance with regard to the implementation of policy. In addition to the use of a resource guide, the Facility's POI also indicated that PSPs would include documentation of discussion about the incident and allegation reporting.	Noncompliance
	(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 DADS policy #021, dated 6/18/10, on abuse, neglect and exploitation required a rights posting. At the Facility, an attractive poster called "You Have the Right" was observed in common areas in all living units visited, and widely displayed in other buildings. In addition to some printed information, the poster included icons to assist individuals who are not able to read in understanding their rights.	Substantial Compliance
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	DADS Policy #021.IV.E addressed referrals to law enforcement. When allegations of A/N/E were made to the DFPS, it was their responsibility to determine when to report to law enforcement. In 70 reports reviewed, there were 22 referrals to law enforcement. Of those, DFPS case #36072429 was referred to the Office of Inspector General, which took the lead in the investigation. Allegations involving sexual exploitation, committed by a mental health services provider must be reported to the appropriate law enforcement agency by the Director according to Policy #002.2, and the companion Facility policy. Based on verbal report, the Facility reported an incident involving potential sexual exploitation to the police. No records of a	Substantial Compliance

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		potential investigation or of the personnel actions taken with regard to this allegation of sexual exploitation of Individual #357 by a staff member was available for review. The Incident Management Coordinator said in interview that a staff member was identified as being in a relationship with this individual, but was no longer employed at CCSSLC. The Facility Policy Manual at DD.9 required the Director to determine if there was potential criminal activity. If so, the Office of Inspector General and/or local law enforcement was to be notified. Since procedures were in place for referring to law enforcement, and review indicated that they were being appropriately applied, this subsection is in substantial compliance.	
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely manner.	DADS Policy #021.IX and the same section of CCSSLC Policy #021.IX prohibited retaliation and set forth recourse for those who feel retaliated against. In addition, the Procedure Manual at D.2 and at D.6 addressed retaliation, providing staff with the option of contacting the Director. In a previous interview with the Director, she made it clear that she did not condone retaliatory action, and had made referrals to the Office of Inspector General on at least two (2) occasions to investigate alleged retaliation. When random staff were asked what they would do if they believed retaliatory action was being taken against them, they consistently indicated they would go directly to the Director to report it. When asked if they ever felt retaliated against, no one said they had, though two qualified their answer with "not yet." Review of 70 A/N/E reports completed by DFPS, however, revealed some indications that retaliation for reporting may be taking place or at least be of concern to some staff. In three cases, investigators commented on concerns about retaliation. In case #36646944, in which a report was made that a staff member punched an individual, the investigator found the allegation unconfirmed, but noted a concern that "staff may be retaliating against each other for providing statements to DFPS." In case #36277270 the investigator confirmed an allegation of emotional/verbal abuse and noted that "…staff who provided testimony in this investigation fear the possibility of retaliation and workplace disharmony…" by the perpetrator. The Monitoring Team will continue to watch for signs of retaliation, and will inquire further into the Facility's efforts to combat it during future reviews. The Facility should continue to strongly train and remind staff, for example, at staff meetings, in newsletters, etc., that retaliation will not be tolerated. In addition, on a case-by-case basis, the Facility should evaluate if actions need to be taken when results of investigations are returned and action is taken, for example, disciplinary action. For example, there might be situations in which based on the results of investigations, and	Noncompliance

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		staff's participation in such investigations, and/or due to strained relationships between staff that some staff need to be reassigned to other units or shifts, or supervision needs to be increased to protect against any possible retaliation. The culture amongst staff of protecting one another as opposed to individuals served can be very strong, and apparently was at Corpus Christi in recent years. Facility management will need to continue to be creative about shifting this culture to one in which the individuals' safety and wellbeing is paramount. Continued focus on instilling the foundational values of protecting individuals who are vulnerable, while at the same time assisting them to enjoy meaningful lives will greatly help in this regard. Any efforts that can be made to reward staff that demonstrate strong values would advance this process.	
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	The DADS policies #021 and #002.1 did not appear to address audits of injuries to determine what should be reported for investigation. The Facility policies did not appear to address this requirement either. The Plan of Improvement indicated that processes for auditing were under development and would include at least semi-annual audits in the future. Quality Enhancement completed a quarterly trend analysis that identified the number, severity, location and type of all injuries. The Third Quarterly Trend Report identified one individual who received 26 injuries in the period, and indicated that this was reported to the Personal Support Team for follow-up. The trend report provided a wealth of information and was available by unit and residence. Based on this report, it appeared that the numbers of injuries had increased considerably between the first and second quarters. However, this was the result of a process change in how injuries were reported and not a sign of an increasing number of injuries. The reports and the graphs within them should reflect when the change was made to avoid confusion. The trend report contained ample information to form the foundation of good audits. It was noteworthy that of 679 injuries reported in the third quarter, only four were serious, none were fatal, and 144 showed no apparent injury. Evidently, according to the definition, potential injuries are reported. For example, if an individual falls, there is potential for injury, so this is reported as an injury. Although it is important to capture this type of information, it may not be the appropriate categorization. For the period of 1/1/10 to 6/21/10, a list of people with serious injuries was provided that listed only 13 injuries affecting 11 individuals. However, what is needed is an audit of the entire list of over 1000 injuries in that period to determine if any of those injuries or patterns of those injuries should have been reported for investigation. Of particular interest are individual-to-individual injuries that might form a pattern suggesting	Noncompliance

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		behavior programs need revision or that environmental issues such as crowded living quarters may be contributing to the pattern of injuries. The POI indicated the elements of this requirement were not in substantial compliance and were assigned to the Quality Enhancement office for attention.	
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.	DADS Policy at 002.2.B and C required Facility investigators to have training in investigations and in working with people with developmental disabilities (courses CIT0100 and MEN0300). The policy did not indicate that the training should be competency-based. DADS Policy at 002.2.I.H also required Facility investigators to be outside the direct line of supervision of the alleged perpetrator. DADS Policy at 021.II (Staff Training) indicated that all staff who investigated A/N/E would have training in working with individuals with intellectual disabilities. DFPS had indicated in a conference call with the Monitoring Teams, and in accompanying power point presentation that DFPS staff have: ▪ ILSD Interviewing Module – half an hour introduction on principles of how to interview persons with DD; ▪ ILSD Terms Module – 3 hours on mental illness and mental retardation terminology and classification; ▪ Field Training -- 2 Web-based training modules on mental illness and mental retardation; and ▪ ILASD Interviewing Module – 3.5 hours how to specifically interview someone with DD. According to the Facility's Plan of Improvement, Facility policy has been completed for this provision. CCSSLC policy #C002.2 adopted the DADS Policy #002.2, and therefore, followed the State's requirements. The Facility Incident Management Unit was staffed by a Coordinator, two full-time	Noncompliance

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		investigators (one of whom had been out on leave), and nine campus coordinators and supervisors who were not full-time investigators, but who could be called upon to conduct investigations. All 11 people worked directly for the Incident Management Coordinator, and, therefore, were more likely to be outside any direct supervision lines of staff being investigated. Review of the training records of Facility investigators revealed that no record was supplied for the Incident Management Coordinator. Of the 11 records supplied: four (36%) had the required training in developmental disabilities (MEN0300), and seven (67%) had training in values (VAL0200). None (0%) had the required course in investigations (CIT0100). The Incident Management Coordinator and nine of her staff had had the Root Cause Analysis training that was required of the IMT. Training records were supplied for seven DFPS investigators through June 2010. Three workers were hired in 2008 or earlier, and four were hired in April or May of 2010. Based on the records provided, and additional clarification from DFPS, at the time of the review, five of the DFPS investigators (71%) had completed "APS Facility BSD 1 and 2," or "MH&MR Investigations ILSD and ILASD" training. This training, although called different names at different times, included basic investigation skills training, and procedural training in working with individuals with developmental disabilities. After the on-site review, DFPS reported that the remaining two investigators completed their training at the end of August. This will be confirmed during the next review. Since it was not clear that the Incident Management Coordinator and all investigators have had the required training and that the training was competency-based, his provision is not in substantial compliance.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	DADS Policy Number 002.1, entitled Protection from Harm – Abuse, Neglect, and Incident Management, referred at I.D to cooperation with DFPS, and Section V.A.2.d also referred to cooperation with DFPS in the conduct of investigations. Policy 002.1 at D provided for reporting to law enforcement, and required staff to abide by all instructions of the law enforcement agency. CCSSLC Policy # 002.1 did the same. In the review of 70 DFPS A/N/E records, there were only a few instances where there appeared to be a lack of cooperation with DPFS investigators. Most involved difficulties in scheduling appointments for interviews with staff, and these were resolved. However, two involved obtaining a speech therapist to interpret the unique sign language of Individual # 302, including DFPS case #35805350 and case #36388969. The therapy staff supervisor declined to permit staff to assist in interpreting until ordered to do so by the Director, at which time the interview was conducted. The second case involved the same individual. Scheduling was again difficult, but eventually the speech staff provided	Noncompliance

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		interpretation services for an interview. Based on the documents reviewed, it was not clear what the supervisor's reluctance was with regard to allowing staff to act as an interpreter. While this particular difficulty did not occur frequently in the 70 reports examined, it was serious and needs to be remedied for the future. It delayed interviews that should have taken place as soon as possible to ensure that important information was not lost. In addition, it is unclear why it was not corrected after the first incident, and was allowed to occur a second time. As a result, there is not substantial compliance with this subsection.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	DADS Policy #021 referred to coordination with law enforcement, and instructed staff to cooperate with all instructions from law enforcement. CCSSLC Policy DD.9 addressed reporting of incidents to law enforcement that did not have to be reported to DFPS, as well as coordination with law enforcement. Twenty-two (22) of the 70 DFPS A/N/E reports reviewed indicated that law enforcement had been notified. In one case, the Office of Inspector General took the lead in the case. It appeared that coordination with law enforcement was ongoing, and that DFPS and the Facility appropriately deferred to law enforcement as appropriate. A request was made for the most recent file for a case involving law enforcement. That case involved the unauthorized departure of Individual #337 in January 2010. The individual was missing for 15 days, so the file included ongoing record of contact with the police and the police report which provided further evidence of cooperation, such as leads provided by CCSSLC and follow-up by the police, and eventual return of the individual. There appeared to be good cooperation with police. CCSSLC's POI indicated the Facility believed it was in substantial compliance with the settlement agreement, which is consistent with the Monitoring Team's findings.	Substantial Compliance
	(d) Provide for the safeguarding of evidence.	DADS Policy #002.2.III.D, E, F and Exhibit B concerning securing evidence, as well as DADS Policy #021.XVI, and Exhibit B addressed the safeguarding of evidence. In addition the CCSSLC Policy and Procedure Manual at DD.10 required all investigators to secure and preserve evidence as part of the investigative process. In the review of 70 DFPS A/N/E reports, all contained lists of evidence collected, most of it being documentary evidence. In an increasing number of cases, videotapes from surveillance cameras on campus were collected as well. It was rare to find that evidence such as clothing was collected or areas cordoned off to preserve possible evidence.	Substantial Compliance

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		However, the reviewer did not find circumstances that suggested the investigator should have made such collections. In the review of investigations of 13 unusual incidents completed by the Facility evidence was collected as appropriate and there were no indications that needed evidence was mishandled. Future visits will include following the chain of evidence for selected cases, but this element appeared to be in substantial compliance.	
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	DADS Policy #002.2.V required the investigation of a serious incident to commence within 24 hours, and for a report to be generated within 10 days. CCSSLC Policy #C002.2 did the same. Both empowered the Facility Director or the Supervisor of Adult Protective Services to grant a written extension to exceed ten (10) days to file the report. In reviewing the 70 DFPS reports of investigations of abuse/neglect/exploitation, it appeared that the reports did not meet the 10-day timeline in 35 cases, or about 50% of the time. Requests for extensions were rare, only two out of 35 cases (6%) that were not within the allowed 10 days contained approvals for extensions. Based on the SA requirement that the provisions in D.3.e needed to be fully implemented within one year, APS policy did not require investigations be completed in 10 days until June 2010. Based on review of 70 investigations completed by DFPS, 55 reports contained completed investigations and 15 were referred back to CCSSLC for administrative action. Fifty-five or 100% of those completed investigations included a summary of the findings, and appropriate recommendations. As noted above with regard to Section D.2.h of the SA, three investigations included recommendations calling for attention to the issue of retaliation. In 13 investigations completed by the Facility of unusual incidents involving six people between January and June 2010, nine reports (69%) were completed within the 10-day timeframe. The results of the investigations were captured in a different format than the DFPS reports, but with essentially the same information and included a summary of the investigation, findings and recommendations, as appropriate.	Noncompliance
	(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	DADS Policy #002.2.V sets out the requirements for SSLC investigative reports and contained the elements required in this subsection of the SA. CCSSLC Policy #C002.2.V mirrored those requirements, and the CCSSLC Policy and Procedure Manual at DD.11 reiterated the requirements Policies related to content of DFPS reports were not submitted for review.	Noncompliance

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	and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	The 70 DFPS A/N/E reports, all were found to be complete with respect to these requirements. Of note, interviews with potential witnesses were being completed and when they were not, there was ample evidence that the investigator has made considerable efforts to get them accomplished. In a case involving Individual #337, a witness was in Dallas and the DFSP investigator offered to have an investigator from that area available to conduct the interview. In another case, as noted previously, the investigator contacted the Director to obtain assistance when an alleged victim could not communicate without a sign language interpreter. The 13 investigative reports completed by the Facility were complete in most respects. However, the following concerns were noted with regard to the thoroughness of some of the reviews: ▪ In one report involving Individual #337 for an incident that occurred on 2/12/10, both DFPS and the Incident Management Unit investigated. The individual stopped at the Vocational Director's office and wanted to speak with him. When the Vocational Director said he was in a meeting and the individual needed to go back to work, it is not clear why the one-to-one staff member assigned to the individual did not guide him out, and there was no indication of whether the staff used the de-escalation process called for in the person's plan. These issues were not adequately addressed in the Facility's investigation. ▪ In another incident, Individual #144 fell while with his family in a park. When the person was out of the home, his PSP called for use of a wheelchair or a gait belt. The unexplored question was why he did not have the gait belt or wheelchair on this outing, and whether staff had provided the supports to the family when he left with them from the Facility. The basic elements of a good process are in place. What is needed is a more thorough analysis of the information.	
	(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	Facility policy at D.12.C required that the Incident Management Coordinator review the incident reports for accuracy, completion and coherency and her signature appeared on the reports under review. It was not clear whether she had returned reports for clarifications or amendments because it is the final report that is kept on file. In some cases the IMC signed as the investigator, and the Director signed the final approval. One example was a case that started as a DFPS investigation, but was referred for administrative action (DFPS case #36812472 and DADS #453195). This happened when there was no investigator available to conduct the evaluation and the supervisor conducted the investigation. As noted in with regard to Section D.3.f of the SA, some investigations needed a more thorough analysis.	Noncompliance

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	shall be addressed promptly.	The DFPS supervisor did not sign the reports that were sent to the Facility. Apparently the supervisor reviewed and approved an electronic copy of the report. However, there is not, as yet, a way to review that process. As was discussed during a meeting between DFPS, DADS, and the Monitoring Teams, a process needs to be devised to allow this review to occur.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	The Facility was investigating and preparing reports of those investigations, and the Incident Management Coordinator was reviewing them. As discussed above with regard to Section D.3.f, a sample of these was reviewed, and some issues were noted with regard to thoroughness.	Noncompliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	Section D.7 of the Facility Policy and Procedure Manual addressed the immediate placement and monitoring of alleged perpetrators (AP) on temporary work assignments. It provided for removing the alleged perpetrator from contact with individuals served, obtaining a signed form from the AP indicating understanding of specific rules for conduct during temporary assignment, and warned that failure to comply may result in termination. A review of the "Staff Status" Logs for January 2010 through June 2010 revealed that of approximately 300 cases logged into the system, staff were generally reassigned when an allegation was made. Of the 300 cases, 29 or 10% were confirmed as A/N/E. Thirteen (13) people were terminated as a result and others were in the process of decisions being made. Seven (7) additional people resigned, even though the cases did not produce confirmed results. However, the tracking logs were incomplete. Data had not been recorded for all cases entered in January, February, March or April 2010. Data for May and June was also incomplete, at the time of the review, although not all data may be available for June due to investigations not being completed, or decisions about personnel action not having been made yet.	Noncompliance
	(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.	DADS policies #02.2 and 021 did not appear to address this. On previous monitoring, this was addressed in Section R.23 of the former Facility Policy Manual. This section included a description of how cases were filed, and designated the Incident Management Coordinator as the person responsible for follow-up tracking of all recommendations made as part of an unusual incident investigation. It was not clear whether R.23 was revised to correspond to the new Policy and Procedure requirements, or whether it continued to exist as R.23 within the manual. As noted during the review, the Facility records were maintained in the Incident	Substantial Compliance

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		Management Department for the fiscal year and reportedly, on campus for considerably longer. During the interview with the Incident Management Coordinator, she was able to quickly access files that were being discussed on her computer. The Incident Management Coordinator maintained records of all completed DFPS investigations at her office where they were available to her staff.	
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.	DADS Policy #002.2 at IX set forth requirements for tracking and trending of unusual incidents and investigations by the Incident Management Coordinator. CCSSLC Policy #C002.2 contained the same language. The Facility Policy Manual contained section DD.13 that was revised on 6/18/10 which was specific to incident trend analysis. This section provided for quarterly trending of incidents by type of incident, staff involved, individual(s) involved, location, day and time of incident, cause of incident, and outcomes of investigation. The Quality Enhancement (QE) process that produced monthly and quarterly trend analyses was reviewed. The QE trend analysis process produced a breakdown of the number of DFPS allegations and cases by category by month with accompanying graphs. Further breakdowns showed allegations by home, by hour of the day, day of the week, and by shift. Data was displayed on outcomes, case disposition. Comparisons to previous months and quarters were provided. The quarterly trend analysis provided a summation and recommendations. The data was not yet trended by staff alleged to have caused the incidents, nor was the outcome of the investigation trended. While data for a reporting period was displayed, it was not graphed over time (trended.) According to the Facility POI, the trending by outcome was in development. At the time of the review, the trend analyses produced considerable data. For example: the report for the third quarter (March to May 2010) showed that of 195 allegations of A/N/E, only 10 or 5% were confirmed. This was a decrease from the previous quarter, during which 14% were confirmed. However, the recommendations did not include any further exploration of this information to determine what might be causing the difference. The ongoing challenge will be to use the generated data to assist in decision-making that will improve the lives of individuals who live at CCSSLC. This will require thorough analysis of the data, and the development of action plans, as appropriate.	Noncompliance
D5	Before permitting a staff person (whether full-time or part-time,	The Monitoring Panel has had discussions with the State regarding how this provision of the Settlement Agreement will be assessed. This is necessary due to the confidentiality	Not Rated

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	temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility.	of the information, and the limited documentation that the State is allowed to maintain regarding the findings of the background checks. To address this, the State will provide the Monitoring Teams with names of staff responsible for the process, so that they can be interviewed, and spreadsheets for each Facility to allow reviews to be conducted to ensure that all staff currently employed have had the necessary checks completed. Until such information is made available, this indicator will not be rated. Based on the review conducted in July, DADS Policy #021.I.E required state centers to review criminal history and factors such as history of perpetrated abuse, neglect or exploitation before permitting a staff person or volunteer to work directly with individuals. CCSSLC's Policy #021 included the same requirements. The POI indicates that the Facility was working on additional facility policy. Section E.27 of the facility procedure manual sets out the requirement that volunteers were required to have signed volunteer statements, criminal history checks with clearance, and abuse/neglect checks with clearance. As noted in the baseline report, Section 3000 of the DADS regulations on Volunteer Programs required criminal background checks on volunteers at section 3200.3. The DADS Operational Handbook, Revision 09-21 Effective 10/29/09, at Part E, Section 19000 required criminal background checks on employees. The DADS criminal history rule also contained prerequisites for allowing staff or volunteers to work directly with individuals.	

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

1. The Facility is encouraged to continue its efforts with individuals with histories of making allegations that have not been confirmed to ensure that: 1) they are adequately protected from harm; and 2) they are provided with adequate behavioral supports, including learning replacement behaviors. The steps that the Facility is taking to carefully review each allegation by involving nursing and the Director or her designee, as well as conducting a full incident investigation should continue.
2. The Facility should move forward with development and implementation of a resource guide for families and individuals to assist in the education process about the reporting process for incidents and allegations.
3. When changes are made to definitions or criteria of incident categories, such as the changes made with regard to injuries, this should be noted clearly in trend reports to avoid confusion, and allow to the extent possible accurate comparisons over time.
4. The Facility should continue to strongly train and remind staff, for example, at staff meetings, in newsletters, etc., that retaliation will not be tolerated. In addition, on a case-by-case basis, the Facility should evaluate if actions need to be taken when results of investigations are returned and action is taken, for example, disciplinary action. There might be situations in which based on the results of investigations, and staff's participation in such investigations, and/or due to strained relationships between staff that some staff need to be reassigned to other units or shifts, or supervision needs to be increased to protect against any possible retaliation. The culture amongst staff of protecting one another as opposed to individuals served can be very strong, and apparently was at Corpus Christi in recent years. Facility management will need to continue to be creative about shifting this culture to one in which the individuals' safety and wellbeing is paramount. Continued focus on instilling the foundational values of protecting individuals who are vulnerable, while at the same time assisting them to enjoy meaningful

lives will greatly help in this regard. Any efforts that can be made to reward staff that demonstrate strong values would advance this process.

5. The detailed action steps in the Plan of Improvement for Section D.2.b of the SA regarding follow-up to allegations of abuse and neglect should continue to be implemented.
6. The Facility should conduct critical analysis of the trend data collected to determine if any actions need to be taken, or action plans developed to address any underlying causes of trends identified.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS Policy #003: Quality Enhancement, dated 11/13/09; o CCSSLC Policy #E.6: Participating in and Completing Client Safety Committee, draft dated 6/10/10; o CCSSLC Facility Policy #E.7 Quality Enhancement Plan, draft dated 6/22/10; o CCSSLC Plan of Improvement, dated 5/17/10; o CCSSLC Supplemental Plan of Improvement, dated 5/19/10; o Auditing Tools, based on SA Monitoring Tools; o Approximately 50 completed audits using the auditing tools; o Corrective Action Plan, undated; o Quality Enhancement Plan FY 2010, draft dated 7/14/10; o CCSSLC Monthly Trending Report from 4/1/10 through 4/30/10, dated 5/4/10; o CCSSLC Quarterly Trending Report from 3/1/10 to 5/31/10, dated 7/7/10; o CCSSLC Monthly Trending Report from 4/1/10 to 6/30/10, dated 7/12/10 (Incidents and Injuries by Residential Unit and Specific Home); o Client Safety Committee Meeting Minutes format, undated; o Program Improvement Committee Minutes, dated 2/24/10, 3/17/10, 3/24/10, 5/5/10, and 7/14/10; o Consumer Satisfaction Survey, undated; o CMS Statement of Deficiencies, dated 9/25/09, 2/10/10, and 4/13/10; o Personal Support Plan Addendum for Individual #172, dated 5/3/10 ▪ **Interviews with**: o Daniel Dickson, Quality Enhancement Director, on July 14, 2010; and o Quality Monitors ▪ **Observations of:** o Program Improvement Committee Meeting on July 14, 2010
	Facility Self-Assessment: CCSSLC has a Plan of Improvement, paralleling the outline of the SA, to self-assess progress toward substantial compliance. The POI did not yet identify the evidence that was used to determine whether the Facility was in compliance or not, but based on discussions with the State, this was going to be added. For Quality Assurance, the POI indicated that CCSSLC was not in substantial compliance. In addition it has a corrective action plan that paralleled the sections of the SA, which listed corrective actions to be taken, expected outcomes, completion dates, and people responsible. The corrective action plan had just gotten underway at the time of this review. For Quality Assurance the corrective action plan included eight action steps, which are discussed in further detail below.

	Summary of Monitor's Assessment: The quality enhancement activities at CCSSLC were moving out of the initial stages of development and into the testing stage of development. New policies were being implemented, committees activated, and new information linkages formed between disciplines. A draft Quality Enhancement Plan had been put in place as of 7/14/10. Quality monitoring tools had been adopted based on the tools used by the SA monitors. At the time of the review, these tools had not yet been modified for use by the Facility's quality monitors, but they had begun to use them in the field. It is positive that the Facility is making use of the tools developed by the Monitoring teams. However, while on site, the Monitoring Team discussed with Facility staff some of the modifications and/or enhancements that would be necessary for these tools to be useful to the Facility. These include, but are not limited to: ▪ The monitoring tools do not currently include instruction sheets or guidelines. These would need to be developed to: o Ensure that various facility staff implementing the tools are using the same methodologies to rate indicators, thereby increasing the likelihood of inter-rater reliability; and o Provide adequate guidance to reviewers who do not have specific subject-matter expertise to ensure accurate rating of the tools. Again, these tools were developed by and for the use of Monitoring Team members with substantial subject matter knowledge. If they are going to be used by, for example, QE staff, who have more limited subject matter expertise, it will be essential that specific, written guidance is available to assist in rating indicators, as well as training, and ongoing technical assistance by subject-matter experts. ▪ There was some discussion that these tools would be used to generate a cumulative score with regard to compliance. The items on the tools have not been weighted, but would need to be if they were going to be used in this manner. ▪ Some of the indicators on the tool are specifically designed for a team approach to monitoring. For example, some indicators reference gathering information from other team members who have specific expertise. Particularly if the Quality Enhancement Department is going to use these tools, such indicators will need to be modified, and more specific methodologies identified to evaluate such indicators. ▪ At times, it may be beneficial for separate scoring sheets to be developed to assist with the data collection necessary to score some of the indicators. Not all of the current monitoring tools facilitate this process because they track very closely the requirements of the Settlement Agreement that calls for, for example, policy development, as well as policy implementation. As a result, they are not necessarily formatted to allow easy review of only individual records or only policy. A separate sheet(s) likely would assist in this process. Trends were being reported quarterly for some key issues, such as abuse allegations, incidents, injuries and hospitalizations. Information was available to show some specific characteristics of incidents, such as where incidents were occurring, what time of day, and on which living units. Breakdowns of data were now available by unit and by residence, making it possible for units and residences to use the data as a tool in analyzing and addressing undesirable trends. Additional indicators will need to be developed to better enable the Facility to identify problems with regard to protections, services, and supports provided to

	individuals served by CCSSLC. The next step will be responding to the identified trends with analyses of potential causes, and the development of action plans to address issues identified. Follow-up will also need to occur to ensure that actions are taken that effectively address the trends.

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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.	DADS Policy #003 was reviewed and found to be consistent with the SA. CCSSLC had not adopted the State policy in its totality as it had the policies for A/N/E and Incident Management. While the SSLCs must adhere to the requirements of State policy, they had not been required to adopt them in total. However, adopting them would be one way of assuring there was no confusion among staff with regard to what is expected. Following that adoption with a series of Facility procedures would be one way to assure that staff understand how policies and procedures were linked together. At the time of the review, there were some activities, including daily Incident Management Review Team meetings, and unit meetings at which data regarding allegations and incidents, restraint, medical issues, and environmental concerns were being discussed. These meetings were a good basis for further review and analysis of individual as well as system-wide data. They also provided a forum from which action plans could be developed and tracked. The "Trend Analysis for June 1-30" contained data and analysis of restraints, unusual incidents, allegations of abuse, and confirmed abuse. In the report, total restraints were analyzed as compared to a year ago; the number of restraints by residence and location within the residence; the number of allegations of abuse by residence; the number of allegations confirmed; the number of incidents involving injury, and the most common type of injury. These data were further broken down according to unit and residence, so they could be available to Unit Directors and Home Leaders as well. This provided each group the opportunity to analyze the underlying data to identify problematic trends, as well as the potential reasons for any issues identified, and to determine what could be done to improve identified issues in the future. They had not yet begun to do this. The Incident Management Review Team, led by the Facility Director, met on weekdays to review the most recent unusual incidents, the status of pending DFPS reports, reports of individual-to-individual aggression, discovered injuries, restraint as a crisis intervention, emergency rights restrictions, and significant medical issues/admission to hospital or infirmary. Members of the team included executive staff, the medical administrator, unit directors and other key staff. They followed an agenda that included reporting of new	Noncompliance

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		incidents or allegations, exchanging and updating information, identifying tasks that needed follow-up, and making assignments with regard to follow-up tasks. As of the updated lists for the 7/13/10 meeting, there were relatively few long-term outstanding issues. It was clear from discussion that follow up on these issues was underway. Updates were reported and notes were taken to update the sheet for the next meeting. In addition, each unit met each weekday to review incidents, allegations of abuse, emergency use of restraints and restrictive procedures, injuries and significant medical issues. They reviewed recommendations for follow-up, assigned persons to be responsible for resolution, and indicated due dates. They also tracked outstanding work orders. This kind of process, when done regularly, can be effective in keeping issues on track for resolution. Since Unit Directors are members of and participants in the IMT meetings, it means they have an opportunity to raise issues that cannot be resolved at the unit level. At the time of the review, there were a number of areas in which data was being collected. For example, the Quality Enhancement Auditors were reviewing individuals' records for Active Treatment requirements. They were just beginning to review restraint records, PSPs, incident management, and other records using monitoring tools derived from those used by the SA monitors. These reviews will result in the collection of data that will be useful if they are aggregated and analyzed, trends identified and action plans developed, as needed and appropriate. At the time of the review, it was not clear how this process would be implemented. In order for the Facility to be in compliance with this component of the Settlement Agreement, a tracking system needs to be in place to allow identification of issues across the many components of protections, supports, and services provided to individuals residing at the Facility. This will require not only review of monitoring data, but also collection and analysis of key indicators or outcome measures. Although the Facility had begun to collect some data, for example, data related to incidents and allegations, it had not yet developed a set of key indicators. This is important for a few reasons, including providing the Facility with the ability to identify objectively the individuals who require additional attention to ensure they are safe and are receiving the supports and services they require, as well as to identify proactively homes, day programs, and/or departments that require improvement, as well as to identify a wide array of potential systemic issues. At the time of the review, the Facility did not have a system such as this in place. Throughout this report, there are references made to data that should be incorporated into such a system. This is not an all-inclusive list, but is meant to provide the Facility with ideas about the types of indicators or outcome measures that should be included in such a system.	

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		As noted above, quality monitoring tools had been adopted based on the tools used by the SA monitors. At the time of the review, these tools had not yet been modified for use by the Facility's quality monitors, but they had begun to use them in the field. It is positive that the Facility is making use of the tools developed by the Monitoring teams. However, while on site, the Monitoring Team discussed with Facility staff some of the modifications and/or enhancements that would be necessary for these tools to be useful to the Facility. These include, but are not limited to: ▪ The monitoring tools do not currently include instruction sheets or guidelines. These would need to be developed to: o Ensure that various facility staff implementing the tools are using the same methodologies to rate indicators, thereby increasing the likelihood of inter-rater reliability; and o Provide adequate guidance to reviewers who do not have specific subject-matter expertise to ensure accurate rating of the tools. Again, these tools were developed by and for the use of Monitoring Team members with substantial subject matter knowledge. If they are going to be used by, for example, QE staff, who have more limited subject matter expertise, it will be essential that specific, written guidance is available to assist in rating indicators, as well as training, and ongoing technical assistance by subject-matter experts. ▪ There was some discussion that these tools would be used to generate a cumulative score with regard to compliance. The items on the tools have not been weighted, but would need to be if they were going to be used in this manner. ▪ Some of the indicators on the tool are specifically designed for a team approach to monitoring. For example, some indicators reference gathering information from other team members who have specific expertise. Particularly if the Quality Enhancement Department is going to use these tools, such indicators will need to be modified, and more specific methodologies identified to evaluate such indicators. ▪ At times, it may be beneficial for separate scoring sheets to be developed to assist with the data collection necessary to score some of the indicators. Not all of the current monitoring tools facilitate this process because they track very closely the requirements of the Settlement Agreement that calls for, for example, policy development, as well as policy implementation. As a result, they are not necessarily formatted to allow easy review of only individual records or only policy. A separate sheet(s) likely would assist in this process. As indicated in the Facility's POI, the Facility was not in substantial compliance on this subsection. However, there was definite progress.	

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E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	Although the Settlement Agreement did not anticipate full compliance with this provision until 6/26/12, some data were already being analyzed regularly into Trend Reports. For example, data on personal and chemical restraints had been displayed by month and quarter since September 2008. By the end of August 2010 there will be two full years' of data on restraints. These reports show a decline in the use of personal restraints until the second and third quarters of 2010, when the use of personal restraints began to rise. Recognition of this trend resulted in a reorganization of the cross-disciplinary Restraint Reduction Committee in an effort to understand the trend of the last six (6) months, and develop and implement plans with the goal of reversing it. The Restraint Reduction Committee held its second meeting during the on-site monitoring visit. While it was clearly still in an organization stage, some restraints were reviewed and there was discussion of some possible ways to reduce use of restraints. This represented a good start and a clear commitment to making changes when data indicates an area of concern. Quarterly trend reports included analyses of data and recommendations. It was not clear whether the recommendations would be tracked on the trend report or a committee such as the Program Improvement Committee. It will be important to close the loop by following the process from data collection, to trend report, to analysis and issue identification, to plan of correction, and finally to outcome. Changes should be seen in the trend data, and if not, changes would need to be made to the action plans. One way that data analyses can be used productively is to identify the areas where several issues occur simultaneously, and where concentrated action might produce the largest positive results. At the last SA Monitoring, the data revealed significant issues with apartment 511. It was the location of many restraint uses and the location of the most injury reports. This suggested that some further investigation and corrective action was needed to reduce such occurrences in that apartment. It was not clear whether this has been done, but it is worth noting that apartment 511 no longer had the highest usage of restraint and/or injuries. The POI reported that the Facility was in the process of developing policies and procedures based on the DADS Policy, and was not yet in substantial compliance. This is consistent with the Monitoring Team's findings.	Noncompliance
E3	Disseminate corrective action plans to all entities responsible for their implementation.	According to the CCSSLC Plan of Improvement, this step was not scheduled to begin until 12/26/09, with full implementation in 6/26/12. At the time of this review, the POI indicated that corrective action plans are in draft and that the QE staff is working on a system to address this and are not in substantial compliance on this subsection. The reviewer agrees. However, the Monitoring Team noted that there were a variety of corrective action plans	Noncompliance

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		attached to different committees and individuals. Each addressed issues raised within its purview. For example: ▪ Client Safety Committee (Procedure at E.6) is responsible for "…establishing a planned, systematic, organization-wide approach to monitoring, analyzing and continually improving the quality of care and services…by identifying risks associated to …system wide processes." The minutes of this committee includes recommendations which require responses within specified timeframes. ▪ The Corrective Action Plan associated with the POI sets out specific tasks that need to be accomplished to bring each section of the Settlement Agreement into substantial compliance. As quality enhancement processes develop, it will be important to distinguish the different "Plans of Correction" or corrective action plans to assure against confusion.	
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.	According to the CCSSLC Plan of Improvement, this step was not scheduled to begin until 12/26/09, with full implementation in 6/26/12. As noted above, at the time of the review, corrective action plans were in the initial stages of development and implementation. This will be reviewed further during future monitoring visits when additional corrective actions plans are available and being implemented.	Noncompliance
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	According to the CCSSLC Plan of Improvement, this step was not scheduled to begin until 12/26/09, with full implementation in 6/26/12. As with Section E.4 of the SA, this will be reviewed during future monitoring visits.	Noncompliance

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

1. The Facility should continue to conduct daily Incident Management Review Team meetings as well as unit meetings. The processes used by these committees should be refined to ensure that critical questions are asked and answered, and follow-up is tracked to completion. In addition, clear criteria should be developed to determine which individuals and incidents the team should review, and when an individual or topic should be closed or removed from the list.
2. Now that a basic Quality Enhancement Plan is in place, focus should turn to implementing and fine tuning it. As is detailed above with regard to Section E.1 of the SA, the SA monitoring tools should be revised to better meet the needs of the Facility. This should include, but not be limited to: revisions to indicators as appropriate, the development of instructions and/or guidelines, availability of training and technical assistance from subject-matter experts on substantive issues, consideration of weighting indicators, and development of scoring sheets, as appropriate.
3. The Facility should develop and implement a tracking system that allows identification of issues across the many components of protections, supports, and services provided to individuals residing at the Facility. This will require not only review of monitoring data, but also collection and analysis of key indicators or outcome measures. Throughout this report, there are references made to data that should be incorporated into such a system. This is not an all-inclusive list, but is meant to provide the Facility with ideas about the types of indicators or outcome measures that should be included in such a system.
4. As problematic trends and/or individual issues are identified, the Facility should develop, implement and monitor corrective action plans.

5. It may be helpful to create a graphic description on a single page of all the quality enhancement activities in place and how they relate to improvements in the lives of the individuals who live at CCSSLC. This can be useful in helping staff understand how what they are doing relates to the Facility as a whole.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o CCSSLC Policy Section F.2: Submitting Personal Support Plans for PST and PSP Review, draft; o CCSSLC Policy Section F.6: Completing Daily Schedules: revised 5/12/10; o CCSSLC Active Treatment Monitoring-Coaching Guide, dated 12/18/09; o Texas Settlement Agreement Monitoring Instrument for Section F; o Active Treatment Checklist (blank), dated 4/1/10; o Completed Active Treatment Checklists since 5/1/10; o List of Individuals with most recent PSP date, and previous date; o Facilitator Notes and PowerPoint Presentation entitled Personal Support Teams: PSP Process, dated 9/21/09; o Staff Training Survey, dated 5/10; o PSP Weekly Meeting Minutes, dated 7/9/10; o QMRP Listing, dated 6/26/10; and o PSPs, Assessments, and Specific Program Objectives (SPOs) for the following individuals: Individual #172, Individual #18, Individual #95, Individual #289, Individual #335, Individual #114, Individual #275, Individual #337, Individual #9, Individual #11, Individual #355, Individual #88, Individual #203, Individual #56, Individual #90, Individual #112, Individual #93, and Individual #321 ▪ **Interviews with**: o Daniel Dickson, Director of Quality Enhancement; o Nelda Gonzalez, QMRP Coordinator; o Rachel Rodriguez, QMRP Educator; o Bruce Boswell, Programs Director; o Various QMRPs; o Individual #275; and o Various staff at apartments 514, 516, 517, and 522A, B, C and D ▪ **Observations of**: o PFW meeting for individual #364; and o PSP meeting for #136
	Facility Self-Assessment: The CCSSLC Plan of Improvement indicated that there was not substantial compliance with any of the requirements of Section F of the Settlement Agreement, because the Facility was waiting for the DADS policy to be issued. This was consistent with the Monitoring Team's review.
	Summary of Monitor's Assessment: Summary of Monitor's Assessment: At the time of the last review, a new PSP format had just been introduced and training was underway for staff. During this most recent

	review, it appeared that further changes were being made to the State PSP policy and template, and the Facility was waiting for those changes. Some of the positive aspects of the PSPs reviewed included efforts to identify the preferences and achievements of individuals served through use of the Personal Focus Worksheet (PFW) Meetings preceding the annual team meeting; inclusion of Legally Authorized Representatives in team meetings, including offering options such as telephone participation; and updating PSPs at least annually. As was identified in the baseline report, the biggest challenge for CCSSLC with regard to PSPs appeared to be ensuring that team meetings included interdisciplinary discussions that resulted in one comprehensive, integrated treatment plan for each individual. This also included the need to incorporate individuals' preferences and desired outcomes into the planning process in a meaningful way. As is noted in other sections of this report, issues with regard to adequate assessments impacted teams' ability to identify strengths, as well as needs of individuals. As assessment processes improve, teams will have better tools on which to base their discussions and the resulting integrated plans. Quality Enhancement activities with regard to PSPs were in the initial stages of development and implementation. As this process proceeds, it will be important to ensure that there is a focus on the integration of all needed supports and services into one comprehensive plan.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:	The DADS policy for this section had not been issued at the time of this review, and so it was not reviewed. Since the last review, the State had provided a copy of the draft policy to the Monitors for review, and the Monitoring Panel provided comments. Section F of the CCSSLC Policy Manual addressed person supported planning and active treatment. Since the DADS policy, which was anticipated to include changes, was not available to the Facility, a comprehensive review of the Facility policy was not completed during this review. Based on a brief review, the draft of Section F.2 of the Facility policy manual established a Personal Support Plan Review Committee to review policies and procedures related to the PSP, and to review and approve PSPs. The QMRP Coordinator served as chair of the committee, and the QMRP Educator provided backup. The draft included committee membership and a form for use in reviewing PSPs. The focus of the questions was on preferences and strengths, prioritized needs, barriers, and other key elements of the PSP that needed to be in place. This process holds promise for helping QMRPs lead teams in developing useful plans. CCSSLC's Plan of Improvement was examined to determine the status of updating policy	

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		sections. Only three items on the Plan of Improvement for this section were noted as "complete." A general review of the policy manual section revealed that it was under development, for example, pages were out of order, mis-numbered, or missing when compared to the table of contents. The 18 PSPs that were reviewed were chosen from among those people who appeared on abuse reports, incident reports, at risk lists and restraint lists, as well as a random sample of individuals who recently had had PSPs developed.	
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.	Reviews of PSPs suggested that the QMRP was the team leader and responsible for ensuring team participation. In one Personal Focus Meeting, the QMRP led the meeting. She was skilled in eliciting information from the individual and in making him feel comfortable with the crowd around the table, but she had not been armed with the facilitation skills needed to elicit input from the other meeting participants. For example, the individual was providing a rich amount of information about himself, while she no doubt made good notes about what was said, putting that information on a graphic to help the group envision how the individual's interests might be woven into a comprehensive plan would have improved the flow of information from the rest of the group and might have inspired some creative ideas. Likewise, the QMRP for Individual #136 clearly knew the individual well, and attempted to incorporate his preferences into the development of goals and objectives. This was more challenging due to the fact that Individual #136 did not communicate verbally. Unfortunately, his communication board was not with him during his PSP meeting that a member of the Monitoring Team attended. Despite this, the QMRP encouraged the team to develop a community-based training goal for him. This was a good example of incorporating the individual's preferences into an objective, and eliciting team participation. Specifically, the team developed an objective that incorporated use of his communication board into a goal to purchase a burger or apple pie from the local burger shop. Despite the psychologist's concerns that Individual #136 might engage in targeted behaviors if he had to wait to return to CCSSLC to have the food pureed, other members of the team creatively developed a goal to provide Individual #136 with the opportunity to expand his communication options as well as his community integration opportunities. However, there were opportunities that were missed during the meeting in eliciting information from team members to ensure the adequate development, monitoring and revision of services. For example: ▪ Individual #136 was only attending day program for one hour per day. There was no integrated discussion about strategies that could be used to increase his attendance or participation. Although at the end of the meeting, the team discussed many of Individual #136's preferences, these were not	Noncompliance

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		incorporated into the discussion about day program. The QMRP did not seek, and the psychologist did not offer any insights into reinforcers, for example, that might encourage greater participation. ▪ Although it was unclear due to different weights being recorded in different parts of the record, it appeared that Individual #136 might have lost 21 pounds over the course of a year. He had experienced a number of health concerns. The nutritionist was not present at the meeting. Although the team discussed his prescribed diet, no objective data was presented or reviewed with regard to how much he was eating. There was speculation about reasons he might not be eating, such as missing his mother. However, there was no integrated discussion regarding strategies that could be developed and implemented, and/or further testing or evaluation that needed to be completed. Staff reported, for example, that at times, he appeared depressed. However, no concrete list of symptoms for depression were discussed, nor was a plan developed to collect objective data regarding possible depression. Based on observations as well as review of PSPs, facilitation of team meetings was not consistently resulting in the adequate assessment of individuals, and the development, monitoring and revision of adequate treatments, supports, and services.	
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.	In PSPs reviewed, there was a sign-in sheet for participants. These revealed considerable variety in who attended the meetings. The Corrective Action Plan which tracks the Plan of Improvement, at F step 5 indicated that there was anticipated to be an "Integrated Protections, Services, Treatments and Supports Database," which would make it possible to track whether staff connected to the person and his/her interests were participating in plans. The database was due to be available in August 2010. In reviews of PSPs, QMRPs were present at the annual meetings. Others participating included nurses; at times, direct support professionals; Legally Authorized Representatives; psychologists; Occupational Therapists (OTs); Physical Therapists (PTs); and other disciplines, depending on the individual's circumstances. Vocational services staff did not always attend. Physicians rarely, if ever, attended. Often, either an OT or PT attended, but not both. As noted in the example of the PSP meeting attended by a member of the Monitoring Team, at times there were issues requiring the attendance of specific team members, but these team members were not in attendance. For example: ▪ Individual #136 had a number of issues related to nutrition and mealtimes, but	Noncompliance

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		the nutritionist was not in attendance. He had had numerous health care issues during the past year, but the physician was not in attendance. ▪ It did not appear from the sign-in sheet that a psychologist/behavior analyst participated in Individual #88's PSP meeting, despite his having significant behavioral issues.	
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.	Most of the PSPs reviewed contained assessments of health, residential living [often Positive Adaptive Living Skills (PALS)], behavior including psychological evaluations, speech, OT/PT, nutrition, self-administration of medication, audiological screening, dental, community living options, and other assessments based on specific needs. Vocational evaluations were in most, but not all, files. Sometimes vocational information was included in the PALS, but not always. Plans included a "Personal Focus Worksheet" that gathered information on the individual's preferences. Some plans included the DADS-authorized assessment forms for various potential risks such as aspiration, weight, nursing risks, and polypharmacy, but in this sample there appeared to be fewer references to risk assessment than in the last review. This Facility's Plan of Improvement Indicated that this was an area in which work was still underway. One assessment that would prove useful for some individuals would be an annual review of incidents, and A/N/E allegations. This would ensure that the team considered how to address whatever themes might be revealed, as an addition to reviewing new allegations or incidents as they arise. As noted in a number of other sections of this report, the Monitoring Team found the quality of assessments to be an area needing improvement. This is discussed in further details throughout this report with regard to the sections of the Settlement Agreement that address psychiatric services (Section J), psychology (Section K), medical services (Section L), nursing services (Section M), physical and nutritional supports and OT/PT (Sections O and P), communication (Section R), and habilitation and skill acquisition (Section S). In order for adequate protections, supports and services to be included in individuals' PSPs, it is essential that adequate assessments be completed that identify individuals' preferences, strengths, and needs.	Noncompliance
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.	The connection between the assessment results and the PSP were not always clear. For example: • Individual #172 frequently engaged in challenging behaviors whenever his preferred staff were not available as evidenced by his engagement in spurious reporting of abuse. And, yet the plan did not address discovering why he found some staff more to his liking than others. • Individual #18 persistently asserted that she wanted to be a movie star.	Noncompliance

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		However, there was nothing in the plan about discovering what it was about being a movie star that attracted her. Although this may not be a dream that she could easily realize, it might be possible to support some part of that dream. Crafting connections between what an individual likes or what interests them to how the person's services and supports are configured can be challenging, but the results can be positive. Conversely, if an individual's preferences are not considered carefully, the provision of adequate treatment may be difficult to attain. • Individual #114 persistently said he wanted to work as an auto mechanic. One of his goals was to stay at work. It seemed that staying at his current janitorial work site was considered to be a requirement before additional efforts would be made to assist him in finding a job that he desired. The team needed to discover what it was that he liked about auto mechanics, and then consider how to create a job for him that used that interest to motivate him to stay at work. • Individual # 93's nursing assessment indicated that he had constipation for which he was prescribed regular medication, and had required several interventions for over the year. The action plan addressing this simply read: "Continue health management plans," and listed doctors and nurses as responsible. It was unclear if his team had discussed ways in which direct support professionals could play a role in encouraging fluid intake, helping him to exercise more, etc. In addition, there appeared to be two major factors negatively impacting the Facility's ability to ensure that assessment results were used to develop, implement, and revise, as necessary, a PSP that outlined the protections, services and supports provided to the individual. These were: 1) as is noted above in the section of this report that addresses Section F.1.a of the SA, there was a lack of consistent interdisciplinary discussion and coordination in the development of PSPs. This limited teams' ability to utilize assessment information to develop integrated protections, supports, and services; and 2) as is noted in other sections of this report, many of the assessments and evaluations being conducted were inadequate. Examples of this include inadequate nursing assessments, vocational assessments, psychiatric assessments, and assessments of individuals' physical and nutritional management support needs. The Facility needs to address these two issues to ensure that appropriate assessment information is available, and that teams use such information in an integrated fashion to develop the comprehensive, individualized plans required by the SA.	
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. §	This provision is discussed in detail later in this report with respect to the Facility's progress in implementing the provisions included in Section T of the Settlement Agreement.	Noncompliance

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	12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999).		
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:	In approximately November 2009, QMRPs underwent training, and a new PSP format was introduced statewide. At the time of the July 2010 review, this newer PSP format appeared to be in use, along with the Personal Work Sheet process, but further changes were expected. As stated previously, the DADS policy on Integrated PSPs had not been completed at the time of this review. The Monitoring Team looks forward to reviewing the DADS policy once it is completed, as well as the Facility's implementation of PSPs in accordance with the new policy and new PSP format.	
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	PSPs reviewed generally included some information regarding the individual's preferences and strengths. However, clear prioritization of the individual's needs or careful delineation of barriers to addressing needs was not found. The integration of individuals' preferences to address needs or barriers also was not consistently seen. It was not consistently clear whether or how the goals and objectives were related to individuals' preferences, or were designed to overcome barriers to living in the most integrated setting. For example: ▪ Individual #172 wanted to leave CCSSLC. He made that clear with his efforts to leave, to act out when he was told he could not, but his PSP did not identify the barriers to his leaving, and creative ways to overcome them. According to his plan, he was a competent artist. Exploring that in positive ways could provide some of the recognition he appeared to crave and help him forge valuable community connections (e.g., a local artist mentor) that might begin to address his problem behaviors. His plan did not appear to incorporate this strength into the treatment being provided. ▪ Individual # 275 ate too fast and slowing her down created behavior problems. It was not clear whether she could be enlisted to help with preparation or some mealtime activity that would help slow her eating down. ▪ Individual #90 had a number of objectives included in the Action plan section of his 6/2/10 PSP. They included bathing, coin identification, privacy awareness,	Noncompliance

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		responsibility awareness, and increasing knowledge of his medications. The PSP did not provide a description of how these had been identified as priorities. Working and participating in community participation were listed as two of the activities that were most important to him. These were not addressed in action plans, despite the fact that it appeared that a 5/12/10 vocational assessment recommended that new job opportunities be explored. As is discussed below with regard to Section S.3.b, the Facility was making efforts to include objectives that encouraged community participation. At the time of the review, approximately eight percent of the individuals at CCSSLC had goal/objectives that specifically were to be implemented in community settings. Additional work was being done to overcome some of the barriers to this. It will be a challenge to address barriers such as transportation, payment of staff's expenses when supporting individuals to participate in recreational and food-related activities, and ensuring adequate staffing is available for individuals to participate in community activities in small groups.	
	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;	As noted in the last monitoring report, PSPs generally included some individualized and measurable goals/objectives, treatment strategies and supports. An example of a plan that included a more extensive list of measurable objectives and strategies was the one for Individual #88. However, in most of the plans reviewed, the expected outcomes were often general and not measurable. For example: ▪ Individual #95's 4/13/10 PSP identified that work was important to him. His team discussed the possibility of community employment. Some issues were identified with regard to his attendance at work, due to what appeared to be psychiatric issues, as well as amputation of his hand that presumably presented challenges with regard to work. However, his action plan related to work read: "Continue working." The frequency was listed as "ongoing," and the responsible person was the "PST." This did not set forth measurable objectives for him or for staff to support him in attaining employment commensurate with his skills, interests, and abilities. ▪ Individual #93's 5/13/10 PSP included an objective that read: "Will increase participation in community events." This was not measurable. As is discussed in further detail throughout this report, improvement was needed in this area. For example, nursing plans, which should have been incorporated into the overall PSP, did not generally contain individualized measurable goals/objectives. This is further detailed in the section of this report that addresses Section M of the Settlement Agreement. Likewise, as is discussed below with regard to Sections O and P of the SA, measurable functional outcomes were not being identified for individuals in need of physical and nutritional supports. At this juncture, behavior support plans and psychiatric treatment plans did not contain all of the measurable goals and/or objectives	

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		that they should.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	PSPs appeared to integrate some, but not all protections, services and supports that individuals required. For example, the health services portion of the plan frequently still stood apart, as did the PBSP and PNMP. As is discussed in greater detail below with regard to Section O of the SA, without a fully functioning Physical and Nutritional Management Team, the integration of such services to address the needs of individuals was lacking. Other examples included the lack of integration between nursing and physical and nutritional supports to incorporate PNMPs with the administration of medication, dental and with dental care, and dental and psychology to develop and implement desensitization plans. All of these are examples of coordination and integration that should be occurring as part of the individual planning process. For example: ▪ Individual # 112 had a PBSP, Dining Plan, and was prescribed psychotropic medication. None of these were referenced in the action plan section of his PSP. These clinical care plans appeared to be separate documents that were not integrated into the plan. ▪ Individual #56 had a PNMP and Dining Plan, neither of which was referenced in her Action Plans.	Noncompliance
	4. Identifies the methods for implementation, time frames for completion, and the staff responsible;	Generally, for the action items identified by teams, methods, timeframes and staff responsible were identified. However, methods for implementation were not always adequate as is discussed in further detail in the section of this report that addresses Section S of the Settlement Agreement.	Noncompliance
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	As identified in other sections of this report, not all of the interventions, strategies and supports offered to individuals at CCSSLC effectively addressed individuals' needs, and not all were practical and functional at the Facility and/or in community settings. Again, these are discussed with regard to the need for improvements with regard to plans to address conditions that place individuals' at-risk, psychiatric treatment plans, nursing care plans, PNMPs, OT/PT treatment plans, and Positive Behavior Support Plans.	Noncompliance
	6. Identifies the data to be collected and/or documentation to be maintained and the frequency of data collection in order to permit the objective analysis of the individual's progress, the	Generally, PSPs and the resulting Specific Program Objectives contained data collection methods, frequency with which data should be collected, and identify a person(s) responsible. CCSSLC Policy Manual contained Section F.41 that covered team participation in PSP Monthly reviews, and specified reporting formats for the QMRP, the medical and the behavioral supports reviews. These reviews were expected to lead to team meetings, and a template to record the results was identified. While this process is useful, it was not clear that the team was required to review objective data.	Noncompliance

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	person(s) responsible for the data collection, and the person(s) responsible for the data review.	Again, as is discussed in other sections of this report, not all components of individuals' PSPs identified the data to be collected, the frequency, and/or the persons responsible for such data collection. For example, some of these elements were missing from the nursing care plans, as well as psychiatric services, such as the monitoring of symptoms that medications were prescribed to reduce.	
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.	As noted above, there were issues with regard to the integration and coordination of outcomes, services and supports in individuals' PSPs. This will continue to be evaluated as the new policy and format for PSPs is implemented.	Noncompliance
F2c	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	At the time of the review, the PSP was located on the residential unit, but locked in a cabinet for security reasons. Given privacy and security requirements, this was appropriate. It appeared that if staff needed access to the locked records, a key was easily available. The SPOs were located on the unit and accessible to staff, usually in folders or notebooks. As the new format for the PSPs is implemented, the Monitoring Team will review whether it is comprehensible to staff responsible for its implementation. This has been deferred until after the new policy is available.	Not Rated
F2d	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary	Section F.41 of the Facility Policy Manual provided for monthly reviews of the PSP, monthly meetings of the key plan participants, and reporting of needed changes. The QMRP was authorized to call a meeting within five working days to review any recommendations, and to complete a PSP amendment. As noted above, while this process is useful, it was not clear that the team was required to review objective data.	Noncompliance

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	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.	According to the Facility Plan of Improvement, this section awaited the development of the state policy. The Facility provided a training presentation on that was dated September 2009. What was provided was not competency-based training as required by the SA. However, it was expected that new training would be implemented with the roll out of the new State Office policy and PSP format.	Noncompliance
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	Since July 1, 2009, no individuals had been admitted to the Facility. Based on the sample of PSPs reviewed, all had been updated within the last year. This was consistent with the data included on the list of individuals the Facility provided with their most recent PSP date. What could not be determined was whether the PSPs went into effect within 30 days. At the time of the review, the Facility had no way of tracking this. Discussions with staff indicated that the expectation was that the plan would be finalized within 30 days of the meeting, and filed in the active record to allow timely implementation. The system of the Personal Support Plan Review Committee reviewing PSPs that the Facility was putting in place appeared to have the ability to closely track the completion of PSP documents.	Noncompliance

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		The Monitoring Team also reviewed some addenda to PSPs that were completed due to the changing needs of individuals. In some cases the PSP addenda were well done. For example: Individual #172 had presented exceptionally challenging issues in the past six months. His file contained numerous addenda as staff tried to address his escalating behavior problems. It is noteworthy that while various approaches were not successful, staff continued to search for more workable options.	
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.	According to discussions with the Quality Enhancement Division Director, work on this provision was underway. More specifically: ▪ At the time of the review, the QE Department was monitoring a sample of plans for timeliness and completeness as part of their active treatment review. ▪ Their review for active treatment did not currently include of all of the indicators required by the Settlement Agreement. ▪ The QE Department had adopted monitoring tools used by the SA monitors. QE auditors had used the forms on about 50 files. Discussion with the auditors and a reading of the files indicated that the tools needed to be modified to work effectively for the Facility monitoring process. Some of the changes that should be considered are detailed above with regard to Section E of the SA. ▪ The Facility was not yet aggregating the data, analyzing it, identifying trends, and/or developing action plans to address identified issues. During upcoming reviews, the Monitoring Team will review the tools and their use, as well as the results of monitoring, and any actions to address issues identified.	Noncompliance

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

1. Section F of the Facility Policy Manual should be modified to address changes in DADS policy once it is finalized. Facility policy should include subsections that:
    a. Explain the role and authority of the QMRP with regard to the team process, or identify an alternative team leader. Such a statement might be included as part of the policy statement at the beginning of Section F; and
    b. Emphasize the need for individuals' teams to include clinical and direct support staff, dictated by the preferences and needs of the individual. This should include vocational and/or day program staff, whenever appropriate.
2. QMRPs and/or others with responsibility for facilitating team meetings should be provided with competency-based training on group facilitation, particularly as is relates to the interdisciplinary team process. The training should include ways to help meeting participants visualize the individual's plan, the individual's contribution to the plan, and the intersection of elements of the plan.
3. Consideration should be given to adding to the PSP process an annual review of incidents, and A/N/E allegations. This would ensure that the team considered how to address whatever themes might be revealed, as an addition to reviewing new allegations or incidents as they arise.
4. As teams are trained on the new PSP policy and format, a focus should be on all team members' role in the interdisciplinary process, including the integration of information and development of strategies to address individuals' preferences and needs, and to identify and overcome barriers. Emphasis should be placed on the need for timely reports to team members.

5. As indicated in other sections of this report, focused efforts should be made to improve the quality of assessments that are used in the development of individuals' PSPs.
6. The Facility is encouraged to continue to address barriers such as transportation, payment of staff's expenses when supporting individuals to participate in recreational and food-related activities, and ensuring adequate staffing is available to enable individuals to participate in community activities in small groups.
7. The Facility's QE processes with regard to PSPs should include reviews to ensure that all of the components of the Settlement Agreement with regard to PSPs are addressed, including but not limited to assessment to ensure that:
    a. Team composition includes the individual, the LAR, the QMRP, staff who regularly provide direct supports to the individual including vocational staff and others that reflect the individual's preferences, needs and strengths;
    b. Comprehensive assessments are completed, and the results integrated into the PSP;
    c. Assessments are completed to identify the preferences of the individual and his/her LAR, and that this information is used meaningfully by the team in developing supports and services for the individual. Teams should constantly challenge themselves to discover creative ways to deliver what is needed in ways that are positive for the individual, and help move her/him farther toward her/his goals.
    d. Team meetings include interdisciplinary discussion that utilizes the team's knowledge of the individual and his/her strengths, preferences, desired outcomes and needs to develop one comprehensive, integrated plan for each individual.
    e. Interventions, strategies and supports are functional at the Facility and in the community.
    f. Community integration is encouraged.

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:** Information gathered as a result of activities undertaken to assess clinical services discussed throughout this report was analyzed to make determinations with regard to the Facility's progress with these provisions of the Settlement Agreement.
	Facility Self-Assessment: Overall, the Facility had assessed itself as being in noncompliance with the requirements in Section G. It was unclear what data it had used to substantiate this, but the Facility was in the process of revising the information included in the POI. The Facility's assessment of noncompliance was consistent with that of the Monitoring Team.
	Summary of Monitor's Assessment: As is discussed in other sections of this report, at the time of this review, there were a number of gaps with regard to the integration of clinical services. It appeared that the Facility was working on methodologies to ensure that recommendations from non-Facility clinicians were reviewed, considered, and documentation maintained justifying decisions.

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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.	As is discussed in other sections of this report, at the time of the baseline as well as this review, there were a number of gaps with regard to the integration of clinical services. Some of the most striking include the need for greater integration between dental/medical and behavioral/psychology; nursing and dental; and between the disciplines responsible for the provision of physical and nutritional supports to individuals served. These are all discussed in further detail in the sections of this report that address these various disciplines. However, the following provide some specific examples: ▪ Based on medication administration observations and interviews with the nursing staff, there was little to no collaboration with the Physical and Nutritional Management Team (PNMT) regarding the safe positioning for individuals when they received medications orally or enterally. Nurses were not checking the Physical and Nutritional Management Plans (PMNPs) prior to administering medications, and usually these plans were not kept in the Medication Administration Records (MARs). The addition of a nurse to the PNMT should be helpful in facilitating this needed collaboration. ▪ A review of the medical emergency drills found that there was no collaboration between disciplines for reviewing the Facility's medical emergency systems. The various specialty disciplines would have valuable input to offer for a system that is essential for the individuals at CCSLC. ▪ The Facility had implemented the Integrated Clinical Services Committee since	Noncompliance

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		the baseline review to collaborate on issues regarding the Facility's POI. As this committee continues to meet and discuss shared issues among disciplines, it is hoped that areas in which collaboration is not occurring, but should be will be identified and addressed. ▪ The Psychiatry Services were integrated with Psychology in that the Psychologists played an integral role in the Psychiatric Clinic process. The Psychiatric Clinics were the primary forum for coordinating that aspect of the medical care of the individuals who reside at the CCSSLC. The Psychologists were responsible for providing the data that influenced and affected the decision-making of the Psychiatrist. However, the review of the individual records described in Section J revealed the behaviors that were described in the Functional Analysis and Behavior Support Plan as being present on a behavioral basis were also described in the Psychiatric section as "targets" for the psychotropic medication. This would suggest that either the psychotropic medications were being used to suppress behaviors related to environmental and interpersonal factors, or there was a lack of integration between the Psychiatry and Psychology Departments in the development of these plans. ▪ The integration between Psychiatry and Medicine was primarily represented by the participation of the Nursing Staff in the Psychiatric Clinic process, as well as the *MOSES/DISCUS* monitoring for side effects. The interaction with the Primary Care Physicians was usually accomplished by written Consultations between disciplines, as well as telephone contacts. ▪ The interaction between Pharmacy and Psychiatry was primarily in the form of the detailed Quarterly Reviews of the psychotropic medications by the Pharm. D. In addition, the Pharmacy entered every new medication order through a software system that checked for potential interactions, and notified the prescriber if there was an issue with the medication. The Psychiatrist would be notified if this occurred with a newly prescribed psychotropic medication.	
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	It appears that the Facility was working on methodologies to ensure that recommendations from non-Facility clinicians are reviewed, considered, and documentation maintained justifying decisions. However, The only routine involvement between Psychiatry and a non-facility physician would be with Neurology. The communication between the Psychiatry and Neurology Departments was accomplished through written consultations. As noted with regard to Section J of the SA, the documentation concerning the review of the Neurology Consultation Reports by the Psychiatrist should be improved.	Noncompliance

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	supports and services.		

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

1. Recommendations regarding integration of clinical services may be found in each of the respective sections of this report.
2. The Facility should continue to move forward with plans to ensure that appropriate clinicians review recommendations from non-Facility clinicians, and document whether or not such recommendations are accepted, and, if not, why not. As appropriate, recommendations should be forwarded to individuals' PSTs.

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:** Information gathered as a result of activities undertaken to assess clinical services discussed throughout this report was analyzed to make determinations with regard to the Facility's progress with these provisions of the Settlement Agreement.
	Facility Self-Assessment: Overall, the Facility had assessed itself as being in noncompliance with the requirements in Section H. It was unclear what data it had used to substantiate this, but the Facility was in the process of revising the information included in the POI. The Facility's assessment of noncompliance was consistent with that of the Monitoring Team.
	Summary of Monitor's Assessment: According to the Facility's Plan of Improvement, the Facility was in the process of developing policies and procedures to implement these provisions of the Settlement Agreement. The target date for most of these activities is 1/30/11. As is illustrated throughout this report, different clinical disciplines were at different stages of ensuring that assessments and evaluations were completed as required or needed, treatment plans were developed and implemented, monitoring systems were in place to measure compliance with and the efficacy of treatment plans, and treatments and interventions were modified as needed.

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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.	As is illustrated throughout other sections of this report, there were issues with regard to assessments and evaluations being completed regularly, and performed in response to development or changes in an individual's status. Some examples of this included nursing assessments, particularly with regard to individuals who experience acute illness; individuals who may benefit from communication systems; individuals being considered for enteral nutrition; and individuals requiring restorative dental care. There was evidence of current Psychiatric Assessments in 85% of the sample of individual records reviewed. There was also documentation that monthly interdisciplinary reviews of psychotropic medication were being uniformly carried out, as well as a quarterly direct observation of the individual by the Psychiatrist. However, the review of individual records described below with regard to Section J indicated that the quality of the documentation contained in the Psychiatry Assessments and the Psychiatry Clinic Reviews did not meet the standards set forth in the Settlement Agreement and Health Care Guidelines.	Noncompliance
H2	Commencing within six months of the Effective Date hereof and with full implementation within one year,	As is illustrated, particularly with regard to psychiatric services, the assessment processes used to determine diagnoses are not always consistent with DSM criteria or generally accepted standards of practice. The psychiatric diagnoses utilized at the	Noncompliance

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	diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems.	CCSSLC were consistent with the nomenclature utilized in the *DSM-IV-TR.* The current deficiency in this area was that there was incomplete (or missing) documentation in the individual records, which set forth the specific symptoms that the individual presented with in a manner that would support the validity of the psychiatric diagnosis.	
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	As is referenced in the section above with regard to Section H.1 of the Settlement Agreement, without timely and thorough evaluations and assessment, the planning of treatments and interventions was hindered. For example, for individuals for whom communication needs are not properly assessed, adequate treatments and interventions could not be developed, and implemented. Likewise, if psychiatric diagnoses were not accurate and/or if psychiatric services were not integrated with behavior supports, then proper treatment likely will not be provided. The monthly Psychiatric Clinics and Quarterly Assessments of the individuals by the Psychiatrist were consistent with the requirements of the Provision, in that they were performed in a "timely" manner. As noted above, the deficiencies regarding this provision related to the requirement that these interventions were "clinically appropriate based upon assessments and diagnosis."	Noncompliance
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.	As is illustrated in various sections of this report, clinical indicators often were not identified. For example, when psychiatric medications were prescribed, the target symptoms were generally not clearly identified, and tracked to assist in determining the efficacy of the treatment. Likewise, nursing plans did not identify what clinical indicators would be tracked, by whom, or when. Physical and nutritional management plans also did not identify the functional outcomes to be measured. In addition, The lack of sufficient documentation concerning the efficacy of the psychotropic medication was a significant deficiency in the utilization of these medications at the CCSSLC. This subject, as well as potential remedies is discussed in detail below with regard to Section J of the SA.	Noncompliance
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.	Again, as is illustrated, for example, in the nursing and physical and nutritional support sections of this report, there were not systems in place to effectively monitor the health status of individuals. Moreover, the psychiatric status of each individual receiving psychotropic medication was discussed on a monthly basis in the format of the Psychiatric Clinics. These meetings also included a discussion by the Nursing Staff of any medical problems, as well as any apparent side effects of the medications. However, this information was not fully documented in the overall Facility health status assessment	Noncompliance

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		process.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	Until accurate clinical indicators are developed and monitored/measured, this will continue to be an indicator on which the Facility needs to work. As is discussed above with regard to Section E.1 of the SA, such indicators need to be incorporated into the QE/Risk Management systems to assist in identifying individuals, homes, and/or departments that need attention, as well as to identify and address systemic issues that impact the Facility's adequate response to clinical indicators. The "clinical indications" that the psychiatrist responded to were primarily represented by the Behavioral Data presented by the Psychologist in the monthly Psychiatric Clinic. As discussed above, and with regard to Section J, a significant deficiency derived from the observation that the "target behaviors" of the psychotropic medication were also described elsewhere in the record as being present on a learned behavioral basis.	Noncompliance
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	According to the Facility's Plan of Improvement, such policies are anticipated to be completed beginning at the end of December 2009, with a target date of 1/30/12. This will be further assessed during upcoming visits.	Noncompliance

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

1. Recommendations regarding the common elements of clinical care are included in other sections of this report.
2. The Facility should continue to develop and implement policies related to the common elements of clinical care.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents:** o DADS Policy #006: At Risk Individuals, dated 10/5/09; o DADS Risk Assessment Tools, dated 8/31/09; o CCSSLC Policy #006: At Risk Individuals, dated 10/5/09; o Medical records for the following Individual #181, Individual #19, Individual #94, Individual #294, Individual #184, and Individual #348; o Policy entitled "Health Status Team," implemented 12/26/09, revised 6/18/10; o Health Risk Assessment Rating Tool; o Health Risk Assessment Tool – Aspiration/Choking; o Health Risk Assessment Tool – Polypharmacy; o Risk Assessment Tool – Challenging Behavior; o Health Risk Assessment Tool – Injury; o Health Risk Assessment Tool – Nursing; o Draft policy "At risk individuals: Actions following health status team meeting," dated 6/18/10; o Personal Support Plan Addendum: Discharge Planning for Infirmary/Hospital Admissions – [includes Risk Level Review]; o Policy entitled "At risk individuals: High risk oversight committee," implemented 6/2/08, latest revision 6/18/10; o Health Status – Identified High Risk Individuals, dated 6/16/10; o Nutritional Management Team Minutes: Home: Pacific Unit, dated 3/30/10; o "High Risks by type – sorted alpha," dated 7/12/10 o List of at risk individuals: bacterial pneumonia, aspiration pneumonia; o List of at risk individuals: individuals experiencing swallowing incidents during time period 1/1/2010 through 6/23/10; o List of At risk individuals: individuals diagnosed with pica disorder; o List of at risk individuals: aspiration; o List of at risk individuals: GERD; o List of at risk individuals: choking; o List of at risk individuals: dysphagia; o List of at risk individuals: falls; o List of at risk individuals: weight loss or gain; o List of at risk individuals: skin breakdown/decubitus ulcer; o List of at risk individuals: impaction/bowel obstruction/constipation; o List of at risk individuals: dehydration; o List of at risk individuals: pica; o List of at risk individuals: seizures; o List of at risk individuals: osteopenia/osteoporosis; o List of at risk individuals: poor oral dental status;

	○ List of at risk individuals: pain, including chronic and acute; ○ List of at risk Individuals admitted to emergency room from 1/1/10 through 6/21/10; ○ "At risk individuals: Individuals admitted to Emergency Room," dated 7/14/10; ○ "Individuals identified with a history of ingesting non-food items," dated 6/29/10; ○ "CCSSLC Individuals involved in possible swallowing of inedible object without pica diagnosis, 7/1/09 to present," dated 7/14/10; ○ "CCSSLC pneumonia report, 7/14/2010"; ○ "At risk individuals: Individuals diagnosed with pneumonia," 1/1/10 through 6/21/10 ○ "2010 Infirmary admissions"; ○ "Hospital admissions January 2010 – July 12, 2010"; ○ "2010 hospital admissions," from 1/6/10 through 5/27/10; ○ List of at risk individuals: 2010 Infirmary admissions January to June 15, 2010 ▪ **Interviews with**: ○ Daniel Dickson, QE Director; ○ Dr. Sandra Rodrigues, Medical Director; ▪ **Observations of**: ○ Integrated Clinical Services Committee, on 7/14/10; and ○ Health Status Team (HST) meeting, on 7/15/10
	Facility Self-Assessment: The Facility recognized that it was in the exploratory phase of the risk assessment process, and was not yet in compliance with the requirements in this section of the SA. This is consistent with the Monitoring Team's assessment.
	Summary of Monitor's Assessment: There had been some initial attempts at developing risk assessment tools, such as the health risk assessment domains. However, these tools, including the severity ratings, were subjective, making consistency across teams problematic. Precise criteria reflective of each level need to be developed as guidance for all the teams. Then, those individuals at risk can be identified, and a plan of care implemented. None of these steps had been completed.

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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.	Based on discussions with the QE Director and the Medical Director, the Facility had modified the system where individuals' risks were scored by the health indicator categories, and they were no longer given an overall score for risk. These indicators were still discussed at the HST meeting where the physician or practitioner assigned the score for each category: Level 1 was the highest risk, Level 2 represented moderate risk, and Level 3 was low risk. In addition, a High Risk Oversight Committee had been created composed of the Health Status Team and department heads appointed by the Director to review monthly the status of care plans implemented by the PST for individuals assigned a Level 1 risk rating. A draft of the At Risk Individuals High Risk Oversight Committee policy, dated 6/18/10, outlined the duties and activities of the committee.	Noncompliance

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		The implementation of additional clinical oversight for high-risk individuals was without question an appropriate safeguard for the risk system. However, it is imperative that the foundation and infrastructure of the system that accurately identifies individuals' risk status be appropriately implemented. At the time of the review, the risk tools being used were not adequate risk assessments. Consistent with the findings during the previous review, the Facility's risk system consisting of the Health Risk Assessment tools and the HST meetings did not result in the appropriate identification of clinical risk indicators. For example: ▪ In the case of Individual #305, the nurse presented information to the HST that included the individual had a history of multiple fractures and had been placed on medication for osteoporosis. A Dexa Scan had been obtained to determine bone density, but the nurse had not brought the results to the meeting. In addition, the individual was noted to be regularly using a wheelchair, and requiring staff's assistance for transfers. The team assigned the individual a low risk for injury. The nurse indicated that since the individual was now using a wheelchair, he was not at risks for injuries. ▪ According to information supplied by the Facility, 13 individuals had been identified as at risk for pica disorder. Interestingly, Individual #7 was not one of them. Individual #7 swallowed a battery and had to be hospitalized. She was being restrained using mitts whenever she was out of her room to prevent her from picking up and ingesting inedible substances. While her room was said to be pica-free, her home was not, creating a very restrictive environment for her. A psychiatrist and psychologist need to determine what the criteria are for a diagnosis of pica. If it does not include individuals such as Individual #7, then some other designation may need to be found to identify her as at risk, since injury and incident reports clearly indicated she was at risk. Risk categories should highlight the need for further attention and aggressive treatment on the part of the PST. Four out of the five records reviewed for individuals requiring seizure management had experienced falls and injuries and other concerns which seemed inconsistent with the risk rating provided. These four individuals might have benefited in heightened awareness of their concerns by being assigned a higher risk rating. More specifically: ▪ Individual #181 record had a section devoted to health risk screening and categorization. In this section, he was assessed as Level III (low) for aspiration/choking, and constipation. Yet, he was on thickened liquids to honey/applesauce consistency, and required a pureed diet with pureed bread. Although there was no diagnosis listed, he likely had a diagnosis of dysphagia to require thickened liquids. Those who require thickened liquids are at increased risk of worsening dysphagia and aspiration. His risk of aspiration was high, not	

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		low. Additionally, he was rated at low risk for constipation. Yet, he had a history of chronic constipation and hypotonic/megacolon. He had abdominal distention associated with Urinary Tract Infection (UTI)/bacteremia on 5/8/09, and 6/4/09. The annual medical assessment indicated he had hypotonic colon with acquired megacolon with recurrent obstructions from impactions, but that he was stable. With a history of megacolon and impactions, it would seem prudent to elevate him as a medium or high level of risk, not low. In this case, osteoporosis should probably be listed as a specific risk, of which he would be medium to high. He had a history of osteoporosis, and several fractures. Additionally, he was taking valproic acid, which may aggravate osteoporosis. He was taking calcium and vitamin D, but no other treatment for osteoporosis. He was at moderate to high risk for subsequent fracture. ▪ The record for Individual #184 included a health risk assessment. The health risk assessment tool for injury indicated that he fell or tripped eight times prior to completion of the form dated 3/5/09, and during one of the February 2009 falls he lacerated his forehead. He was categorized at medium risk. Subsequently, it was recorded he had an extensive laceration to his elbow on 5/8/09, and this was reinjured on 5/14/09. From the integrated progress notes, he fell on 2/16/10 with a laceration requiring sutures to the forehead, and a fall requiring a trip to ER on 5/14/10. This last fall was related to a seizure. He also had a history of spastic quadriparesis. Additionally, he had had a number of fractures, including the left distal fibula in 2009, and the ninth and tenth ribs in 2008. He was on Depakote. He took calcium for osteoporosis prevention as well as Vitamin D prophylaxis. Based on this information, he would likely fit into a high-risk category for injury. However, the rationale for categorizing an individual for any of the three levels of risk was not clear. Although he had not had fractures since 2009, he remained at significant risk for falls with fracture. ▪ Individual #294 was considered to be at low risk for injuries, according to the interpretation of the health risk assessment tool. However, according to submitted documentation, she had three falls without injury in 2009, and one fall in 2009 with injury, but the injury was considered non-serious. She had a diagnosis of spastic paraparesis, and had difficulty with ambulation. She was at risk for falls due to the number of seizures, as well as the polypharmacy used to control the seizures. The team met with Physical Therapist (PT) and determined that she had lost the ability to walk without falling. As a result, wheelchair use had been implemented for long distances, and the individual preferred to use the wheelchair. She should be considered moderate to high risk for injury due to her gait, history of falls, and frequency of seizures. Yet, the risk assessment score did not capture the significant historical information. Lastly, the 2/22/10 overall risk rating was left blank. No risk level was determined. ▪ Individual #94 was at risk for injury. He fell on 1/19/10, during a behavior with	

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		a peer. There was another aggressive episode between peers on 1/23/10. On 1/29/10, he became angry and kicked and punched home furnishings, sustaining two lacerations to the hand. The 9/17/09 annual medical assessment also documented that he had multiple falls with no fractures or serious injuries. On 3/24/10, he had a seizure while smoking, adding additional risk of complications to his seizure disorder. On 4/7/10, he punched a glass door, but there was no injury. Later that same day, he punched a fence in the patio area. On 4/7/10, there was information recorded about a seizure with a fall, during which his head hit cement. He sustained a bruise to his scalp. During an altercation, he attempted to hit a peer on 4/9/10. On 4/27/10, he developed a bruise on his wrist. Despite the difficulty in controlling seizures, the frequency and length of the seizures, the smoking habit, the history of falls from seizures, and injuries associated with anger, his health status risk was recorded as low. On the health risk assessment rating tool dated 11/9/09, he was rated as low risk for such areas as challenging behaviors (despite the injuries and potential for injuries), rated as medium risk for injuries (which seems inconsistent with the low risk assigned to challenging behaviors), and medium risk for seizures (although he remained difficult to control, and the seizure activity was prolonged, requiring as-needed medication for control, and at one point, hospitalization). Polypharmacy was not rated, despite his requiring four anti-epileptic medications. This description would suggest his health status risk is greater than low, and there should be consistency across some of the related areas, such as challenging behaviors and injuries. However, interpretation of rating levels appeared to be subjective, rather than relying on specific criteria or data. Justification for any level should be followed by listing the reasons or events to support that determination. ▪ Individual #19 had a seizure disorder, which remained difficult to control. He also had athetoid cerebral palsy. He had had a number of injuries in the past few months. On 12/23/09, he developed abrasions from a shower mat. On 1/7/10, he fell while getting out of bed. On 2/5/10, he fell, hitting his head on a wall and scraping his back. On 2/8/10, he fell while seated on the toilet. On 2/15/10, he fell backwards when getting up from a wheelchair, and sustained scratches to his back. Later that same day, he fell backwards while getting up from his recliner. On 3/8/10, he was found to have bruises to his left hip. On 3/9/10, he was found to have a swelling of his left forearm due to a fall. He also had two scratches to his left knee. His health risk for injury was categorized as medium. Given the number of falls, but without serious injury, this may be appropriate, but there are no set criteria that are used from unit to unit. Several lists were requested concerning potential risk categories. The following were concerns that resulted from review of the lists provided:	

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		▪ "Poor oral dental status" - There was only one individual listed. The database query was for only 6/22/10 through 6/23/10. This was an inadequate list, because as discussed in further detail in Section Q, there were many dental needs on campus. ▪ "Health Status – Identified High Risk Individuals" - Some areas such as osteoporosis were left blank except for an occasional rating of an individual, suggesting the need for further record review. As one common example of a risk area that did not appear to be defined to capture individuals at risk, constipation appeared to be a rare risk problem at CCSSLC. It is recommended that criteria be listed related to ER visits or hospitalizations due to fecal impaction or obstipation or obstruction, such as a diagnosis of megacolon, need for three or more routine laxatives, requiring over a certain number of enemas in a week or a month. Polypharmacy rarely was listed in Level 1 - High, yet there were probably many individuals with three or more psychotropics, three or more anti-seizure medications, etc. Valid criteria need to be developed for each clinical problem, including criteria that have known face-validity. A person with megacolon is likely to always be at Level 1 - High, for instance. ▪ "Pain, including chronic and acute" - Only four individuals were listed. It is likely there are many more individuals on non-steroidal or acetaminophen products, etc. The database may not reflect all the diagnoses. The active problem list (part of the annual medical assessment) in the record also may not be complete, which would be one of the first steps in a chain of steps necessary to ensure that individuals risk levels are appropriately identified. Records need an updated diagnosis list located in one place. This list can then be entered into the database system, which would assist in the creation of reliable risk lists. ▪ "Impaction/bowel obstruction/constipation" - Despite the high number of individuals with this concern, the "Health Status-Identified High Risk Individuals" only listed one individual for Level 1 – High, and two individuals for Level 2 - Medium. As mentioned above, more precise criteria may help identify the list of those individuals at highest risk for this category. ▪ "Dehydration" - Only one person was listed. ▪ "Pica" - This list did not include individuals who did not have a diagnosis of pica, but who had behaviors of eating inedible objects. From a medical viewpoint, the ingestion of a substance that is not edible has the potential to cause harm. It may occur due to a thought disorder, or emotional distress, or unexplained craving, and may or may not respond to psychotropic or other medication. For purposes of the list, all those who eat inedible objects should probably be considered at heightened risk (moderate to severe) for health and safety, depending on their history of ingestion, type of ingestion, and complications. Those who have responded favorably to a PBSP, and have no pica habits recorded after several years (the threshold determined by the PST) should be	

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		considered low risk (as long as they remain on the successful PBSP). Further criteria can be added to determine a change in the level of the risk and clarify the level of this risk. Regardless of the risk category, almost all need an ongoing extensive PBSP or PSP plan. ▪ "Osteopenia/osteoporosis" - Sixty-five individuals were identified as at risk for osteopenia/osteoporosis. There are many factors that should be considered in determining the risk of developing osteoporosis or a complication of osteoporosis, such as a fracture. It might involve results of a DEXA scan, prior fractures, as well as ataxia or unstable gait. ▪ Gastroesophageal Reflux Disease (GERD) - The list only included six names, yet based on review of many records, it was commonly noted. This may mean a master diagnosis list needed to be updated in each record. ▪ "Weight loss or gain" – This list appeared to be based on one unit's dietary review. This list likely represents underreporting. From a quality assurance perspective, the Facility had some processes in place that could assist in identifying individuals at risk. For example, as part of managing quality and monitoring trends, there were lists of individuals at risk due to a swallowing incident, diagnoses of pneumonia, hospital admissions or emergency room (ER) admissions. While the individuals' risks were not measured using a screening tool, this is one method of identifying people who might be at risk, and elevating the attention paid to preventing recurrences.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	Standardized statewide tools should be used by all the Facilities in assessing and documenting clinical indicators of risk. In addition, there should be criteria for the risk categories for consistency so that the process is less subjective. CCSSLC and the State Office recognized that they were not in compliance with this requirement of the SA, which is consistent with the review teams' findings. The Risk System is the essential foundation that identifies those individuals who warrant the most clinical intensity, and is the alarm for other systems to be called into action. The misidentification of individuals who are at risk substantiated that the foundation had not been appropriately built and consequently, other associated systems were rendered nonfunctional. Once this system is adequately implemented and individuals' risks are appropriately identified, the PSTs need to conduct integrated team reviews, and develop plans to address identified areas of risk. The Facility had the draft policy/procedure dated 6/18/10, entitled "At Risk Individuals: Actions following health status team meeting." It was in draft form, and was not a working document at the time of the review. It represented a good first step in adopting an at-risk plan. The focus was on monitoring of the at-risk level, and implementation steps required by the PST when there was a change in health status and a change in risk	Noncompliance

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		categorization. In the meantime, there was ample information that would allow the Facility to pilot aspects of a potential at risk program. For example, Corpus Christi provided a number of lists of individuals that provide the names of individuals with which to begin an at risk process. Some of these lists included: ▪ A list of individuals from October 1, 2009 to the present who had been diagnosed with lung infections (bronchitis, pneumonia, etc.) who were treated at the facility or went to the ER or were hospitalized. ▪ A pneumonia report, dating back to November 2009 to the present. It included 43 individuals diagnosed with pneumonia during the reporting period. ▪ A list of individuals hospitalized from January 1, 2010 to July 12, 2010. ▪ A list of individuals admitted to the infirmary from January 1, 2010 to June 15, 2010. Any of these lists could be used by the Facility to begin the process of assessing individuals at risk. For example, the PSTs could review each individual with pneumonia or hospitalized with pneumonia to determine if there was a change in the individual's condition, specifically functional change or need for more or different assistance/supervision/equipment, change in medications for any of the organ systems, change in ambulatory status, change in texture of diet or change in thickening of liquids, new use of respiratory therapy, etc. This would assist the Facility to begin to create criteria that could be used as part of the assessment system, at the same time beginning the PST process of identifying and treating at-risk issues. Another area of great concern that would benefit from at-risk criteria and implementation of assessment and interventions, was those individuals who swallowed inedible objects, including those individuals listed as having pica and those not on this list, but who swallowed inedible objects. CCSLCC submitted a list of those who do not have a pica diagnosis, but who may have ingested an inedible object, dating back to 7/1/09. Fourteen individuals were named. The instance in which the individual eats an inedible object or substance should be considered a criterion indicating a change in the individual's condition. No matter what the scenario or thought process involving the ingestion, the ingestion becomes a medical problem until resolved, and a series of tests and observations are indicated until the issue is resolved. In addition, there is a need to address the at risk problem in an interdisciplinary manner, including development or considered revisions to a BSP, increased supervision, training of staff, and reviewing and adapting the environment to meet the health and safety requirements of the individual. The focus should be that an event has occurred at CCSSLC that is not acceptable and dangerous to the individual. The team then should meet to determine how to treat and prevent its reoccurrence. This also would require a monitoring system to ensure steps	

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		are completed as agreed upon at the meeting. A Health Risk Assessment Rating Tool created 7/15/09 was attached to the at-risk list. It tallied into three levels the common conditions in the intellectual disability/ developmental disability (ID/DD) population. Focus was on polypharmacy, challenging behavior, injury, aspiration/choking, and weight. It also included a health risk assessment tool from the nursing department dated 8/31/09, which included such areas as cardiac, constipation, dehydration, diabetes, GI concerns, hypothermia, medical concerns (other), osteoporosis, respiratory, seizures, skin integrity, and urinary tract infection. Concerns with this system included the subjectivity of what each level of risk meant for any one clinical area. The departments needed guidance in this area. There was also concern that significant risk may be bypassed and given a lower rating. For instance, a person who had ingested inedible objects and may have had surgery to remove such items should be high risk for challenging behavior, but may be given a low rating for unclear reasons. An individual with multiple fractures in the past, with diagnosed osteoporosis, may be placed at a low rating if there had been no fracture in the past year, when the risk remains unchanged. There was also the concern of reducing the current safety steps being taken to reduce falls and fractures in someone with osteoporosis, which would make the individual more vulnerable to osteoporosis complications. The Facility submitted "Nutritional Management Team Minutes from Pacific Unit," dated March 30,2010. It outlined the reason for review and the results and follow up. Several individuals had a change in risk category. It was difficult to determine what criteria were used to change an individual's risk category. Some serious conditions and concerns were rated similar to those with chronic, but less urgent problems. For instance: ▪ Individual #245 was noted to be five pounds over weight range, and the risk level was increased from Level 2 - Medium to Level 1 - High. ▪ Individual #328 was 7.6 pounds below ideal weight range and from this brief report, appeared to be continuing to lose weight. He also was changed from Level 2 - Medium to Level 1 - High. However, the second individual was much more at risk for future negative health outcomes, yet both had been assigned equal levels of risk. Levels are intended to alert the team to potential serious outcomes in the near future, and indicate where teams should spend their time, energy and focus. If a risk is at Level 1, but is chronic or not causing immediate problems, the team will be spending time on this when a positive impact from their efforts would be more effective on someone with more urgent concerns. The health status of the latter would be expected to improve rapidly, but for an individual in the former category, with a chronic condition, the health	

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		status would not be expected to change over days or weeks, but over months to years. Additionally, from the minutes provided, there was no indication when the next meeting was to be held, whether monthly or quarterly, etc.	
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.	Another list created by CCSSLC was entitled "At risk Individuals: Individuals admitted to Emergency Room." It is recommended that any individual that goes to an ER or is hospitalized have a PST meeting to address any updated recommendations, new diagnoses, and any new information which would suggest a decline in health or functional status. This should occur independently of the need for an at-risk system, but should already be in place. The team should then develop the interventions, preventive aspects, as well as ongoing care issues that need urgent or immediate implementation. These plans and steps should be incorporated into the ISP. Measurable criteria would need to be developed to track progress to full implementation. These steps do not have to wait for full implementation of an approved at-risk plan, but should be a part of quality care already in existence. Another potential risk list is the "High Risks by Type – sorted alpha" dated 7/12/10. These are individuals already identified as having serious health and safety issues who need their PST to meet and develop integrated plans to minimize their risks and create measurable objectives, and monitoring criteria to ensure progress is made toward resolution of their risk factors. In this regard, the future at risk assessment and implementation system should be a quality improvement system based on seriousness of risk and changes in condition, and should be occurring for all individuals living at CCSSLC. The facility had developed several policies, including ▪ Policy: At Risk Individuals, implemented 10/5/09; ▪ At risk individuals: Health Status Team, implemented 12/26/09, and revised 6/18/10; ▪ At risk individuals: actions following health status team meeting, draft dated 6/18/10; and ▪ At risk individuals: High-risk oversight committee policy, revised as of 6/18/10. These policies begin to build essential steps for the system, but as of the monitoring team visit, had had little opportunity to be implemented.	Noncompliance

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

1. At-risk criteria need to be developed that:
    a. Are easy to interpret by a wide audience of participants;

b. Represent true and valid risks of the individual at that time;
c. Have a concrete and measurable component that guides teams as they determine when someone is placed on or taken off an at risk list;
d. Have sufficient specificity to detect the highest risk individual without creating so many false negatives that those deserving urgent attention are missed;
e. Have sufficient sensitivity to detect the highest risk individual without creating so many false positives that it dilutes efforts away from those who need it; and
f. Provide precise criteria so each unit across the Facility is using the same measurement system.

2. As appropriate, the State should consider identifying and implementing standardized tools to be used by all the Facilities in assessing and documenting clinical indicators of risk. These standardized tools should be selected based on their reliability and validity, as well as their ability to provide a weighted score, and meaningful clinical information to allow teams to identify objectively individuals' level of risk in the appropriate clinical areas.
3. In addition, there is a variety of information available from which to identify individuals who are potentially at risk, such as incident management data. The policies and procedures for a risk management system should draw together the various risk assessment instruments and procedures into one process that can reliably identify individuals whose health or well-being are at risk, and to address their needs.
4. The Facility should develop and implement interdisciplinary assessments of services and supports for the individuals identified as at risk, and in response to changes as measured by established at-risk criteria, according to the required timeframes set forth in the Settlement Agreement.
5. As required by the SA, for each individual assessed, the Facility should establish and implement a plan within fourteen days of the plan's finalization, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk. More immediate action should be taken when the risk to the individual warrants. Such plans should be integrated into the PSP, and should include the clinical indicators to be monitored and the frequency of monitoring.
6. The Health Status Team meeting format should be redesigned to ensure that appropriate criteria and structure are in place to assist the teams in accurately determining risk levels. The assignment of such risk levels should result in the teams identifying an associated level of intensity of clinical supports to address the risks, as well as proactive measures aimed at preventing risks.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Policies Related to the Use of Pre-Treatment Sedation Medication; o List of Individuals Prescribed Intra-Class Polypharmacy; o Schedule and Dates of All Psychiatric Treatment Reviews for the last year; o List of all Meetings and Rounds that are typically attended by the Psychiatrist including other professional disciplines that usually attend those meetings; o Blank copy of the Professional Service Log for Psychiatrists; o Psychiatric Evaluation Form; the o CCSSLC Quarterly Psychiatric Review Form; o CCSSLC Monthly Psychiatric Review Form; o List of CCSSLC Board Certified Psychiatrists, as of 6/15/10; o Curriculum Vitae of Ginari Price, M.D.; o List of Support Services for Psychiatry Department; o Minutes of Polypharmacy Reviews for the last six months; o Response to requests for a list/summary/documentation pertaining to/regarding complaints about the psychiatric and medical care at CCSSLC since 1/1/10 (Response: No complaints); o Current list of families/guardians that refused to authorize psychiatric treatments and/or medication recommendation. (Response: Currently there are no families/guardians that refused to authorize psychiatric treatment.); o Information requests for which no response list was provided: ▪ Availability of genetic testing; ▪ Health services team reports for five recently admitted individuals and seven additional individuals; ▪ A list of individuals with tardive dyskinesia; ▪ A description of current processes for evaluating mental health needs of individuals who receive pre-treatment sedation and monitoring data and/or reports addressing the use of a pre-treatment sedation medication; o Medical records for the following individuals: Individual #292, Individual #295, Individual #84, Individual #9, Individual #90, Individual #246, Individual #141, Individual #317, Individual #230, Individual #69, Individual #117, Individual #372, Individual #363, Individual #19), Individual #281, Individual #327, Individual #365, Individual #305, Individual #146, Individual #7, Individual #275, Individual #109, Individual #140, Individual #326, Individual #325, Individual #312, and Individual #26; o Policy for Prescribing Psychoactive Medication, revised 6/22/10; o List of all individuals prescribed psychotropic medication with diagnosis; o List of all individuals receiving anticonvulsant medication; o Psychiatric Services Consultation Request, including Psychiatric Services Response for the

	following individuals: Individual #300 (1/28/10); Individual #118 (4/12/10); Individual #9 (1/28/10); Individual #218 (4/5/10); Individual #19 (4/15/10); Individual #95 (4/5/10); Individual #186 (1/21/10); Individual #325 (4/5/10); o The Reiss Screen for the following individuals: Individual #36, Individual #4, Individual #367, Individual #200, Individual #356, Individual #182, Individual #228, Individual #201, Individual #266, Individual #270, Individual #57, Individual #340, Individual #232, Individual #68, Individual #274, Individual #4, Individual #287, Individual #208, Individual #375, Individual #132, Individual #181, Individual #299, Individual #134, Individual #242, Individual #303, Individual #104, and Individual #89; o Spreadsheet of Psychiatric Reiss Examinations with due date, and Delinquency Report for all CCSSLC individuals as of 7/14/10; o List of individuals reviewed during 7/14/10 Psychiatry Clinic, including medications and relevant laboratory data; o Challenging Behaviors Report on all individuals at CCSSLC as of 7/14/10; o CCSSLC Plan of Improvement, dated 5/17/10; o List of individuals receiving anticholinergic medication; o List of individuals prescribed benzodiazepines; o List of individuals since 7/1/09 who may have swallowed an inedible object; o Individual Psychiatric Consultations by Dr. Michael Hernandez for the following individuals: Individual #38 (5/28/10); Individual #26 (4/23/10); Individual #30 (3/5/10); Individual #186 (5/12/10); Individual #218 (4/6/10); Individual #326 (3/27/10); Individual #140 (3/26/10); Individual #275 (3/30/10); and Individual #105 (6/12/09); o List of high-risk individuals sorted by type, dated 7/12/10; o Completed MOSES Side Effect Scales during the last year for the following individuals: Individual #282, Individual #31, Individual #209, Individual #3, Individual #285, Individual #139, Individual #15, Individual #57, Individual #307, Individual #239, Individual #173, Individual #79, Individual #43, Individual #134, Individual #299, Individual #293; and o Completed DISCUS Evaluations during the last year for the following individuals: Individual #124, Individual #205, Individual #127, Individual #195, Individual #134 ▪ **Interviews with**: o Glynn Bogard, Psychiatric Assistant, 7/13/10; o Michelle P. Lora-Artega, RN, Psychiatric Nurse, 7/13/10; o Brinda Fuller, RN, Psychiatric Nurse, 7/13/10; o Joseph Ward, Psychiatric Assistant, 7/13/10; o Michael Hernandez, MD, Consulting Psychiatrist, 7/14/10; o Beverly Okin-Larkin, Systems Analyst, 7/14/10; o Robert Cramer, Psy.D, Chief of Psychology Services, 7/14/10; o Shellee Scott, Nursing Operations Officer, 7/14/10; o Colleen Gonzales, Chief Nurse Executive, 7/14/10; o Elena Menchaca Unified Records Coordinator, 7/14/10;

	○ Sandya Suri, R.Ph., Director of Pharmacy Services, 7/15/10; ○ Mina Nguyen, Clinical Pharmacist, 7/15/10; ○ Sandra Rodriguez, MD Medical Director, 7/15/10; ○ Various staff on living units ▪ **Observations of**: ○ Psychiatric Clinic on Kingfish Living Unit, on 7/14/10; ○ Health Status Review Meeting on Ribbonfish Living Unit, on 7/15/10; and ○ Observations of the following individuals: Individual #30, Individual #359, Individual #109, Individual #295, Individual #66, Individual #233, Individual #118, Individual #289, Individual #368, Individual #275, 140, Individual #326, Individual #236, Individual #77, Individual #146, Individual #196, Individual #154, Individual #290, Individual #278, Individual #2, Individual #21, Individual #316, Individual #176, Individual #292, Individual #19, Individual #211, Individual #86, Individual #333, Individual #315, Individual #75, Individual #273, Individual #155, Individual #65, Individual #38, Individual #42, Individual #202, Individual #371, Individual #263, Individual #213, Individual #208, Individual #119, Individual #234, Individual #76, Individual #165, Individual #184, Individual #235, Individual #186, Individual #172, Individual #218, Individual #255, Individual #158, and Individual #114
	Facility Self-Assessment: The Facility Self-Assessment, as reflected in the CCSSLC Plan of Improvement, dated 5/17/10, acknowledged the deficiencies related to the Facility's lack of a sufficient number of staff psychiatrists. The records review described in the CCSSLC Plan of Improvement were described as meeting many of the provisions of the Settlement Agreement related to the provision of Psychiatric Services. Those findings are significantly different from those described in the Monitoring Report that follows. Although it was not possible to determine the reason for this discrepancy because the POI did not provide a description of the steps the Facility took to assess compliance, it was most likely related to the Facility's focus on whether documentation related to psychiatric services was either present or absent in the records, whereas the Monitoring Team's review not only assessed for the presence of the documentation, but also whether or not that material met the quality standards set forth in the Settlement Agreement. As the State works with the Facilities to add a description of the self-assessment process, the Monitoring Team will better be able to identify the reasons for such discrepancies to assist CCSSLC in developing an accurate self-assessment process. The Monthly Multi-disciplinary Team that had been established to address issues related to polypharmacy was an important addition to the process of self-assessment at the CCSSLC. The minutes of these monthly meetings contained a section that addressed the status of the Psychiatry Department's efforts toward meeting the provisions of the Settlement Agreement.
	Summary of Monitor's Assessment: There was not adequate psychiatric staffing to provide for the needs of the individuals at the Facility. The Facility was engaging in a number of activities to bring the staffing to

	acceptable levels. However, at the time of the review, CCSSLC employed two part-time psychiatrists to provide psychiatric services to the 150 individuals who were prescribed psychotropic medications. One of the two psychiatrists who had spent approximately 16 hours per month preparing Psychiatric Assessments was expected to be leaving in the near future. This will leave the Facility with the 12 hours per week provided by a consulting psychiatrist. Eight hours of his time was devoted to the Monthly Psychiatric Clinics and four hours to consultations, meetings with families, and other ancillary functions. The Psychiatry Department had two full-time Psychiatry Nurses, as well as two full-time Psychiatry Assistants. The support provided by these professionals had provided the structure required to ensure that the Psychiatric Clinics took place on a monthly basis and that the psychiatrist saw each individual on a quarterly basis. These professionals had also overseen the administration of the MOSES/DISCUS side effect monitoring, as well as the administration of the Reiss screening instrument. The analysis of the medical records of individuals served by CCSSLC identified three fundamental problems, including: 1. The identification of the specific symptoms that support the psychiatric diagnosis was absent. 2. In every record, the behaviors that were described as "targets" of the psychotropic medication were also referred to in the Behavior Plan and Functional Analysis as being present on a learned-operant basis and/or a response to environmental factors. 3. There was a lack of documentation to confirm that the psychotropic medication had been useful in reducing the frequency and severity of the behaviors they were prescribed to address. CCSSLC had implemented a monthly meeting to address polypharmacy with psychotropic medication. The minutes of these meetings also tracked the progress of the Psychiatry Department in meeting the provisions of the Settlement Agreement. There had been a great deal of progress in meeting the requirements of the Settlement Agreement related to the periodic assessment of the MOSES/DISCUS side effect monitoring instruments and the administration of the Reiss Screen to individuals who were not currently receiving psychotropic medication.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	Dr. Michael Hernandez, Consulting Psychiatrist, was Board Certified in Adult Psychiatry by the American Board of Psychiatry and Neurology. During the interview, which took place on 7/14/10 in the Psychiatry Services office, he indicated that in addition to his consultation at CCSSLC, he also provided psychiatric services to individuals with intellectual disabilities/developmental disabilities (ID/DD) through his private practice and through a community provider of residential services. In addition, he evaluated and treated outpatients with ID/DD through a local community mental health clinic.	Substantial Compliance

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		The Consulting Psychiatrist estimated that he had engaged in providing psychiatric services to individuals with ID/DD for five years. He had been a psychiatric consultant to CCSSLC for approximately three years. Thus, in addition to being Board Certified in Adult Psychiatry, he also had substantial clinical experience in working with individuals with ID/DD and their unique needs. The Facility also had contracted with Ginari Price, M.D. Her curriculum vitae indicated that she was in the second year of her Child and Adolescent Psychiatry Fellowship at the Baylor College of Medicine in Houston, Texas. Dr. Price's psychiatric consultation consisted of approximately 16 hours per month, which was devoted to performing psychiatric evaluations at CCSSLC over one weekend per month. At the time of the review, it was anticipated that she soon would be completing her Child Psychiatry Fellowship, and did not plan to continue as a consultant to the Facility in the future. As is discussed in further detail below with regard to Section J.5 of the SA, although both consulting psychiatrists were qualified to provide services to individuals with co-existing mental health concerns and ID/DD, the limited number of hours they were available to the Facility significantly impacted the quality of services provided. The Facility was making efforts to identify additional psychiatric coverage. As additional psychiatrists are engaged by the Facility, the Monitoring Team will review and evaluate their credentials.	
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	The Consulting Psychiatrist's time commitment to the CCSSLC consisted of three four-hour blocks of time per week. He was present at the Facility for four hours on Tuesday and Wednesday mornings, and it was during these time periods that the Psychiatry Clinics took place. The third block of time that he was at present at CCSSLC was on Friday afternoons. This time was allocated to psychiatric consultations, meetings with families/guardians as needed, and responding to urgent requests for psychiatric follow-up outside of the Psychiatry Clinics. Two Psychiatric Nurses, as well as two Psychiatric Assistants supported the Consulting Psychiatrist. The Clinical Nurses and Psychologists on the residential units also worked with the staff of the Psychiatry Services Office to schedule the Psychiatry Clinics and the direct observations of individuals by the Consulting Psychiatrist. The goal of the Psychiatry Department at CCSSLC was to have every individual prescribed psychotropic medication reviewed on a monthly basis; and directly observed by the Consulting Psychiatrist on a quarterly basis. The administrative support described above enabled the Consulting Psychiatrist to achieve this goal. The review of the individual records of 18 percent of the individuals who were receiving psychotropic	Noncompliance

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		medication (methodology is described below with regard to Section J.13 of the SA) indicated that the completion of a monthly review in the Psychiatry Clinic was documented for all of the individual records reviews. The corresponding goal to observe every individual at least quarterly was also attained for all of the individual records reviewed. The review of this sample also indicated that there was a current Psychiatric Evaluation (within the last 12 to 18 months) for all but the following individuals: Individual #90, Individual #109, Individual #158, and Individual #325. Thus, a current Psychiatric Evaluation was located for 23 of the 27 records reviewed (85%). This provision of the Settlement includes the qualification that the evaluation and diagnostic process will be conducted "in a clinically justifiable manner." Although the frequency of the reviews and observations was appropriate, the process, in and of itself, was not capable of producing the thorough psychiatric evaluation and diagnostic process that is referenced in the Settlement Agreement. The current format for the Psychiatry Clinics provided a mechanism for week-to-week management of psychotropic medication, but did not meet the standards set forth in the Settlement Agreement. Specific departures from the process described in the Settlement Agreement included: ▪ There was a lack of the identification of the specific symptoms to support the *DSM-IV-TR* Axis I and Axis II diagnoses. ▪ There was no documentation as to how the identified target behavior (usually aggression and/or agitation) was derived from and related to the identified psychiatric diagnosis for which the medication was prescribed. ▪ The behaviors that were identified as "targets" of the psychotropic medication were also described in the Functional Analysis and Behavior Support Plan as being present on a learned or operant basis. ▪ The psychiatric evaluation process operated in a parallel manner to the monthly and quarterly psychiatric review process, and not in an integrated manner. This was most likely secondary to the observation that the psychiatrist who was available for weekend consultation had performed a significant number of the Psychiatric Evaluations, whereas the Consulting Psychiatrist managed the monthly Psychiatric Clinics on Wednesdays and Thursdays. Thus, there was little opportunity for joint review of the individuals. It was noteworthy that the Psychiatry support staff, working in conjunction with the two part-time psychiatrists, had been able to develop the infrastructure that enabled them to complete the reviews on a schedule that was compatible with the timelines identified in the Settlement Agreement. Implementation of changes to the psychiatric evaluation format to address the deficiencies identified above should make it possible to move the process closer to compliance with the specific terms of the Settlement Agreement related to the quality of the evaluations and assessments.	

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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.	There was no indication that psychotropic medication was utilized at CCSSLC as a punishment, or for the convenience of the staff. All of the individuals who received psychotropic medication had a treatment program and one or more psychiatric diagnoses. However, as will be discussed in more detail below with regard to Section J.13 as well as Section K of the SA, psychotropic medication was utilized for individuals whose behavioral programs were not adequate, and in many cases, the psychiatric diagnosis on record was not supported by adequate documentation in the clinical record with regard to the symptoms that supported the diagnosis. In addition, the behaviors that were monitored to assess the efficacy of the psychotropic medications were also referred to in the Functional Assessment and Behavior Support Plans as being present on a learned basis, as a reaction to demand situations and/or are related to environmental factors. As a result, psychotropic medication was being used in the absence of an adequately justified psychiatric diagnosis, and potentially as a substitute for adequate treatment.	Noncompliance
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.	During an interview on 7/14/10, the Director of Behavioral Services at CCSSLC, indicated that the Psychology Department was only in the preliminary stages of developing desensitization and other behavioral strategies to minimize or eliminate the need for pre-treatment sedation. According to staff, at the time of the review, adequate plans did not yet exist for individuals prescribed pre-treatment sedations for routine medical or dental care. In reviewing records, no such plans were identified. With regard to the coordination between psychiatry, pharmacy, and medical, there was no documentation that the Psychiatry Department had provided input into the development of the protocols for the use of psychotropic medication as pre-treatment sedation, nor was the Pharmacy Department formally involved in the development of these orders. However, if a physician ordered a pre-treatment medication that presented a risk of an interaction with an existing routine medication, the automated software would alert the Pharmacy to this potential interaction when the order was entered. The Pharmacist would then alert the physician. The review of individual records (methodology described below with regard to Section J.13 of the SA) identified documentation of "Sedation Care Plans" for the following individuals: ▪ Individual #84 (Ativan 2mg and Atarax 200 mg); ▪ Individual #90 (Ativan 2mg); ▪ Individual #343 (Ativan 2mg and Atarax 200mg); ▪ Individual #141 (Ativan 2mg and Atarax 100mg); ▪ Individual #69 (Ativan 2mg); and ▪ Individual #372 (Ativan 1mg).	Noncompliance

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		Based on this small sample, it appeared that the most common medications utilized for pre-treatment sedation prior to medical appointments at CCSSLC were the benzodiazepine medication Ativan [dosage range of 0.5 milligram (mg) to 2 mg], and the antihistamine agent Atarax (dosage range of 100mg to 200mg). In the sample, the two agents were also frequently used together. The pre-treatment sedation protocols for these individuals provided general guidance. The Sedation Care Plans identified the date and time of the appointment, the time the medication was administered, the vital signs before the medication was administered, the vital signs when the individual returned to the home, and documentation of whether the individual was awake, drowsy, asleep, or unarousable/lethargic for the following four hours. The Licensed Vocational Nurse (LVN) signed the vital sign documentation. A direct support professional who was responsible for monitoring the individual post-sedations signed to verify that they had reviewed the plan. The signature of the "RN initiating care plan" was also present. The "DCP [Direct Care Professional] Care Instructions" that were uniform on all of the "Sedation Care Plans" appeared adequate and were as follows: *"DCP CARE INSTRUCTIONS* 1. *If sleepy place in bed for 1-2 hours and allow to rest* 2. *Use wheelchair or assist with ambulation until individual has recovered from sedation* 3. *Do not feed when client is drowsy* 4. *When in bed be sure head of bed is elevated at all times* 5. *Notify nursing if client is un-arousable/lethargic/nonresponsive* 6. *For the first 4 hours monitor for respirations, skin color, rash/hives to skin and report immediately* 7. *If client eats PO [by mouth] monitor for any coughing with fluids/food and hold. Notify nursing for further orders."*	
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	The baseline review of psychiatric services at CCSSLC indicated that two full-time psychiatrists (or the equivalent amount of Consulting Psychiatrists) would be required to adequately evaluate and provide psychiatric services to the individuals who reside there. This would equate to a caseload of approximately 75 individuals for each Psychiatrist. Many of the individuals who reside at the CCSSLC present with complex psychiatric disorders, and the current utilization rates of multiple psychotropic agents for numerous individuals would suggest that this is a reasonable estimate.	Noncompliance

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	necessary for implementation of this section of the Agreement.	At the time of the review, the Facility had relied on Dr. Michael Hernandez, Consulting Psychiatrist to provide the day-to-day psychiatric care to all of the 150 individuals who were receiving psychotropic medication. His allotment of time was four three-hour blocks per week. The Consulting Psychiatrist was currently available for 12 hours per week, which was slightly more than 25 percent of one full-time equivalent psychiatrist. Dr. Ginari Price had been providing approximately 16 hours of consultation time over one weekend per month, which had been primarily devoted to performing individual psychiatric evaluations. Dr. Price was completing her Child Psychiatry Fellowship at the Baylor College of Medicine, and was planning to end her consultation arrangement with the CCSSLC. As a result, the Facility would be relying solely on the Consulting Psychiatrist's 12 hours per week allotment of time. During the interview with the Facility's Medical Director, on 7/15/10, she described the efforts that CCSSLC had undertaken to recruit additional psychiatrists, which has included an increase in salary, networking with local physicians, and advertising in national publications, such as the *Psychiatric Times*, and *Career Builders*. Thus, the facility administration was making an active, sustained effort to address this deficiency.	
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.	As noted above, two psychiatrists who worked on a contractual basis provided the psychiatry services at CCSSLC. The primary contact that the psychiatrist had with the individuals and their teams took place in the context of the monthly Psychiatric Clinics. Each individual on psychotropic medications was reviewed monthly, and directly observed by the psychiatrist every three months. The monthly meetings, including the quarterly observations, occurred as scheduled. This was evident in each of the records reviewed in both a random and non-random sample. The Psychiatry Nurses, Psychiatry Assistants, and the living unit nursing staff, working in conjunction with the members of the psychology staff, contributed to the successful execution of this schedule of Psychiatric Clinic reviews. Current Psychiatric Assessments were identified in 23 of the 27 records reviewed (85%). However, the psychiatric assessments that had been completed did not meet the requirements of the Settlement Agreement. Deficiencies related to both the documentation of the Psychiatry Clinics and the Psychiatric Assessments are described in more detail below with regard to Section J.13 of the SA. The missing documentation included the identification of the symptoms that support the psychiatric diagnosis; the information that would link the monitored behavior, such as aggression, agitation, and/or self-injurious behavior, to the psychiatric diagnosis of record; and empirical data that would substantiate that the psychotropic medication had been effective. The latter point is important, in that this information is necessary in documenting that the benefits of the medication(s) outweigh the risk that they present, based on their side effect	Noncompliance

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		profile(s).	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	The CCSSLC Psychiatry Department implemented their first series of Reiss Screens in August 2009. This process involved the screening of individuals who were not receiving psychotropic medication. According to staff, the protocols were then processed through the appropriate software program, and the individuals who were identified as requiring a Psychiatric Evaluation were referred to the Consulting Psychiatrist for a consultation. The second annual round of implementation of the Reiss Screen had recently begun. At the time of the review, the census of CCSSLC was 295. Psychotropic medication was being administered to 150 of these individuals; and as part of the process, each one should have had a Psychiatric Evaluation. This would mean that 145 individuals should have been administered the Reiss Screen. A spreadsheet entitled the "CCSSLC: Psychiatric Reiss Exams – due dates and Delinquency Report," dated 7/14/10, indicated that a total of 144 individuals were administered the Reiss Screen in 2009 and 2010. The spreadsheet data provided would suggest that the Facility had (or was close to) meeting this requirement. However, during on-site review, copies of all of the most recent Reiss Screens were requested, as well as copies of the consultations that had been performed for those individuals whose scores were high enough to prompt a Psychiatric Evaluation. In response to this request, the Psychiatry staff produced the Reiss Screen for Maladaptive Behaviors – Version 1.1 (1988) pertaining to individuals whose scores were below the cut-off point that would necessitate a Psychiatry Evaluation. They were provided for the following 20 individuals: Individual #242 (7/5/10); Individual #303 (8/12/09); Individual #104 (8/12/09); Individual #134 (8/12/09); Individual #299 (8/12/09); Individual #181 (8/12/09); Individual #132 (8/11/09); Individual #375 (8/11/09); Individual #89 (8/24/09); Individual #287 (7/7/10); Individual #4 (8/10/09); Individual #274 (8/10/09); Individual #68 (8/12/09); Individual #232 (8/11/09); Individual #340 (8/11/09); Individual #57 (8/19/09); Individual #270 (8/11/09); Individual #266 (8/11/09); Individual #201 (8/11/09); and Individual #36 (8/11/09). A copy of a completed Reiss Screen for Maladaptive Behaviors was available for the following additional seven individuals, but there was no date of administration listed: Individual #182; Individual #356; Individual #200; Individual #367; Individual #208; Individual #228; and Individual #193. The Psychiatric Evaluation performed by the Consulting Psychiatrist dated 9/18/09, concerning Individual #193, indicated that the reason for the evaluation was "elevation of maladaptive behavior per Reiss Screen on 7/4/09." Although a copy of that particular Reiss Screen was not provided, but a more recent one dated 7/5/10, was present. This	Noncompliance

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		was the only example of a Psychiatric Evaluation being performed for an elevated score on a Reiss examination that was provided for review. The request for a copy of the Reiss Screen for all individuals who had one performed in the last year yielded the documents described above. This documentation was not consistent with the "CCSSLC: Psychiatric Reiss Exams – due dates and Delinquency Report" dated 7/14/10. As noted above, this document indicated that a total of 144 individuals were administered the Reiss Screen in 2009 and 2010. It is unclear if the discrepancy between the number of Reiss Screens presented, versus the number identified as being completed in the 7/11/10 spreadsheet, was due to a misunderstanding about the documentation requested or an inability to locate the copies of the actual Reiss Screens. This subject will be revisited at the time of the next monitoring review. However, based on the lack of documentation provided in response to the Monitoring Team's request, a finding of noncompliance has been made.	
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 Consulting Psychiatrist worked closely with the members of the Psychology Department. This was especially evident at the 7/14/10 Psychiatric Clinic. The Psychologist who was responsible for the individual being reviewed led the presentation of the individual and discussed the behavioral data for the month. It was clear that the Consulting Psychiatrist relied upon this information when making decisions regarding the use of psychotropic medication, and when implementing changes to an individual's pharmacological regimen. During the tour of the individual living units, it was also clear that the Psychologist responsible for the individuals who were observed was familiar with the individuals' psychotropic medication, as well as their Behavioral Plan. Within the sample of individual records reviewed, it was evident that each individual who was prescribed psychotropic medication had an active, positive Behavioral Support Plan. More information regarding the quality of the BSPs is provided below with regard to Section K of the SA. The areas in which there were deficiencies in the integration of psychiatric services and psychological services were as follows: ▪ In all of the 27 records reviewed, the symptoms that were described as being "targets" of psychotropic medication were also described in the functional analysis as being present on an operant basis, or a response to a demand situation, representing an escape behavior, or being related to environmental and/or stressful events. It is conceivable that the symptoms of a psychiatric disorder could be affected by these factors, but the documentation necessary to support such a connection was not present. For example: o The Psychiatric Clinic notes indicated that Individual #292 was	Noncompliance

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		prescribed Zyprexa for a diagnosis of Intermittent Explosive Disorder, but the 11/09 Behavior Support Plan indicated that the Zyprexa was prescribed for "aggression" (page 11). The BSP also later stated: "[Individual #292] is prescribed psychoactive medication to assist in reducing his aggression. In addition, it appears help [Individual #292] to manage his obsessive thoughts and actions" (page 12). Page 4 of this document described the determinants of his aggressive behavior as "a means to gain attention and/or avoid boredom," and "to protect what he perceives as his boundaries". Thus aggression was identified as the target behavior of the Zyprexa while the BSP clearly described the behavioral determinants of the aggressive behavior. It also should be noted that this individual was prescribed Lexapro for a diagnosis of Major Depressive Disorder, and Ativan for a diagnosis of Generalized Anxiety Disorder, but no symptoms of these Psychiatric Diagnoses appeared in the record, and the only overt behavior that was monitored on an ongoing basis was the frequency of aggression and the need for protective interventions related to the occurrence of aggression. o Another example was found in the documentation related to Individual #363. The most recent Psychiatric Clinic notes listed his Psychiatric Diagnosis as "Personality Change due to Encephalitis and Generalized Anxiety Disorder." He was prescribed three psychotropic medications: Ativan for "Personality change/Anxiety," Zyprexa for Personality Change/Agitation," and Tenex for "Personality Change." The Psychiatric Evaluation dated 4/5/09 noted the same Axis I psychiatric diagnosis, but notes in the Treatment Plan stated to "continue Zyprexa 20 mg bid to decrease impulsivity and aggressivity associated with mental retardation," and "continue Lorazepam 1 mg po tid to reduce symptoms of anxiety and agitation." The HRC Review of the BSP dated September 2009 described the "Justification" for the use of psychotropic medication as Individual # 363 "will bite others when angry. The biting often breaks the skin and may result in a potentially serious injury. The medication helps control his anger resulting in fewer episodes of aggression." The BSP dated 9/23/09 stated: "Aggression is an expression of anger. Anger often stems from being redirected from a desired monitored behavior." The other monitored behavior was "Bolting," which "usually occurs when he desires something, such as coffee and less often when he may desire choices." The data charts that list the Psychotropic Medications and dosages indicated that Aggression and Bolting are the monitored behaviors whose frequency is used to assess the efficacy of the Psychotropic medications. Thus it would appear that the Psychotropic medication was primarily being used to	

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		suppress behaviors that were described as being present due to situational factors. It also should be noted that the current dose of Zyprexa was 20 mg bid, which is twice the upper limit of the FDA recommended dosage range of 0 to 20 mg per day. These examples are representative of the documentation found throughout the records that comprised the review sample. ▪ The available documentation indicated that the psychotropic assessment process and the psychological assessment process were operating in a parallel manner and were not integrated. ▪ The documentation also gave the impression that the psychotropic medication was being prescribed to treat "target behaviors" such as "aggression," "agitation," and "self-injurious behavior (SIB)," rather than the symptoms of an identified psychiatric disorder. The integration of psychiatric services with psychological services at CCSSLC could be improved by integrating the Treatment Plans for the use of psychotropic medications with the Behavioral Support Plan, so that it is clear which of the identified behaviors are directly related to a symptom of the identified psychiatric disorder, as opposed to being related to behavioral or environmental etiologies. In those cases where the identified behavior is thought to be determined by both biological and psychological processes, this should be clarified.	
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-	This provision of the SA describes a collaborative process through which "the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition." There was no documentation in the records reviewed that this collaborative process was occurring at the CCSSLC. The Psychiatry Clinics were attended by multiple disciplines, including the primary care physician (PCP), nursing staff, direct support professionals, psychology staff, and QMRPs. The composition of the disciplines that was in attendance at the Psychiatry Clinics would qualify as an IDT. The topic of the discussions at these Clinics was primarily focused on the effects of prescribed medications, as determined by the frequency of the monitored target behaviors, which were presented by the psychologist. The discussion also included the subjective impressions of other team members, as well as a description of any medication side effects by the nursing staff. There was very little discussion of alternate treatment approaches, other than those related to the psychotropic medications, although there was discussion of environmental factors and/or changes in physical status that might be affecting the frequency of the monitored behavior adversely. The Consulting Psychiatrist clearly took this information into account when making decisions.	Noncompliance

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	pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible.	There was no evidence in the records reviewed that there was an interdisciplinary, integrated process to determine if psychotropic medication was the "least intrusive" approach to the individual's presentation before the pharmacological approach was chosen over a less intrusive behavioral approach. Likely due to staffing issues, psychiatrists did not attend individual planning meetings during which it would be expected that this discussion also would occur. The discussion above (see information related to Section J8 of the SA) regarding the lack of integration of psychiatric and psychological services is also relevant to this provision, as is the discussion in section below related to Section J.13 of the SA.	
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 the medications.	This provision discusses the importance of carefully assessing the risk of the utilization of specific psychotropic agents against the risks posed by the side effects of those medications. For individuals at CCSSLC, the primary documentation of this process appeared in the Human Rights section of the record. For none of the records reviewed was an adequate risk-benefit analysis completed. More specifically, the documentation consisted of only limited terminology to the effect that the benefits of the medication outweighed the risks and then a listing of the most commonly known side effects of the medication, without any indication of the likelihood of these side effects occurring, based on the published literature, or any discussion regarding the likelihood that the medications would reduce significantly the recurrence of the behavior (i.e., the expected effectiveness of the medication). There also was no discussion about whether the medication was expected to have any higher level of success than other less risky or intrusive options (i.e., effectiveness of alternative strategies). An example, which was randomly selected from the sample, is the following excerpt from the HRC Review of the BSP for Individual #90, dated 9/16/09: *Program description (to include restrictive/intrusive components): BSP to address aggression and inappropriate sexual behavior. He has a restriction from going places in the community in which children frequent or having items that involve children such as pictures. He also takes psychotropic medications: Zoloft 100 mg am and Risperdal 3 mg daily.* *<u>Possible Side Effects</u>:* ▪ *Risperdal: (Risperidone)* *Constipation; coughing; diarrhea; drowsiness; dryness of mouth;*	Noncompliance

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		headache; heartburn; increased dream activity; increased length of sleep; nausea; sore throat; stuffy or runny nose; unusual tiredness or weakness; weight gain ▪ *Zoloft: (Sertraline)* *Decreased appetite or weight loss; diarrhea or loose stools; dizziness; drowsiness; dryness of mouth; headache; increased sweating; nausea; stomach or abdominal cramps, gas, or pain; tiredness or weakness; trembling or shaking; trouble in sleeping* *<u>Less intrusive approaches previously attempted</u>:* *Counseling, redirection, positive reinforcement, and replacement behavior training.* *<u>Risk vs. Risk Analysis</u>:* *The risk of him not taking his medications would be aggression that could lead to injuries to himself and others. There is also the serious risk of him sexually abusing others. The risks of taking the medications are the possible side effects. The PST feels that the risks of not taking his medication and having the restriction about children, outweighs the risks of the side effects.* *<u>Plan to remove restriction/Intrusive component</u>:* *His response to his BSP will be evaluated monthly in the progress note. By 9/10/10, he will be able to identify at least three appropriate ways to address things that are bothering him, four out of four trials per week for six consecutive months. By 9/10/10, he will be able to identify at least one appropriate alternative to inappropriate sexual impulses, once per week for in 4 out of 4 trials per month for 12 consecutive months. Medications will be reviewed/evaluated at least monthly in psychiatric clinic. Any recommendations, changes additions or discontinuations will be made at that time.* This example is actually somewhat more detailed than others, as it alludes to the specific risk of sexual harm to others. The information that was missing related to how the Risperdal and/or the Zoloft would decrease the risk "aggression that could lead to injuries to himself and others" or "the serious risk of him sexually abusing others." There	

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		was also no discussion of the data that this risk had been (or is likely to be) reduced either in quantitative or qualitative terms.	
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.	The CCSSLC had developed a Polypharmacy Committee that met monthly to review those individuals whose psychotropic medication profiles were consistent with the definitions of polypharmacy. The meeting was referred to as the Monthly Psychiatric Services Review (PSR). Minutes of these meetings were available for the last six months with the most recent meeting having occurred on 5/28/10. The following excerpt from those minutes lists the individuals who would typically attend this meeting: *Date of Meeting:* *5/28/20* *Primary Facilitator(s):* *Glynn J. Bogard, psychiatric assistant* *Participants:* *Dr. Hernandez, psychiatrist* *Joe Ward, psychiatric assistant;* *Dr. Thompson, clinical psychologist* *Dr. Nguyen, clinical pharmacist* *Michelle Arteaga, psychiatric RN* *Nelda Gonzales, QMRP Coordinator* *Dr. Brown, MD, PCP* The meeting minutes of the meetings were prepared by one of the Psychiatric Assistants, and consisted of approximately six single-spaced pages. It was clear from these documents that detailed, case-based discussions took place during the meetings. The final section of the minutes also contained a review of the Psychiatry Department's efforts and current progress with regard to meeting the provisions of the Settlement Agreement related to polypharmacy. The identified goal of this process was to ensure that "medications that are not clinically justified are eliminated." The clinical justification of the use of multiple medications for the individuals who reside at the CCSSLC will be difficult to document without fundamental changes in the existing data collection systems that are described below with regard to Section J.13 of the SA. The development of this Committee and the documentation provided by the minutes represent important steps in meeting the requirements of this provision. The Psychiatry Department had extensive information regarding the use of polypharmacy at the CCSSLC. The spreadsheet of individuals receiving psychotropic medication dated 6/24/10 indicated that 61 individuals (40% of those on psychotropic medication) were receiving one or two psychotropic medications. Fifty-one individuals (34%) were prescribed three psychotropic medications. The distribution of the number of individuals receiving more than three psychotropic medications was: four	Noncompliance

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		psychotropics =20 individuals (13%); five psychotropics = 11 individuals (7%); six psychotropics = seven individuals; and eight psychotropics = one individual. It would be useful if the minutes of these Meetings also contained similar statistical data for the CCSSLC population, so that the actual progress in reducing polypharmacy can be visually tracked on a monthly basis. Over time, the accumulation of this data will enable them to document the progress toward meeting this provision of the Settlement Agreement.	
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.	The individual records reviewed contained evidence that the Monitoring of Side Effects Scale (MOSES) was being done as specified. The MOSES was performed on a quarterly basis for individuals receiving psychotropic medication. A psychiatric nurse administered these evaluations. To assess for compliance, a sample was selected of 27 individuals, or 18 percent of the individuals at CCSSLC who were receiving psychotropic medication at the time of the Monitoring Team's on-site review of the Facility. The composition of the sample population is described in detail later in this report with regard to Section J.13 of the SA. A review of the medical records for those individuals yielded documentation that a MOSES evaluation had been performed on a quarterly basis over the last year, and was current for all but the following individuals: Individual #225 (quarterly for the last year, but not current because the most recent evaluation was on 3/29/10), Individual #90 (current and quarterly for the last year with the exception of five month gap between 12/17/09, and 5/26/10), and Individual #275 (the only evaluations in the record for the last year were dated 1/11/10 and 1/15/10). Therefore, 89 percent of the sample met this provision of the Settlement Agreement. The MOSES was also performed at the CCSSLC for individuals who were receiving anticonvulsant medication for a seizure disorder and who were not receiving additional psychotropic medications. This distinction is relevant, as a member the nursing staff from the individuals' residential units administered the MOSES Scale for these individuals, rather than a Psychiatric Nurse. The sample population for this analysis was developed by obtaining a master list of all individuals who were receiving anticonvulsant medications. This list was then correlated with the list of individuals who are receiving psychotropic medication, so that these individuals could be deleted from the master list. This process yielded a list of individuals who were receiving anticonvulsant medication for a seizure disorder, and not for mood stabilization or other psychiatric purposes. The MOSES evaluations for the last year were then requested for 20% (every fifth individual) of this population. The process yielded a total of 22 individuals. The CCSSLC response to the request for this information indicated that the documentation could not be provided for one individual, as their living unit was under quarantine for medical reasons, and that a power outage made it impossible to locate the documentation for another individual. Completed quarterly MOSES evaluations for the last year were documented for 15 of the remaining 20 individuals (75%).	Substantial Compliance

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		A psychiatric nurse also administered the Dyskinesia Identification System: Condensed User Scale (DISCUS) on a quarterly basis by a Psychiatric Nurse for the individuals who received antipsychotic medication. The sample of 27 individuals, or 18% of individuals who receive psychotropic medication indicated that documentation of current and quarterly evaluations for the last year could be identified for the entire sample, except individuals Individual #225 (quarterly for the last year, but not current because most recent evaluation 3/29/10), Individual #90 (current and quarterly for the last year with the exception of the five month gap between 12/17/09 and 5/26/10), and Individual #275 (the only evaluations in the record for the last year were dated 1/11/10 and 1/15/10). Therefore, 89% of the sample met these criteria. The DISCUS was also performed at CCSSLC for those individuals who were receiving Reglan. The rationale for this was that although Reglan was used to treat severe gastroesophageal reflux disease (GERD), it has dopamine-blocking properties that are similar to those of some of the antipsychotic agents and also can produce extrapyramidal motor side effects. The Clinical Nurses on the residential units performed the DISCUS for these individuals. The sample for this analysis was constructed by obtaining a list of all individuals who were prescribed Reglan from the pharmacy. The individuals who also received psychotropic medication were deleted, and a copy of the DISCUS for the last year was requested for every third name (33%). This process produced a total of six individuals. The documentation that was provided by the CCSSLC in response to this request indicated that the DISCUS had been completed quarterly, and was current for five of the six individuals identified (83%).	
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	This provision of the Settlement Agreement addresses three significant and inter-related factors that are central to the appropriate use of psychotropic medication for individuals with ID/DD. These factors are: 1) documentation of the validity of the psychiatric diagnosis; 2) the relationship of that diagnosis to the behaviors that are identified as targets of the psychotropic medication; and 3) the objective documentation that the medication has been effective for the disorder for which it was prescribed. In order to assess these factors, a random sample (10%) of individuals was selected by identifying every tenth individual receiving psychotropic medication. This sample comprised the following 15 individuals: Individual #69, Individual #117, Individual #372, Individual #363, Individual #292, Individual #225, Individual #84, Individual #9, Individual #246, Individual #343, Individual #141, Individual #317, Individual #230, Individual #90, and Individual #19. The psychiatric section of the record for Individual #19 was missing from the documentation provided, thus, this record was excluded from the analysis. An additional sample of 15 individuals was requested. This sample was not random, as the selection was based on factors such as: number of psychotropic medications	Noncompliance

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	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.	received, psychiatric profile, and/or their risk profile. The individuals selected on this basis were: Individual #365, Individual #105, Individual #146, Individual #7, Individual #275, Individual #140, Individual #326, Individual #325, Individual #312, Individual #26, Individual #109, Individual #158, Individual #325, Individual #281, and Individual #327. The records of individuals Individual #281 and Individual #327 were excluded from the final review sample, as they were incomplete and therefore not suitable for review. This resulted in a total sample of 27 individuals. The sections of the records for the above individuals that were requested are as follows: ▪ Social History; ▪ Annual Physical and Problem List; ▪ Psychiatry Section; ▪ Positive Behavioral Support Plan and Progress Notes; ▪ Positive Behavioral Support Plan and Addendum (if present); ▪ Human Rights Section; ▪ Consents for Psychotropic Medication; ▪ Client Injury Reports (for last 4 months); ▪ Neurology Consultations; ▪ Quarterly Drug Regimen Reviews (Pharm.D.); ▪ MOSES/DISCUS Evaluations (for the last year); ▪ Sedation Care Plans; ▪ Medication Administration Records; and ▪ Psychiatry Clinic Consultation Flow Sheets (kept separate from the record). A description of the specific symptoms, which support and document the diagnosis of a DSM-IV-TR Axis I Psychiatric Disorder, could not be located in any of the records contained in this sample. The information was not available in either the Psychiatric Assessments or the Psychiatry Clinic Notes. This deficiency could be addressed by adding a section in the Psychiatry Evaluations that specifically lists the identified symptoms that support the psychiatric diagnosis. This information could then be carried forward in the Psychiatry Clinic Notes and amended as changes occur. There were documents in the records of Individual #225, Individual #9, Individual #343, Individual #317, Individual #230, Individual #117, Individual #365, Individual #105, Individual #109, Individual #326, and Individual #158, which tended to support the diagnosis of record, but not to the degree described above. In general, these were individuals who functioned in the higher levels of ID/DD and had major Axis I psychiatric disorders, which had led to external psychiatric hospitalizations in the past. The documentation of the symptoms related to the psychiatric diagnosis primarily appeared in those external records. A related issue was the lack of documentation linking the monitored target behavior to	

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		the identified symptoms of the psychiatric disorder. The primary behaviors that were monitored to assess the efficacy of psychotropic medication at the CCSSLC were aggression, self-injurious behavior (SIB), and agitation. The documentation in the records that provided the linkage between the psychiatric diagnosis and the occurrence of these behaviors was either lacking or insufficient in the entire sample reviewed. As noted above (see information related to Section J.8 of the SA), these behaviors were also identified in the Functional Analysis and Behavioral Support Plan as being present on a learned-behavioral basis, represented a response to demand situations, and/or were used by the individual to escape or avoid a situation. The dual identification of the behavior as being both a target of the psychotropic medication(s) and being present on a behavioral basis was consistent throughout the study sample. Detailed examples of records that documented the lack of a clear description of the symptoms that would support the psychiatric diagnosis of record and that also would link the monitored behavior to that diagnosis are provided with regard to Section J 8 of the SA. These examples also illustrate the degree to which the behaviors that are described as the target behaviors of the psychotropic medication are also identified elsewhere in the record as being present on a situational and/or learned basis. Another relevant example that illustrated the confluence of these three related deficiencies is as follows: ▪ Individual #140 was receiving six psychotropic medications for three distinct psychiatric diagnoses. Strattera and Tenex were prescribed for Attention Deficit Hyperactivity Disorder, Clomipramine was prescribed for Obsessive Compulsive Disorder, and the antipsychotic agents Invega and Seroquel were prescribed for "intermittent Explosive Disorder/aggression." The Psychiatric Clinic notes documented the use of these medications for these diagnoses, but did not describe the specific symptoms of these disorders. The notes did contain monthly data concerning the frequency of aggression, disruptive behavior, and self-injurious behavior but there was no documentation as to how these specific behaviors were derived from or related to the identified Psychiatric Diagnoses. The Psychiatric Evaluation dated 4-11-10 also made reference to the same Psychiatric Diagnoses. The Mental Status Examination section of that record did not make reference to any symptoms that would support these Diagnoses. The treatment Plan section of this report described the purpose of the Clomimpramine as "to decrease anxiety and preservative behaviors," the rationale for the Straterra was "to decrease symptoms of inattentiveness," and the Tenex was described as being prescribed "to decrease impulsivity." The rationale for the antipsychotic agent Invega was described as "to decrease impulsivity and aggressivity and for stabilization of mood," whereas the second antipsychotic agent Seroquel was prescribed "for	

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		stabilization of mood and reduction of anxiety." Thus the only references to specific symptoms of a psychiatric disorder were the mention of "inattentiveness", "perserverative behaviors," and "anxiety." These are general descriptors of an individual's presentation and do not qualify as sufficient documentation to support a Psychiatric Diagnosis. The HRC Review of the BSP dated 9/23/09 described the "justification" for these psychotropic medications as "[Individual #140] has a history of aggressive behavior to self or others, and inappropriate Sexual behavior" which can result in injuries to self or others. This was also the identical justification for the restrictive aspects of her behavioral program. These behaviors were also described as resulting from environmental and interpersonal factors. Thus, as with the examples cited above in section J8, there was the appearance that the psychotropic medications were utilized to suppress problematic behaviors, rather than to address the symptoms of a documented psychiatric disorder. It is, of course, conceivable that a specific behavior could be related to an underlying psychiatric disorder and also be effected by environmental and/or behavior factors. In those situations where there is evidence to support that the behaviors have both biological and behavioral etiologies, this distinction should be identified, documented, and verified. As with the identification of the symptoms that support the psychiatric diagnosis, once this process has been completed, the information can be carried forward in the records and modified as needed in the future. This process may also reveal that there are individuals for whom the psychiatric medication is being utilized primarily to suppress behaviors that are derived from and maintained by behavior-environmental factors. In those cases, the PST should reconsider the appropriateness of the continued use of those medications. As noted above, another important aspect of this provision relates to the effectiveness of the psychotropic medication. The behavioral data present in the sample of records reviewed lacked the sufficient information necessary for either the PST or an external reviewer to determine if the medications that were currently being utilized had been effective to a degree that justified their continued use. A primary deficiency was the lack of any baseline data that could be compared to the contemporary data to determine efficacy. In the context of this review, baseline data refers to the frequency of the monitored behavior for at least three months prior to the introduction of the medication, which can then be compared to the most recent three months of data after the medication is thought to be at a therapeutic level. The behavioral data that related to the frequency of the monitored behaviors that were identified as the targets of the psychotropic medication were contained in the Psychology section of the medical record as these behaviors were also identified in the BSP, as a goal of the BSP was to reduce the frequency of these behaviors. The tabular presentation of these behaviors did include information regarding the names and dosages of the	

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		psychotropic medication so that the addition of a new medication or a change in dosage would be evident. However the record contained only the frequency data for the last 12 to 18 months. Thus, it was impossible to directly compare the most recent three months of frequency data to three months of baseline data, if the medication had been started and/or a dosage change had occurred prior to this time frame. Establishing such a comparison in those situations would require reference to the historical archives, which is cumbersome and time consuming. The process of determining and documenting the efficacy of the psychotropic medications that are utilized for a specific individual naturally becomes mathematically much more complex when multiple medications are prescribed and/or multiple changes are made in close temporal proximity to each other. The amount and length of the frequency data that needs to be carried forward should be determined on an individual basis and relates to the: 1) start date of the medication; 2) amount of time at each dosage of the medication (to determine a dose response pattern); and 3) accepted length of time it usually takes to observe a positive response once a therapeutic dose of the medication is reached. The usual therapeutic dose and the length of time needed to determine efficacy vary by medication, but the Psychiatrist should know these. In most cases, a comparison of three months of baseline pre-medication data to the most recent three months, and/or three months post attainment of a therapeutic dose will be adequate to determine efficacy. However, for cyclical disorders or low frequency high profile behaviors, six months of comparative data may be necessary. In order to accomplish this analysis, either the baseline data needs to be carried forward in tabular form and/or onto a long-term longitudinal graph with phase lines. The data should be reviewed at each meeting and carefully analyzed, once sufficient time has elapsed to make a determination of efficacy. The current policy of only carrying forward 12 to 18 months of frequency data in the record makes this type of statistical analysis impossible for longstanding medications. Implementing these procedures will ensure that the utility of each medication has been documented, which will also assist in risk versus benefit considerations. The difficulty in assessing the utility of multiple medications becomes self-evident when these procedures are implemented. Another purpose of maintaining this type of detailed, longitudinal data is to remind the PST about the difficulty in determining the efficacy of the pharmacological interventions when multiple changes in psychotropic medications are implemented at the same time or in close proximity to each other. As noted above, this longitudinal data was in historical files, and not easily available to PSTs at CCSSLC. The Psychology Department, working in collaboration with the Psychiatry Department, should be able to construct data collection and reporting systems which make this type	

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		of analysis possible. Examples of effective strategies include graphs with phase lines that indicate the time of changes in psychotropic medications, as well as changes in behavioral interventions with the ongoing frequencies of the monitored behaviors. Tabular systems that carry forward the first three months of data following the introduction of the psychotropic medication and/or a change in dosage can also provide this information, but can be cumbersome to maintain.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	The section of the medical record that contained the Informed Consents related to the use of psychotropic medications was reviewed for the entire sample of 27 individuals described above, with the exception of Individual #225, which indicated a completion rate of 96%. The individual's guardian had signed consent documentation for 10 individuals (38%). The Facility Director had signed consents for the remaining individuals who did not have a Guardian of the Person. This review indicated that signed consent documentation was being obtained for virtually all of the individuals residing at the CCSSLC. However, the Risk versus Benefits section in the records, as discussed above with regard to Section J.10, were so minimal and formulaic in nature that it is doubtful the information presented to the guardian or Facility Director would have been sufficient to provide a truly informed decision. The implementation of the changes in the sections of the record related to the risk-benefit considerations in the use of psychotropic medication should make it possible to provide the necessary information to the guardians, so that they can make an informed decision regarding their approval for an individual's psychotropic medication.	Noncompliance
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	The coordination of services between Psychiatry and Neurology was discussed during the 7/14/10 interview with Consulting Psychiatrist. He indicated that he reviewed the Neurology Notes for those individuals that he followed in the Psychiatric Clinics and initialed the Neurology Consults. He also indicated that he sought clearance from the Neurologist if he was going to start an individual on an anticonvulsant medication for mood stabilization, as well as individuals who may be considered for prescription of a benzodiazepine. The Consulting Psychiatrist also indicated that if the Neurologist were going to begin an anticonvulsant for a seizure disorder, he would alert the Psychiatry Department so that they could observe the individual for any clinical effects on their psychiatric presentation. The Neurology section of the records contained information for 13 of the 27 individuals in the sample including for: Individual #292, Individual #225, Individual #84, Individual	Noncompliance

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		#9, Individual #246, Individual #343, Individual #141, Individual #372, Individual #363, Individual #19, Individual #327, Individual #109, and Individual #26. The Neurology Notes contained in the records referenced psychiatry or communication with psychiatry for only the three following individuals: Individual #26, Individual #292, and Individual #372. These Notes uniformly listed the psychotropic medications that the individual was receiving, as well as the anticonvulsant medications. Thus, the Neurologist was aware of the psychotropic medications that were prescribed. There were no examples of the specific types of communication between the two Departments that the Consulting Psychiatrist described in the 7/14/10 interview, but this could be due to the needs of the individuals in the sample pulled. The Consulting Psychiatrist' signature or initials could not be specifically identified on any of the Neurology Consultation Notes, although some notations were not legible. A potential solution to this would be to add signature lines for both the Psychiatrist and the PCP to the Neurology Consultation forms in the same manner as they appear on the Pharm.D. Quarterly Review of Psychotropic Medication. The review of the records identified an apparent miscommunication between the Neurology and Psychiatry Department, which may have clinical significance. The record for Individual #327 was requested as part of the non-random sample due to reports that she was crying an inordinate amount of time. The record was not formally scored as part of the sample, because there were too many missing requested sections. The record that was available did not contain the Psychiatry Clinic Notes, but the "Psychiatric Consult Flow Sheet" was present. The most recent entry on this document stated: *Clinic Date: 7/6/10* *Present Psychotropic Medications/Medication changes:* *Remeron 30 mg q hs – add pseudo-bulbar affect* *Risperdal 1 mg qd – pseudo-bulbar affect* *Change diagnosis to pseudo-bulbar affect* *D/C from psych. clinic* *Level values/date: N/A* *Comments:* *Allergies: CODEINE, MOTRIN/NSAIDS* *Reviewed in psychiatric clinic by Michael Rodriguez, MD. According to Dr. Rodriquez, it was the neurologist who ordered the Remeron and Risperdal*	

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		for pseudobalbar affect. Since she will be followed by the neurologist, she will be discharged from psychiatric clinic. New order to discontinue diagnosis for Remeron and Risperdal from Major depression to pseudo bulbar affect. *Michelle Lord-Arteaga, R.N.* This documentation indicated that the individual was being discharged from the Psychiatry Clinic, because the crying was felt to be due to the neurological condition "pseudo-bulbar affect." The Neurology section was also present for review. The Consultation Report from Jorge Mendizabel, MD, dated 5/14/10 listed the reason for the request: *REQUEST: Neurological Diagnosis – Intermittent Frontal lobe behavior, not consistent with Pseudobulbar affect or drug reaction.* *1) MR Profound* *2) Spastic Quadriparesis* His handwritten response was as follows: *Persist paroxysmal crying (not <u>pseudobulbar</u> in this case)* *Rec: Try Remeron 30 mg/D with* *Risperdal 1 mg/D in combination* The typed Neurological Evaluation note is excerpted below: *DATE: May 24, 2010* *[Individual #327's] case was brought up for re-consultation. The patient is not present today, she is undergoing a mammography. She continues to have episodes of frequent crying spells, we have not believed these episodes are consistent with – ___ bulb or palsy, or a drug reaction.* [Reproduced from original – most likely means pseudo.] *The patient was never tried on Remeron and Zyprexa mainly due to concerns of pinpoint pupils.* *She has been managed mostly with narcotic analgesics.* *Impression: Benign but paraxslsmal crying episodes.*	

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		Recommendation: I recommend trying Risperdal as an alternative to Zyprexa, 1 mg per day, in combination with Remeron 30 mg per day. *Follow up is recommended within the next six months.* As noted above, the complete Psychiatry section of this record was unavailable. It is possible that there is additional documentation between the 5/14/10 Neurology Note and the description of the 7/6/10 Psychiatry Consult. This should be clarified, and if there is a discrepancy between the opinion of the Psychiatrist and Neurologist, this should be reviewed.	

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

1. DADS should proceed with the development of statewide policies regarding the provision of psychiatric care. Such policies should be comprehensive, and address all relevant components of the Settlement Agreement, as well as the Health Care Guidelines.
2. Psychiatry staffing should be increased to the two (2.0) full-time equivalent positions currently budgeted for CCSSLC. The Facility should continue to advertise to fill its psychiatry positions.
3. The Facility should develop, implement, and maintain a process to identify and document the specific symptoms that support the psychiatric diagnosis of record.
4. Consideration should be given to integrating the Treatment Plans for the use of psychotropic medications with the Behavioral Support Plan, so that it is clear which of the identified behaviors are directly related to a symptom of the identified psychiatric disorder, as opposed to being related to behavioral or environmental etiologies.
5. For each individual prescribed psychotropic medication, if a specific behavior is listed as both being present on a behavioral basis and also as a target behavior of psychotropic medication, the rationale should be identified and documented.
6. The existing data-collection system should be modified so that it can be utilized to document the efficacy of psychotropic medications in decreasing the frequency and intensity of the behaviors for which they are prescribed.
7. Procedures and individualized programs procedures should be developed and implemented that will decrease the reliance on psychotropic medication to pre-sedate individuals for medical and dental procedures.
8. A system should be developed to document that the psychiatrist reviews the Neurology Consultation Notes in a timely manner.
9. The discussion of the risk-benefit considerations should be expanded in the Guardian's Consent documentation and the Human Rights Committee approval process in a manner that more fully articulates the probability of the potential benefits of the medications, as well as any potential risks.
10. Efforts should be continued to monitor and reduce polypharmacy with psychotropic medication. This will require improvements in the systems for identifying and monitoring the symptoms of psychiatric diagnoses, and prescribed medications effects on such symptoms.

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:** The following activities occurred to assess compliance: ▪ **Review of the Following Documents**: o Individual degree certificate/vitae of newly contracted Board Certified Behavior Analyst (BCBA) level consultant - Robin Palmer Blue, MA BCBA, MT-BC; Note - Requested degree certificate/vitae of other newly hired behavioral services staff (since January 2010), but no additional information was provided; o CCSSLC Policy: Psychological and Behavioral Services (dated 7/9/10); o New Psychological and Behavioral Services Policies, including the following documents that were revised (7/1/10), approved (7/9/10), and planned for implementation (on 8/9/10): 1) Positive Behavior Support Staffing; 2) Psychological Evaluations; 3) Structural and Functional Assessments; 4) Positive Behavior Support Plan; 5) Counseling; 6) Suicide Precaution Guidelines; 7) Competency Based Training for PBSP; 8) Measurement and Analysis of Effectiveness of Positive Behavior Supports; and 9) System to Review Quality; o Behavioral Services Action Plan to "Develop, Recruit and/or Retain BCBA"; o Behavioral Services Training Roster – University of North Texas (UNT) Course Information, dated 5/6/10; o Behavior Services UNT BCBA Sign-up List, dated 7/12/10; o Behavioral Services Employee Information and BCBA course completed worksheet, updated 6/24/10; o Behavioral Services Completion Grid of Dates for Psychological Assessment and Structural Functional Assessment (VIII.4); o Behavioral Services Behavior Support Committee (BSC) Tracking Tool (VIII.6); o Behavior Support Committee (BSC) Meeting Minutes, dated January 2010 through June 2010; o Behavioral Services Committee Weekly Meeting Agenda, dated 7/13/10; o Psychiatric clinic summary notes, dated 7/13/10; o Behavioral Services "Competency Check for Behavior Support Plan"; o Excel summary of dates identifying completion dates for Psychological Assessment and Structural Functional Assessment (VIII.4); o Human Rights Committee (HRC) meeting minutes, dated 12/30/10 through 6/2/10; o Summary of Community Outings per residence (last 6 months); o Treatment goal summaries for individuals receiving counseling/psychotherapy (VIII.8); o Positive Behavior Support Plans (PBSPs) for: Individual #172, Individual #186, Individual #297, Individual #246, Individual #275, Individual #27, Individual #20, Individual #7, Individual #226, Individual #300, Individual #165, Individual #69, Individual #191, Individual #312, and Individual #304; o Safety Plans for Crisis Interventions (SPCIs) for: Individual #172, Individual #186, Individual #297, Individual #7, Individual #300, Individual #275, Individual #20, and Individual #246;

	○ Psychological Assessments or Behavior Services Evaluation (BSE), including Inventory for Client and Agency Planning (ICAP) evaluations (as provided) for: Individual #172, Individual #186, Individual #297, Individual #218, Individual #296, Individual #275, Individual #246, Individual #369, Individual #27, Individual #20, Individual #226, Individual #7, Individual #87, Individual #300, Individual #165, Individual #69, Individual #191, Individual #312, Individual #304; and Individual #95. ○ Structural and Functional Assessment Reports (SFARs) for: Individual #186, Individual #297, Individual #296, Individual #218, Individual #275, Individual #369, Individual #27, Individual #226, Individual #312, Individual #13, Individual #336, and Individual #315; ○ PSP Monthly Reviews for last six months (or less) as provided for: Individual #172, Individual #186, Individual #297, Individual #27, Individual #7, Individual #300, Individual #165, Individual #69, Individual #191, Individual #312, Individual #226, Individual #275, Individual #20, Individual #246 and Individual 304; ○ Training Documentation (referred to as "ITTPs") for PBSPs, SPCIs, and/or Specific Program Objectives (SPOs), when available, for: Individual #172, Individual #186, Individual #297, Individual #218, Individual #296, Individual #275, Individual #246, Individual #369, Individual #27, Individual #20, Individual #226, Individual #7, Individual #87, Individual #300, Individual #165, Individual #317, Individual #315, Individual #380, Individual #69, Individual #191, Individual #312, Individual #304; and Individual #95; ○ Counseling/psychotherapy treatment plans/goals for: Individual #191, Individual #7, Individual #51, Individual #140, Individual #6, Individual #94, Individual #230, Individual #275, Individual #66, Individual #246, and Individual #357; ○ Onsite chart reviews of: Individual #165, Individual #300, Individual #7, Individual #315, Individual #317, and Individual 46 ▪ **Interviews and Meetings with**: ○ Bruce Boswell, Director of Active Treatment, Nelda Gonzalez, QMRP Coordinator, and Rachel Rodriquez, QMRP Educator, on 07/12/10; ○ Dr. Robert Cramer, Director of Behavioral Service and Chief Psychologist, on 07/13/10; ○ Bruce Boswell, Director of Day Programs/Active Treatment, on 07/15/10; ▪ **Observations Conducted**: ○ Quarterly Psychiatric clinic with Dr. Hernandez and many of the residents of the Pompano residence and attended by several Nursing and Behavioral Services staff members, on 7/13/10; ○ Observation and discussion with staff members at the Behavior Support Committee meeting, on 07/13/10; ○ Observation and discussion with staff members at the Personal Focus Meeting for Individual #181; ○ Observation and discussion with staff members at the treatment team meeting for Individual #7; ○ Onsite direct observation, including interaction with direct care staff and other professionals including residence coordinators, psychologists, psychology assistants, home team leaders and assistants, active treatment and community integration specialists,

	and/or site QMRPs were conducted throughout the morning, day and/or evening hours at the following residential and day programming, and habilitation sites: ▪ Apartment 510 (Sailfish), on 7/12/10; ▪ Apartment 511 (Pompano), on 7/12/10 and 7/15/10; ▪ Apartment 517 (Angelfish), on 7/12/10; ▪ Apartment 516 (Sand Dollar), on 7/12/10; ▪ Apartment 515 (Seahorse), on 7/12/10; ▪ Apartment 522A (Kingfish 1), on 7/13/10; ▪ Apartment 522D (Kingfish 4), on 7/13/10; ▪ Adult Life Skills Building (512), on 7/13/10 and 7/15/10; ▪ Vocational Building (513), on 7/15/10; ▪ Apartment 524D (Ribbonfish 4), on 7/13/10; ▪ Apartment 524A (Ribbonfish 1), on 7/13/10 and 7/14/10; ▪ Apartment 518 (Starbright), on 7/14/10 and 7/15/10; ▪ Apartment 524C (Ribbonfish 3), on 7/14/10; ▪ Apartment 514 (Dolphin), on 7/14/10; and ▪ Apartment 522C (Kingfish 3), on 7/15/10
	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Although the POI reviewed for CCSSLC did not include this component, the POI did contain action steps, required evidence, Facility target dates, SA implementation dates, judgment on compliance and additional comments. The majority of target dates identified on the POI were for at least six months or more from the current review, and assessment of many of the sections were dependent upon development or revisions of policies, assessment templates, or tracking tools. Subsequently, this process is a work in progress. According to the POI, CCSSLC indicated that it was in substantial compliance with Sections K.2 and K.13, and non-compliance with the all of the remaining sections. These findings were consistent with the Monitoring Team's review with one exception. Based on the Monitoring Team's review, the Facility is not in substantial compliance with Section K.13. More specifically, although the staff-to-individual ratio for behavioral services professionals was acceptable according to the SA, none of the current psychologists are BCBAs, and the behavior plans reviewed did not consistently meet the requirements of the SA.
	Summary of Monitor's Assessment: In general, progress was observed in many areas of psychological care and services. It was obvious that efforts were underway to improve the psychological supports and services at CCSSLC in order to meet the requirements of the Settlement Agreement. Although changes were evident since the baseline review, many areas still required additional time and work to adequately address components of the SA. Indeed, discussions and interviews with many administrative, clinical and direct support professionals reflected an acknowledgement of and sincere investment in the continued work that will be required to progress toward compliance. CCSSLC had made progress by developing and approving formal Psychological and Behavioral Services

	Policies. As staff members within psychological and behavioral services move forward, they will need to work out the details of implementing these new policies and procedures. The Monitoring Team looks forward to reviewing the progress that these professionals will make over the next six months. CCSSLC had successfully developed and begun to implement a policy targeting the recruitment of and/or training of BCBA-level professionals. This included the recent hiring of a Board Certified Behavior Analyst as a consultant to provide peer review and supervision to psychology staff members who have committed to starting (or continuing) graduate coursework in Applied Behavior Analysis (ABA). The peer review process had been supported by the addition of a contracted BCBA consultant who had begun to attend BSC meetings. It was too early to adequately examine if other changes, such as re-structuring of the administrative structure, had led to improvements in BSC membership and attendance. Efforts to supplement peer review through additional external members were ongoing. Progress also had been made in the area of data collection and monitoring of PBSPs. Improved access to computers appeared to have facilitated the use of data management systems as well as graphic displays, including both target and replacement behaviors, that ultimately will promote more efficient and effective monthly reviews. As with any new system, however, there were "bugs" to work out (in the graphing of data) that, when corrected, will eventually assist with more effective visual analysis. Timely and reliable data collection continued to be an area of concern. It was clear that, since the baseline review, improvement had been made in the area of psychological assessments, especially with the introduction of the newly revised Structural and Functional Behavior Assessment (SFBA) format. This new format appeared to support a more comprehensive assessment process (i.e., using direct assessment methods) and, subsequently, is likely to promote more assessment-linked interventions. At the time of the review, this process was still relatively new and will continue to require refinement as psychologists learn to apply new methodology and strategies to examine and change challenging behaviors, as well as teach new skills. Challenges continued to exist in ensuring that each individual residing at CCSSLC had a current psychological evaluation, as well as with the ongoing monitoring of approvals, consents, and/or trainings associated with PBSPs. In addition, counseling services continued to lack measurable objectives. Improvement in the area of PBSPs was noted since the baseline review. This included the inclusion of data graphs as well as replacement behaviors. Areas for improvement included ensuring adequate operational definitions for replacement behaviors, prescribing meaningful antecedent strategies, and defining functionally equivalent replacement behaviors. Systems examining the treatment integrity of PBSPs had recently been developed and implemented as well. This will allow a more systematic examination of the effectiveness of staff training.

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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.	It appeared that progress had been made in developing and implementing a policy targeting the recruitment and/or training of BCBA-level professionals. More specifically, a new policy had been written, approved and implemented. The policy entitled "Psychological and Behavioral Services Positive Behavior Support Staffing" set forth a process to develop, recruit, and/or retain BCBA and Board Certified Assistant Behavior Analyst (BCABA) level behavior analysts. The policy involved a three-tiered approach, and CCSSLC had started to implement the first of these three steps. This involved contracting with a BCBA consultant to provide supervision for Psychology staff undergoing the certification process. In addition, this consultant had already been available to attend BSC meetings, and provide on-site peer review as well as off-site case review. Currently, ten of the sixteen (i.e., 63%) Master's and Doctoral-level Psychological and Behavioral Services staff members had verbally committed to registering for online courses at the University of North Texas in the Fall of 2010. Two of these ten had previously completed some of the required courses. In addition, four of the seven Psychological Assistants had committed to registering for coursework this Fall as well. The upcoming enrollment of these staff, in line with tier two of the new policy, will reflect a significant step toward obtaining necessary competencies in ABA. Verbal reports from the Director of Behavioral Services also indicated active attempts to recruit and contract with additional BCBA-level professionals to provide supplemental peer review. This reflected the third step of the policy that involved the initiation and maintenance of a statewide recruitment program to locate and augment current psychological and behavioral services staff. Overall, it appeared that there was a policy in place to recruit and/or train professionals with competencies in ABA. At the time of the review, this policy had just been implemented, and reports reflected initial progress. Once BCBA-level professional were hired or current staff receive board certification, the policy did outline annual audit of their credentials. This provision item was rated as noncompliance because the professionals in the psychology department were not yet demonstrably competent in applied behavior analysis as required by this provision item as evidenced by the absence of professional certification, as well as by the quality of the programming observed at the Facility. Issues related to the quality of behavioral programming are discussed in further detail below with regard to Section K.9 of the SA.	Noncompliance
K2	Commencing within six months of the Effective Date hereof and with	The Director of Behavioral Services and Chief Psychologist, Dr. Cramer, had a Doctor of Psychology (Psy.D.) degree in Clinical Psychology with Child and Family Specialization	Substantial Compliance

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	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.	and was a licensed Psychologist and Professional Counselor in the State of Texas. As of August 2010, he would have been in his current position for five years. Although he did not have an advanced degree in ABA, he had successfully completed the first of the required online courses through the University of North Texas to be eligible for BCBA certification. Verbal reports indicated that he planned to continue to complete all of the required coursework and related supervision. The Director of Behavioral Services appeared to be providing leadership to ensure that the psychological services at CCSSLC were improved and met the required standards. Previous reports of psychological and behavioral services staff (obtained during baseline reviews) reflected positive reviews of his interactions and support of staff. During the review in July 2010, there were no observations or reports that would suggest that this has changed since the initial baseline review.	
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.	It appeared that progress had been made in the area of peer review within psychological and behavioral services. A new policy addressing peer review, entitled "Psychological and Behavioral Services System to Review Quality," had recently been developed and was soon to be formally implemented. This policy addressed the review of Positive Behavior Support Plans and Psychological Assessments, including Structural and Functional Behavior Assessments, and outlined the composition and roles of internal (Behavior Support/Peer Review Committee), as well as external reviewers. It appeared that the peer review process had already undergone some initial changes prior to the formal implementation of the above policy. That is, internal review of assessments and programming had been supplemented by the addition of the external BCBA-level consultant who had been providing support since June 2010. In addition, the change from a unit-based to a discipline-based structure since May 2010 appeared to have facilitated better attendance at Behavior Support/Peer Review Committee as evidenced by verbal report and brief observation during the on-site visit. In general, review of provided BSC meeting minutes (i.e., January through June 2010) did not provide sufficient information to determine if membership attendance had improved as suggested by verbal report. Names of BSP participants, including the external reviewer and at least one psychological assistant, however, were included on the utilized meeting minutes template, but it was not always clear who, of those listed, attended the meetings (i.e., check marks indicating who was in attendance were not recorded on some provided documentation). The new policy recommended diverse membership of the BSC committee including, for example, professional and clinical staff, authors of reviewed PBSPs, direct support professionals, campus coordinators and quality enhancement staff. It was unclear from the policy if membership included: 1) nonclinical residential staff who, in addition to	Noncompliance

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		clinical staff, monitor the implementation of behavioral programming, but who have direct administrative supervisory authority; and 2) psychological assistants who may be involved in the design and training of a PBSP. As the time of the review, however, this policy had not been formally implemented and will, therefore, need to be more closely assessed at the next review. As previously reported, it continued to appear that a substantial number of assessments (Structural and Functional Assessments) and behavioral programming (PBSPs and safety plans), in addition to ongoing psychology department business, were reviewed at each weekly meeting. This had the potential to limit the committee's ability to thoroughly review each presented assessment and/or plan. As previously recommended, a process should be established (e.g., a hierarchy based on restrictiveness, etc.) that ensures sufficient time for adequate review, especially of the most intensive or challenging of cases. It was unclear from the review of the policy entitled Psychological and Behavioral Services System to Review Quality if this issue had been considered or addressed. It was also unclear from this specific policy if annual review of each SFBA and PBSP was required (i.e., as outlined in other policies), and whether or not data was required to be presented and/or utilized during BSC peer reviews. Direct observation of one of the BSC meetings during onsite review by a member of the Monitoring Team reflected good attendance by behavioral services staff, as well as other professionals, active participation of team members, and data-based review and decision-making. Review of provided BSC meeting minutes demonstrated that meetings were typically held approximately every week, and were attended, at times, by a diverse group of professionals. However, several meeting minutes lacked sufficient detail regarding membership attendance (e.g., the meeting minutes from 4/13/10, 5/13/10, 6/1/10, and 6/6/10). Based on this information, progress was noted, but does not consistently reflect adequate compliance with the SA. Review of information displayed on the BSC Tracking Tool indicated that approval dates for psychological assessments, including the Behavioral Services Evaluations and Structural and Functional Behavioral Assessments, as well as approval and implementation dates of Positive Behavior Support Plans and Safety Plans for Crisis Intervention were tracked over time. Dates recorded on this tracking tool suggested that a high percentage of annual approval dates of BSEs (47%), BSPs (27%), and SPCIs (38%) had lapsed. In addition, approval dates of psychological evaluations were missing for a substantial number (30%) of individuals; subsequently, it was unclear if these individuals had current (or previously completed) psychological evaluations. Verbal reports indicated that some confusion stemming from feedback from the Monitoring teams may have been responsible for a lapse in updating assessments earlier this Spring. That is, it had been interpreted that annual review/update of psychological assessments	

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		was not necessary. BSC meeting minutes reflected active review of this tracking grid, and prompts highlighting missing or delinquent assessments or plans (e.g., BSC meeting minutes from 1/15/10 and 2/9/10). It was unclear if other dates (e.g., HRC committee approval) were similarly tracked. On a positive note, 39 new SFBAs had been completed in 2010 concurrent with the PSP cycle. Behavioral services staff expected that, by the end of the year, each individual who currently had a PBSP would have a completed SFBA. Provided documentation did reflect that the majority of SFBAs (67%) were completed within one month of the annual PSP. SFBAs should be completed sooner if appropriate (i.e., when clinically demanded or justified). If necessary, the completion of these assessments should be prioritized to ensure most critical issues are examined first. Review of behavioral services also continued to include the CCSSLC Human Rights Committee (HRC). Review of recent Human Rights Committee (HRC) meeting minutes continued to reflect limited attendance, at times with only three members in attendance (e.g., minutes from 2/24/10, 3/3/10). In addition, membership also appeared to be predominately constituted by individuals who were employees of CCSSLC. However, meeting minutes did reflect typical attendance by at least one community volunteer or parent/guardian, as well as one individual who resided at CCSSLC. Verbal reports indicated that a new ombudsman would be appointed and HRC officer hired, in addition to trying to encourage other individuals not employed by CCSSLC to supplement the HRC membership. The Ombudsman would not be an employee of CCSSLC, and would be external from the DADS system. As previously presented, procedures regarding external peer review had also been developed. Currently, the BCBA consultant had been providing some peer review through on-site BSC meeting attendance as well as off-site case review. This review had only been in place a few months. Supplemental and potentially more comprehensive external peer review through the use of other BCBA-level professionals, potentially other Texas State BCBAs/supervisors was also being pursued. According to CCSSLC policy, monthly notes or minutes from any external review process would be completed.	
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	It appeared that progress continued to be made in data collection and monitoring of PBSPs since the January 2010 baseline visit. At that time, graphing of data had just recently been started, and only a few psychologists and psychology assistants were using graphic display of data because the new approach was limited by the lack of computer access. According to verbal reports during the July 2010 review, computer access had significantly improved. Each psychologist and psychology assistant had their own computer and ready access to data management systems. As designed, this system allowed integration of collected data across a number of reports (e.g., PBSP, SFBA, PSP	Noncompliance

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	meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	Monthly Reports). At the time of the review, according to feedback from behavioral services staff, all staff were familiar with the data management system and had begun incorporating graphed data within their psychological assessments, PBSPs, and PSP monthly reviews. Review of 15 sampled PBSPs indicated that 100 percent of the plans prescribed the collection of data on one or more target behaviors (behaviors for decrease), and one or more replacement behaviors [behaviors for increase, or, in some cases, labeled as Skill Acquisition Objectives (SAOs)]. As will be discussed below, although all the plans included reference to replacement behaviors, the operational definitions of many of these were incomplete. Review of PSP monthly reports demonstrated that data on target and replacement behaviors were reported for 100 percent of the individuals sampled. According to the provided BSC tracking tool, these 15 plans reflected a sampling of eight percent of the total PBSPs in place at the time of the review. Review of eight sampled SPCIs indicated that 100 percent prescribed the collection of data on the use of restraints. Review of PSP monthly reports revealed that data on use of restraint, in some cases both physical and chemical restraint, was summarized, in tables and/or graphs, for 100 percent of the individuals sampled. It appeared that only frequency data on the use of restraints was collected. In some cases, it might be helpful to have additional data (i.e., dimensions of behavior) collected and summarized, such as the duration of each restraint. According to the BSC tracking tool, reviewed plans reflected a sampling of 31 percent of the total SPCIs in place at the time of the review. Documentation for some individuals (i.e., Individual #27, Individual #226, and Individual #165) who did not appear to have SPCIs, reflected the ongoing monitoring of the frequency of restraints including, for some, both chemical and physical restraints. It was unclear if these individuals did indeed have SPCIs and specific documentation was just not provided, or if this data was just routinely collected without the implementation of a SPCI. Further investigation using the BSC tracking tool did not indicate that these individuals had a SPCI; however, one individual sampled, who did have a SPCI, was not identified on the BSC tracking tool as having a SPCI. In general, review of collected data displayed within requested samples of PBSPs, BSEs or Psychological Assessments, SFARs, and PSP Monthly Reviews reflected improvement and refinement over time. Documents written last summer or fall tended to include data only in table format and/or appeared likely to display incomplete data (missing either data on target behavior or replacement behaviors). For example: ▪ Data was only displayed in table format with the PBSP for Individual #172. ▪ In addition, the PBSP for Individual #226 included a data table that did not include target(s) for decrease. However, other documentation for this individual reflected the incorporation of graphic displays over time (e.g., PSP	

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		monthly reviews from 10/09 through 2/10). ▪ Psychological evaluation as well as the PBSP for Individual #304 displayed data only in tables and did not include any data on replacement behaviors. These findings were consistent with findings of previous document reviews during the initial baseline visit. Alternatively, documents written more recently (i.e., this past winter and spring) tended to include data on both target and replacement behaviors, as well as include data displayed in graphic form, allowing more efficient and effective visual analysis. These changes could be seen, for example, in PBSPs, SFBAs and/or PSP Monthly Reviews of Behavioral Services for Individuals #297, Individual #27, and Individual #300. Only one of the sampled individuals, Individual #20, with a PBSP written recently (in late February 2010) did not display data in graphic form. These improvements appeared to be consistent with changes in procedures involving data collection, as well as revisions within the formats of the PBSP and SFARs discussed during the initial baseline review. These changes were reflected more recently in the approved (dated 7/9/10) CCSSLC Psychological and Behavioral Services Policies for Structural and Functional Behavior Assessments and Positive Behavior Support Plans. The use of data management systems and graphing was new to some of the psychology and behavioral services staff. Because this process had only been in place for the last six months, it was not surprising that there were still some 'bugs' to work out. Verbal reports indicated a recognition that improvements in graphing would undoubtedly occur over time. One needed improvement that psychology staff voiced, for example, included the utilization of phase change lines to emphasize substantial changes in treatment. This could be applied, for example, to how medication changes are illustrated. That is, by using phase change lines, text boxes, or dosages in a table just below the graph to highlight dosage changes, medication values would not need to be graphed thereby reducing the, at times, required extreme range of the Y axis. This change would allow more effective interpretation of data that would otherwise be compressed and potentially overlooked. As can be seen in some graphs, the extreme Y axis needed in order to accommodate the medication dosages did not allow viewers to adequately see the variability in target or replacement behaviors (e.g., data graphs for Individual #46, Individual #165, Individual #297, and Individual #312). Other issues related to graphing that were observed during review of sampled documents included light line color (e.g., on PSP Monthly Reviews for Individual #172 and Individual #191), missing axis labels (e.g., PBSP graphs for Individual #297, Individual #27, and PSP Monthly Review for Individual #226), use of bar graphs (e.g., graphs in PBSPs for Individual #7, Individual #226, and Individual #300), and/or displaying multiple dimensions of behavior (or medication) on the same axis (e.g., PSP	

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		Monthly Reviews for Individual #69 and Individual #186), or just attempting to place too much information on a single graph (e.g., individual #275). All of these issues potentially made interpretation less efficient and more challenging. Direct observation during onsite visits also evidenced continued inconsistencies across staff with regard to the timeliness of data collection. When asked when data collection should occur, several staff indicated that data collection was typically completed at the end of the shift. This was inconsistent with expectations of psychology staff. Conversely, in some cases, staff working with individuals on enhanced supervision correctly indicated that data was collected at the end of the prescribed interval (i.e., an hour). Any delay in data recording, however, is likely to increase the error within the data collection process. Direct observation during the onsite visit also revealed a resident (Individual #7) who demonstrated significant pica behavior (ingestion of inedible objects), but did not have a pica diagnosis. In this case, the lack of a diagnosis certainly limited awareness of this challenging behavior (e.g., she was not listed as "at risk for pica"), and appeared to potentially limit the effectiveness of how well this behavior was monitored. That is, this behavior was included within the definition of SIB. Due to the severity of this behavior and potential dangerous outcomes, consideration should be given to labeling any ingestion of inedible objects as pica behavior (even if the individual is not diagnosed with pica), and tracking it separately from other behaviors. If data was collected on pica behavior separately from SIB, then the individual's team would have adequate information with which to base decisions regarding treatment options, as well as necessary protections. At the time of the review, based on provided documentation, 14 residents who ingested or may have ingested inedible objects (over the past year) did not have a pica diagnosis. The effectiveness of data collection was also at a disadvantage when data books were not easily accessed or were unavailable. On several occasions, data books were not readily available at the residence, and had to be found by staff (i.e., books for Individual #165 and Individual #208 on 7/13/10; and books for Individual #296 and Individual #69 on 7/14/10). In addition, several on-site chart reviews indicated that data was inconsistently recorded or missing for some individuals (e.g., 43% of intervals on July data sheet not completed for Individual 315; several missing days of data on monthly data sheet for Individual#165). Some chart reviews reflected adequate collection of behavioral data, but poor collection of SPO data (e.g., June and July data for Individual #277 and last six months of SPO and behavioral data for Individual #300). On a positive note, there were occasions where staff accurately identified where data was recorded, readily accessed the appropriate books, and data appeared to be collected as indicated and consistently across reviewed documentation (e.g., on-site chart review of Individual	

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		#317). Lastly, the current data collection system continued to reflect a "one-size-fits-all" approach across settings. Limited review of onsite data sheets and discussions with staff continued to reflect that the primary method of collecting behavioral data continued to be frequency count. Given the large numbers of individuals with PBSPs and the diverse nature of the hundreds of behaviors targeted, it seems likely that other dimensions of behavior would be important to measure as well. In addition, unless an individual was on an enhanced level of supervision (i.e., where data is collected at the end of one hour intervals), data was typically collected at the end of each eight-hour shift. That is, a frequency count for each targeted response over the entire eight-hour interval was recorded at the end of the shift. This system appeared to be problematic as it may not produce acceptable levels of reliability, especially for highly frequent responses. Psychology staff's verbal report indicated that data collection systems had begun to be more individualized for select cases (e.g., the data sheet for Individual #7), and that similar changes were likely to occur moving forward. At the time of the review, data reliability was not being assessed. This is discussed further below with regard to Section K.10 of the SA. This was consistent with findings from the initial baseline review. Verbal reports indicated that psychological and behavioral services staff were still working to determine the most effective and efficient methods to collect inter-observer agreement. According to verbal reports, data was collected, summarized, and graphed by psychology assistants and reviewed monthly by psychologists. Review of provided PSP Monthly Behavioral Services reports for 15 sampled individuals suggested that collected behavioral data, in some cases along with medication and restraint information, was summarized monthly in tables and graphs for all individuals, with one exception (i.e., graphs were not completed for Individual #20). Although the last six months of PSP monthly reviews were requested, only an average of four months of reports for each individual (range of two to seven months) were provided. In addition, 71 percent of the individuals reviewed had at least one month (typically May 2010 or later) for which SPO data was graphed. Taken as a whole, it appeared that for most individuals, behavioral data was summarized and graphed on a monthly basis and, for a large percentage of individuals, SPO data has begun being graphed as well.	
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	As reported in the initial baseline review, the psychological assessment process at CCSSLC had undergone significant changes over the past two years. Prior to 2008, a single psychological assessment was completed on an annual basis. Throughout 2008 and 2009, two assessments including a psychological assessment and a behavior assessment were completed on an annual basis. In December 2009, changes within both	Noncompliance

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	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 psychological assessment and behavior assessment processes occurred. In regard to the psychological assessment, criteria were changed to ensure that an ICAP was completed at least every three years. In regard to changes within behavior assessment, a new assessment process involved the completion of a structured functional behavior assessment (SFBA), a more comprehensive behavioral approach to assessing the function underlying behavior, was started in November of 2009. At the time of the most recent review, formal policies and procedures regarding the completion of psychological assessments (Psychological and Behavioral Services Psychological Evaluations) and SFBAs (Psychological and Behavioral Services Structural and Functional Behavior Assessment) had recently been approved (dated 7/9/10). According to these policies, each individual residing at CCSSLC had to have a current psychological assessment, and each adult would be evaluated at least annually. The policy allowed this evaluation to be an update, and was required to include a review of ICAP scores (completed at least every three years or sooner). It required an SFBA to be completed if an individual demonstrated challenging behaviors, and a PBSP was being developed, or if an individual already has a PBSP. As presented below with regard to Section K.7 of the SA, review of requested documentation showed that of the 20 individuals sampled, 75% of individuals had a psychological assessment (or BSE) updated within the last 12 months. For the remaining 25%, psychological assessments were either not provided as requested (i.e., for Individuals #7 and Individual #218) or were updated over 12 months ago (i.e., Individual #27, Individual #95 and Individual #275). According to verbal reports, confusion apparently related to feedback from the Monitoring Teams following the baseline visits may have resulted in many psychological evaluations not being updated earlier this spring. That is, psychological assessments were not completed, as was typically the process, concurrent with PSP meetings. According to the Chief Psychologist, this confusion was rectified in April and psychological assessment updates were expected to be completed as individual PSP meetings occurred in the future. Available psychological assessments were examined to identify information on ICAP evaluations. As presented below with regard to Section K.6 of the SA, examination revealed that 80 percent of psychological assessments identified and summarized an ICAP evaluation completed within the last three years. It appeared, that for some individuals however, an ICAP evaluation identified in the psychological evaluation was completed over three years ago (i.e., Individuals #27, Individual #312, and Individual #369) or, in one case, data from an ICAP evaluation was not identified at all (i.e., Individual #95). In two cases, psychological assessments were not available but ICAP	

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		documentation was provided (i.e., Individuals #7 and Individual #218). As discussed below with regard to Section K.6 of the SA, of the psychological assessments currently available for review (i.e., assessments for Individual #7 and Individual #218 were not provided), 100 percent summarized results of previously completed standardized tests of intelligence. These tests generally included the use of the Wechsler, Slosson, and/or Leiter and were completed, on average, approximately 14 years ago (range of five to 22 years). The vast majority, or 83%, of these IQ tests were conducted over 10 years ago. Scores from standardized assessments of adaptive functioning, typically the Vineland Adaptive Behavior Scale, were summarized in 89 percent of the assessments reviewed. According to the Chief Psychologist, a variety of standardized intelligence and achievement tests, as well as standardized assessment of adaptive ability had recently been ordered. It was unclear how often or under what conditions these assessments will be regularly completed or required. In addition to the above assessments, screening for psychopathology, emotional and behavioral issues was completed either through participation within and monitoring through psychiatric clinic, or through the utilization of the Reiss Screen for Maladaptive Behavior. Currently, the Reiss screenings target individuals who are not receiving psychiatric services and are completed annually. The Facility's compliance with the implementation of the Reiss screening process is discussed above with regard to Section J.7 of the SA. A significant change and improvement in area of assessment since the baseline review had been the increasing completion of SFBAs. Review of pre-visit document request summaries indicated that 28 SFBAs had been completed since January 2010. Review of requested documentation indicated that nine SFBAs have been completed for the individuals currently sampled. As a result, the sample reviewed reflected 32 percent of the total number of SFBAs that have been completed since January. Based on information on the BSC Tracking Grid, 16% of 179 individuals with PBSPs currently had completed SFBAs. It appeared that the reviewed SFBAs all followed a similar format, however, some more closely adhered to the standard rubric than others. For example, several reports closely matched the standard (e.g., for Individual #218 and Individual #27), while others presented information in an altered order (e.g., for Individual 297 and Individual #296) or was missing expected content all together (i.e., Individual #186). Based upon review of the "Structural and Functional Behavior Assessment" rubric, revised 9/28/09, the typical format presents content, including data on target and replacement behaviors; preferences and reinforcers; information on setting events, antecedents, consequences and potential underlying function(s); as well as proposed hypotheses and related	

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		interventions that were derived from widely accepted assessment methods, including the Functional Analysis Screening Tool (FAST), Motivation Assessment Tool (MAS), direct observation, and structured interviews, including the Functional Assessment Interview (FAI). A positive trend observed throughout the document review included the increasing use of more direct methods of assessment, in additional to only indirect methods utilized in the past. In general, the reports typically included the use of one or more of these methods and provided information across the majority of prescribed content areas. However, based on information presented, some reports appeared to utilize assessment methods according to accepted practice (e.g., Individual #27 and Individual #218), while others presented process or content information that prompted questions regarding the author's understanding of and competency in effectively utilizing these methods (i.e., Individual # 297 and Individual #369). For example, it was not apparent that the author utilized any form of formal direct observation methodology or a structured interview format while conducting the SBFA for Individual #297 or Individual #369. Information provided in this report also suggested that the author did not fully understand the differences between setting events, antecedents, and consequences, how the objective description of these variables could be helpful, and appeared not to link the assessment findings with recommended interventions. Similar questions regarding the accuracy of the identification process and the usefulness of identified setting events, antecedents and consequences were also raised in the SFBA for Individual #296. They were not clearly identified/described in the text. More specifically, in the text (not the table), the author appeared to have difficulty clearly discriminating between the setting events (crowded environment) and the antecedent (invading his space), and when describing the antecedent the author referred to "frustration," which is not helpful when trying to identify antecedents to staff. In addition, when defining the "consequences," the author identified " … [Individual #296] will be involved in a client to client altercation and possible injury can occur." Consequences typically refer to the maintaining variable (attention, escape, etc.) or to the underlying function of behavior not the behavior itself (aggression/altercation), or the physical result (injuries) that may result. The provided table was much clearer, except for the mistake of suggesting under the function or consequence column that the behavior "removes others from his personal space (tangible)." This is not a typical "tangible" function. Usually tangible refers to someone's behavior resulting in access to a tangible item/activity, not escape or avoidance, which appears to be the case here. In addition, the link between SFBAs and the interventions recommended in PBSPs, including functionally equivalent replacement behaviors, did not appear to be consistently demonstrated throughout the plans sampled. As an example, the primary function underlying the challenging behavior of Individual #369 was determined to be escape, but this function did not appear to be addressed by any of the interventions recommended. In addition, general impressions from the sample reviewed suggested	

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		that the stated function underlying many identified target behaviors (e.g., spurious allegations, SIB) appeared to be communication of anger or frustration. Psychologists should consider, that is some cases, these behaviors are likely to occur to obtain social attention. Reviewed plans did not appear to encourage interventions such as differential reinforcement or time out, for example, even when assessments identified social attention as the primary or secondary hypothesized function. Overall, the mentalistic language that was repeatedly found throughout many of these SFBAs should be minimized. References to "needs," "obsessions," "moods," and "control," to name a few, were unhelpful and distracted from identifying meaningful environmental determinants of behavior. For example, the reference to how "… mood, wants, and needs which seem to be antecedents (to) aggression" did not encourage staff to examine the environment and indentify important variables that influence behavior. In general, the newly revised SFBA format appeared highly likely to improve behavioral programming by facilitating a stronger link between assessment and intervention. The psychologists utilizing these methods will learn over time how to use them more effectively, through experience, coursework and supervision, and begin to understand how this technology can lead to a better understanding of the function(s) underlying behavior and how this knowledge can inform more precise and, subsequently, more effective interventions. Lastly, consideration should be given to removing any information that may be unnecessary or found in other documents. For example, some reports included content (e.g., ICAP and IQ scores in the SFBAs for Individual #186 and Individual #296 and medication side effects in the one for Individual #369) that may have been better presented or found in other documentation (i.e., psychological assessment).	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	At the time of the review, psychological and behavioral services psychological evaluation policies indicated that each individual residing at CCSSLC must have a current psychological evaluation. Previous discussions with behavioral services staff reflected the expectation that a psychological assessment would be completed, updated and/or reviewed at least annually for each individual served. This included reviewing summary data from previous Inventory for Client and Agency Planning evaluations on an annual basis, with the requirement of conducting a re-evaluation (using the ICAP) at least once every three (3) years or sooner if significant events appeared to impact adaptive functioning. Review of requested documentation indicated that, of the 20 individuals sampled, approximately 75 percent of individuals had a psychological assessment updated within the last 12 months. In addition, closer examination revealed that 80 percent of psychological assessment updates identified and summarized an ICAP evaluation	Noncompliance

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		completed within the last three years. It appeared, that for some individuals however, an ICAP evaluation identified in the psychological assessment update was completed over three years ago (i.e., Individual #27, Individual #312, and Individual #369) or, in one case, data from an ICAP evaluation was not identified at all (i.e., Individual #95). In two cases, psychological assessments were not available, but ICAP documentation was provided (i.e., Individual #7 and Individual #218). Although requested, copies of actual ICAP evaluations were not provided for a number of individuals sampled (i.e., Individuals #87, Individual #296, and Individual #300) and, when copies were available, they often did not appear to be those identified within the psychological assessment (i.e., Individual #27, Individual #165, Individual #172, Individual #246, Individual #304, Individual #312, and Individual #365). That is, the identified ICAP evaluation in the psychological assessment report did not match the date on the provided ICAP document. Interestingly, in some cases, more recent ICAPs were conducted soon after annual psychological assessments, which reported information from the outdated ICAP evaluations (i.e., Individual #27 and Individual #304). It was unclear why these assessments were not completed sooner allowing the inclusion of more current ICAP data in the annual psychological assessment. Of the psychological assessments available for review (psychological assessments for Individual #7 and Individual #218 were not provided), 100 percent contained results of previously completed standardized tests of intelligence. These tests generally included the use of the Wechsler, Slosson, and/or Leiter and were completed, on average, approximately 14 years ago (range of five to 22 years). The vast majority, or 83%, of these IQ tests were conducted over 10 years ago. And, only two individuals sampled had standardized tests of IQ and Adaptive Behavior completed within the last 5 years (e.g., Individual #20 and #300). Lastly, behavioral data was provided in table and/or graph form in either the psychological assessment or SFBA, if completed, for all sampled individuals, with the exception of two individuals (i.e., evaluations for Individual # 20 and Individual #87), one of which did not have a PBSP (Individual #87) and would likely not require the collection of data. A similar trend was revealed with newer assessments, especially SFBAs, including data on target behaviors for decrease as well as increase (replacement behaviors) and older assessments not always including data on replacement behaviors (e.g., BSE for Individual #304).	
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,	In general, review of requested documentation indicated that 75 percent of individuals sampled had a psychological assessment (or BSE) completed within the last 12 months. For the remaining 25%, psychological assessments were either not provided as requested (i.e., for Individuals #7 and Individual #218) or were outdated (i.e., Individual #27, Individual #95, and Individual #275). For some of these individuals with missing	Noncompliance

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	the Facility shall complete psychological assessment(s) of each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	or outdated psychological evaluations, SFBAs were recently completed (for Individual #27, Individual #218, and Individual #275). The sample of 20 individuals reflected approximately 9% of individuals on total individuals listed on the BSC tracking tool or approximately 13% of individuals listed on pre-visit requested documentation identifying individuals with psychological assessments (document requests labeled #VIII.4). It appears that this latter document (VIII.4) contained either highly inaccurate or simply outdated information. That is, review of information provided (i.e., recorded dates) suggested that 64 percent of psychological assessments were either outdated (i.e., not updated within 12 months of the current review) or dates were missing or not reported. This was inconsistent with findings from the limited review of sampled documentation discussed previously. Cross-referencing revealed a substantial number of dates that were inconsistent across this summary document and available documentation for the individuals included in the sample. In addition, it appeared that this summary document was not a comprehensive listing of all individuals served by CCSSLC. As a result, with the information currently available, it was difficult to accurately estimate the total number of individuals with or without psychological assessments, and/or when these assessments were completed. As noted above, progress had been made in completing the new SFBA since the baseline visit. Review of requested documentation of the 20 sampled individuals reflected a total of nine completed SFBAs (45%). Review of pre-visit requested summary documentation indicated that 28 SFBAs have been completed so far in 2010. It was reported that psychology and behavioral services staff plan to complete SFBA for each individual concurrent with their upcoming annual PSP meetings. Although, these sooner should be completed sooner, if clinically warranted. There were no new individuals admitted to CCSSLC. Therefore, examining the timeliness in which psychological assessments were completed following admission was not pursued.	
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.	As reported in the baseline report, needed psychological services, other than PBSPs, included counseling services. At the initial baseline review, there were two community-based therapists hired through behavioral services to provide counseling services to individuals identified as needing counseling. At the time of the July 2010 review, documentation from the community counseling center suggested that there was one consultant who was providing counseling services to 11 individuals living at CCSSLC. At the time of the baseline review, it was unclear if data was being collected or if individualized goals and objectives were developed to examine the potential therapeutic	Noncompliance

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		effects of the provided counseling. At the time of the July 2010 review, it appeared as though the contracted therapist had developed individual goal(s) for each individual receiving therapy. For many of these individuals, however, the developed goals did not appear to be clear, objective, or measurable. For example, stated goals including "… develop positive tools for modulating her emotions and for healthy self-esteem" (Individual #357), or "… explore emotions of grief with the goal of acceptance" (Individual #94) were subjective, ambiguous, and immeasurable. Interestingly, the time period identified for each individual to demonstrate success was the same across all individuals. In addition, based on the information provided, it was unclear if any baseline or ongoing data was being collected to evaluate whether or not progress was being made. Lastly, treatment plans were not provided as requested; therefore, it was not possible at the current time to determine whether or not counseling services employed evidenced-based practices. Psychological evaluations for individuals receiving counseling services were reviewed, as available, from the sampled documentation. Four individuals within the currently requested sample were identified as receiving counseling services, including Individual #191, Individual #7, Individual #275, and Individual #246. Unfortunately, the psychological evaluation for Individuals #7 was not provided as requested, and only the first half of the evaluation for Individual #246 was provided. Review of the remaining two complete psychological assessments indicated that counseling was recommended for Individual #275, but not for Individual #191. It should be noted that policies regarding counseling services had recently been approved by CCSSLC. These policies addressed many of the issues noted here and were formally implemented on 8/9/10. In addition to counseling services, other types of therapeutic services continued to be observed during onsite visits. These included sensory rooms where individuals were offered opportunities to experience different sensory stimulation across many modalities (visual, tactile, olfactory, etc.). Other environments included, for example, the Comfort Zone and Snoezelen Room where individuals were encouraged to participate in other formal or informal programs and activities. Occasionally, the utilization of these environments was listed as a recommendation within psychological evaluations (e.g., recent psychological assessment/update for Individual #42 and Individual #326). It still remained unclear, however, if these environments were being utilized as part of formal skill acquisition programs, behavioral programming, and/or any other form of therapeutic intervention for those individuals that utilized these settings. If such settings are designed to assist in providing individuals with therapy or treatment, then, as previously recommended, specific outcomes should be identified for each individual, and data collected and reviewed to determine the therapy's effectiveness on an individualized basis.	

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K9	By six weeks from the date of the individual's assessment, the Facility shall develop an individual PBSP, and obtain necessary approvals and consents, for each individual who is exhibiting behaviors that constitute a risk to the health or safety of the individual or others, or that serve as a barrier to learning and independence, and that have been resistant to less formal interventions. By fourteen days from obtaining necessary approvals and consents, the Facility shall implement the PBSP. Notwithstanding the foregoing timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	As previously presented, progress had been made in the area of PBSPs. That is, new policies targeting the development, review and ongoing monitoring of PBSPs had recently been approved. In addition, with the assistance of the newly contracted BCBA, psychological and behavioral services staff continued to work to complete the final PBSP format and ensure consistency with policies. The Monitoring Team's review of sampled PBSPs continued to reflect some inconsistencies in format, because some plans included certain content areas and others did not. For example, sections highlighting information on fundamental outcomes, Functional Behavioral Assessment (FBA) processes, data display (using graphs), reinforcers, and/or environmental supports may or may not have been included in some plans. This inconsistency across plans and time, however, is understandable given the many changes that have taken place throughout the last year. It is expected that detailed FBA information that was found in some plans (e.g., Individual #191) will likely be removed and presented with future SFBA. It some plans, the preventative, proactive, or antecedent-based approaches appeared to more closely resemble reactive or consequence-based approaches. For example, as described in the PBSP for Individual #172, proactive techniques instruct staff to redirect, ignore, problem-solve or engage him following display of target behaviors. Clear antecedent-based strategies should be developed, based on the identified function of target behaviors, which provide opportunities to reinforce more adaptive or alternative functionally equivalent responses. Ideally, this would involve the utilization of preventative or proactive approaches prior to the occurrence of the target response. A good example of identifying precursors to target behaviors and intervening with antecedent strategies was found in the PBSP for Individual #296. In this plan, for example, direct support staff were instructed to look for signs of escalating agitation, prior to the exhibition of aggression, and encouraging communication or redirection to a quieter area, and reinforcing adaptive responding. Identifying precursors and reinforcing alternative responding as it occurs in the natural environment will increase the likelihood of desirable behavior change. The inclusion of replacement behaviors, or Skill Acquisition Objectives (SAOs), in PBSPs was also an area of improvement. Of the plans sampled, 100 percent had sections describing replacement behaviors. Consideration should be given, however, to more specifically labeling and defining each replacement behavior (SAO). In some plans, it was difficult to find specific definition of replacement behaviors or, when they were found, examples of responses were incorporated within subsequent teaching procedures. For example, in the PBSP for Individual #191, specific examples of "… acceptable alternatives/options to deal with anger/frustration …" were difficult to find. There were similar omissions in the PBSPs of Individual #95, and Individual #69. Reliability of data collection and treatment integrity is likely to improve if replacement behaviors are more obvious and clearly defined. Measurement should occur of the occurrence of	Noncompliance

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		replacement behaviors outside of formal SAO teaching trials. Only measuring these responses during teaching trials is somewhat artificial and is likely to limit understanding the nature of these responses in the larger, natural environment. The inclusion of graphs in increasing numbers of PBSPs also had been a recent improvement. Most of the PBSPs reviewed included data displayed in tables and graphs. Two exceptions that did not include data graphs were PBSPs that were completed earlier in the year (i.e., Individual #312 and Individual #191). As more comprehensive data is monitored, more objective criteria of success should be identified, including target behaviors, as well as including these criteria when determining plans for reducing the restrictions within PBSPs. More specifically, the "Plan for Reducing Restrictions" section of PBSPs should consistently reflect behavioral objectives, including both targets for decrease and increase, and highlight potential reductions in restrictive behavioral strategies in addition to potential medication changes. As was discussed in the previous baseline report, "campus bucks" appeared to be a commonly utilized reinforcer across PBSPs throughout CCSSLC. Direct observation revealed that this token system was highly valued by many individuals who live at CCSSLC. Reviewed plans also demonstrated that, for some individuals, individualized reinforcers were also incorporated into prescribed strategies. Unfortunately, for Individual #300, it did not appear that these reinforcers were being utilized or recorded correctly during the monitoring visit. Overall, PBSPs continued to vary in how reinforcers were described and utilized. Consideration should be given to how, and how often reinforcers are formally assessed, and how this information will be highlighted in PBSPs in the future. As found during the baseline review, the interventions found in PBSPs often did not appear to be linked to assessment findings. And, at times, they appeared to be counter-therapeutic. For example: ▪ SFBA results for Individual #297 clearly indicated that the primary function underlying SIB was access to social attention (or preferred items), and yet antecedent- and consequence-based interventions provided no strategies to either increase social attention prior to SIB, or attempt to limit social interaction (as safety permits) following SIB. Indeed, procedures in the PBSP encouraged staff to implement coping and communicative interventions as soon as she demonstrated SIB. This plan instructed staff, however, to not allow escape from current activities following target behaviors. This intervention, as well as similar strategies found in other plans (e.g., Individual #369), appropriately addressed one of the underlying functions (i.e., escape) identified in the SBFA. The next step for these two plans would be to include similar strategies targeting other identified functions, in this case social	

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		attention, and limit as much as possible social interaction following target behaviors. As described previously with regard to Section K.5 of the SA, the use of mentalistic terms when describing antecedents, behaviors, consequences, or underlying function of behavior distracted staff from clearly identifying and understanding relevant contingencies in the environment. Identifying internal constructs or states as potential antecedents or consequences is problematic as these are not objective, measurable, or useful when attempting to examine and change the environment in an effort to promote more adaptive responses. Examples of setting events or consequences that would have been more useful if stated behaviorally included, for example: when an individual "… feels he is being ignored …" or "… feels he will get what he wants" (Individual # 312), or the use of terms such as "power struggle" and "perceived power and control" to describe a potential function of behavior (Individual #128). Requested documentation, including the HRC Review of BSP form, BSC Review and Approval Form, and/or Consent to Treatment-Therapy form, as provided, was reviewed to ensure that consents and approvals for PBSPs and SPCIs were obtained prior to their implementation. Of the 19 sampled individuals with PBSPs (plans for Individuals #218 and Individual #297 were not included in this review because implementation dates were not recorded), 84% and 68% appeared to have gone through the necessary HRC and BSC approvals, respectively. It should be noted, however, that the information included in the individuals' records was sometimes inconsistent with that found on the BSC tracking tool, including information for Individuals #172, Individual #275, Individual #27, Individual #95, and Individual #312. Although dates were documented for these individuals on the BSC tracking tool, the documentation provided did not confirm such approvals had been obtained on the specific date. For those individuals for whom documentation was found, implementation dates, dates of consent as well as dates of approval from BSC and HRC were typically displayed on the first page of the PBSPs. This was helpful in ensuring that adequate oversight had been obtained prior to starting behavioral programming. For some PBSPs, however, the dates did not match those on the actual documents produced by these committees (i.e., for Individual #186, Individual #296, and Individual #246), or the PBSP document was not dated adequately (e.g., implementation dates not recorded on PBSPs for Individual #297 and Individual #369). Lastly, given the implementation and approval dates listed on sampled documentation, it appeared that for three out of the 19 PBSPs (16%) were implemented prior to receipt of necessary approval and/or consent (i.e., Individual #369, Individual #317, and Individual #312).	

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		Review of available documentation also suggested that 68 percent had signed Consent to Treatment-Therapy forms. This would mean that for six individuals (32%) had PBSPs implemented without adequate consent documented.	
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.	As found during baseline, inter-observer agreement (IOA) for PBSP data was not being collected. As a result, the accuracy of the data could not be assured. As discussed above with regard to Section K.4 of the SA, there were concerns related to the collection of accurate and reliable data. The availability of data that PSTs can have confidence in is essential in ensuring that teams are making effective data-based decisions. Psychology and behavioral services staff, including the Chief Psychologist, acknowledged the value in collecting this data and continue to examine actively various methodologies that would be both effective and efficient in collecting sufficient reliability data. It should be noted that a formal policy regarding the collection of IOA data had recently been approved, entitled Psychological and Behavioral Services Measurement and Analysis of Effectiveness of Positive Behavior Supports, and was scheduled to begin to be implemented in August 2010. PSP monthly review meetings continued to be held to discuss each individual's progress. Since the previous baseline review, increasing numbers of monthly reports appeared to contain graphic display of data, which is a significant improvement. Indeed, at times, data was displayed in both table and graph format. Information included in graphs typically included data on target and replacement behaviors, restraints, and medication(s), including dosage. As previously discussed with regard to Section K.4 of the SA, monthly graphing of behavioral data for most individuals appeared to currently be the norm. More specifically, data graphs were found for all but one individual included in the sample of 15 individuals (7%) (i.e., PBSP, psychological evaluation and PSP monthly reviews 1/10 to 5/10 for Individual #20). At least since June 2010, for some individuals, skill acquisition data also was starting to be graphically displayed. Direct observation during psychiatric clinic revealed that psychology and behavioral services staff utilized PSP monthly behavioral reviews, including summary data, to facilitate discussions about current behavioral functioning of individuals in attendance. In addition, observation during BSC meetings reflected active discussion and analysis of graphs provided during discussion of several individuals (e.g., SFBAs of Individuals #338 and Individual #326), and their behavioral programming. As the graphing of data is a relatively new practice, there were still some issues to work out. As presented earlier with regard to Section K.4 of the SA, the way in which many graphs were constructed or labeled likely made interpretation difficult. Common issues included: 1) displaying multiple types of data (e.g., frequency, percent, milligram) on a single Y axis; 2) using color data paths that did not copy well; 3) not labeling axis,	Noncompliance

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		especially multiple Y axis; 4) compression of some data (usually target or replacement data) due to the high range of other displayed data (usually medication dosages); and 5) the inclusion of too much data on one graph. Consideration should be given to: 1) labeling axis; 2) only graphing data that is clinically justified (e.g., remove restraint data if not necessary); 3) illustrating data differently (e.g., provide medication dosages in tables below graphs), when appropriate; 4) using multiple Y axis to display different dimensions of behavior; and 5) utilizing phase/condition change lines to demarcate changes in treatment or other significant changes in functioning, etc. For example: ▪ Making the following changes to the graph displayed in the PBSP of Individual #218 would likely improve interpretation: 1) add a second Y axis to better illustrate percentage of replacement behavior (this would allow better display of variability over time); 2) then, label both Y axis (frequency and percentage for target and replacement behaviors, respectively); 3) remove medication data paths from graph and express dosages only in tables. This will still allow easy comparison of changes in medication with potential changes in responding and will make the graph easier to comprehend; and 4) utilize darker color data paths in addition to different data markers across different variables. ▪ It appeared that, for some individuals, data on restraint use was tracked within tables and graphs (e.g., Individual #27 and #226). Because some tables and graphs often had substantial amounts of information displayed, removing "restraints" as a variable typically monitored may be appropriate. That is, if an individual does not have a SPCI and is typically not restrained, then the use restraint may not need to be routinely tracked, thereby reducing some of the information presented in tables and graphs. For Individuals #27 and #226, all the tables and graphs indicated were repeated zeros across months. If, however, these individuals were to have an incident of one or more restraints, this information could be quickly included within tables and graphs.	
K11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that PBSPs are written so that they can be understood and implemented by direct care staff.	It appeared that some progress also had been made in monitoring and ensuring adequate treatment integrity of PBSP implementation and data collection. That is, according to staff verbal report, integrity checks, using the Competency Check for Behavior Support Plan, been occurring since April 2010. This new rubric examined how knowledgeable a chosen staff member was regarding a randomly selected PBSP, including ability to identify challenging behaviors and potential functions, replacement behaviors, antecedent and consequence-based interventions, as well as point out medications, and explain data collection procedures. These random checks were completed by a "psychologist on duty" or "clinician on call," a newly designed role, on a daily basis in at least one residence per unit. It appeared that all psychologists took turns in this role and responded to calls, as well as conducted unannounced visits between 4:00 p.m. and 12:00 a.m. daily. It was anticipated that staff members from other disciplines and	Noncompliance

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		departments would increase their active involvement in these checks in the future. Although data had been collected using this new tool since April 2010, according to staff reports, the data had not yet been sufficiently analyzed. Consequently, there was no aggregate data or evidence to review at this time. Therefore, a review of summary data, hopefully including process as well as outcome data, from these treatment integrity reviews will be completed at the next on-site visit. In an effort to evaluate staff knowledge of PBSPs, direct observations and discussion with direct support professionals were conducted across residential programs during the recent on-site visit. These questions produced mixed results in the accuracy of staff's responses regarding general knowledge of individuals served, as well as specific information regarding behavioral programming and data collection. For example: ▪ A recently hired (three months tenure) direct support professional correctly identified the target behaviors of Individual #191 and Individual #158. ▪ However, another more experienced direct support professional (working at CCSSLC for over 1.5 years) was not aware of a major component and related reinforcers of an individual's PBSP (i.e., behavioral contract and sticker chart outlined in PBSP for Individual #300). ▪ Other staff members, one recently hired (three months prior to the review), and one rather experienced (three years tenure), reported implementing activities not prescribed in PBSPs following agitation of sampled individuals, including Individual #317 and Individual #296. One consistent finding across settings, during both the baseline and recent monitoring visit, was that when questioned about programming, staff members who were unsure of the correct answer appeared to know where to look and were willing to actively find the answer. This also might have reflected training of staff on how to respond to the Monitoring Team's questions as well. That is, on several occasions, multiple staff were reluctant to answer the Monitoring Team member's questions without first obtaining documentation on selected individuals. This occurred following questions simply asking staff whether or not particular individuals had PBSPs. However, this is information that staff supporting individuals directly should know. Without such knowledge, they cannot provide adequate protections and supports to individuals to whom they are assigned. As previously reported, PBSPs tended to have an average length of approximately 11 to 12 pages, with a range from six to 19 pages in length. It is important to note that these estimates do not include safety plans that were at least an additional two pages. A previous recommendation made by the Monitoring Team was for CCSSLC to consider use of an "abbreviated PBSP" or "cheat sheet." This had not yet been examined. According to the Chief Psychologist, work to ensure an acceptable and consistent format for PBSPs was planned prior to implementing any abbreviated forms.	

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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.	At the baseline review, verbal reports indicated that Associate Psychologists primarily conducted staff training on PBSPs (i.e., they were responsible for developing the PBSP). Psychology Assistants reported that if minor changes were made to behavioral programming that they, the treatment team leaders, or the active treatment specialists would train residential staff members. Further discussions with staff suggested that new direct support staff members also were provided with three days to shadow an experienced staff member, during which time further training took place. In an attempt to verify that current staff had been trained on specific PBSPs requests were made to review training logs for PBSPs. As during the baseline review, training logs were again, unfortunately, consistently unavailable and there appeared to be substantial confusion across all levels of staff who were asked about where these documents were or should be stored. There was one exception, however, when training documentation was finally located for Individual #165, it provided an adequate record of which staff had participated in the training provided. Of the requested training documentation of sampled individuals, training documentation for only 12 out of 22 (54%) was provided for review following the on-site visits. Of these the following issues were noted: ▪ Three were not adequately dated (i.e., specific dates were not recorded on training documents for Individual #218, Individual #317, and Individual #191). ▪ Several appeared to be recent trainings for PBSPs that were dated last year (i.e., PBSPs dated 6/1/09 and 12/31/09, for Individual #172 and Individual #300, respectively). ▪ One training session appeared to be held approximately six months after BSC approval and four months after the plans implementation date (i.e., Individual #246). ▪ A similar trend of staff training being completed after the date of implementation as recorded on PBSPs – was found on available documentation for almost all other individuals sampled (i.e., as documented on the PBSP and ITTPs for Individuals #369, Individual #20, Individual #7, Individual #300, Individual #165, and Individual #315. Taken on face value, these available dates suggested that PBSPs were implemented prior to the staff training sessions. In only two cases, based on available documentation, the date recorded for PBSP implementation was the actually on or after the documented training date (i.e., as documented on the PBSP and ITTP for Individual #65 and Individual #275). The above trainings appeared to reflect the initial staff training following the development of a PBSP or the annual revision/update. Psychologists who conducted these trainings reported that an effort was made to incorporate active learning strategies	Noncompliance

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		(e.g., modeling, rehearsal, repeated practice, etc.) during the meetings. These types of strategies had been highlighted in recently approved Psychological and Behavioral Services Positive Behavior Support Plan polices. Unfortunately, however, direct observation of training meetings has not occurred during the monitoring visit. Training documentation indicated that several training in-service sessions were only 15 minutes in length (e.g., PBSP training for Individual #20, #172, #165; and SPO training for Individual #186). It is unlikely that in-service sessions of this duration would be adequate enough to support competency-based training. Teaching methodology utilized during staff trainings will need to be assessed on subsequent monitoring visits. It was not possible, particularly given the lack of available documentation to closely examine whether or not the direct support professionals were appropriately trained on the PBSPs of individuals for whom they were assigned. This was complicated by the fact that direct support professionals only provided their signature on the training documentation. In other words, they did indicate by providing a date in addition to their signature when they received the training. Based on available documentation, then, all staff who signed the document were assumed to have been in attendance at that specific training. If this is the case, it was unclear when the staff who could not attend the scheduled training (or hired after the training) documented that they were trained It was still unclear how the training of staff who are hired after this training occurs or how the training of relief staff (pulled from other programs) was documented. In addition, it was unclear how CCSSLC supervisory staff monitors or accesses this information when attempting to make decisions about staffing coverage. Recently approved policy, discussed above, also suggested that the Facility will implement a system to insure that all pulled and relief staff receive competency-based training on the PBSPs that they will be responsible for implementing. Based on this information, it is assumed that this system was not in place at the time of the review. Further review of system(s) designed to ensure that direct support professionals are competent in implementing PBSPs across settings will be reviewed further during upcoming monitoring visits.	
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology assistant for every two such professionals.	At the time of the baseline review, CCSSLC employed 14 Associate Psychologists and seven Psychology Assistants. During the July 2010 review, in addition to the Chief Psychologist, there was a Clinical psychologist, 14 Associate Psychologists, and seven Psychology Assistants. None of these professionals were currently BCBAs. However, there was a contracted BCBA-level professional who was assisting with peer review and, very soon, with supervision for BCBA candidates. Based on the provided overview of staffing within psychological and behavioral services (document updated 6/24/10), six of these staff appeared to be new additions since the baseline visit. As of the most recent on-site review, CCSSLC served 294 individuals. Based on this number and the	Noncompliance

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		understanding that the new Clinical Psychologist may not carry a caseload, this resulted in an approximate average ratio of 1:21 (psychologist-to-individual served). In the likely case that the role of a psychologist is reassigned, resulting in a reduced or no caseload for this professional, the ratio would still approximate an average of 1:23. At the time of the review, there was a ratio of 1:2 psychological assistants for every associate psychologist. However, as noted with regard to Section K.1 of the SA, this provision was rated as noncompliance because the professionals in the psychology department were not yet demonstrably competent in applied behavior analysis as required by the SA as evidenced by the absence of professional certification, as well as by the quality of the programming observed at the Facility.	

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

1. CCSSLC should continue to implement and monitor the effectiveness of newly approved Psychological and Behavioral Services Policies.
2. Efforts should continue to be made to attract additional BCBA-level professionals to assist with review of psychological assessment, skill acquisition, and behavioral programming. If possible, the development of a supplemental external peer review committee, comprised of BCBA professionals from other Texas facilities, could offer alternative perspectives, evaluations, and feedback on perhaps more restrictive or intrusive behavioral programming.
3. CCSSLC should ensure that the contracted BCBA professional has sufficient time to adequately supervise staff members enrolled in coursework according to supervision guidelines outlined by the Behavior Analyst Certification Board (BACB).
4. The reasons why the remaining psychological and behavioral services staff members are reluctant to take graduate coursework should be examined, and, if possible, consideration should be given as to whether or not supports can be identified to overcome limiting factors.
5. BSC meeting minutes should be written to capture content as well as attendance information. Efforts should be made to continue to encourage attendance by those professionals involved in the development, implementation and monitoring of PBSP.
6. Consideration should be given to the development and monitoring, if not already in place, of a more comprehensive spreadsheet to assist in the timely completion of all psychological assessments (including pre-requisite assessments such as the ICAP, etc.) and behavioral programming, including dates of completion, implementation, and training as well as dates of receipt of necessary consents and approvals (HRC, BSC, etc.). This spreadsheet could be designed to provide summary data on items that are missing or out of date, and be utilized by CCSSLC during self-assessment or future reviews by the Monitoring team.
7. As recommended previously, given the significant number of plans that require annual (at a minimum) review, a process should be established that ensures sufficient time for adequate review. That is, a hierarchy should be developed for behavior plans (perhaps based on restrictiveness, intrusiveness, severity of target behaviors, etc.) that would prescribe more or less time or, perhaps, comprehensiveness or frequency of review dependent upon where the plan falls on this hierarchy.
8. Efforts should continue to develop a supplemental external peer review committee comprised of professionals not employed by CCSSLC. Membership of this committee should include professionals who are board certified in behavior analysis. This committee would potentially meet less often than the BSC, but would likely offer alternative perspectives, evaluations, and feedback on perhaps more restrictive or intrusive behavioral programming.
9. Efforts should continue to supplement membership of the current human rights committee to ensure that meetings have adequate quorums, and include members that are not employees of CCSSLC.
10. On behavioral graphs, just as target behaviors are labeled (e.g., aggression, SIB, etc.), replacement behaviors should be labeled, and similarly

and conspicuously operationally defined.

11. In an effort to facilitate more efficient and effective visual analysis of graphs, psychologists should consider the following:
    a. Ensure that all axis are labeled;
    b. Utilize line instead of bar graphs;
    c. Use different markers (instead of line colors) to differentiate between variables (light colors do not copy well);
    d. Use multiple Y axis to illustrate multiple dimensions of behavior (frequency, percentage, etc) or values/dosages of medication;
    e. Remove medication as a value on the Y-axis (and data path) to avoid extreme ranges in scores, and instead use text boxes, phase change lines, or tables under graphs to highlight changes in medication.
12. Raw data collection systems should be individualized. A review of the nature of target and replacement behaviors should be completed, and consideration given as to whether or not an alternative or supplemental data collection methodology may be more appropriate and/or would provide more meaningful data (i.e., scatter plot, A-B-C data, partial interval, duration recording, measure of intensity, etc.). Changes to the system should be weighed against potential negative effects of multiple or increasingly diverse data collection systems, as well as the systems' acceptability and feasibility as judged by those collecting the data.
13. In an attempt to avoid confusion, consider not collecting, summarizing, and/or displaying data on the use of restraints for individuals unless clinically justified (i.e., an individual does not have a SPCI, and/or has not required restraint for a period of time). Or, as an alternative, collect data on the use of "emergency restraints" for individuals who do not have a SPCI, or where collecting data on restraints does not appear to be clinically justified.
14. Consider whether or not collecting data on other dimensions of restraint (e.g., duration) would be helpful or necessary.
15. As previously recommended, data should be collected on the use of any intervention conceptualized, described or utilized as therapeutic (or therapy). This includes, for example, psychotherapy or counseling. This data should facilitate the examination of whether or not the identified therapeutic intervention is effective. In addition, therapeutic interventions should include goals with measurable objectives, outline treatment expectations, and provide sufficient content describing the intervention so that determination of whether or not procedures reflect evidenced-based practice can occur. Subsequently, psychological and behavioral services staff as well as the PSP team can determine whether or not the time and resources spent on these therapies are effective.
16. The empirical support should be reviewed for any therapies provided to individuals served by CCSSLC whether on or off campus. In addition, PSP teams should consider whether or not other evidenced-based practices (e.g., functional communication training, picture exchange communication system, etc.) might be a better match to address the underlying needs of those identified.
17. Peer reviews of PBSPs should determine if prescribed interventions address identified hypotheses, if replacement behaviors are functionally equivalent, and whether or not antecedent interventions are truly preventative in nature.
18. Work should continue on developing a systematic format for PBSPs. Consideration should be given to placing functional assessment data before information on interventions so the link between assessment and intervention is more apparent. This information could be very brief (perhaps just the identified function of each target behavior), especially if this information is reliably available in psychological assessment documentation. A brief section on history of previous interventions should be included. In addition, true baseline data (e.g., the average monthly frequency of a targeted response prior to plan implementation) should be provided in addition to the data from the previous year.
19. As recommended in the baseline review, with regard to reinforcers:
    a. Use of positive reinforcement should be enhanced across antecedent and consequent-based intervention strategies;
    b. Reinforcers should be as individualized as possible; and
    c. As appropriate, differential reinforcement should be used during formal teaching (SAO) programs. That is, provision of reinforcer (and/or quality of reinforcer) should be dependent upon the accuracy of responding.
20. In addition to previous recommendations regarding reinforcers, formal reinforce/preference assessments should be completed with regularity.
21. A system should be developed for assessing and monitoring inter-observer agreement for PBSP data.
22. As previously recommended, consideration should be given to developing a very short [one- (1) or two- (2) page] "abbreviated PBSP" that can

be utilized as a training document or ongoing quick reference (i.e., "cheat sheet") for direct support professionals. This should contain the most critical data collection and intervention strategies, including operational definitions of targets and replacement behaviors. A table with an "if, then" format might be very helpful.

23. The section on reducing restrictiveness of interventions found in PBSPs should contain specific criteria (clear objectives) of behavioral progress (or deterioration), including target and replacement behaviors that would identify when team reviews or PBSPs revisions would be considered.
24. The way in which replacement behaviors are tracked should be changed; that is, true replacement behaviors should be measured as they occur in the natural environment and not only during formal teaching programs.
25. A system or training log should be developed, adequately maintained and readily stored at each residential program that allows supervisory staff to determine quickly if pulled or relief direct support professionals have the necessary training to work at the site, and/or with specific individuals.
26. SFBAs should be completed sooner than annual PSO meetings if necessary (i.e., when clinically demanded or justified). If appropriate, the completion of these assessments should be prioritized to ensure that most critical issues are examined first.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o CCSSLC - Medical Services Organization Chart, dated June 2010; o Number of individuals on each physician's caseload; o Tropical Unit Census, dated 6/14/10; o Atlantic Unit Client List, dated 2/24/10; o Coral Sea Case List, dated 5/26/10; o Pacific Unit Client List, dated 6/10/10; o List of Continuing Medical Education Activities Attended by Medical and Psychiatry Staff; o Over the past 12 months, a list of educational lectures and in-service training provided by psychiatrists and medical doctors to Facility staff; o Description of medical quality improvement program; o Most recent results/report of the medical quality improvement program; o Most recent results/report of the Facility-wide medical review system; o Description of Facility-wide medical review system; o CCSSLC's Policy for Emergency Carts, dated 7/16/10; o Revised Emergency Competency Checklist form; o Sixty-eight (68) Emergency Competency Checklists; o Emergency Cart Checklists for all 11 units; and o CCSSLC's Mock Medical Emergency Drills from December 2009 through April 2010; o CCSSLC Deaths during Time Period 7/1/09 to 6/1/10; o Medical records on mortality cases within past year, including records for: Individual #341, Individual #71, Individual #169, Individual #78, and Individual #96; o Medical record reviews on the following individuals residing at CCSSLC: Individual #183, Individual #240, Individual #179, Individual #211, Individual # 87, Individual #380, Individual #379, Individual #22, Individual #43, Individual #307, Individual #131, Individual #348, Individual #207, Individual #183, Individual #67, Individual #228, Individual #284, Individual #52, Individual #340, Individual #173, Individual #7, Individual #159, Individual #153, Individual #184, Individual #94, Individual #181, Individual #19, and Individual #294 ▪ **Interviews with**: o Dr. Julie Moy, DADS SSLC Medical Services Coordinator; o Dr. Sandra Rodriguez, Medical Director; o Norma Brown, MD, Attending Physician; o Sharon Alexander, Nurse Practitioner; o Colleen M. Gonzales, BSHS, Chief Nurse Executive; o Rhonda Lynn Warner, RN, QA; and o Shelly Scott, RN,C Nursing Operations Officer ▪ **Observations of**: o Individual #43;

	o Individual #211; and o Use of emergency equipment at Sea Horse
	Facility Self-Assessment: The Facility was currently revising the POI to provide a description of the steps the Facility is taking to assess compliance with regard to the specific sections of the Settlement Agreement related to medical care. Although the POI for CCSSLC did not include this component, the POI highlighted the breadth of tasks and challenges ahead, outlining specific areas that CCSSLC believed would need to be accomplished in order to be in compliance with the SA. All areas were identified as "a work in progress." There had been progress in the areas of seizure management. Seizures were being tracked as to type of seizure, and length of seizure, and these were being tabulated to determine frequency per month, and included the time of day. All of these are important to the neurologist attempting to provide adequate treatment. There was a neurologist consulted on each seizure management case reviewed (see assessment of status L.1 of the SA). All of the areas related to medical care will need guidance in developing policies and procedures in order to ensure ongoing quality of care. At the time of the review, no policies had been developed or implemented, because the medical department was in the beginning stages of implementing the POI. Also, there was no medical QI system in place. There recently had been signed a contract for an outside vendor to complete mortality reviews, but there had been no finalization of plans or implementation of a medical review system by non-facility physicians. The facility was accurate in self-assessing noncompliance in all four SA requirements. There had been improved compliance in some areas of documentation, but without policies and procedures to standardize this process, it will be difficult to maintain consistency across the Facility. The POI also indicated that L4 related to the development of policies and procedures was under the guidance of the State Office.
	Summary of Monitor's Assessment: The Facility was in the beginning stages of addressing the medical care components of the SA. They had not made progress in many areas, but there were positive steps, such as improvement in documentation in seizure management and transitioning of individuals to and from the hospital. Adequate medical staffing necessary to provide needed medical supports to individuals residing at CCSSLC was not in place at the time of the review. The CCSSLC Medical Director carried a caseload that was too large to allow her time to complete the duties of Medical Director. In addition, the Facility had been using contract physicians who were there for short periods of time, making training and supervision difficult. DADS had taken a number of steps to help recruit physicians, including increasing base salaries, and advertising on a local as well as national level. Based on documentation provided, there were no continuing education opportunities being provided to medical staff. It is important that such opportunities be offered, and include education on general medical topics, as well as topics specific to treating individuals with intellectual disabilities/developmental disabilities (ID/DD).

	The clinical death review process was generally not adequate to identify areas requiring attention, and the reviews generally did not result in recommendations that would be helpful in making improvements to the supports and treatment offered at the Facility. A death review should be considered a rich source of information for quality improvement and risk management. Each department should review the records of the individual to determine what alternatives could have been explored or what improvements or updates should be considered. As an important but separate component providing external review, a contract had been recently signed with a patient safety organization. They will be conducting mortality reviews of CCSSLC death cases. This is an important step in meeting the requirements of the SA. Based on a review of five mortalities that occurred during the past year, and the finding that all of these deaths were attributed to aspiration pneumonia or pneumonia, there is concern about the standard of care being provided to medically complex individuals with respiratory complications. This should be an area of urgent review by the medical department. A medical review system that consisted of a non-Facility physician case review had not begun. There had been some informal discussion concerning recruiting and choosing the physicians who would best meet the needs of the Facility and the requirements of the SA. However, at the time of the review, there had been no contract created or signed to begin this process. A comprehensive set of policies, procedures, and clinical pathways/guidelines still need to be developed. Clinical pathways should set forth standardized expectations concerning diagnosis and treatment, including time lines for moving to the next clinical step. Areas of priority for the development of policies, procedures, and clinical pathways include ones to address: pneumonia, chronic constipation, gastroesophageal reflux disease, dysphagia, enteral nutrition, rumination, pica, diabetes insipidus, and osteoporosis.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the	At the time the document request information was submitted to the Monitoring Team, there were 297 individuals residing at CCSSLC. Of these, 110 were assigned to one primary care physician (PCP), 80 were assigned to a Nurse Practitioner (NP), and 107 were assigned to the Medical Director. The 107 assigned to the Medical Director were also considered the most medically complex. One standard used for medical staffing equates 100 individuals of average complexity per PCP. That there were 107 individuals of high medical complexity assigned to the Medical Director indicated that there was little to no time available to fulfill the role of medical director. One hundred and seven (107) medically complex individuals is more than a full-time case load for a PCP.	Noncompliance

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	applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	At the State-level, the DADS SSLC Medical Services Coordinator was aware of the urgent need to recruit qualified primary care physicians, and had taken some important steps in recruiting over the past few months. With success, under the DADS SSLC Medical Services Coordinator's administrative guidance, the State recently had increased the salary of primary care physicians at CCSSLC to be more competitive with other opportunities available to physicians. Also, the DADS SSLC Medical Services Coordinator gained approval to recruit for openings at CCSSLC in full-page advertisements in state, regional, and national family medicine, internal medicine, and psychiatry journals. Recruitment also was going to be done through the regional family medicine and internal medicine professional meetings. This approach appeared to have been initially successful, because as of the week of the site visit, there were six applicants applying for the physician vacancies. This process also will be of benefit to recruit permanent positions. Until recently, physicians were recruited through contract agencies and were short-term appointments. This was an added drain on CCSSLC's system, especially on the Medical Director and nursing department, because time would need to be spent orienting these new physicians to a unique and complex system, only to have them replaced a few months later. The Medical Director also was in the process of being provided additional support in secretarial assistance. The role of Medical Director will require administrative secretarial support, and this was a newly approved position. It will be a valuable position, especially due to the essential need for development of policies and procedure, and development and implementation of a quality improvement system, including reviews, and monitoring. However, there remain challenges ahead, which will require ongoing decisions at the State-level. It will be a priority not only to recruit qualified primary care physicians to the system, but also to maintain them and minimize turnover. This is particularly important given the complexity of health care needs of individuals served by CCSSLC, and the essential need for interaction and communication with members of other departments. Continuity of care is always an added benefit in any patient population, but has a high impact on this population. Individuals with intellectual disabilities/ developmental disabilities living in large facilities are best treated by physicians who know them well. Therefore, retaining qualified primary care physicians for the long term is the next step. This will require ongoing salary adjustments to maintain competitiveness. It will require funding to provide for continuing medical education in the form of medical conferences that focus on primary care and areas of particular significance to this population. This will also require time away to attend these meetings. In response to a pre-tour document request, no information was submitted concerning whether the Medical Director, PCP, or NP attended continuing medical education	

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		opportunities. This suggests the need for significant review of this area, and for opportunities to be created to encourage PCPs and NPs to attend medical conferences. Additional opportunities could be provided by inviting outside speakers to discuss topics common to individuals with ID/DD, and opening this educational process to physicians, but also to dentists, pharmacists, nurses, and other health professionals, as appropriate. According to the information submitted, there was no evidence that this opportunity had been considered or promoted. As an additional positive effect, it would enhance or create networking opportunities to diversify referral patterns to meet the needs of individuals with ID/DD living at CCSSLC. In order to comply with Section L.4 of the Settlement Agreement, the Medical Director also will need to develop policies and procedures, including clinical pathways and clinical guidelines. This will require periodic literature searches on an ongoing basis for both new initiatives, and updating any clinical pathways and guidelines that have already been created. At the time of the review, there was no access to the current medical literature at the Facility. There are various routes to accomplish this, such as subscription to online search engines, but the State also may consider using its own medical school library system as an online resource to the Medical Director and other primary care physicians that work at CCSSLC. Without library access to journal articles and medical literature, the Medical Director will not be able to accomplish the important task of creating and updating policies, procedure and guidelines. At the time of the review, daily medical debriefing was informal and rapid. During the site visit, the debriefing was between two physicians and lasted approximately five minutes. Because there were only two physicians and one nurse practitioner providing the medical care at CCSSLC and each had a full case load, there appeared to be little time to spend each morning sharing information about what occurred during overnight coverage, and/or collaborating on challenges that each had encountered with their caseloads. Once a full complement of PCPs is on board, there should be formal medical staff morning meetings each business morning, to review medical problems that occurred in the past 24 hours, so all physicians are aware of the current critical cases at the Facility. Such meetings allow opportunities for all physicians to share ideas on a variety of clinical issues, as well keeping the Medical Director updated concerning the entire population. It also would allow the Medical Director to provide open and consistent guidance in clinical areas. Pharmacy and nursing staff should be invited to participate, depending on the availability of staff in those departments. They also would benefit from being updated and learning of the clinical problems, but also learning about such problems from the physicians' perspective. This is an important area of communication that is needed at	

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		the Facility. Minutes should be taken and recorded. The medical records was reviewed on each of the following individuals for evidence of routine preventive care: Individual #207, Individual #153, Individual #22, Individual #380, and Individual #228. Specifically: ▪ Five out of five (100%) records showed evidence of flu vaccine administration. ▪ Five out of five (100%) records showed evidence of H1N1 virus vaccine. ▪ For routine care, four out of five (80%) had a timely annual medical assessment completed in the year prior to the site visit. ▪ All had lipid profiles drawn in the past year (four of these were for preventive maintenance, and one was for routine care as the individual was on a lipid lowering agent. These indicators showed evidence of good preventive care, and routine maintenance care approaching expected standards. For the most part, the remainder of the discussion will focus on acute intervention, either as an emergency or as an active problem that required evaluations, lab and radiologic data collection, and appropriate treatment in a timely manner. Based on a review of five mortalities that occurred during the past year, and the finding that all of these deaths were attributed to aspiration pneumonia or pneumonia, there is concern about the standard of care being provided to medically complex individuals with respiratory complications. A review of these cases indicated that the terminal acute illness was generally recorded (in at least four out of five cases) as sudden, with little warning. However, this pattern would suggest a need to explore the standard of care with several departments, including but not limited to nursing, medical, direct support professionals, and respiratory therapy. Certainly, if early warning signs were missed, or if staff were not trained to observe for early clinical signs of change in health status, the first observed change would be serious deterioration. The window of opportunity to treat at an early phase in the illness would be missed in such cases, at a time when treatment would be highly effective. Instead, early signs might be missed and the individual's deterioration would not be noticed until urgent transfer to the hospital for treatment was required. Based on this sample of five records, these clinical trends of: 1) only recognizing the illness when the individuals were beyond recovery; and 2) all of the individuals having severe respiratory problems suggests the need for improvement in routine, maintenance, preventive, as well as urgent and emergency care of the individuals served by CCSSLC. Direct support staff need to have training and routine refresher training on health status changes, in which they are taught to observe for early warning signs of illness or developing health problems, such as pneumonia, dysphagia, GERD, constipation, etc.	

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		Because they all died of respiratory complications, this should be an area of urgent review by the medical department. One of the deaths was complicated by the H1N1 virus. Within this individual's records, there was notation that one building at the time had an outbreak of H1N1, but it was believed up to that point that it had been successfully isolated to that building. However, during the diagnostic evaluation of the individual who had become acutely ill (according to the medical record), it was discovered the test results returned H1N1 positive, indicating spread to another part of the campus. This suggested the need to review infection control measures for individuals living at the Facility, as well as employees, and visitors during times of outbreak. However, review of the Infection Control meeting minutes showed no review of this death or the surrounding circumstances related to H1N1. This population is known to be higher risk for morbidity and mortality if infected with H1N1, and outside expertise in public health would be important to meet the professional standards of care in this ever-changing area of healthcare. Additionally, the deaths involved those with feeding tubes. Feeding tubes may be associated with complications such as severe reflux, and aspiration of reflux, especially if the staff are not highly sensitized to the critical focus on positioning. Additionally, the placement of a gastrostomy-tube (G-tube) without review of the presence of Gastroesophageal Reflux Disease (GERD) may aggravate reflux. Attention to positioning needs to be absolute from one shift to the next, regardless of activity (feeding, bathing, toileting, etc.). Although there were orders written on many of the records requiring upright position at all times, there is a need for significant monitoring of all individuals with feeding tubes. A simple walk-through of the homes and day activity sites with a check off list would provide much valuable information as to whether prescribed positioning is always followed. The clinical death review process was generally not adequate to identify areas requiring attention, and the reviews generally did not result in recommendations that would be helpful in making improvements to the supports and treatment offered at the Facility. The following provides additional information about the individuals who died, as well as the death review process: ▪ Individual #341 was noted to be suddenly ill the morning of 8/3/09, with oxygen (O2) saturation down to 83% on two liters of O2. Individual #341's temperature was 101.5° Fahrenheit (F), and pulse was 107, respirations were 27. He was noted to have coarse breath sounds bilaterally. He was transferred to the Emergency Room (ER) and hospitalized for a left lower lobe pneumonia. He died on 8/23/09. He had had numerous pneumonias in the months preceding, including on 7/16/08, 9/17/08, 9/29/08, 11/12/08, 2/25/09 with a prolonged hospitalization, transferring back to the infirmary on 4/1/09, and	

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		eventually to his home unit on 5/6/09. Despite a history of aspiration pneumonia from 2/5/09 to 3/12/09, there seemed to be no monitoring system for direct support professionals to record every 15 minutes to one hour whether the head of his bed was elevated. He was enterally fed continuously and this simple positioning was vital. Without valid documentation, there was little to confirm that this required positioning was consistently done. Additionally, there was no administrative monitoring or documentation of this monitoring to ensure the direct support professionals were attentive to the need for consistent positioning, and documented Individual #341's positioning accurately. There were no recommendations from the clinical death review committee. The death review concentrated on events 72 hours prior to death. Because he was hospitalized for the last 20 days of his life, the review was not focused on his last days at CCSSLC. It would be advantageous to CCSSLC if the medical review covering 72 hours was in reference to the last 72 hours of the individual's life at CCSSLC. Much more would be gained concerning how to improve treatment and the supports and services provided by other departments at CCSSLC. Additionally, it was striking that the review was done only by the medical department. As a priority, review by the medical department is essential. However, a death review should be considered a rich source of information for quality improvement and risk management. Each department should review the records of the individual to determine what alternatives could have been explored or what improvements or updates should be considered. This may mean considerations for changes in policy and procedure, improvement in communication, need for new or different equipment, need for second opinions or additional referral patterns to specialists, new monitoring mechanisms, among many other opportunities. Each department should be challenged to develop one or more recommendation to be implemented, including time lines for completion, and persons responsible. For habilitation and behavioral services, among others, it may mean reviewing many years of information to determine how the outcome could have been changed or redirected. Focus of the death review in these departments could be on quality of life and functional status. ▪ Individual #169 died on 9/20/09. A nursing assessment at 1:45 p.m. on 9/19/09 indicated he had yellow nasal drainage and cough, respiratory rate was 24, but vital signs were stable (temperature was 98.7, O2 saturation was 93 to 98%), and lungs were clear to auscultation. There was an order to do a complete blood count (CBC), Comprehensive Metabolic Panel (CMP), and chest x-ray. Dimetapp was ordered. The next note was on 9/19/09 at 6:45 p.m., by the NP, at which time he had a temperature of 102.3° F rectally, pulse was 130,	

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		respirations were 24, and his chest had coarse breath sounds throughout. He had abdominal breathing, and breathing was described as labored. He was sent to the ER, and died the following day. He appeared to dramatically worsen in a few hours. The day prior to the onset of illness, on 9/18/09, the G-tube had fallen out and was replaced. Some bleeding was noted at the stoma site. Staff checked for placement by auscultation and residual. The individual was reported to have tolerated the procedure well. ▪ Individual #78 died on 10/23/09. On 10/20/09, at 10 a.m., the O2 saturation dropped to 90%. Placed on four liters of O2 by mask, this improved the O2 saturation to 92%. There was wheezing on the left side and bilateral rhonchi. By 12:30 p.m., the O2 saturation had dropped to 89% when placed back to 2L, and the oxygen then was changed to 3L. At 2 p.m., the O2 saturation was 94%. There was no distress. At 3:40 p.m., the Medical Doctor (MD) checked the individual. The respiratory therapist had suctioned the individual, and the O2 had been increased to 6L. There was no cough or nasal drainage. The individual was moved to the infirmary. The next morning, 10/21/09 at 7 a.m., the individual's temperature had dropped to 95° F and O2 saturation was 92%. Warming procedures were started. By 1:30 p.m., the individual was coughing and suctioning was performed of thick secretions. Rectal temperature remained at 95.1° F, respirations were 20, and oxygenation was 92% on 4L. The individual was noted to be sleepy but arousable. The breathing pattern was noted to be different. The individual was sent to the ER, and admitted with pneumonia and sepsis. Of note, Klonopin was started on 10/13/09 at 0.25 milligrams (mg), three times a day (TID). Given the recent introduction of Klonopin, a review would have been helpful to rule in or out whether there was an adverse effect from this newly prescribed medication, such as respiratory depression either alone or in combination with other medications, which led to hypoventilation, inability to clear secretions, and then pneumonia and respiratory failure. If this were a possibility, then this would be a learning point. When a person is transferred to the ER and then subsequently dies in the ER or after hospitalization, it would be valuable to have a copy of the information packet sent to the ER included in the individual's record to ensure all important documents were sent. This would allow a quality improvement review to ensure that all important and appropriate clinical documents were forwarded to the ER. The Facility should review its policy regarding the transfer of information to ERs and hospitals to ensure the needed information is available. Unless one copies a duplicate transfer packet, then there is no proof and no way to monitor the transfer of essential information to the ER. It is recommended that the medical department, in collaboration with the nursing department, develop a system to monitor the actual information that is being transferred with the individual to the hospital. It also would allow further investigation if the ER did not receive	

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		the information (i.e., review of the EMS transport system, etc.). ▪ Individual #96 died 11/18/09. On 11/5/09, it was recorded that she had no bowel movement (BM) for three days, and an enema was given with results. On 11/7/09, her abdomen was palpated and was recorded as firm. A soap suds enema was given with results. At that time, respirations were recorded as even and unlabored. Then, on 11/8/09, she was found in respiratory distress, with O2 saturation at 74%, temperature 99.2° F temporal, pulse 124, and respirations 28, with blood pressure at 95/65. Breath sounds were coarse. She was sent to the hospital, where she was found to have bilateral infiltrates, and she died of pneumonia. From the history, although one cannot readily conclude the constipation and enema administration caused the deterioration, since this was someone fed by an enteral tube, one question arises with regard to the position of the individual at the time of the enema administration. If she were lying flat, and her tube feeding was in progress, or completed within two hours, or if she had severe GERD and should not have been lying flat under any circumstance, she could have refluxed the formula into the lung, causing acute distress and respiratory failure. This question was not asked or answered as part of the death review process. The clinical death review committee had no recommendations in this case. Again, all departments should be participating in a death review focusing on the each department to determine what can be learned and what can be improved or changed. A diagnosis of seizures was one of the most common diagnoses at CCSSLC. Submitted data indicated that 147 individuals had a seizure diagnosis. This represented about 50 percent of the population residing at CCSSLC. Records on five individuals were reviewed for seizure management. Generally, it appeared that seizure management was adequate. Individuals were followed closely by neurologists. Although a number of the individuals in the sample were prescribed more than one medication to control their seizures, this appeared to be appropriate. Changes were made to medications based on review of laboratory results and seizure records. There were some discrepancies between seizure records and the cumulative seizure logs. Direct support professionals would benefit from additional training in observing for seizure activity, which may vary from one individual to another; training should include consistent documentation of seizure activity, and time activity begins and ends. Length of seizure and time of day are critical data in providing an optimal medication regimen. The following provides additional information about each of the individuals reviewed: ▪ Individual #181 required a vagus nerve stimulator (VNS) unit, as well as three antiepileptic drugs (AEDs). Co-morbid conditions associated with seizures on the active problem list included chronic constipation and hypotonic colon. There was some confusion because the inactive problem list included abdominal distension (recorded on 5/8/09 and 6/4/09), and fecal impaction. The reason	

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		why these were listed as inactive was not clear as they represented a continuum of findings for constipation and hypotonic colon. He was considered high risk for seizures and medical concerns, and low risk for aspiration/choking, constipation, and polypharmacy. He had serial Dilantin levels and Valproic acid levels obtained, and these were reviewed by the neurologist. He last saw the neurologist on 2/8/10, and was to be seen in six months, but was seen also on 3/8/10. A seizure record was kept, and there appeared to be reduced numbers of seizures per month compared with 2008 and earlier. There was an up-to-date flow sheet recording the number of seizures per month, current AED regimen, and any drug levels. The number of seizure records submitted reflected all the seizures, with one discrepancy in January. There were four seizure records submitted for January (1/23/10, 1/23/10, 1/24/10, and 1/26/10), one seizure record submitted for February (2/10/10), four seizure records for March (3/10/10, 3/11/10, 3/14/10, and 3/15/10), and one for April (4/15/10). However, the seizure disorder flow sheet recorded three seizures in January, one in February, four in March, and one in April. In the integrated progress notes, there were several MD notes during this time. Overall, care seemed attentive and the number of seizures have decreased over time. Despite a VNS placement, three medications for seizures were necessary, but drug levels were monitored routinely. A neurologist was seeing the individual at least twice a year. Risk factor analysis is discussed with regard to Section I of the SA that addresses At-Risk Individuals. ▪ Individual #184 also has a VNS. He was prescribed two AEDs. He was seen by the neurologist on 2/8/10, 3/8/10, and 4/13/10. His seizures had remained low in number and persistent (January 2010 – 1, February 2010 – 3, March 2010 – 2, April 2010 – 2, May 2010 – 2), but the length had increased from 30 to 45 seconds to one to six minutes. Seizure records were submitted for 1/1/10, 2/3/10, 2/16/10, 2/23/10, 3/1/10, 3/16/10, 4/9/10, 4/8/10, 5/27/10, 5/29/10, and 6/2/10. This identically matched the seizure log. He sustained a laceration from the 2/16/10 seizure. At that time, he was sent to the ER for suturing, as well as computed tomography (CT) scan of the head. On 2/3/10, he required Diastat for seizure control. He was prescribed Keppra and Depakote ER. Overall, seizure management appeared to be adequate, and well documented. Risk factor analysis is discussed with regard to Section I of the SA that addresses At-Risk Individuals. ▪ Individual #294 was prescribed Keppra, Lamictal, Zonegran, Klonopin, and had a VNS. As of a 2/28/10 nursing assessment, she had 240 seizures in the year, which was a decrease from the previous year during which she had 343 seizures. The seizures tended to be brief, 10 to 15 seconds, and, at times, occurred in clusters. However, she had had to be given Diastat 22 times in the same period, versus seven times in the previous year. Recent neurology consultations over	

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		the past six months were obtained, including on 12/22/09, 2/8/10, and 3/8/10. Since November 2009, she had had less seizures compared to prior months except in April (15 in November, 15 in December, 13 in January, 7 in February, and 14 in March, and 23 in April.) Seizure management was adequate, and well documented. ▪ Seizure management was reviewed for Individual #94. As of 9/17/09, he was prescribed Trileptal, Depakote ER, Keppra, and Lyrica. In the past six months, he had been seen by a neurologist on 1/11/10. Lab levels indicated elevated Depakote, and the neurologist decreased the dosage, although he had no signs of toxicity. He was hospitalized for a series of five seizures on 3/25/10, requiring Valium en route, and Ativan in the ER. A CT of the head was completed, with no acute findings. The Depakote dosage was decreased further, as it was still elevated, and his Lexapro was decreased, because it is known to affect the seizure threshold. His sodium (Na) level was decreased, and his Trileptal dosage was decreased. He was discharged on 3/31/10. On 5/4/10, Neurontin was stopped, and he was started on Vimpat. He had no recorded seizures in January, three in February, seven in March, and eight in April. The seizure record forms were consistent with the cumulative log for February and April, but there were more reported seizures than in the cumulative log (in March there were 11 described, not seven). The reason for the discrepancy is not clear. His seizures were described as lengthy. On 4/15/10, he had cluster seizures of nine minutes duration. On 3/22/10, he had a 13-minute seizure. On 4/23/10, he had a 12 minute seizure. The neurologists continued to adjust his medications, and he was followed closely. Risk factor analysis is discussed with regard to Section I of the SA that addresses At-Risk Individuals. ▪ Based on a 5/14/10 nursing assessment, Individual #19 was prescribed Lamictal, Zonegran, and Vimpat. He had received Diastat once in the prior three months. According to the nursing assessment, he had eight seizures in November 2009, six in December 2009, and one seizure in January 2010. However, the seizure records indicated six seizures in January, five seizures in February, seven seizures in March, and four seizures in April. VNS was recommended, but the family declined. He saw the neurologist on 12/2/09, and on 4/12/10. His seizure management was adequate. Risk factor analysis is discussed with regard to Section I of the SA that addresses At-Risk Individuals. Additional concerns regarding the medical care and treatment being provided at CCSSLC are discussed with regard to Section L.4 of the SA. Although these concerns relate to the general medical care provided, they appeared to be particularly hampered by the lack of adequate policies and procedures as required by Section L.4. An important component of the provision of emergency medical care is ensuring	

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		readiness with regard to the implementation of emergency procedures. Since the baseline review, the Facility had modified the emergency equipment checklist and had added it to the Medication Pass Assessment tool audits so that when a nurse was observed for medication administration, they also were asked to demonstrate the use of the emergency equipment. A review of the RN/LVN Competency Checklists found that 67 nurses had received competency-based trained since February 2010. Observations of these skills should be conducted at least quarterly. In addition, the Medical Director reported that physicians were also attending the Medical Emergency Drills. From review of CCSSLC's Medical Emergency Drills Checklists from December 2009 through April 2010, the Facility appeared to be conducting drills on a monthly basis with a majority of the drills being conducted on day shift. It was noted from a review of the drills that many of the drills were being conducted on the same day within 10 to 15 minutes of each other. For example, of the 17 drills that were held in December 2009, 11 were conducted on 12/14/09, and five were conducted on 12/22/09. In addition, the drills were conducted in succession with only 10 to 15 minutes noted between drills. For March 2010, of the 17 drills that were conducted 15 were conducted on the same day, many only 15 minutes apart. This trend was found for each month reviewed. Conducting 15 emergency drills on the same day does not provide an adequate assessment of the emergency systems, especially when the drills are conducted 10 to 15 minutes apart. This may be the reason why most of the drills reviewed included no comments or recommendations. When evaluating emergency systems, it would be rare that there would not be some additional recommendations resulting from the review of the drill procedures. It appeared that conducting the emergency medical drills had become merely a task, rather than an opportunity to assess, evaluate, and improve a critical system for the individuals at CCSSLC. For the few comments found on the drills, there was no indication that any corrective actions were taken. Consistent with the baseline findings, there was no system in place to document that issues found during the emergency drills were timely and appropriately addressed. In addition, there was no system in place for regular review of the Facility's medical emergency procedures or analysis of the drills regarding trends that generate corrective actions and outcomes. It appeared that there had been no review of the drills conducted at all by either the Nursing Department or Medical Department. The purpose of conducting regular medical emergency drills is to identify strengths and weaknesses of the Facility's response to emergencies by continuously assessing the process as well as the staffs' knowledge and competency in executing emergency procedures. The Facility needs to develop and implement a system for reviewing and analyzing emergency procedures, and data generated from the emergency medical drills.	

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		Also, review of the drills found that the Facility did not incorporate the actual use of the emergency equipment during drills. This is essential and ensures that when an emergency arises, the nurse and other medical personnel are familiar with the equipment that might need to be used. Observations of emergency equipment use by staff on the Sea Horse unit found that the nurse was able to appropriately demonstrate the use of the oxygen, suction machine, and AED. However, problems were found in that the backup oxygen tank was not being checked, and staff were only turning on the oxygen and suction machines once a week to actually see if they were in good working condition. All emergency equipment needs to be turned on and tested to ensure it is working properly daily. A review of the Emergency Cart Checklists for the units found inconsistent documentation that equipment was checked daily. In addition, the forms used by the units were very difficult to read, and to determine how often the equipment was checked and how the equipment was being checked. These forms should be revised so that the information regarding the checking and testing of the Facility's emergency equipment is clearly documented. Although training documents indicated that the Facility had been providing training regarding the use of emergency equipment, while on-site, one of the nurses who was asked to demonstrate the use of the emergency equipment was unfamiliar with how to turn the oxygen on. The Facility needs to implement a system in which nurses are regularly observed checking the emergency equipment to ensure they are familiar with the use of the equipment. It is imperative that all licensed staff receive competency-based training regarding emergency procedures and equipment use. The Facility needs to continue to conduct observations of these skills quarterly.	
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.	A medical review system that consisted of a non-Facility physician case review had not begun. There had been some informal discussion concerning recruiting and choosing the physicians who would best meet the needs of the Facility and the requirements of the SA. However, at the time of the review, there had been no contract created or signed to begin this process. One possibility that had been discussed was recruiting physicians from a medical school faculty, with a focus on primary care residency programs. The potential benefit of such an agreement would serve a dual role. Medical school faculty would provide state-of-the-art consultation and teaching to the physicians and clinical staff at CCSSLC. Also, as individuals transition to the community, the need for primary care physicians with experience in caring for individuals with ID/DD will be essential. Many of the individuals will be best served in primary care practices, as well as in the medical school residency programs. This ongoing exposure by medical school faculty and residents would provide an additional opportunity to work with this medically challenging group of individuals.	Noncompliance

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		An important part of a medical review system at the Facility includes mortality reviews. Historically, at CCSSLC such reviews had always been done by the medical department. An outside peer review process to ensure objectivity of focus and conclusions would be an essential component of the medical review system required by the SA. As an important but separate component providing external review, a contract had been recently signed with a patient safety organization, Quantos, Inc., based in California. They will be conducting mortality reviews of CCSSLC death cases. This is an important step in meeting the requirements of the SA.	
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.	At the time of the review, there was no medical quality improvement program in place. No initial steps had been taken, in part due to the lack of human resources in the medical department. There were no results/reports of the Facility-wide medical review system submitted in response to information requested prior to the visit. There were also no recent results/reports of the medical quality improvement program submitted prior to the visit. The Medical Director confirmed through interview that no such information was available. As mentioned previously, the current Medical Director had a full-time caseload of individuals for which to provide medical care, which did not allow this physician to assume the duties required to create a medical quality improvement system. This area will not likely grow until other PCP positions are filled, releasing the Medical Director to focus on the overall direction of the medical department. The Medical Director is encouraged not carry any caseload, but to use 100 percent of her time on medical direction. The Medical Director should maintain current medical skills and decision-making by providing back up for the PCPs when they are on vacation, at CME courses, etc. However, this should not consume more than 25% of the Medical Director's time. If it does, then cross cover by other PCPs or recruitment of other PCPs for an additional 0.25 to 0.50 full-time equivalent (FTE) should be considered. The time dedicated to medical direction should be protected to ensure compliance with the SA.	Noncompliance
L4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly	At the time of the review, in the medical department, there were no formal policies and procedures which would ensure an adequate standard of care at CCSSLC. The Healthcare Guidelines agreed to by the parties is a baseline from which future policies and procedures will be derived. The DADS SSLC Medical Services Coordinator indicated that she was responsible for initial development of these policies and procedures. This will require some updating of information, and a system to continue to periodically review the policies and procedures for ongoing updates. It also will require fine-tuning of the Healthcare Guidelines document to adapt it meet the needs of the CCSSLC. According to the DADS SSLC Medical Services Coordinator, any draft form will need to be approved by	Noncompliance

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	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 Assistant Commissioner for State Supported Living Centers. Then, there will be the required dissemination of information and education of physicians with expectations with regard to policy implementation clearly defined. During the Monitoring Team's review, many areas of clinical concern were identified as needing medical department review and guidance in the form of policies and procedures and clinical pathways/guidelines. One such area was pica, which requires interdisciplinary input. Ingestion of inedible objects can be life threatening, yet preventable. A list of those individuals identified as having a pica diagnosis was submitted, but it did not include all those individuals who ate inedible objects. For example, the following individuals were not included on the list, but had histories of eating inedible objects: Individual #140, Individual #317, Individual #66, Individual #7, Individual #77, Individual #30, Individual #84, Individual #110, Individual #159, Individual #191, Individual #315, Individual #297, and Individual # 275. Although the diagnostic criteria for pica may be interpreted as to exclude certain individuals who swallow inedible objects, the sequelae is the same, potential harm and the need for monitoring until resolution. The seriousness of the behavior may be underestimated. Pica tends to be a life-long habit, that may be dormant or exacerbated over time. The lack of clear policies, procedures, and clinical pathways/guidelines at CCSSLC resulted in inconsistencies in addressing pica, and, as a result, placed individuals at increased risk of harm. Such policies and procedures should describe the interdisciplinary team process necessary to ensure the safety of individuals who ingest inedible objects, including the diagnosis process, testing that should be considered to rule out medical causes, preventative as well as acute aspects of care, as well as the protections that should be put in place to prevent harm to the individual. Medical staff should be involved throughout the process, including in discussions that individuals' teams have with regard to downgrading protective measures that have been implemented. The following provide some examples of individuals for whom pica was not adequately addressed by individuals' teams and for which adequate medical oversight, particularly with regard to planning for preventative and acute care was not evident: ▪ Individual #7 had ingested many inedible objects over time. From a medical perspective, a clinical pathway to ensure optimal preventive and acute illness care was essential, but was not noted in the record. Some of the dates of ingestion and the object ingested included: on 4/30/08, a curvilinear metallic object; in 2/09, a tack which lodged in her lung and required a partial lung removal; on 9/15/09, a cuticle stick and a ring; on 1/30/10, an earring; on 2/8/10, a tab from a soda can; on 2/14/10; a rock; on 2/20/10, a piece of a	

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		compact disc (CD), on 3/2/10, glass; on 4/11/10, an AAA battery; on 4/13/10, paint chips; and on 6/23/10, gauze. She will require ongoing interdisciplinary communication and meetings to strategize. However, from a medical perspective, she would benefit from a clinical guideline that covers both preventive aspects of care, as well as acute care needs. ▪ There seemed the tendency to minimize the problem for Individual #380, who's BSP stated, "no pica attempts in over a year, will not be a target behavior but will continue to track since there is a history," as well as "provide with opportunities to use crayons for drawing as part of g activities. Staff must monitor her when she is using them to make sure she does not try to ingest them." These statements likely give mixed signals to the direct support professionals as to the seriousness of the behavior. In addition, the removal of pica as a target behavior appeared inconsistent with the BSP's Intellectual and Adaptive Assessment of individual #380, in which pica was rated as being of moderate severity, and that she generally had zero to one pica event a year. If pica behavior is no longer going to remain a target behavior, then the BSP should include other means to reinforce to staff the significance of this moderately severe and potentially dangerous behavior. ▪ Individual #67 was found to have string in her BM on 3/30/09. The PST inventoried her clothing for appropriateness, and "agreed that all DCP staff be re-in-serviced for bedding appropriateness." It was not clear at what point other apparel or bedding was allowed. However, introduction of inappropriate materials placed her at potential risk of harm. A clinical pathway would assist with medically reviewing any relaxing of environmental restrictions such as type of clothing. Pica is often life-long and reintroduction of materials at some point in time has the potential to create complications from pica. The guideline should provide some clarification as to level of supervision and length of time for that supervision. In the case of Individual #67, there was no change in level of supervision. ▪ Individual #22 had a long history of ingesting a variety of objects, including foam pieces from furniture, plastic, buttons, rubber bands, artificial flower petals, nail clippers, paper crayons, and objects retrieved from the floor, as documented on a 5/22/09 PSP Addendum. In 1991, she required a laparotomy because of ingestion of an inedible object. A 1/21/10 PSP Addendum indicated that in 2007 she ingested a balloon, as well as hair, and attempted to ingest a piece of paper towel. There had been no other reports of pica, although the document did not indicate over what time period the observations occurred. A PSP Addendum Transfer indicated that she did not have a diagnosis of pica, and did not have a BSP. Given the wide variety of objects ingested, one requiring surgery, her ingestion of inedible objects should have an in-depth plan and tracking of events.	

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		At the time of the review, she was on routine supervision. Again, pica is generally a life-long habit, and no incidents over a year or two should not be cause for complacency by the team. Without rigorous monitoring and attention to her environment, an unsupervised event may occur leading to potential harm. With routine supervision, she could be ingesting objects, but such incidents would not be witnessed. Attention should to be focused on the care and safety of the individual, and her plan appears to understate her habit and its potential harm. ▪ Individual #340 choked on the adapter from his G-tube on 5/7/10. His supervision was subsequently increased to one-to-one. His BSP reflected his long history of pica, and a psychological evaluation dated 8/4/09 described his mouthing of the g-tubing. As his function declined, the protective mechanisms slowly, such as bed linens made out of canvas and one piece overalls, were dropped. The PST again seemed to have been complacent by the lack of observed pica. Prior measures that worked should be reconsidered. ▪ Likewise, Individual #87 had a history of pica, but the BSP was discontinued because his challenging behavior was extremely low in frequency and low in intensity. In the past, pica was controlled by limiting his access to soft paper items. It also was stated in a behavioral services evaluation that: "He is more likely to engage in this behavior when he is certain staff is not paying attention to the environment or if they aren't around." With removal of the BSP, and no updates or refresher information available to the staff, there was the possibility that the behavior could occur undetected. Staff working with Individual #87 always need to be trained and vigilant, but it was not clear that the team response was adequate when considering the potential life-long behavior of pica. A recent nursing summary indicated that this individual "had a package of thumbtacks in his possession. All tacks were accounted for no ingestion was noted." However, there should have been systems still in place to ensure this individual did not have access to inedible objects that he has ingested in the past. The question that needed to be answered was whether removing the BSP for pica was in the best interest of the individual, and ensured his safety and health. ▪ Individual #307 had a history of pica, including foam from a mattress, pieces of a digital video disc (DVD) cover, paper, depends plastic. Following a pica protocol would allow for medical treatment to be complete and standardized. ▪ Individual #379 had a history of pica, ingesting a wide variety of objects, and according to the behavioral services evaluation, had a BSP. Following a pica protocol would ensure medical care was thorough for both preventive measures and acute care treatment. ▪ Individual #355 had a history of pica including lotions, cologne, bath oil, grass, etc. He also would benefit from medical care that is thorough in both preventive	

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		measures and as part of acute care. ▪ Individual #310 had a long history of eating inedible objects, such as play dough, beads, and pegs. He had a BSP to address this behavior in the past. More recently, a behavioral services evaluation dated 1/27/10, considered discontinuation of the BSP at his annual PSP on 1/27/10. However, 1/14/10 he ingested some hand sanitizer, and on 1/28/10, he was exposed with potential ingestion of tena wipes. At the time, "based on the psychiatrist's assessment, the individual does not exhibit any symptomology to suggest the need for psychiatric medication, …he will continue to follow his routine programming." It is important to note that he continued to exhibit this dangerous behavior, and, as indicated by the psychiatrist, programming was indicated. The PST should not consider pica resolved despite a season of time in which it did not occur. It may mean the program or monitoring was working, or may mean that there was not sufficient supervision to notice the pica habit. The psychology department needs to consider pica a life-long habit in many cases, and should see success as not a reason to discontinue or consider discontinuing a support program that targets eating inedible objects. Another urgent need is for policy and procedures to be developed concerning when to consider placing a G-tube, a gastrostomy/jejunostomy (GJ) or transgastric Jejunostomy tube, or a jejunostomy tube (J-tube), as well as monitoring and providing guidance to prevent and treat complications. In developing such policies and procedures, consideration should be given to Nissen fundoplication for severe reflux. The following provides examples of individuals for whom concerns were noted with regard to enteral nutrition: ▪ Individual #380 had G-tube leakage at the ostomy site and required replacement of the tube. She also had a diagnosis of GERD, which can worsen with G-tube placement. ▪ Individual #183 had a J-tube placed on 5/5/10, and on 5/29/10 required replacement of the J-tube after the original one fell out. The PST met on 5/18/10, and recorded that the abdominal binder had not been used since the J-tube placement. The PST then agreed to discontinue this. The PST stated that "should [Individual #183] attempt to pull at the J-tube the PST will meet and discuss the re-implementation of the binder." Usually barriers are placed to prevent pulling the tube out, either accidentally when caught on clothing or a bedrail, or by the individual until 30 days passes and the ostomy site is mature. Clinical guidelines would have been helpful in reinforcing this important point to prevent the need to reinsert a tube before healing has occurred at the site. ▪ Individual #43 had a G-tube placed on 5/24/09, and a Nissen fundoplication on	

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		11/05/09. She had had several aspiration pneumonias in part due to severe reflux disease. However, she continued to have bouts of vomiting (12/3/09, 5/3/10, 5/10/10, and 6/24/10), and aspiration (on 1/26/10, transferred to the hospital with pneumonia and sepsis). She was noted to have phlegm with formula on 5/23/10, suggesting recurrent severe reflux. The nursing Health Management Plan of 3/10/10 detailed several steps should vomiting occur. However, details of the plan should have included next steps (diagnostic and therapeutic) when continued reflux with aspiration is occurring or believed to be occurring. Without further intervention in a timely manner, the continued vomiting and aspiration with pneumonia and sepsis will greatly compromise this individual. ▪ Individual #22 had a G-tube (placed on 5/7/08) for supplemental feeding and hydration should she not be able to take sufficient amounts by mouth. She was on a pureed diet with cubed breads. She had pneumonia on 2/11/09, 5/11/09, and 10/11/09. Further work-up would be indicated to determine whether she had aspiration from GERD, and whether her by mouth (PO) diet was contributing to silent aspiration. A clinical guideline that directs the physicians and staff with regard to the next steps when a G-tube is already in place, but an individual continues to experience problems such as pneumonia would be important in standardizing care across the Facility. ▪ Individual #340 had a vagotomy, pyloroplasty, and fundoplication in 1991 and G-tube placement in 1992. More recently, he was hospitalized for vomiting and pneumonia on 4/25/09 and 2/15/10, required bi-level positive airway pressure (BiPAP) for apnea, was found to have regurgitated formula on 3/31/10, and had pneumonia on 6/8/10. The possibility of severe GERD and associated aspiration with pneumonia needs urgent review, which should also be included in any clinical guideline. ▪ Individual #173 had a G-tube converted to a J-tube on 1/15/10. A number of complications followed, including: the J-tube was removed with replacement by a G-tube temporarily on 4/22/10, rescheduling replacement with a J-tube 4/23/10, clogging of the J-tube with replacement on 6/8/10, and clogging of the J-tube on 7/1/10. A clear policy of maintenance and care of the J-tube would define steps to be taken and by which department. For example, such a policy would require that the direct support professionals be trained in ways to bathe, turn in bed, and dress individuals with feeding tubes so as to not inadvertently dislodge the tube. Nursing would be provided education concerning how to ensure the tablets are crushed or dissolved before administration through the J-tube, as well as what to do when a J-tube becomes clogged. If an appropriate policy were in place and being implemented, pharmacy would recommend	

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		liquid regimens to reduce the need to crush and dissolve tablets, the medical department would order the appropriate liquid equivalents of medication for administration, and nursing and physicians would collaborate to clarify orders for positioning, flushing of the tube, checking tube patency, positioning, and function before medication or formula administration, notification of the physician in a timely manner, etc. Another area that would benefit from policy, procedure, and/or a clinical pathway/ guideline to standardize care across the Facility is the identification and treatment of constipation. The following provide some examples of individuals who had issues related to constipation who would have benefitted from such a clinical pathway/guideline: ▪ Individual #153 was noted to be constipated, and subsequently vomited on 2/6/10. He was sent to the ER. Abdominal x-ray in the ER showed moderate constipation. A follow-up study on 3/8/10 described worsening constipation, with a large amount of stool in the transverse and descending colon. He had been taking magnesium hydroxide since 12/29/08. On 2/9/10, docusate and methylcellulose were added. Miralax was added on 2/19/10. A later note on 6/24/10 indicated there were continuing problems as he had light brown liquid emesis, and had no BM in three days. Bowel hygiene is an interdisciplinary concern and requires guidance from the medical department, including components of a diagnostic work-up, including in severe cases, motility studies, and surgical consultation in extreme cases. It is likely in this case that the constipation had become a significant issue long before it was discovered. An appropriate clinical pathway/guideline would include at a minimum: a rigorous system of monitoring and documentation, in-service training for direct support staff, and the medications to be chosen and at what clinical point in time. Such guidelines would assist in ensuring that there is early and aggressive treatment of this illness. It also would standardize care for this problem across the Facility. ▪ Individual #207 developed severe constipation on 3/26/10, after having recorded no BM in five days, at which time an impaction was found requiring an enema. Medications were changed prior to this finding. Metamucil was discontinued on 2/4/10 and Amitiza was restarted. A Docusate suppository was given every morning. Prune juice was added. Despite these changes, on 4/7/10, moderate stool was noted in the pelvis on x-ray. Not providing more aggressive treatment until five days of no BM indicates a need for clinical guidance with timelines included and expectations of next steps. ▪ Individual #348 had a history of constipation. The 12/10/09 annual medical assessment indicated she was on Senna/Docusate, Lactulose, and Miralax. On 4/29/10, an x-ray demonstrated a large amount of gas and stool throughout the entire colon. By 7/2/10, she was still constipated, and prune juice was added.	

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		Immobility and pain management for a bimalleolar ankle fracture with open reduction and internal fixation (ORIF) on 2/24/10 likely exacerbated this condition. However, a clinical pathway would allow for the next series of steps to be taken until resolution of the constipation. Aspiration and GERD are also common problems with severe complications. This is another area in which a lack of policy, procedures, and clinical pathways/guidelines negatively impacted the care and treatment provided to individuals at CCSSLC. For example: ▪ Individual #153 completed a Modified Barium Swallow Study (MBS) on 2/12/10, with findings of trace aspiration with thin liquids. He was placed on nectar thick liquids. He required a very slow rate of intake, and 90-degree upright posture. A physical nutritional management program would be highly beneficial in assisting in this area. Reflux can be severe and can cause esophagitis and aspiration as well. In this case, Individual #153 also had a large hiatal hernia, and required an upper gastrointestinal (UGI) scoping to determine any pathology. However, instead of seeing these pathologies (dysphagia, aspiration, reflux, esophagitis,)as related to one another, and potentially ending in the same complication or complications, each was treated separately. A clinical guideline would provide information as to the next clinical step to be taken and at what point in time. ▪ Individual #207 had both GERD and dysphagia, and required nectar thickened liquids. A risk tracking record dated 9/15/09 indicated that she was at risk for aspiration and choking and at risk for dehydration in part because she required total staff assistance during meals and drinking, and required others to put food and fluids into her mouth. An additional problem of food and fluid falling out of her mouth was also noted. In the documentation provided, there was inconsistency between the orders, in one place stating she required nectar thickened liquids, and in another pudding thickened liquids. This suggested confusion among staff members, and the need for guidance and instruction. This can best be done with precise clinical guidelines for GERD and dysphagia and a dedicated physical nutritional management team, which is discussed further below with regard to Section O of the SA. She also developed a series of decubiti (three decubiti), and required nutritional supplements of protein, minerals, and vitamins to heal. ▪ As of 1/26/10, Individual #67 was on a ground diet with pureed breads. On 4/16/10, this individual had a choking episode. A quarter size piece of meat was removed, providing evidence her food was not pureed. Clear expectations of treatment of aspiration, with adherence to diet requirements are imperative. It also in essential for direct support professionals to complete competency-based	

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		training on diet orders, and for regular monitoring to occur to ensure adherence to the requirements. This is discussed further below with regard to Section O of the SA. ▪ Individual #131 had had numerous episodes of aspiration pneumonia as well as a history of GERD. He had a g-tube. He had patchy infiltrates in the right mid and lower lung on 6/24/09; right lung base on 7/20/09; pneumonia on 1/11/10; infiltrate in right mid and right lung on 3/9/10, increasing to bibasilar infiltrates on 3/10/10; and bibasilar pneumonia due to aspiration of vomitus on 4/7/10. This individual needed to be considered for evaluation for GERD as the potential cause of the pneumonia, because if this were the case, then other treatment options would be indicated. A clinical pathway for aspiration due to GERD is needed to provide direction to the medical staff. Another subset of aspiration and dysphagia is choking. Choking can occur from difficulty in swallowing, or also from unsafe eating habits. A policy, procedures, and/or clinical pathways/guidelines were needed in this area as well. Individuals were affected by a lack of clear guidance. For example: ▪ Individual #52 had a prior episode in 9/07 of choking on potato wedges, and more recently on 2/19/10, choked on an orange. He had unsafe eating habits, such as eating quickly, placing too much food on his utensil, and stuffing his mouth. It also was reported that he does not chew his food well. The speech therapist recommended no change in diet. The recommendations were that he be provided continuous reminders to slow down, to take small bites, and chew thoroughly and take sips of liquid after a few bites. Oranges were to be cut up into pieces. He was to have continuous one-to-one supervision during meals. There were several concerns with this approach. If this is similar to the former plan, then it is insufficient, as he choked during 1:1 supervision and verbal cues. If he does not chew well, he perhaps should be given ground meat and soft food, or chopped food. Consideration should have been given as to whether he needed to have adapted utensils, such as a spoon with a shallow bowl, so his bite size amount was smaller. Another option that should have been systematically considered was whether his small amounts of food needed to be serially plated to assist him in slowing his pace. He did require an abdominal thrust during the choking incident, and it is important not to repeat this. Also, on review of the integrated notes, there was no documentation of close follow-up by nurses or direct support professional. It is important, after an incident of choking to obtain vitals signs at least twice a day, including pulse oximetry readings, for up to seven days. At times, a chest x-ray is obtained urgently, but clinical exam may be sufficient. However, a clear clinical guideline will provide an outline of the requirements to which staff need to adhere when someone chokes.	

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		Rumination also is a topic that needs clear clinical guidelines, because it is difficult to treat, and confuses the treatment of other clinical areas that may appear to be similar, such as GERD. However, the indications for surgery, as well as the BSP, should take into consideration a diagnosis of rumination if it exists. Individual #183 had rumination, GERD, and the placement of a feeding tube. A clinical pathway created in advance with the assistance of community specialists would assist in providing appropriate and timely care of individuals with rumination. It would also provide the outside medical consultants with a guideline of potential options/expectations and suggested timelines. The treatment of diabetes insipidus can be lifesaving, and needs to be consistent. Physicians need to understand the pathophysiology, and be comfortable with administration of desmopressin (DDAVP). A clear clinical guideline would assure these individuals are monitored closely, and prompt treatment administered to maintain their health. The following are examples of individuals for whom such a clinical pathway was needed: ▪ Individual #183 developed diabetes insipidus, and required hospitalization for his hypernatremia to determine the diagnosis. Coordination of information in and out of the hospital with the need for DDAVP (Desmopressin, which reduces production of urine to prevent dehydration) will prevent additional complications in any future hospital admission. ▪ Individual #211 also had a diagnosis of diabetes insipidus in the past, and improved with removal of lithium from his medication regimen. He would benefit from a standardized approach to vigilant monitoring to recognize any worsening of this diagnosis. As mentioned above in discussion of the mortality reviews, a clinical pathway/guideline would assist in standardizing care and expectations concerning diagnosis and treatment of pneumonia. The goal is to prevent clinical deterioration to the point of requiring hospitalization. It would also translate into less sick days and better quality of life for the individuals served by the Facility. Example of individuals who would benefit from such a structured approach include, for example: ▪ Individual #179 developed pneumonia on 6/5/10, and hypoxia and pneumonia on 7/17/10. The Health Management Plan dated 1/26/10 referenced that he had three pneumonias and one episode of bronchitis over the prior calendar year. A standardized guideline with emphasis on early diagnosis and treatment would have applied to this individual. It also could be used as a monitoring tool, creating standard expectations that are measurable as to documentation of vital sign frequency, initial communication with the physician and content of that communication, initial lab and x-ray orders, initial respiratory therapy orders,	

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		and initial choice of antibiotics. The Medical Director can then expect that each time a physician is called to a see an individual with potential pneumonia, the direct support professionals and nursing staff have written documentation containing quality information with regard to observations made and examinations completed. Based on this information, the physicians would be expected to order certain tests and medications. ▪ Individual #307 had had pneumonia on 3/19/09, 5/28/09, 6/1/09, and 11/28/09. The etiology of the frequency had not been determined, although she has a diagnosis of GERD and dysphagia. Historically, her pneumonia was preceded by health status changes such as unresponsiveness and hypothermia. A clinical pathway with early warning signs may allow for early recognition of the pneumonia. ▪ Individual #284 had had many diagnoses of pneumonias in the recent past, including on 3/24/09, 4/23/09, 8/20/09, 12/30/09, 3/26/10, and 5/7/10. She had asthma, and had had additional attacks of shortness of breath and bronchospasms. She also had a g-tube and a diagnosis of GERD. Further evaluation of causes of her frequent pneumonia would be valuable. The potential for GERD to be causing aspiration may be an important consideration to rule out. A clinical pathway would provide guidance on this issue. ▪ Individual #379 had a history of pneumonias, including on 12/23/09, 1/15/10, and 2/8/10. She would benefit from following a clinical pathway for pneumonia that would ensure review of potential causes and timely interventions and treatments. ▪ Individual #173 had several pneumonias, including on 6/1/09, 8/17/09, 11/09, and 1/8/10. He eventually received a J-tube, which replaced a G-tube. A policy on pneumonia that identified the time lines at which another therapeutic step should be considered (for example, after the second pneumonia, a J-tube should be considered to replace a G-tube, or a fundoplication should be considered, etc.) is essential to minimize permanent damage to the lungs and the weakening of the individual's physiologic state. Osteoporosis is another common problem for individuals with ID/DD. Prevention of its development and active treatment of osteoporosis are essential in reducing the frequency of fractures. A clinical guideline needs to be developed to guide physicians in testing frequency, and pharmaceutical and physical therapy options. For example: ▪ Individual #179 had osteoporosis, according to his annual medical assessment, but was only taking calcium carbonate. Additional choices should be outlined in the guideline so the most aggressive appropriate treatment is offered to the individual. ▪ Individual #379 had a history of osteoporosis and fractures, yet was only on	

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		calcium supplement according to the information submitted. The infirmary was the location at the Facility where those with acute care problems that required nursing and medical care exceeding the abilities of staff on the residential units were placed temporarily. Up to 14 individuals could be treated on this unit at one time. It was often the unit where individuals who had been discharged from the hospital were placed and post hospital care provided. This was another area in which clear policies and procedures were needed. Given the intensity of care provided at this unit, it would be important to have defined criteria concerning eligibility for admission to the infirmary, as well as defined criteria with regard to when an individual should be transferred back to his/her home unit. This would ensure that nursing attention is directed to those critically and urgently ill, and nursing staff in the unit is not having to care for those who could obtain quality of care in a regular residential unit.	

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

1. Annual salary adjustments commensurate with community physician income should be considered in order to retain quality PCPs and maintain continuity of care.
2. Opportunities should be provided for continuing education for PCPs and NPs on general health care topics as well as topics specific to providing medical treatment to individuals with ID/DD. This could be done in various ways, including, for example:
    a. PCPs and NP could be offered annual reimbursement to attend a primary care conference or conference focusing on the needs of individuals with ID/DD, as well as providing them administrative time to attend to the conference; and/or
    b. Outside community physicians could be recruited to speak to health care departments on important topics related to caring for the ID/DD population.
3. Consideration should be given to providing online access to medical library system to assist in creating and/or updating policies, procedures, and clinical pathways and guidelines.
4. The Medical Director position should be free of a clinical caseload, except for coverage of other physicians not scheduled to work, due to vacation, CME course, etc.
5. Once there are three to four primary care providers, there should be a formal medical staff meeting each business day with minutes taken. These meetings should be designed to provide an opportunity for the medical team to review medical problems that occurred in the past 24 hours, so all physicians are aware of the current critical cases at the Facility. Such meetings also should provide opportunities for all physicians to share ideas on a variety of clinical issues, keep the Medical Director updated concerning the entire population, and allow the Medical Director to provide open and consistent guidance in clinical areas. Pharmacy and nursing staff should be invited to participate, depending on the availability of staff in those departments.
6. Direct support professionals and nursing staff should conduct monitoring of the positioning of those with feeding tubes on all shifts, with documentation of observations.
7. Direct support professional and nursing documentation should be validated through administrative monitoring.
8. The medical department, in collaboration with the nursing department, should develop a system to monitor the actual information that is being transferred with the individual to the hospital.
9. Clinical death reviews should be improved. The following recommendations are offered to assist in this process:

a. Mortality reviews should focus on the last 72 hours of life at CCSSLC, not the last 72 hours of life, which often occur in the hospital;
b. All departments should be required to review their department involvement with the individual over a long span of time, if necessary obtaining peer review of that department through a sister facility;
c. Mortality reviews should be used as a quality improvement tool and risk management tool for all departments;
d. Mortality review reports should include recommendations to address any areas in which improvements should be considered and/or made. Each such recommendation should be considered carefully, and, as appropriate, action plans should be developed and implemented to address the recommendations. Such action plans should include action steps, person(s) responsible, anticipated outcomes, and timeframes for completion.

10. There is an urgent need for development and implementation of a clinical pathway on pneumonia, especially focusing on health status changes early in illness, and a pathway that includes a multidisciplinary approach.
11. Policies and procedures should be reviewed to ensure the Facility is providing ERs and hospitals with all pertinent information concerning the individual being sent, including reason and supporting recent clinical history, as well as lab/x-ray results.
12. Direct support professionals should receive training on health status change.
13. Direct support professionals should receive additional training on the accurate completion of the seizure record.
14. The Facility should identify potential reasons for the discrepancy in information between the seizure record and the seizure log, and develop and implement a plan to resolve such discrepancies.
15. The Facility should develop and implement a system ensuring that the process of conducting emergency medical drills is a meaningful review of the medical emergency response system. This should include:
    a. A Facility policy that requires that Medical Emergency Drills are conducted at least quarterly on every unit and every shift, and include the use of the emergency equipment.
    b. A policy/procedure that outlines the levels of committee review for Medical Emergency Drills, actual Code Blues, and emergency procedures.
    c. A system to ensure that Medical Emergency Drills and actual Code Blues are critically analyzed, and plans of correction developed and implemented to address problematic issues.
    d. Competency-based training should continue to be provided regarding emergency procedures that include the use of the emergency equipment.
16. Emergency equipment should be checked and tested daily, and this should be clearly documented.
17. The State and Facility should finalize plans for a contract/arrangement with an external medical review process.
18. The Facility should develop a medical quality assurance program as soon as resources are obtained to lessen the primary care caseload of the Medical Director.
19. There is an urgent need for development of policies, procedures, and a clinical pathway/clinical guidelines for treatment of pica. Such a clinical pathway/guideline should address the diagnosis process, testing to rule out medical causes, preventative as well as acute care and treatment, and the protective measures that should be considered by the interdisciplinary team, including medical staff.
20. Both individuals with a diagnosis of pica, and without a diagnosis but who eat inedible objects or liquids should be included in the high-risk category for challenging behavior.
21. The clinical pathway/clinical guideline for pica should apply to those diagnosed with pica, as well as those not diagnosed with pica, but who have a history or habit of eating inedible objects or liquids.
22. A BSP should not be stopped abruptly if pica is no longer being recorded. Pica may be intermittent over an entire lifespan. Six to 12 months of pica free behavior does not indicate that pica behavior has been resolved. Although psychiatry may assess the individual as not benefiting from psychiatric medication, a life-long BSP or PSP that addresses eating inedible objects should be considered to meet the health and safety needs of the individual, and such plans should include regular training of the direct support professionals, and other members of the PST on pica and the need for vigilant monitoring.

23. A comprehensive set of policies, procedures, and clinical pathways/guidelines need to be developed. Clinical pathways should set forth standardized expectations concerning diagnosis and treatment, including time lines for moving to the next clinical step. Areas of priority for the development of policies, procedures, and clinical pathways include:
    a. Pneumonia;
    b. Chronic constipation;
    c. GERD;
    d. Dysphagia;
    e. Enteral nutrition;
    f. Rumination;
    g. Diabetes insipidus; and
    h. Osteoporosis.
24. An additional area requiring policy development is with regard to admission and discharge from the Facility's infirmary. Criteria should be developed to ensure that individuals being served in the infirmary are appropriate for the level of care provided there.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o CCSSLC's POI, dated 5/17/10; o CCSSLC's Nursing Supplemental POI; o CCSSLC's Nursing Department Presentation Book; o Nursing Peer Review Meeting minutes dated 2/4/10, 2/11/10, 2/18/10, 3/25/10, 4/23/10, 5/27/10, and 6/24/10; o Twelve audits generated from Nursing Peer Review Meeting; o CCSSLC's nursing staffing vacancies; o Infection Control Committee Meeting minutes dated 3/12/10 and 6/25/10; o Pharmacy and Therapeutics Committee Meeting minutes, not dated, but indicated "mostly between June 21-June 30, 2010"; o Revised Policy C.1, Isolation Precautions, dated 6/17/2010; o Infection Control Environmental Checklists (63) from 12/09 through 7/10; o Two emails dated 4/19/10 from the Director of Infection Control noting problematic issues regarding soap dispensers and ARJO tubs; o Infection Control course curriculum and post-test for initial and refresher training; o Environmental Checklist Review for Tropical Unit, dated 7/8/10; o The revised procedure Guidelines for Comprehensive Nursing Assessment; o The revised Comprehensive Nursing Assessment form; o CCSSLC's Comprehensive Nursing Assessment training rosters; o The competency-based training curriculum for the Comprehensive Nursing Assessment; o Draft of the At Risk Individuals High Risk Oversight Committee, dated 6/18/10; o Corrective Action Plan from Nursing Education; o Facility training rosters; o Medication Administration Workgroup minutes, dated 2/26/10, 3/8/10, 3/22/10, 3/29/10, 4/19/10, and 5/3/10; o Medication Error Committee minutes, dated 1/28/10, 2/26/10, 3/30/10, 4/29/10, 5/27/10, and 6/24/10; o Health Risk Assessment Tool-Nursing; o Quality Assurance (QA) Nursing Audits from February through June 2010, and compliance data; o Timeline for Respiratory Illness on Sailfish; o MAR Review Tool data from February through June 2010; o CCSSLC's High Risks By Type list; o The Health Care Protocols: A handbook for DD Nurses; o A memo dated 5/25/10 from Valerie Kipfer, State Nursing Consultant; o Medication Passes Assessment tool audits (128); o Medical records for the following individuals: Individual #7, Individual #375, Individual #86, Individual #304, Individual #94, Individual #297, Individual #348, Individual #172,

	Individual #188, Individual # 284, Individual #160, Individual #247, Individual #350, Individual #335, Individual #183, Individual #105, Individual #314, Individual #340, Individual #21, Individual #131, Individual #38, Individual #145, Individual #9, Individual #183, Individual #340, Individual #131, Individual #284, Individual #160, Individual #247, Individual #350, Individual #335, Individual #255, Individual #66, Individual #207, Individual #181, Individual #268, Individual #19, Individual #294, Individual #356, Individual #114, Individual #231, Individual #353, Individual #109, Individual #158, Individual #174, Individual #315, Individual #228, Individual #126, Individual #3, Individual #105, Individual #320, Individual #86, Individual #180, Individual #58, Individual #247, Individual #274, Individual #245, Individual #145, Individual #206, Individual #359, Individual #44, Individual #157, Individual #9, and Individual #38, and Individual #305; o Nursing Staffing levels; o CCSSLC's Infection Control computerized surveillance data list; o CCSSLC's Table of Organization; o Facility list of individuals with Methicillin-resistant Staphylococcus aureus (MRSA); Hepatitis A, B, and C; human immunodeficiency virus (HIV); positive Purified Protein Derivative (PPD); converters; Clostridium difficile (C-Diff); H1N1; and sexually transmitted diseases (STDs); and o CCSSLC's lists of individuals who were seen in the emergency room, hospital, and Infirmary ▪ **Interviews with**: o Colleen M. Gonzales, BSHS, Chief Nurse Executive; o Rhonda Lynn Warner, RN, QA; o Shelly Scott, RN,C Nursing Operations Officer; o Teresa Irvine, RN, MSN, Infection Control Nurse; o Mary Wilcox, RN, Infirmary; o Sharilynn Lee, Respiratory Therapist; o Daniel Dickson, QE Director; o Dr. Sandra Rodrigues, Medical Director; o Della Cross, RN, Nurse Educator; and o Julie Graves Moy, MD, MPH, DADS SSLC Medical Services Coordinator ▪ **Observations of**: o Medication administration at Sand Dollar and Sea Horse; o Nursing QE meeting, on 4/15/10; and o Use of emergency equipment at Sea Horse
	Facility Self-Assessment: The Facility was revising the POI to provide a description of the steps the Facility is taking to assess compliance with regard to the specific sections of the Settlement Agreement related to nursing care. Although the POI for CCSSLC did not include this component, the POI highlighted the commitment the State and the Facility has to the thoughtful implementation of the processes and systems needed to provide quality services. Overall, CCSSLC indicated that it was not in compliance with

	Section M of the SA, which was consistent with findings for this review. There were some items that the Facility had scored as being in substantial compliance regarding nursing assessments and clinical indicators of risk for infection control. However, based on the Monitoring Team's Review, the Facility was not in substantial compliance. To move into a position of substantial compliance, there are a number of foundational systems that have to be solidly built before the additional needed systems are constructed. This concept will affect the determination of substantial compliance in many areas. Quality, not just completion is the determining factor in appropriately assessing compliance. In addition, it will necessary to provide data validating substantial compliance that includes the total population being reviewed (N), and the sample of that population audited (n) to yield a percent sample to indicate the relevance of the compliance scores. Usually, compliance scores for under 20 percent of the relevant population cannot be applied to the total population. Without this information, data cannot be accurately interpreted, analyzed, or accepted as valid reflections of the practices being measured.
	Summary of Monitor's Assessment: Although many of the systems were not in place addressing the requirement of the SA to meet substantial compliance, the Nursing Department had made significant progress in moving forward. Many of these accomplishments are described below, and are detailed further in the sections below that address each of the requirements of Section M of the SA. Since the baseline review, CCSSLC continued to have adequate nursing staff, even with some vacancies. The Chief Nurse Executive had reallocated a position for Nursing Education to work half time with Infection Control, which was filled on 5/1/10 according to the CCSSLC's Supplemental POI. In addition, Nursing had also reallocated an RN position for a full-time Program Compliance Nurse, which was posted on 3/4/10 according to the Facility's Supplemental POI. During an interview with the Nurse Executive, an additional position reallocation was being evaluated regarding having a Wound Care Nurse to collaborate with Physical Therapy for issues related to skin and positioning. At the time of the review, there were no job descriptions/job duties yet developed addressing these newly allocated positions. The Facility had continued to not need the use of any agency nurses. CCSSLC's QE Nurse and Nursing Department had begun using the Monitoring Teams' review/monitoring tools in a number of areas. Although some data was generated from the auditing, this process continued to be in the initial stages of staff becoming familiar with the tools. Once the Facility has more experience with these tools, instructions will need to be developed for each monitoring tool. As these are developed, the Facility will also need to develop and implement a procedure for establishing inter-rater reliability at 85% or above. Although the Facility is at the beginning stages of implementing monitoring systems, the progress made by QE and Nursing since the baseline review was impressive. Consistent with the findings from the baseline review, there continued to be a number of significant problematic issues that were found regarding complete and adequate nursing assessments of symptoms for acute changes in status. There were problems noted regarding the lack of adequate documentation when the individual began showing symptoms of a status change, and of assessments prior to the transfer to an off-site medical center as well as upon return to the Facility. The Nursing Department had implemented a peer review process focused on individuals with acute illness and requiring hospitalization.

	They were in the process of using the monitoring tools when assessing the care and documentation, which should lead to the implementation of plans of correction to address the identified deficiencies. Consistent with the baseline findings, significant problems were found regarding the quality of the Nursing Assessments and Nursing Care Plans. Since the baseline review, in July 2010, the State Office had modified the procedure Guidelines for Comprehensive Nursing Assessment, as well as the Comprehensive Nursing Assessment form. The implementation of the modified Comprehensive Assessment was reported to begin 8/1/10. In addition, the State Office had decided to use the Health Care Protocols: A handbook for DD Nurses and the Lippincott Manual of Nursing Practice, 9th Edition for nursing protocols and nursing care plans. Although competency-based training was initiated for these areas, the competency-based training curricula were not adequate and needed to be revised. Since the baseline review, the Nursing Department had implemented a number of interventions associated with the medication administration system. The Medication Observation tool was appropriately revised to include all the basic elements of medication administration orally, by injection or via tube, and was implemented in February 2010. In addition, the frequency of the medication observations for nurses was changed from annually to at least quarterly, and more often, if necessary. Also, in an attempt to eliminate auditor error, the department had limited the auditors for medication observations to two Nurses from Nursing Education and the QE Nurse, rather than the variety of nurses previously used. A Medication Administration Workgroup was established and convened in February 2010 to review the Facility's medication administration system.

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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.	Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different sub-sections that address various areas of compliance, as well as factors that have the ability to affect the Facility's compliance with the Settlement Agreement. These sections include staffing, quality enhancement efforts, assessment, availability of pertinent medical records, infection control, and code blues drills. Additional information regarding the nursing assessment process, and the development and implementation of interventions is found below in the sections addressing Sections M.2 and M.3 of the SA. <u>Staffing</u> As reported in the baseline report, CCSSLC continued to have 61 positions allotted for Registered Nurses (RNs) with six vacancies, and 50 positions for Licensed Vocational Nurses (LVNs) with 5.5 vacancies according to the Facility's Supplemental POI. However, the documentation provided by the Chief Nurse Executive during the review indicated that there were 3.5 LVN vacancies and 7 RN vacancies. Aside from this discrepancy, the Chief Nurse Executive reported that the nursing staffing remained stable even with these current vacancies.	Noncompliance

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		Since the previous review, the Chief Nurse Executive had reallocated a position for Nursing Education to work half time with Infection Control, which was filled on 5/1/10 according to the CCSSLC's Supplemental POI. In addition, Nursing had also reallocated an RN position for a full-time Program Compliance Nurse, which was posted on 3/4/10 according to the Facility's Supplemental POI. During an interview with the Nurse Executive, an additional position reallocation was being evaluated regarding having a Wound Care Nurse to collaborate with Physical Therapy for issues related to skin and positioning. At the time of the review, there were no job descriptions/job duties yet developed addressing these newly allocated positions. Also, there were no policies, procedures or protocols modified or developed addressing the integration of these positions into the Nursing Department. CCSSLC continued to maintain an adequate and consistent nursing staff from the previous review. As noted from the baseline review, the Facility had continued not to need the services of agencies to augment nursing staffing coverage. The Facility continued to host nursing students from the local nursing schools for clinical training, thus having a pool from which to recruit new nursing graduates. The Facility should continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the requirements of the Settlement Agreement. At the time of the review, CCSSLC had a census of 294 individuals (one individual was transitioned to the community during the week of the review, reducing the census to 293). The structure of the Facility's nursing services remained the same since the previous review: ▪ Two of the residential buildings had 24-hour nursing care, specifically the Infirmary and Sand Dollar. ▪ During the day, nurses were assigned to each building. During the night shift, the Facility utilized a Campus Nurse who made rounds, and covered the rest of the Facility. ▪ CCSSLC's nursing staffing assignments continued to include five Nurse Managers, a group home manager, and two Psychiatric Nurses assigned to the Psychiatric Clinic. ▪ The Chief Nurse Executive continued to directly supervise the Hospital Nurse Liaison, Nurse Educator, the Infection Control Nurse, the Nurse Operations Officer, an Administrative Assistant, Medical Appointment Secretary, the Lab Technician, and the Transporter. <u>Quality Enhancement Efforts</u> Since the baseline review, the QE Nurse had begun using the Monitoring Teams' review/monitoring tools in a number of areas. Although some data was generated from	

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		her auditing, she reported that she was still in the initial stages of becoming familiar with the tools. In addition, she candidly reported that in many areas, the items addressing quality of documentation had not been assessed. Once the Facility gains more experience with these tools, instructions will need to be developed for each monitoring tool. As these are developed, the Facility will need to develop and implement a procedure for establishing inter-rater reliability at 85% or above. Although the Facility was at the beginning stages of implementing monitoring systems, the QE Nurse had already started using many more of the tools than would be expected in only a six month period of time. Additionally, CCSSLC's Nursing Department had adopted the monitoring tools provided by the Monitoring Teams. The Chief Nurse Executive reported that the department had chosen to focus on auditing individuals who experienced acute illnesses and hospitalizations for peer review. Review of the tools and piloting their use was initiated in February 2010. At the time of this review, twelve monitoring tools had been completed and submitted to this reviewer, but no actual aggregate data had been generated thus far. This was due to the fact that the department was in the process of becoming familiar with the tools and discussing the documentation contained in the medical records related to compliance with the items on the tools. While observing a Nursing QE meeting on site on 4/15/10, auditing discrepancies were discussed regarding what documents met the criteria for compliance and differences in compliance ratings. The Facility in conjunction with the State Office should develop instructions for each monitoring tool to ensure that all auditors are using the same documentation and criteria to determine each item's compliance, which will assist in establishing inter-rater reliability. From interviews with nursing staff and observations while on site, the Nursing Department was clearly invested and committed to understanding, learning, and implementing monitoring systems to identify strengths and weaknesses in nursing practices at the Facility. With that being said, the Nursing Department needs to continue to focus on the implementation of monitoring systems that generate clinical data focused on the quality of nursing services and not just merely the completion of required documentation. In addition, clinically competent and critical auditing that accurately reflect the quality of the nursing care being provided will yield timely identification of problematic trends, so that timely plans of correction can be implemented. Once the QE systems are in place, these data need to be integrated into the Facility's Quality Management and Risk Management systems. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> Although the Nursing Department had begun the implementation of monitoring individuals who experienced an acute illness and/or hospitalizations, since the baseline	

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		review, there was no improvement found in the quality of the nursing documentation in the medical records for this population. The Chief Nurse Executive acknowledged that the work being conducted regarding acute illness and hospitalizations had not yet had any effect on clinical outcomes. A review of 20 individuals' medical records (Individual #7, Individual #375, Individual #86, Individual #304, Individual #94, Individual #297, Individual #348, Individual #172, Individual #188, Individual # 284, Individual #160, Individual #247, Individual #350, Individual #335, Individual #183, Individual #105, Individual #314, Individual #340, Individual #21, and Individual #131), who had been transferred to a community hospital, emergency room, or the Infirmary found that there continued to be significant problems regarding the nurses' documentation in the following areas: ▪ A lack of documentation regarding the status and appropriate assessment of the individual at the time of onset of the symptoms; ▪ The type of temperature taken not consistently documented; ▪ A lack of follow-up from issues noted in previous nurses' progress notes; ▪ A lack of specific description, size, and location of rashes; ▪ A lack of documentation of surgical site assessments; ▪ Administration and follow-up for PRNs (as needed medications) not documented; ▪ Inadequate assessments and follow-up for pain; ▪ A lack of mental status assessments documented during status changes; ▪ A lack of adequate descriptions of the site of injuries; ▪ A lack of lung sounds assessed and documented for respiratory issues; ▪ No documentation from Respiratory Therapy found in medical records; ▪ A lack of neurological checks documented for individuals with a significant change in mental status; ▪ A lack of assessment of bowel sounds and abdomen for individuals with constipation. ▪ Physician/Practitioner not timely notified of change in status; ▪ No documentation that there was communication with the PNMT regarding changes in status for individuals at risk of aspiration/choking; ▪ Nurses writing progress notes that lacked adequate objective data; ▪ The lack of specific descriptions of the individuals' behaviors and mental status, assuming that all staff reading the progress notes were familiar with the individuals, i.e., "back to normal," "back to his old self"; ▪ Lack of analysis of contributing problematic issues affecting change of status; ▪ Inappropriate abbreviations; ▪ A lack of documentation regarding the individual's status and assessment at the time of transfer to and from the Infirmary; ▪ A lack of documentation regarding the individual's status and assessment at the time of transfer to hospital or emergency room;	

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		▪ No documentation indicating that an information packet was sent to the receiving hospital at the time the individual was transferred; ▪ Inconsistent documentation that the nurse or physician notified the receiving facility of the individual's transfer; ▪ Inconsistent documentation of the time, date, and/or method of transfer to the receiving facility in the progress notes; ▪ Lack of a complete nursing assessment upon return to the Facility, especially addressing the symptoms that precipitated the transfer; ▪ Dates and times not consistently documented for progress notes; ▪ Inconsistent use of format for progress notes [Description, Assessment, and Plan (DAP), Data, Action, Response, and Treatment (DART)]; ▪ Lack of an adequate updated Nursing Care Plan to reflect changes in status and new interventions; and ▪ Many nursing progress notes and signatures were illegible. Similar to the findings from the baseline review, there were a number of significant problematic issues found regarding complete and adequate nursing documentation and assessments of symptoms for acute changes in status for individuals. Also as found during the baseline review, the documentation provided by the hospital liaison nurse for individuals who were hospitalized was consistently exceptional. As an example of some of the problems noted: ▪ In the case of Individual #105, there was no documentation included in the progress notes indicating that he was to have a surgical procedure for sleep apnea prior to his transfer to the hospital. In addition, there was no nursing documentation indicating that he had actually had the surgery done upon his return to the Facility. The medical record lacked adequate nursing assessments prior to his transfer to the hospital and upon his return. There were no nursing progress notes found addressing the description and condition of his surgical site throughout all the Infirmary notes, even though he was being given an oral narcotic for pain management. Although while on site the nursing staff reported that this individual was able to indicate when he experienced pain, there were no adequate assessments of his pain documented prior to administering the pain medication or his response after receiving the medication. The progress notes indicated that his pain medication dosage had been increased, however, there was no documentation supporting the increase in dosage. There was a progress note indicating that Respiratory Therapy (RT) had come to assess the individual. However, there were no notes found in the individual's record from RT. From a discussion with a Respiratory Therapist, the Facility had no policies or procedures addressing the RT's documentation requirements.	

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		Selecting this area as a priority for the implementation of a monitoring system was an appropriate decision due to the significant problematic clinical issues found during the baseline and current reviews. By the next review, the Facility should have generated data for a number of months, and have developed and implemented plans of correction addressing the problematic issues related to acute changes of status. As noted from the baseline review, CCSSLC did not have a nursing protocol addressing change of health status. The Nursing policy reviewed during the baseline review entitled "Acute Illness/Injuries" found that the timeframes for the assessment by an LVN (within four hours), by the RN (within four hours), and by the physician (within 24 hours) to be inconsistent with current standards of practice, as defined by the SA and Health Care Guidelines. The Facility's Supplemental POI indicated that the State Office had approved the use of the Lippincott Manual of Nurse Practice, 9th Edition for Nursing Procedures and Protocols. The Facility had ordered the Manual on 6/1/10, and had not received it at the time of the review. In addition, the Supplemental POI indicted that prior to the Facility's implementation of the Manual, the State Office would need to develop and/or amend existing policies in alignment with the elements contained in the Manual. The target date for implementation listed in the Supplemental POI was September 2010. A memo dated 5/25/10, from the State Nursing Consultant, verified that the State had decided to use the Health Care Protocols: A handbook for DD Nurses and the Lippincott Manual of Nursing Practice, 9th Edition for nursing protocols and care plans. The Facility had onsite a copy of the Health Care Protocols: A handbook for DD Nurses, and had a purchase order form verifying that the Lippincott Manual of Nursing Practice, 9th Edition had been ordered. At the time of the review, the Facility did not have a plan for when training would be conducted for newly developed protocols and/or when implementation would occur. Based on the number of medically compromised individuals who had been admitted to the hospital, seen in the emergency rooms, admitted to the Infirmary, and the significant problematic issues found from the baseline and current reviews of acute status changes, this area should be considered a priority for implementation of nursing protocol(s). As noted previously, the Chief Nurse Executive reported that in February 2010 the department had initiated using monitoring tools related to acute illnesses and hospitalizations as a method for internal nursing peer review. From review of the Peer Review minutes from February through June 2010, chart audits were conducted during the meetings identifying problematic issues. Some of the issues noted and/or actions taken that were documented in the minutes included: ▪ Case Managers needed to complete quarterly assessments, and file them in medical records when individuals were in the Infirmary;	

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		▪ Nurses needed to ensure that all medications that had been resumed or discontinued post hospitalization were written out or reconciled using the WORx system; ▪ Laminated cards were made that included criteria for nursing documentation according to the Health Monitoring Tools; ▪ Documentation was needed indicating that a PSPA was conducted; ▪ PSPAs needed to be filed in the correct section of the medical record; ▪ There was a need for follow-up by nursing when an individual was returning to dorm after hospitalization, emergency room visit, or Infirmary; ▪ Some integrated progress were not signed; ▪ Nurses needed to print names due to legibility issues; ▪ Timeliness of quarterly assessments needed to be improved; and ▪ Appropriate documentation format not consistent (DART). Although some trends and issues were identified in the minutes and a staff member assigned responsibility for each issue found, there were no corrective actions noted for those issues. In addition, the minutes indicated that when staff documentation was found to be complete, letters of recognition were awarded. The efforts that the Nursing Department had put into this process since the last review appeared to be very promising, and should generate data that reflects the clinical practices of the Nursing Department in this area. Case reviews of individuals who have had to be transferred to the emergency room, hospital, or Infirmary is a clinically relevant area to target for resuming nursing peer reviews. Regarding the auditing of these cases, in order to generate accurate data, it is recommended that the auditing staff first read the "story" included in the progress notes from the start of the change of status to the individuals' return to their home unit, and then score the tools. This method would help to ensure recognition of the quality issues related to clinical care and the completeness and appropriateness of assessments, rather than just their completion. From interview with Nursing Department staff and review of the Facility's POI, the Facility's extensive policy addressing Nursing Peer Review had not yet been modified and reflected peer review as an investigational process rather than educational. As defined by the American Nurses Association (ANA) in 1988, peer review is an organized effort whereby practicing professionals review the quality and appropriateness of services ordered or performed by their professional peers. Peer Review in Nursing is the process by which practicing Registered Nurses systematically assess, monitor, and make judgments about the quality of nursing care provided by peers, as measured against professional standards of practice. Discussions with the Chief Nurse Executive and	

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		review of the Nursing Peer Review meeting minutes and associated audits reflected that CCSSLC had implemented the peer review process in alignment with the ANA's definition of peer review, despite the fact that the policy had not been revised to accurately reflect nursing peer review. Although not a requirement of the Settlement Agreement, the introductory section of the HCG highlights the value of nursing peer review. The Nursing Department is encouraged to move this process forward by regularly conducting peer review focused on the identification of strengths and weaknesses of the Facility's nursing practices, and including critical analyses of nursing practices, identification of problematic trends with plans of correction generated for problematic areas found, and continual monitoring for improved clinical outcomes. If done correctly, these activities will certainly contribute to the Facility's compliance with Section M of the SA, as well as with the Facility's efforts with regard to self-assessment. <u>Availability of Pertinent Medical Records</u> At the time of the review, based on information provided by Medical Records staff at the entrance meeting, the Facility was in the process of transitioning the medical records to a new format, and had completed the Atlantic Unit and Sand Dollar Home. In reviewing records onsite, it was noted that significantly fewer documents had to be obtained from the units compared to the baseline review. There was some occasional confusion regarding finding sequential progress notes since only some of the medical records had been transitioned to include the most current note at the beginning of the progress note section. However, all progress notes were found to be available in the medical records from this reviewer's sample. There were problems finding the PSPA's and HST minutes in the records for a number of individuals. The Facility's target date for the completion of the transition of all the PORs was reported to be October 15, 2010. The Facility needs to continue to ensure that documents are filed in a timely manner in the individuals' records, so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services. The Facility reported that five charts were to be audited each month to ensure completeness. As this process continues, Although the Settlement Agreement only requires five charts to be audited each month, consideration should be given to increasing the sample size with the goal of auditing 20 percent of the medical records each month to be able to have confidence that the findings of the audits can be applied to all of the medical charts. Although not related to compliance, it would be a beneficial practice. <u>Infection Control</u> The Facility continued to have a registered nurse with public health experience from the State's Infection Control Office in the position of the Infection Control/Employee Health Nurse. Since the baseline review, the Facility had added a Registered Nurse as an	

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		Assistant Infection Control Nurse. On 6/1/10, this position was added to assist with the tracking of individuals' immunizations, PPDs, and vaccinations, as well as developing and maintaining a database for these items. The Assistant Infection Control Nurse was expected to focus on delegated areas related to the individuals, while the Infection Control Nurse was to continue to develop systems for the department, and address infection control issues related to the employee issues. The Infection Control Nurse reported that she had done some limited training with the new assistant, and had conducted some competency-based training with her regarding immunizations and Tuberculin Skin Tests (TSTs) during evenings and weekends. However, there was no documentation to verify this had been done. Although some informal training was reported as completed for the new assistant, it needs to be formalized and documented to ensure that Infection Control staff is clinically competent in this specialized area. As mentioned previously, at the time of this review, there were no job descriptions/job duties yet developed addressing this newly allocated position. Also, there were no policies, procedures or protocols modified or developed addressing the integration of this position into the Nursing Department. Consistent with the findings from the baseline review, the Facility's Infection Control (IC) program continued to track the basic areas regarding the surveillance of MRSA; Hepatitis A, B, and C; positive Tuberculin Skin Tests (TSTs); HIV; Syphilis; current immunizations; current vaccines; and antibiotic use. However, an interview with the Infection Control Nurse validated that there continued to be no formalized system in place to ensure the reliability of the Facility's IC data. Based on CCSSLC's POI, the Facility reported that they were in substantial compliance regarding having a system to assess and document clinical risk indicators for infections, and that the Facility actively collected data with regard to infections and communicable diseases. However, without a system in place to determine the reliability of the infection control data, neither the Facility nor the Monitoring Team can confirm the validity of this information to make a finding of substantial compliance. Both the Facility's POI and the Supplemental POI indicated that a procedure needed to be developed, but required a policy from the State Office with the target date set as 12/26/10. Delaying this system until December 2010 compromises the clinical care of the individuals and places both individuals and staff at risk regarding infectious and communicable diseases. Due to the clinical relevance and ramifications of this area, data reliability for infection control is essential. Without ensuring that the IC data is reliable, the Facility cannot accurately identify its trends, problematic changes in trends requiring timely corrective interventions, ensuring that treatments and treatment plans are	

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		clinically sound, ensuring that timely and appropriate training is being provided, or initiating proactive interventions from analyses of past data trends. The Infection Control Nurse described using systems such as laboratory data, physician orders for antibiotics from the pharmacy, and 24-hour Facility reports to capture incidents of infectious issues, because notification of infectious issues from the units was not reliable. However, this was not a formal system and no data regarding discrepancies between these databases was being tracked. From the baseline review, the Infection Control Nurse reported that the documentation of the activities of the IC Department was contained in both the IC Committee Meeting minutes and in the Pharmacy and Therapeutics Committee Meeting minutes. The Facility used the IC Committee to address issues that pertained mainly to the direct support professionals, and the Pharmacy and Therapeutics Committee was used to address some limited clinical IC issues such as antibiotic use. From review of the Pharmacy and Therapeutic Committee meeting minutes that did not include a date but rather indicated "mostly between June 21-June 30, 2010," there was no mention of infection control issues or antibiotic usage. From review of the IC Committee Meeting minutes for 3/12/2010 and 6/25/2010, the content had not changed since the baseline review. The meeting minutes included supplemental raw data related to IC issues without a comprehensive analysis regarding any trends of the Facility's basic surveillance data. Since the baseline review, there had been no additional processes implemented to comprehensively analyze and address trends in the IC data, inquires into problematic trends, corrective actions addressing any problematic trends, or monitoring of outcomes in relation to the activities and interventions of Infection Control in conjunction with the practices on the units. Consistent with the findings during the previous review, the documentation reviewed from Infection Control included minimal narrative descriptions of the meaning of the data related to clinical issues. For example, the IC Committee Meeting minutes for 6/25/2010 indicated that from a 17 month review of pneumonia data, there was one individual who had pneumonia four times, six individuals who had pneumonia three times, and eight individuals who had pneumonia twice. Although the months and the individuals that were reviewed were not identified for these valuable data, the report indicated that the data was shared with the Dental Department for consideration when adding new dental hygiene treatment cases. Even though the Dental Department was an appropriate discipline to share these data, there was no mention that these data were shared with the Physical Nutritional Management team, the HST, the individuals' teams, or nursing. These disciplines also need this information to ensure that clinical attention is being paid to individuals with repeated illnesses. Collaboration with these disciplines would facilitate the identification	

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		of the etiology of such trends and could result in proactive interventions being implemented for other individuals. In addition, the Medication Error Committee meeting minutes dated 1/28/10 indicated that H1N1 vaccinations for Ribbonfish and Coral Sea were not timely administered, placing individuals at increased risk. The minutes indicated that staff's reasoning for delaying the vaccines were because they had ill individuals on the units, they did not know they had a deadline, and they did not want the individuals on their units to get sick. Clearly, this issue indicated breakdowns of a number of systems; including infection control practices. However, from review of the Infection Control meeting minutes, there was no mention of this issue and thus, no analysis conducted regarding any negative clinical effects from the delay, and what corrective action needs to be put into place to prevent this from reoccurring. While the Monitoring Team was on site, on 7/12/10, the Facility experienced an outbreak of respiratory symptoms and implemented quarantine for Apartment 510, Sailfish. A review of the document entitled Timeline for Respiratory Illness on Sailfish indicated that an individual from Sailfish had been admitted to the Infirmary for respiratory illness complicated by Asthma on 7/3/10. A rapid Flu test was conducted that was negative indicating that the flu was not the etiology of the symptoms. The individual was discharged from the Infirmary on 7/7/10. The timeline reflected that between7/7/10 and 7/11/10, 11 staff and seven individuals were experiencing similar symptoms. It was not clear from the documentation if all involved were from the Sailfish area. The timeline then indicated that when a staff member came to the IC nurse complaining of symptoms on 7/12/10, and she called the area to inquire about other staff illness, she was then informed that a total of 13 staff and nine individuals were experiencing symptoms. At the time the IC nurse was informed of the situation, she set the system for isolation, precautions, and notifications in motion. The concern this event raises is the fact that no one from the Sailfish area notified the Infection Control personnel about the situation. When the IC nurse initiated the call to Sailfish, four days had already lapsed from the identified onset of symptoms. This situation clearly indicates that formal systems and communication lines between the units and the Infection Control personnel need to be established, and memorialized in policies and procedures. Although the Facility's Supplemental POI indicated that action plans were added to the format of the IC Committee Meeting minutes on 6/15/2010, the IC Committee Meeting minutes dated 6/25/2010 did not contain action plans. Both the Facility's POI and the Supplemental POI indicated that the Facility action addressing this issue will begin after receipt of new/amended policy and direction from the State Office. The target date for full implementation noted on CCSSLC's POI was 12/26/2010. From interviews with the	

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		Infection Control Nurse, the department appeared to be involved in a number of activities/training that was not reflected in the minutes of the IC Committee. The Facility needs to continue to modify the format of the minutes to include and accurately reflect pertinent information regarding issues discussed; corrective actions/interventions; dates, timeframes and assigned responsibility of action steps/interventions; outcomes; and how the implementation efforts will be monitored to ensure the desired clinical outcome is achieved and maintained. Consistent with the baseline findings, there were no IC audits being conducted to ensure that appropriate treatment practices were being implemented regarding infection control issues. For example, there was no monitoring system in place to ensure that individuals with MRSA were audited regarding treatment with the appropriate antibiotic in alignment with the culture and sensitivity results, or individuals with Hepatitis C were screened for their immunization status for Hepatitis A and B, and, if needed, had timely received them. In addition, the Facility had not begun to address systems regarding individuals who refused treatments, such as immunizations or TSTs, to ensure that that their treatment teams were addressing the refusals and implementing interventions. At the time of this review, there had not been a system developed for Infection Control data to be integrated into key indicator data for Quality Management/Risk Management. As the Facility continues to develop their Quality Management Systems, Infection Control information should be integrated into this system, as well as integrated into the other disciplines within the Facility. From the baseline review, there was slightly more documentation indicating a clinical connection between the activities of Infection Control and interventions provided by the unit staff to individuals who had an infectious disease. A review of Individual #38 for a herpetic lesion, Individual #145 for Clostridium difficile (C.difficile), and Individual #9 for MRSA found that staff training rosters indicated that staff were trained using the Centers for Disease Control and Prevention's general information sheet for Clostridium difficile, a MRSA Fact Sheet, and a Cold Sores Topic Overview sheet. The progress notes contained a note from Infection Control regarding staff training, and had additional notes from the Campus Nurse regarding additional training and the continued precautions. Once the Facility implements a monitoring system for Infection Control practices, observations of staff implementing the appropriate precautions should be completed to ensure that individuals and staff are protected from further spread and/or complications from the infectious disease. Although there was some improvement in the progress notes regarding staff training, the Nursing Care Plans addressing infectious disease were inadequate, which was consistent with the baseline findings in this area. As discussed in further detail in the portion of this	

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		report that addresses Section M.3 of the Settlement Agreement, of 15 records reviewed, only four had a Nursing Care Plan specifically addressing the infectious diseases, but all were found to be inadequate. The Chief Nurse Executive reported that some Nursing Care Plans were initially put in place for individuals with infectious diseases, but were taken out of the records since they were not the approved templates from the State Office. The Facility and State Office need to reconcile a balance between the immediate need for the provision of appropriate clinical care to the individuals, and the policies and procedures the State Office is in the process of developing. Since the baseline review, the Infection Control staff had begun to research the immunization status of the individuals at CCSSLC to ensure that all had received the needed immunizations and vaccines, and were in the process of setting up the database for this information. At the time of the review, there was no plan in place outlining how many individuals' immunizations were going to be researched per week or per month, and when the timeframe for completion was set . A schedule addressing these issues should be developed to ensure individuals are appropriately prioritized and that no one is overlooked. In addition, at the time of the review, there had been no system implemented addressing the documentation regarding individuals who are Purified Protein Derivative (PPD) positive including ensuring that: ▪ A baseline chest X-ray was obtained and in the medical record; ▪ Nursing Summaries included the PPD status and/or other infectious diseases; and ▪ A Nursing Care Plan was in place that addressed routine screenings for the signs and symptoms of active disease. Regarding the Facility's Infection Control policies, both the Facility's POI and the Supplemental POI indicated that the department was awaiting policies from the State Office with a target date of implementation on 12/1/10. On 6/17/10, the Facility did modify Policy C.1, Isolation Precautions. A review of this policy found that the role of the Infection Control Nurse was specifically outlined, but there were a number of areas in the policy that needed to be clarified and modified. For example, the policy included a number of duties to be performed by the Infection Control Nurse, but did not indicate how these duties were to be implemented when and if the IC Nurse was not available i.e., after hours. The policy also stated that "if the condition is not unusual…" however, the term unusual is not defined as compared to what would constitute a usual condition. The Isolation Procedures Notification Guidelines tool appeared to be a good form to remind all staff involved of steps to be taken, and would be useful when they were actually implemented in the event that an individual were to be placed on precautions. However, a review of Individual #105's Isolation Procedures Notification Guideline form for Contact Precautions found that there were no dates, times or initials indicating when	

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		actions had been taken as required by the form. Overall, the Facility continues to need IC policies, protocols, and procedures that address the operations of the IC Department, the duties and responsibilities of the Department, and Infection Control treatments and practices for infectious diseases. All departments should have accessibility to these policies, including housekeeping and maintenance to ensure adherence to IC procedures, and proper disposal of contaminated materials. A review of 63 Infection Control Environmental Checklist forms from 12/09 through 7/10 found that the form itself had not been modified, and continued to be very basic. Similar to the findings from the baseline review, there was no indication that problems identified were actually tracked to resolution, or that there was a comprehensive analysis of findings that led to any type of proactive interventions being implemented. The following are examples of issues that required follow-up: ▪ An Environmental Checklist Review for Tropical Unit dated 7/8/10 did include the name of the responsible person for a problematic issue found, a projected completion date, and a column for evidence that included dates when work orders were submitted. This format was promising, but needed to include the date when the problem was actually resolved. ▪ The Director of Infection Control provided two emails dated 4/19/10 that noted issues with several broken soap dispensers, and staff not knowing how to use the tub cleaner for the ARJO tubs. There was no documentation provided that these issues were addressed and corrective actions were implemented. The Supplemental POI was unclear in that it indicated that in July 2010, the Risk Manager and the Infection Control personnel would conduct the Environmental rounds, but did not specify if these would be done jointly or rotated between departments. The Supplemental POI also indicated that Facility action will begin after receipt of new/amended policy and direction for the State Office. A review of the Facility's Infection Control course description for orientation and annual refresher classes demonstrated that hand-washing and Standard Precautions were included in the curriculum and in the post-test. However, from review of the curriculum and the post-test for Infection Control provided by the Facility, the post-test did not adequately measure competency regarding the course content. The Facility needs to modify the post-test so that it is reflective of the infection control information taught to the staff to ensure competency in this area. Consistent with the findings during the baseline review, the lack of Nursing Care Plans addressing infectious diseases warrants additional and on-going competency-based training for the Nursing staff. As noted from the previous review, the Infection Control Nurse had experience and	

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		background in Infection Control. Since the last review, the Facility had added a Registered Nurse to the department as an Assistant Infection Control Nurse who had little to no experience in Infection Control, and had not been deemed competent in Infection Control at the time of this review. Chronic and acute infectious and communicable diseases are not benign conditions, but rather clinically complicated diseases that require timely and systematic interventions to ensure the individual, his or her peers, and staff are protected from health risks. Delays in the development and implementation of policies, procedures, and treatment plans while awaiting State Office templates is not clinically acceptable. Additional expertise in Infection Control is needed to assist the Infection Control personnel in implementing systems to effectively operationalize Infection Control in alignment with IC standards of practice, as defined in the Health Care Guidelines and the Settlement Agreement.	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	Since the baseline review, the State Office had modified the procedure Guidelines for Comprehensive Nursing Assessment, as well as the Comprehensive Nursing Assessment form in July 2010. The Supplemental POI indicated that implementation of the modified guidelines and nursing assessment form was to begin 8/1/10. The Chief Nurse Executive reported that training was initiated on 6/25/10 for the policy regarding Comprehensive Nursing Assessment, and training rosters reviewed verified that 23 nurses attended this training. The implementation of the modified Comprehensive Assessment was anticipated to begin 8/1/10 initially by the Facility's 16 RN Case Managers, and then additional training was expected to be conducted for the direct RNs. A review of the competency-based training curriculum for the Comprehensive Nursing Assessment found that it did not adequately measure competency regarding the collection and analysis of data to produce a quality Nursing Assessment. The methodology used consisted of blocks of data and information that nurses had to place in the correct area of the Assessment form. There was no requirement to actually analyze the data and compose a clinical nursing summary. Building competency in this area is critical since the nursing summary section should provide a clinical analysis of all the data from previous sections regarding the individual's progress related to their health and behavioral goals. The competency-based training for the Comprehensive Nursing Assessment needs to be revised to adequately measure nurses' competency in producing a quality comprehensive nursing assessment. The records of 28 individuals were reviewed, including: Individual #183, Individual #340, Individual #131, Individual #284, Individual #160, Individual #247, Individual #350, Individual #335, Individual #255, Individual #66, Individual #207, Individual #375, Individual #181, Individual #268, Individual #19, Individual #294, Individual #356, Individual #114, Individual #231, Individual #353, Individual #109, Individual #158, Individual #174, Individual #315, Individual #228, Individual #126, Individual #3,	Noncompliance

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		and Individual #357. A review of the past two quarterly nursing assessments found that all of the individuals (100%) had quarterly nursing assessments that were timely completed. Consistent with the findings during the baseline review, the quality of all 56 of the most recent assessments were extremely poor and required significant improvement. The summary narrative section for all of the 56 quarterly assessments reviewed continued to contain basically raw data without analysis of the data regarding the individual's health status. There were no comparisons of health or behavior data between the previous quarter, and the current quarter to assess if the individual was doing better or worse regarding their health issues, and/or if there was progress or lack thereof on measurable objectives, services and/or supports that were included in the Nursing Care Plans. For example, the nursing assessment dated 2/19/10 for Individual #158 indicated that he had been refusing lab work since August 2009, and again refused his lab work in January 2010. However, the type of lab work he was refusing was not addressed. Also, the assessment indicated that he had changes in his medication for constipation (Milk of Magnesia) and psychotropic medication (Ativan), but did not indicate if these were increases or decreases and what precipitated the changes in dosages. The date when the PPD was administered was noted to be 5/23/09. However, the results of the PPD were noted to be "Not documented" without further follow-up. The documentation for the Physical Assessment section of the assessment noted that he had refused the assessment four times, and that the assessment was conducted by visual observation only. However, areas such as finger nails, extremities, and musculoskeletal were not completed. The assessment also indicated that the individual was self-injurious, aggressive and interactions were inappropriate for the situation. His desired weight range was between 145 and 180 pounds, and his current weight was 357 pounds. The assessment noted he had six seizures in the last quarter, and a total of 16 for the past year. His last seizure was 2/19/10. The documentation in the section entitled Nursing Diagnosis, which reflected what nursing care plans were in place, indicated that there were "none." His nursing quarterly summary stated: *"1. His health has been stable this past quarter with no significant illness, injuries or accidents.* *2. No current health management plans.* *3. No new health management plan developed based on my assessment.* *4. No new recommendations."* A review of additional data gathered from Individual #158's medical record noted that he was having variances in his pulse and blood pressure readings. On January 3, 2010 his blood pressure was 104/82, and pulse was 107. On May 1, 2010 his blood pressure was 109/78 and pulse, was recorded as 63. On July 2, 2010 his blood pressure was 139/102, and pulse was 93. In addition, a review of his Growth Record in the chart	

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		found his weight had increased from 342 pounds in December 2009 to 357 pounds in January, the latter of which was noted on the Nursing Assessment. Unfortunately, his 15 pound weight gain, fluctuations in blood pressures and pulse, refusal of lab work and assessment, changes in medications for constipation and mental health issues, unknown results of his PPD, and his psychosocial assessment of self-injurious and aggressive behaviors did not result in any type of a nursing clinical assessment for this individual that should have led to the implementation of Nursing Care Plans, as well as a PSPA to collectively address this individual's numerous health risks. The next Nursing Assessment dated 5/22/10 for the same Individual (#158) again noted his refusals for lab work since August 2009. The assessment also noted that a medication change was made on 3/23/10 consisting of Haldol 15mg twice a day for Schizoaffective disorder, but did not note if this was a new medication or a decrease or increase in an existing medication. His weight was noted to be 365 pounds on 4/3/10, an eight pound weight gain from the previous assessment's recorded weight. The documentation for the Physical Assessment section noted that he had refused the assessment four times, and that the assessment was conducted by visual observation only. The assessment also indicated that the individual was self-injurious, aggressive and interactions were inappropriate for the situation. The PPD results were noted as negative. The assessment noted he had six seizures in the last quarter and a total of 22 for the past year. His last seizure was on 5/20/10. The documentation in the section entitled Nursing Diagnosis, which reflected what nursing care plans were in place, indicated that there were "none." However, there was a Health Management Plan found dated 4/12/10 that included a Nursing Diagnosis of "Imbalanced nutrition related to excessive intake in relation to metabolic needs aeb (as evidenced by) wt (weight) gain of 73 lbs in one year." His nursing quarterly summary stated: *" 1. His health has been stable this past quarter with no significant illness, injuries or accidents.* *2. Pt. continues to refuse medications; noted 27 missed medication passes this quarter.* *3. Pt. continues to refuse blood draws for labwork, although he did allow TB screen.* *4. Pt. continues t refuse medical appointments including neurology this quarter.* *5 No current health management plans.* *6. No new health management plan developed based on my assessment.* *7. Recommendations are for PST to develop and implement a plan next quarter that may encourage (Individual #158) to cooperate with medical treatments and appointments."* Again, the lack of an appropriate clinical nursing assessment and analysis indicated that nursing staff, as well as the rest of his team were not attending to his health risks and the changes in his health indicators, placing him at serious risk. The recommendation addressing the need for the PST to implement a plan for his refusals to undergo medical	

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		evaluation was appropriate; however, waiting for the next quarter to address an issue that had been consistent and ongoing since August 2009 was not appropriate, particularly because such evaluations were important to assess more fully his health status. The Nursing Quarterly Summary for Individual #114 dated 2/17/10 indicated that he was diagnosed with Diabetes Mellitus and started on the medication, Metformin. It also indicated that another medication was added to his regimen to help control his blood pressure. He also was placed on Tricor for elevated triglycerides, as well as Vitamin D for low Vitamin D levels. The assessment also indicted that he received medication 13 times in the past quarter for pain in "various locations." His PPD was given on 5/6/09. However, the results were "not documented." His nursing quarterly summary stated: "His health has been stable this quarter. He has not had any significant injuries or hospitalizations." These conclusions were drawn despite the fact that the nurse then listed the above issues. In addition, the summary included the fact that the Nursing Diagnoses not addressed in a Health Management Plan included "pain, hypertension, constipation, etc." and "will be monitored informally during the quarterly nursing assessment process." The lack of Nursing Care Plans (discussed in detail below in M3), the lack of a clinical assessment of critical health indicators, the lack of follow up on unresolved issues, the lack of an analysis of the obvious clinical risks, the lack of clinical and critical thinking was found in all 28 nursing assessments reviewed. These findings are significant and highlight the need for the Nursing Department to ensure that it is providing clinically appropriate, competency-based training regarding Comprehensive Nursing Assessments. In addition, as the monitoring process unfolds for this area, the Facility needs to ensure that the staff auditing this area are clinically competent in determining compliance ratings addressing the quality of nursing assessments.	
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	Since the baseline review, the State Office had decided to use the Health Care Protocols: A handbook for DD Nurses and the Lippincott Manual of Nursing Practice, 9th Edition for nursing protocols and nursing care plans. The Facility had onsite a copy of the Health Care Protocols: A handbook for DD Nurses, and had a purchase order for the Lippincott Manual of Nursing Practice, 9th Edition. The Chief Nurse Executive reported that competency-based training regarding Nursing Care Plans had been initiated, and the training roster dated 6/25/10 verified that 23 RNs out of 47 RNs required to attend the training had attended. A review of the competency-based training curriculum found that the contents of the training were not adequate to determine competency regarding developing and writing nursing care plans. Similarly to the training discussed above regarding the Comprehensive Nursing Assessment, the test	Noncompliance

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	by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	of competency consisted of taking pre-written statements and placing them in the appropriate section of the care plan, which was referred to as individualizing the plan. The post-test did not require the nurse to actually develop and write a care plan based on the scenarios in the training content. The section of the care plans addressing goal development appeared to be the only section that the nurses had to actually develop a portion of the care plan, and in doing participate in a competency-based evaluation. In addition, a review of 14 completed Comprehensive Health Care Protocol competency tests for RNs that had been deemed as competent, found that all 14 had inappropriate goals entered on the plans. For example, one of the scenarios indicated that a fictitious person had a urinary tract infection (UTI) with an elevated white blood count (WBC), which indicated an infection. An appropriate nursing goal for this issue would be related to the prevention of additional infections targeting the etiology or risk factors that could have precipitated the infection such as low fluid intake, tendency not to void when feeling the urge, or inappropriate hygiene care provided by staff. On all of the competency tests reviewed, the goal was that the person would have a repeat urinalysis (UA), and have a white blood count within normal range. These tests are objective indicators by which to measure how successful nursing was in meeting a goal for prevention of further UTIs based on the interventions that were initialed. Nursing cannot control what the white blood count value should be. However, nursing can ensure that an individual has a specific amount of fluids each day, is taken or reminded to use the bathroom twice a shift, and monitor/oversee staff when they are providing personal hygiene care to ensure the proper techniques are used. These specific actions constitute some of the nursing interventions that might be included in a plan to prevent a person from experiencing a UTI. Having goals that nursing has no control over, such as "will give medications as ordered," leads to interventions that are not proactive, and takes nursing out of the clinical picture of having an impact on an individual's health risks. The second scenario included in the Comprehensive Health Care Protocol competency test indicated that another fictitious person had Diabetes Mellitus, Insulin Dependent, and had their insulin dose adjusted seven times in the past year. The goal contained on all competency tests reviewed stated that the person would have four adjustments to their insulin in the next year. An appropriate nursing goal for this issue would be related to trying to stabilize the Diabetes using strategies such as exercise disguised as some type of fun activity, education about Diabetes, or food choices. Fewer insulin adjustments certainly are an indicator that an individual's Diabetes is under better control, and is an objective indicator by which to measure how successful nursing was in meeting a goal related to stabilizing the Diabetes. Setting a goal of fewer insulin adjustments without a connection to strategies for better control of the Diabetes relegates the goal to wishful thinking.	

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		This approach only leaves nursing with interventions that are based on the provisions of services such as: monitor blood sugars as ordered; maintain weight range within normal limits; administer blood glucose and insulin accurately; and avoid controllable factors leading to complications. Unfortunately, these were the interventions listed on the new Health Care Plan template for Diabetes Mellitus used for the competency test. Health Care Plans that only include interventions that nursing has to perform such as give medication as ordered begs the question: what is nursing doing to have a positive impact on individuals' health status? The nursing care plans need to reflect what nursing is doing for prevention, health maintenance, and health promotion. The new Health Care Protocols will need to include appropriate goals and significant individualization to become quality Health Care Plans. The competency-based training for the Comprehensive Health Care Plans needs to be revised to adequately measure nurses' competency in producing a quality care plan. The records of 20 individuals who were identified by the Facility as being at high risk for specific health indicators were reviewed, including: Individual #255, and Individual #66 for Diabetes; Individual #207 for dehydration; Individual #375 for cardiac; Individual #181, Individual #268, Individual #19, Individual #294, and Individual #356 for seizures; Individual #114, Individual #231, Individual #353, Individual #109, Individual #158, Individual #174, and Individual #315 for weight issues; Individual #131 for constipation; Individual #126, Individual #3, and Individual #357 for skin issues. Individual #174 was found not to have a nursing care plan addressing weight despite being identified as high risk for this health indicator. The remaining 19 nursing care plans were found to be templates with little to no individualization, which was consistent with the baseline findings. Most of the interventions contained in the plans were service provisions, such as "administer medication as ordered," "vital sign monitoring," and "monitor for effectiveness of prescribed medications and treatments." The lack of individual-specific interventions based on individualized needs provided little to no direction for caring for individuals who were identified as high risk, and/or for measuring individuals' progress toward their goals. In addition, consistent with the baseline findings, the interventions contained in the nursing care plans were not geared toward prevention or minimizing the health risks. As discussed in detail above, the goals contained in the Nursing Care Plans reviewed were not appropriate and there was no evidence that interventions listed in the Nursing Care Plans were actually being implemented in most cases. None of the nursing interventions contained in the 19 Nursing Care Plans reviewed indicated who would implement the intervention, how often they were to be implemented, where they were to be documented, how often they would be reviewed, and/or when they should be considered for modification. Also, a number of the nursing diagnoses were either	

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		inappropriate or were not clinically sound. For example: ▪ The Nursing Care Plan for Individual #294 indicated that she had a total of 240 seizures that year, and had 22 emergency doses of Diastat. One of her goals included in the Health Management Plan stated she would have only 220 seizures within the year. Most of the interventions in the plan included: provide medications as ordered; administer oxygen as indicated; and monitor vital signs after prolonged seizure or respiratory distress. There was one intervention included that was not a service provision, but rather an action nursing would do to try to identify triggers for her seizure activity. The intervention stated "investigating trigger factor, constipation, noise, lights, change in routine, anticonvulsant levels and fever." There was no indication on the Care Plan as to where this information was to be documented, who would evaluate the information, and how often it would be reviewed. Unfortunately, there was no indication that this information was being collected and evaluated. ▪ In the case of Individual #357, her Nursing Care Plan noted she had 14 interventions consisting of medications and lotions for skin impairment to her right arm due to self-injurious behaviors. Her goal listed in the Nursing Care Plan was that she would only have 12 interventions for skin impairment in the next year. None of the interventions included in her Care Plan addressed preventing her from engaging in SIB, or collaborating with psychology to collect behavioral data and develop strategies to prevent skin break down and injuries. All the interventions in the plan only addressed what to do when she injured herself. Consequently, it appeared that the only nursing care provided was when she actually has a skin break down or injury. An additional sample of individuals' records was reviewed to determine if individuals with infectious diseases had appropriate care plans to address their needs since the baseline review. Specifically, a review was completed of 15 Individuals diagnosed with a variety of infectious diseases, including: Individual #105, Individual #320, Individual #86, Individual #180, Individual #58, Individual #247, Individual #274, Individual #245, Individual #145, Individual #206, Individual #359, Individual #44, Individual #157, Individual #9, and Individual #38. Of the 15 individuals, 11 had no Nursing Care Plans for these issues and of the four Individuals who did have a Nursing Care Plan addressing the infectious disease, only one (Individual #105) Nursing Care Plan for MRSA showed some improvement regarding specific interventions addressing prevention of the spread of MRSA. As discussed previously, this area needs significant attention due to the clinical relevance of infectious and communicable disease. Consistent with the baseline findings, there continued to be no system in place that ensured that individuals with infectious diseases were being provided the appropriate infection control procedures, or that clinically appropriate interventions to prevent the spread of infection were being consistently implemented.	

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		Since the previous review, the Facility reported that the QE Nurse audits the Nursing Care Plans. However, based on discussions with the QE Nurse, the auditing did not reflect the quality of the Nursing Care Plans or the implementation of the interventions; only the completion. Until adequate competency-based training addressing Nursing Care Plans is provided, the monitoring data for this area will not accurately reflect quality and clinical appropriateness of the Nursing Care Plans. At the time of the review, the Facility was continuing to use nursing care plans, as opposed to integrated care plans. However, collaboration with other disciplines regarding care plans needs to occur regardless of the format, so that an interdisciplinary team approach is used consistently, and interventions from other disciplines are integrated in all treatment plans as required by Sections G and F of the SA. The commitment, energy, and professional enthusiasm demonstrated by the CCSSLC Nursing Department since the baseline review with regard to their efforts in trying to improve the nursing assessment and nursing care planning processes was extraordinary. However, efforts and energy expended that do not yield the expected outcome can ultimately be demoralizing to a department. The problematic issues discussed in this section and above with regard to Section M2 of the SA regarding the nursing assessment and nursing care plan competency-based training underscores the need for strong leadership on the State level and additional nursing expertise at the Facility level to assist the Facility in building a clinically sound foundation from which to build nursing systems.	
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.	As reported previously, the Facility's Supplemental POI indicated that the State Office had approved the use of the Lippincott Manual of Nurse Practice, 9th Edition for Nursing Procedures and Protocols. The Facility had ordered the Manual on 6/1/10, and had not received it at the time of the review. In addition, the Supplemental POI indicted that prior to the Facility's implementation of the Manual, the State Office would need to develop and/or amend existing policies in alignment with the elements contained in the Manual. The target date for implementation listed in the Supplemental POI was September, 2010. At the time of the review, the Facility did not have a plan for when training would be conducted for newly developed protocols based on priority and when implementation will occur. As is discussed in detail above with regard to Section M.2 NS M.3 of the SA, at the time of the review, the Facility did not have an adequate assessment process in place, nor did it develop appropriate nursing care plans. As a result, the Facility was failing to address adequately the health care needs of the individuals it served.	Noncompliance
M5	Commencing within six months of the Effective Date hereof and with	Since the baseline review, CCSSLC continued using the Health Risk Assessment Tool-Nursing as the tool for the identification of clinical risk indicators for individuals. As	Noncompliance

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	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.	noted from the previous review, this tool was scored either "yes" or "no" for items in areas regarding Cardiac, Constipation, Dehydration, Diabetes, GI concerns, Hypothermia, Medical Concerns (other), Osteoporosis, Respiratory, Seizures, Skin Integrity, Urinary Tract Infection, and Aspiration/Choking. Based on discussions with the QE Director and the Medical Director, the Facility had modified this system. Individuals were no longer given an overall score for risk, but were scored for each of the health indicator categories. These indicators were still being discussed at the HST meeting at which time the physician or practitioner assigned the score for each category: Level 1 was the highest risk, Level 2 represented moderate risk, and Level 3 was low risk. In addition, a High Risk Oversight Committee had been created composed of the Health Status Team and department heads appointed by the Director to review monthly the status of care plans implemented by the PST for individuals assigned a Level 1 risk rating. A draft of the policy entitled At Risk Individuals High Risk Oversight Committee, dated 6/18/10, outlined the duties and activities of the committee. The implementation of additional clinical oversight for high-risk individuals was without question an appropriate safeguard for the risk system. However, it is imperative that the foundation and infrastructure of the system that accurately identifies individuals' risk status be appropriately implemented. At the time of the review, the risk tools being used were not adequate risk assessments. Consistent with the findings during the previous review, the Facility's risk system consisting of the Health Risk Assessment tools and the HST meetings did not result in the appropriate identification of clinical risk indicators. The Facility continued to use an appropriate standardized tool, the Braden Scale, to assess skin integrity issues. The following is an example of an individual for whom adequate review of her risk status did not occur: ▪ In the case of Individual #305, the nurse presented information to the HST that included the individual had a history of multiple fractures and had been placed on medication for osteoporosis. A Dexa Scan had been obtained to determine bone density, but the nurse had not brought the results to the meeting. In addition, the individual was noted to be regularly using a wheelchair, and requiring staff's assistance for transfers. The team assigned the individual a low risk for injury. The nurse indicated that since the individual was now using a wheelchair, he was not at risks for injuries. Standardized statewide tools should be used by all the Facilities in assessing and documenting clinical indicators of risk. In addition, there should be criteria for the risk categories for consistency so that the process is less subjective. CCSSLC and the State Office recognized that they were not in compliance with this requirement of the SA,	

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		which is consistent with the Monitoring Team's findings. The Risk System is the essential foundation that identifies those individuals who warrant the most clinical intensity, and is the alarm for other systems to be called into action. The misidentification of individuals who are at risk substantiated that the foundation had not been appropriately built, and consequently, other associated systems were rendered nonfunctional. Once this system is adequately implemented and individuals' risks are appropriately identified, the PSTs need to conduct integrated team reviews, and develop plans to address identified areas of risk.	
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.	Since the baseline review, the Nursing Department had implemented a number of interventions associated with the medication administration system. The Medication Observation tool was appropriately revised to include all the basic elements of medication administration orally, by injection or via tube, and was implemented in February 2010 shortly after the baseline review. In addition, the frequency of the medication observations for nurses was changed from annually to at least quarterly, and more often, if necessary. At the time of the review, the policy regarding medication observations had not been revised to reflect this change in procedure. In addition, in attempts to eliminate auditor error, the department had limited the auditors for medication observations to two Nurses from Nursing Education and the QE Nurse, rather than the variety of nurses previously used. This revised methodology should produce reliable data regarding medication observations to assist the Facility in identifying areas of strength and weakness in this system and to be able to implement targeted plans of correction for deficient areas. A review of Medication Passes Assessment Tools verified that thus far, 60 out of 64 LVNs and four out of 12 RNs had been observed for two quarters since February 2010. The Nursing Education Department had a tracking system to ensure that each nurse was observed at least quarterly. The Supplemental POI and Chief Nurse Executive indicated that inter-rater reliability had been established for auditing medication administration. Two completed Medication Passes Assessment Tools were submitted to demonstrate that this had been done. However, without knowing how the Facility established inter-rater reliability, the percentages established, and data to verify this, the Monitoring Team was not able to validate that this had been done. The Facility needs to develop and implement a procedure addressing establishing inter-rater reliability since a number of monitoring systems are being implemented by several disciplines. A review of 128 Medication Pass Assessment tool audits completed between February and June 2010 found that there was a significant difference in the comments and audit	Noncompliance

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		results as compared to those found during the baseline review. Some of the data from the audits indicated the following issues: ▪ Pre-initialing the MARs when medication had not been administered; ▪ Post-initialing the MAR after administering all the scheduled medications; ▪ Not washing hands between administering medications to individuals; ▪ Pre-setting up narcotics prior to administration; ▪ Leaving medication cart unlocked; ▪ Nurses not able to answer questions about medications they were administering; ▪ Medications not administered within the proper timeframe; ▪ Not inspecting stoma site for individuals with tubes prior to medication administration; ▪ Not ensuring that the individual was in the proper position to receive medications; ▪ Not pouring liquids at eye level; ▪ Not flushing tubes with water after administration of mediation via tube; ▪ Not checking tube placement prior to medication administration; ▪ Medication Error reports not being initiated for mediation variances; ▪ Not following the individuals' programs for self-administration of medications; ▪ Not promoting independence while administering medications; and ▪ Not using the MAR when administering medication. The Monitoring Team's findings from the medication observations conducted during the baseline review and the July 2010 review validated the Facility's data. Although this was a daunting list of deficiencies regarding medication administration, the changes initiated by the Nursing Department regarding medication administration were proving to be positive and effective in that the Facility was now more accurately identifying some of the inappropriate practices that had existed in the department. Having a monitoring system that accurately identifies the problems enables the department to resolve those problems. At the time of the review, there was no report summarizing the issues found from the audits. In addition, there was no indication that the audit findings were discussed in the Medication Error Committee meetings or the Medication Administration Workgroup. The Nursing Department submitted a Corrective Action Plan, but the Monitoring Team was not able to interpret it. The issues listed on the Corrective Action Plan were not clearly identified and consequently, the action steps were not clearly written. In addition, there were no dates of actual implementation included in the Corrective Action Plan to indicate if actions and interventions were actually implemented. The Facility needs to develop a system for aggregating this data so it becomes usable to facilitate	

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		corrective actions. When observing medication administration while on site for individuals living at Sea Horse, the following significant issues were identified, most of which placed the individuals involved at risk. Specifically, the nurse did not: ▪ Stop administering medications via tube while the individual was having seizure-like activity; ▪ Assess the individual having seizure-like activity until prompted; ▪ Stop administering medication via tube while an individual began coughing; ▪ Assess the individual who began coughing until prompted; ▪ Obtain the proper assistance when needing to move an individual up in the wheelchair until prompted; ▪ Intervene when staff laid the individual with a tube who was coughing flat to change their position; ▪ Ensure the individual was in the proper positioning prior to medication administration; ▪ Provide information to the individual prior to medication administration; and ▪ Wash her hands in between individuals; During the observation, the Nurse Educator who had conducted many of the medication administration observation audits accompanied the reviewer. The Nurse Educator provided appropriate prompting and feedback to the staff nurse who was being observed. A review of the medication variances reported by the Facility indicated the following; ▪ February: 40 reported variances ▪ March: 29 reported variances ▪ April: 18 reported variances ▪ May: 48 reported variances For a facility of its size and the number of medications given each day, as well as the data collected by the Facility through its medication administration auditing process, these data indicated that there continued to be a significant issue of underreporting of medication variances. A review of the minutes of the Medication Error Committee from January through May 2010 indicated that the Facility was aware that they have a significant issue with the under reporting of medication variances. In response to issues identified from the baseline review and the Facility's medication observation audit data, a Medication Administration Workgroup was established and convened in February 2010. They had met five times since the baseline review, and had	

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		three canceled meetings due to the lack of a quorum. The minutes indicated that the committee was reviewing some procedures, such as process for physician orders and clarifying accountability and responsibility. However, follow-up and actions taken were not clearly outlined in the minutes. Modifying the format of these minutes would clarify the issues and actions of the committee by including items such as: issue discussed; plan of correction, person responsible, and target date for implementation; actual date of implementation; and outcome and/or follow-up. Based on interviews with the Chief Nurse Executive, the Facility had modified the Medication Error form to make it look less intimidating in the hopes it would defuse the resistance to reporting medication variances. The new form was initiated in February 2010, but was pulled and replaced with the original form since it did not appear to make a difference in the reporting. The department did implement a process for spot checking the MARs weekly in February 2010. A review of the MAR Review Tool indicated that this system had captured and identified medication variances that may have otherwise been missed. The department was cognizant of reassuring staff that finding and reporting medication variances will not result automatically in punitive measures. Enlisting staff in reporting variances will take time and consistency for them to trust that the information is used to assess the strengths and weakness of the Facility's medication administration system. Having medication nurses involved in the Medication Administration Workgroup and the Medication Error Committee is a positive step in diffusing the anxiety nurses experience regarding medication variances. Although not all systems are in place addressing this requirement of the SA to meet substantial compliance, the Nursing Department has made significant progress in moving forward in this critical area.	

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

1. The Facility should develop and implement job descriptions/job duties addressing any newly allocated nursing positions.
2. The Facility should develop or modify appropriate policies, procedures and/or protocols addressing the integration of newly allocated nursing positions into the Nursing Department.
3. The Facility should continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the requirements of the Settlement Agreement.
4. The Facility in conjunction with the State Office should develop instructions for each monitoring tool to ensure that all auditors are using the same documentation and criteria to determine compliance with each item, which will assist in establishing inter-rater reliability. As these are developed, the Facility should develop and implement a procedure for establishing inter-rater reliability at 85% or above.
5. Documents should be filed in a timely manner in the medical records so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services.
6. The Facility in conjunction with the State should develop and implement policies and procedures addressing the services and documentation requirements of Respiratory Therapy.

7. The Facility should develop a schedule for training on the newly developed nursing care protocols, based on priority of need, as well as when implementation will occur.
8. Although not required by the SA or HCG, the Facility is encouraged to move the peer review process forward in alignment with the American Nurses Association (ANA) definition that states: peer review is an organized effort whereby practicing professionals review the quality and appropriateness of services ordered or performed by their professional peers. Peer Review in Nursing is the process by which practicing Registered Nurses systematically assess, monitor, and make judgments about the quality of nursing care provided by peers, as measured against professional standards of practice. Such efforts should substantially assist the Facility in meeting other requirement of the SA, as well as meeting the goal of adequate self-assessment.
9. Competency-based training needs to be documented for Infection Control staff. Such training should ensure that the staff are competent in conducting their duties for the department, including audits, and that they are competent in infection control practices.
10. The Infection Control Committee and the Pharmacy and Therapeutics Committee should collaborate to ensure that infection control issues are adequately addressed in each respective committee.
11. Once the Facility implements a monitoring system for Infection Control practices, observations of staff implementing the appropriate precautions should be completed to ensure staff understood the training material, and that individuals and staff are protected from further spread and/or complications from the infectious disease.
12. A schedule addressing when individuals will be researched for possible needed immunizations should be developed to ensure individuals are appropriately prioritized and that no one is overlooked.
13. The Facility should modify the post-test regarding the Infection Control training so that it is reflective of the infection control information taught to the staff to ensure competency in this area.
14. Formal systems and communication lines between the units and the Infection Control personnel should be established, and memorialized in policies and procedures.
15. The Facility and State Office should reconcile a balance between the immediate need for provision of clinical care to the individuals, and the policies and procedures the State Office is in the process of developing to ensure that individuals are provided with the care and treatment they require.
16. Serious consideration should be given to securing the services of an expert in the areas of Infection Control and Nursing to provide consultation and onsite assistance to the State and Facilities.
17. IC data should be integrated into the Facility's Quality Management system.
18. The competency-based training for the Comprehensive Nursing Assessment needs to be revised to adequately measure nurses' competency in producing a quality comprehensive nursing assessment.
19. The State should identify tools and training to improve the quality of nursing assessments, and nursing care plans to allow the Facility to build the foundation on which adequate nursing supports can be provided.
20. The role of nursing in the interdisciplinary treatment team process should be expanded to ensure that treatment plans are derived from an integration of the individual disciplines' assessments, and that goals and interventions are consistent with clinical assessments.
21. Nursing Care Plans should be revised to include specific goals/objectives that are objective and measurable, as well as interventions that identify who is responsible for implementing the interventions, how often they are to be implemented, where they are to be documented, how often they are reviewed, and when they should be modified.
22. The Facility needs to ensure that the staff auditing clinical issues for nursing such as Comprehensive Assessments, Nursing Care Plans, progress notes, medication administration observations, or any other clinical issues are clinically competent in those areas to accurately determine compliance ratings addressing correct execution of procedures, and the quality of the documentation.
23. The Facility needs to develop a system for aggregating the nursing data it has started collecting so it becomes usable to facilitate corrective actions.
24. As is recommended with regard to Section I of the SA, standardized risk assessments with established reliability and validity should be used by

all the Facilities in assessing and documenting clinical indicators of risk. Once this system is implemented and individuals' risks are appropriately identified, teams need to conduct integrated team reviews, and develop appropriate proactive treatment plans to address identified areas of risk.

25. The Facility needs to consider modifying the format of the Medication Administration Workgroup minutes to clarify the issues and actions of the committee by including items such as: issue discussed; plan of correction, person responsible, and target date for implementation; actual date of implementation; and outcome and/or follow-up.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents:** o Pharmacy Services and Safe Medication Practices [DUE]; o Pharmacy Policy and Procedure Manual: Adverse Drug Reactions, revised 5/28/10, implementation date 6/5/10; o Pharmacy Services and Safe Medication Practices [ADR]; o Corpus Christi State Supported Living Center Pharmacy Manual, dated June 1, 2010; o Drug Regimen Review Log – Corpus Christi State School 2010; o Policy: Drug Regimen Review, revised 11/4/09; o September 2008 – August 2009 raw data – medication errors; o September 2009 – August 2010 raw data – medication errors; o Medication Errors 12 month Summary (to 4th Q 2010); o Medication Errors (Procedural) 12 month summary (to 4th Q 2010); o Fiscal 09 Procedural Medication Errors (total # of errors/building/month); o Fiscal 09 Procedural Medication Errors (total # of errors/error type/month); o Fiscal 09 Procedural Medication Errors 12 month summary (total # of errors/month/error type); o Fiscal 09 Procedural Medication Errors 12 month summary (total # of errors/month/error class); o Fiscal 09 Medication Errors (total # of errors/month/error type); o Fiscal 09 Medication Errors 12 month summary (total # of errors/month/error class); o Fiscal 09 Medication Errors 12 month summary (total # of errors/month/error type); o Fiscal 09 Med Errors (total # of errors/month/unit) o Pharmacy Policy: Pharmacy Medication Error Reporting Policy, revised 6/2/10; o Nursing Policy: Medication Errors, implemented 1/1/2010; o Medication error report dated 3/8/10 for Individual #21; o Medication error report dated 4/20/10 for Individual #114; o Medication error report dated 4/8/10 for Individual #377; o Medication error report dated 4/30/10 for Individual #297; o Medication error report dated 5/4/10 for Individual #297; o Medication error report dated 5/4/10 for Individual #367; o Medication error report dated 5/7/10 for Individual #8; o Medication error report dated 5/20, 5/21, and 5/24/10 for Individual #43; o Medication error report dated 5/3/10 for Individual #139; o Minutes of Medication Administration Workgroup, dated 2/26/10, 3/8/10, 3/22/10, 3/29/10, 4/19/10, and 5/3/10; o Minutes of Medication Error Committee, dated 1/28/10, 2/26/10, 3/30/10, 4/29/10, 5/27/10, and 6/24/10; o Quarterly Drug Regimen Reviews: Individual #66 dated 2/1/10, Individual #38 dated

	2/12/10, Individual #140 dated 3/11/10, Individual #218 dated 3/4/10, Individual #298 dated 3/10/10, Individual #255 dated 2/18/10, Individual #284 dated 3/6/10, Individual #300 dated 2/2/10, Individual #25 dated 3/8/10, Individual #238 dated 3/3/10, Individual #295 dated 3/4/10, Individual #13 dated 2/4/10, Individual #298 dated 7/5/10, Individual #226 dated 7/5/10, Individual #321 dated 7/5/10, Individual #122 dated 6/9/10, Individual #15 dated 6/9/10, Individual #272 dated 6/9/10, Individual #167 dated 7/5/10, Individual #133 dated 7/5/10, Individual #251 dated 7/5/10, and Individual #275 dated 7/5/10; o Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint: Individual #191 dated 2/26/10 at 8:31 a.m., Individual #191 dated 1/11/10 at 3:14 p.m., Individual #191 dated 6/6/09 at 9:40 p.m., Individual #191 dated 5/23/09 at 9:35 p.m., Individual #7 dated 1/13/09 at 10 p.m., Individual #95 dated 5/3/10 at 9:42 p.m., Individual #118 dated 1/30/10, Individual #218 dated 4/6/10 at 4:40 p.m., and Individual #218 dated 4/7/10 at 9:45 a.m.; o Medical record for Individual #348; o Policy and Procedure: Notification of a prescriber regarding potential unexpected or undesired outcomes with addition of a new medication in combination with existing medication regimen including supporting documentation, revised 3/3/10; o Policy and Procedure: Pharmacist Review of New Medication Orders, revised 6/2/10; o Policy and Procedure: Polypharmacy Definition – Psychotropic Medications, revised 6/2/10; o Policy and Procedure: Prescriber Medication Order Policy, revised 6/2/10; o Policy and Procedure: Pharmacist Review of New Medication Orders, implemented 11/23/09, revised 6/2/10; o Draft guidance for anticonvulsant monitoring, dated 11/19/09; and o Lubbock State School Recommended Diagnostic Testing Schedule, 2008 Version ▪ **Interviews with**: o Minh Nguyen, PharmD; and o Sandya S. Suri, Pharmacy Director
	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Although the POI reviewed for CCSSLC did not include this component, according to the Facility's self-assessment, each of the requirements for Section N of the SA remained in noncompliance. However, the POI recognized considerable progress that was being made in some areas. These findings were consistent with the Monitoring Team's findings. For example, policies and procedures had recently been implemented, but had not had time to be effective. Pharmacists were able to process new orders through the WORx system, but lab reviews were in a different database, which remained a challenge. Drug Utilization Evaluations (DUEs) had not occurred yet. Quarterly Drug Regimen Reviews (DRRs) were being completed, but there remained communication and coordination issues with physician input into this process, which remained poorly documented on the record. Medication variance tracking was in its beginning stages of development. Pharmacy was involved in polypharmacy review, and in use of stat (emergency) medications, but the impact was not clear.

	Summary of Monitor's Assessment: The pharmacy had been ambitious with development of policies and procedures, but they were in the beginning stages of implementation. Quarterly drug regimen reviews appeared to be excellent, and should be considered in the team approach to the care of the individual. The pharmacy review included laboratory results, therapeutic drug levels when appropriate, evaluation of current dosage with recommended standard range of dosage, potential drug interactions, with recommendations for potential changes. Also included in most were an evaluation of whether MOSES or DISCUS was required, and whether it was up-to-date. DRRs were only being completed for individuals prescribed psychotropic medication. They need to be completed for individuals prescribed any medication(s). A system needs to be instituted to ensure that physicians and/or nurse practitioners respond to recommendations included in the quarterly DRRs. A policy and procedure had been created to assist in tracking and resolving medication errors and variances. However, according to the Medication Error Committee minutes, there were a number of problems associated with the medication administration system, medication errors were not being reported consistently, and, even when issues were identified, systems were not being improved.

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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	Pharmacy review of the individual's record is important in several areas. This includes ensuring that the record includes accurate information, and reviewing the orders to remove confusing statements. The following is an example of where this would have been important: ▪ In the new orders of 7/8/09 for Individual #348, the allergies listed cause clinical confusion in attempting to interpret the information. At the top of the New Orders, the allergies are listed as: "Lithium, no known allergies, penicillin G potassium, phenothiazines, sulfa (sulfonamide antibiotics)." Confusing statements such as this should not exist on the record, and pharmacy staff entering data for physician orders should screen the entire page and remove such confusing statements, and also clarify which phrases are accurate. The system is dependent on the pharmacist to document allergies accurately in order to be helpful to the physician in choosing safe and effective treatment. Additionally, when an individual is hospitalized, there was no system to ensure that information concerning any drug allergies discovered at the hospital are communicated to the pharmacy department, so that it may be added to the database and placed on the individual's record at CCSSLC. At the time of the review, the system was informal and relied on a nurse liaison who interfaced with the hospitals and provided feedback to	Noncompliance

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	Facility policy or current drug literature.	CCSSLC. However, a review of documents received at time of discharge from the hospital by the pharmacy to specifically focus on medication allergies and serious side effects may be indicated. At the time of the review, the Facility had a policy in place in alignment with the requirements of the Settlement Agreement. The Chief of Pharmacy indicated that when a new medication was ordered for an individual, the pharmacist received a fax of the order, and entered it into the WORx software system which completed an automatic review of the new medication, reviewing for appropriate dosing, listed allergies, and potential interactions with the individual's current medication regimen. If a problem was identified, the physician was notified. One problem noted, though, was that the Pharmacy used both the WORx system and the Avatar database. However, the two were not integrated. The Avatar system was the database where lab data were stored. However, the pharmacist did not have ready access to this information, when the new order is entered. The WORx system provided warnings for drug interactions and allergies. Minimum and maximum drug dosages were determined by the available literature and clinical knowledge base of the pharmacy staff. It is hopeful that a future electronic record will resolve this lack of coordination of vital information. As an additional check, the Quarterly Drug Regimen Review did encompass all these areas. However, the Quarterly Drug Regimen Review was not done on every individual at CCSSLC. In addition, from the interview with the Chief Pharmacist, notification of the physician was now being documented in the WORx order entry system in the intervention section of WORx IP. According to the Chief Pharmacist, all new orders for medications were automatically reviewed for significant drug interactions with the individual's current regimen, serious side effects, and known allergies, as well as accepted dosage range. All discussions with the physician had been documented in the computerized system, and recommendations concerning the new order accepted and order changed at time of communication, or the pharmacist had agreed with the physician order based on additional physician information. Since the recent revision of the appropriate policies: Notification of a prescriber regarding potential unexpected or undesired outcomes with addition of a new medication in combination with existing medication regimen including supporting documentation (revised 3/3/10), and Pharmacist review of new medication orders (revised 6/2/10). This was a new process that will both benefit the individual and provide documentation for the pharmacist. Based on interview, there had not been a case in which the physician refused the recommendation and the pharmacist determined that continuing the order would be harmful to the individual. The above policy (revised 3/3/10) included clinical direction	

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		for this matter, but the Chief Pharmacist indicated there had been no such instance to date.	
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.	The pharmacy department provided a calendar of the months in which the residential units of the campus would undergo drug regimen reviews. The entries indicated that the reviews had been completed through May 2010 for all units on a quarterly basis. Updated information provided indicated the reviews were completed into July 2010. The policy entitled "Drug Regimen Review," revised on 11/4/09, appeared to be focused on psychoactive medications and recommendations to psychiatry. This is a priority class of medications, but all individuals would benefit from quarterly reviews, even if no psychoactive drugs are prescribed for an individual. The Settlement Agreement does not distinguish between psychoactive medications, and other medications with regard to the need to complete quarterly DRRs. The policy should be broadened to reflect all medications. Individuals with ID/DD often are prescribed a complex regimen of medications to treat many conditions, including, for example, GERD, osteoporosis, constipation, heart disease, etc., and would benefit from a quarterly review by the expertise of the clinical pharmacist. At the time of the review, if a DRR indicated the need for a change in a psychotropic medication order, the psychiatrist was informed. If the psychiatrist was in agreement, the change was ordered. However, there was no step in the process to inform the PCP of this change. It is strongly recommended that there be an information loop to the PCP regarding any changes to medications. Simply copying the DRR including the psychiatrist's comment or order, and sending it as a courtesy to the PCP would suffice. There may be potential for confusion or harm when the PCP is called to prescribe medication by phone, meanwhile unaware of a change in psychotropic medication. Quarterly Drug Regimen Reviews were an ongoing procedure, completed by the PharmD. Several were submitted for review (Individual #66 dated 2/1/10, Individual #38 dated 2/12/10, Individual #140 dated 3/11/10, Individual #218 dated 3/4/10, Individual #298 dated 3/10/10, Individual #255 dated 2/18/10, Individual #284 dated 3/6/10, Individual #300 dated 2/2/10, Individual #25 dated 3/8/10, Individual #238 dated 3/3/10, Individual #295 dated 3/4/10, Individual #13 dated 2/4/10, Individual #298 dated 7/5/10, Individual #226 dated 7/5/10, Individual #321 dated 7/5/10, Individual #122 dated 6/9/10, Individual #15 dated 6/9/10, Individual #272 dated 6/9/10, Individual #167 dated 7/5/10, Individual #133 dated 7/5/10, Individual #251 dated 7/5/10, and Individual #275 dated 7/5/10). The pharmacy review included laboratory results, therapeutic drug levels when appropriate, evaluation of current dosage with recommended standard range of dosage, potential drug interactions, with recommendations for potential changes. Also included in most were an evaluation of whether MOSES or DISCUS was required, and whether it was up-to-date. The quarterly	Noncompliance

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		DRR completed by the PharmD represented concise information important to the care of the individual, and provided guidance to the physician. In most instances, the physician read and acknowledged the quarterly drug regimen review by signing the form, but in many instances did not agree with the recommendation. However, there was no reason provided which justified lack of clinical action or follow up, but simply the word "noted." This is discussed further with regard to Section N.4 of the SA.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	There remained no Pharmacy Department policy that provided guidance with regard to 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; monitoring the use of benzodiazepines, and anticholinergics, to ensure clinical justifications and attention to associated risks; and monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications. There was a polypharmacy definition in the psychotropic medications policy, revised 6/2/10, which provided guidance on the meaning of polypharmacy. However, there were procedures in place by which the pharmacy was participating in some level of monitoring each of these areas. <u>Use of "Stat" or Emergency Medication and Chemical Restraints</u> According to the Pharmacy Director, for the use of emergency medications and chemical restraints, the pharmacist comments would be found in the document entitled: "Face to face assessments, Debriefings, and Reviews for Crisis Intervention Restraint." The pharmacist received this form at some point after the emergency medication had been given, and commented under the section entitled: "Chemical Restraint Clinical Review: Note if documentation indicates whether the medication was used in a clinically justified manner, the potential medication related risks that should be considered, and actions/recommendations, if any." Several examples of these forms were reviewed. Based on a review of nine reviews, there was not documentation of review by a pharmacist in five of them (56%). More specifically, the following provide examples of medication uses not reviewed by the pharmacist: ▪ For Individual #191, a form was submitted for emergency medication that was administered on 1/11/10 at 3:14 p.m. The Chemical Restraint Clinical Review was not reviewed or signed by the pharmacist or psychiatrist. ▪ For Individual #191, a form was submitted for emergency medication that was administered on 2/26/10 at 8:31 a.m. The PCP reviewed the case and had no recommendations. There was no evidence the pharmacist reviewed the case. ▪ For Individual #7, a form was submitted for emergency medication that was administered on 1/13/09 at 10 p.m. The psychiatrist was informed, and no new orders or changes in regimen were given. There was no evidence the pharmacist reviewed the case. ▪ For Individual #218, a form was submitted for emergency medication that was	Noncompliance

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		administered on 4/6/10 at 4:40 p.m. There was no evidence that a pharmacist reviewed the case. A psychiatrist did review the case. ▪ For Individual #218, a form was submitted for emergency medication that was administered on 4/7/10 at 9:45 a.m. There was no evidence the pharmacist reviewed the case. The psychiatrist reviewed the case. The following showed review by the pharmacist: ▪ For Individual #191, a form was submitted for emergency medication that was administered on 5/23/09 at 9:35 p.m. The pharmacist reviewed the case, but had no recommendations. ▪ For Individual #191, a form was submitted for emergency medication that was administered on 6/6/09 at 9:40 p.m., a pharmacist reviewed the case but had no recommendations. The psychiatrist reviewed the case also. ▪ For Individual #95, a form was submitted for emergency medication that was administered on 5/3/10. The PharmD reviewed the case and had no recommendations. The psychiatrist also reviewed the case. ▪ For Individual #118, a form was submitted for emergency medication that was administered on 1/30/10 at 9:25 a.m. The pharmacist reviewed the case and had no recommendations. The psychiatrist reviewed the case and suggested starting Zyprexa. From this information, it is evident that the pharmacist was not reviewing all cases of "stat" psychotropics. The reason for this should to be determined and corrected. Further, these reviews were done after the event, allowing time for additional information to be sought and analyzed . In none of the cases did the pharmacist document critical clinical thinking. These reviews have the opportunity of providing new insight into the events leading to the use of emergency medication. They should be reviewed with the same depth of detail as the quarterly DRR. For example, there was no comment as to whether environmental issues should have been altered to prevent the event, whether the BSP was being followed, whether there were precursor behaviors which could have predicted the need for sooner intervention, whether there was any potential drug interaction, whether that was the best choice of emergency medicine, etc. This type of analysis will be necessary to ensure that chemical restraint is not being used as a substitute for long-term treatment. There was no mention of prior emergency medication use, the circumstances of that use, the dosage, the effect, etc. A log that reflects these dates, times, medication name, dosage, and route of previous "stat" medications would be a valuable attachment to this form. It would assist others in determining if the BSP is being successful with a reduction in frequency and amount of medication required. This information was listed in the Nursing Assessment, but there were no comments about how this information was utilized to change the next dosage to	

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		be administered. The pharmacist would be able to provide valuable input into other options, and side effects for which to observe. <u>Polypharmacy, Benzodiazepines, and Anticholinergics</u> The quarterly Drug Regimen Review form included the following probe that addressed polypharmacy: "Is polypharmacy present?" The quarterly Drug Regimen Review monitored all medications for side effects, clinical justification including documentation of diagnosis, and appropriate lab values to monitor for physiologic risks and toxicity. Benzodiazepines, anticholinergics, and polypharmacy were included in this aspect of the research done by the PharmD at each quarterly review. There was also a question that probed the metabolic and endocrine risks of the new generation antipsychotic medications: "Metabolic and endocrine risks associated with the use of new generation of antipsychotic medications reviewed." However, these areas of review, especially the polypharmacy, need to be understood by the physician, using historical and background information. This would best be done at a meeting or forum in which the sharing of information and opinions would occur in a non-confrontational way with discussion between the two departments. Simply sending a report to the physician may not be the best route to review concerns of medication regimens. At the time of the review, the Pharmacy Department was reviewing polypharmacy, benzodiazepines, anticholinergic medication, and metabolic effects of psychotropic medications through the quarterly drug regimen review process. However, collaboration with the physician was an ongoing concern (more discussion is found with regard to Section N.4 of the SA) Pharmacy Services and Safe Medication Practices had been revised and implemented, to document communication with the physician, Stat medications would benefit from an in-depth clinical review. Although they occur after the event, they would provide guidance to the physicians for future events with that individual.	
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	The quarterly DRRs often included a variety of recommendations. In reviewing the DRRs and the follow-up documentation to determine if there was evidence that physician orders reflected these recommendations or there were written reasons for not following the recommendations, the following observations were made: ▪ For six of the 22 DRRs reviewed (27%), recommendations were followed by a physician's order addressing the recommendation. For example, this was the case for Individual #38 for a DRR completed 2/12/10, Individual #300 for a DRR completed 2/2/10, Individual #25 for a DRR completed 3/8/10, Individual #13 for a DRR completed 2/4/10, Individual #133 for a DRR completed 7/5/10, and Individual #321 for a DRR completed 7/5/10. These may or may not have been	Noncompliance

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	recommendation is not followed.	accompanied by a note on the form or elsewhere. ▪ For one of the 22 DRRs reviewed (5%), recommendations were simply reviewed and noted, at times, with reasons written on the form noting the physician's counter view or alternative opinion. This was the case for Individual #284 for a DRR completed 3/6/10. ▪ For nine of the 22 DRRs reviewed (41%), no reason or justification for not following the recommendation was documented. For example, this was the case for Individual #66 for a DRR completed 2/1/10, Individual #251 for a DRR completed 7/5/10, Individual #275 for a DRR completed 7/5/10, Individual #167 for a DRR completed 7/5/10, Individual #272 for a DRR completed 6/9/10, Individual #15 for a DRR completed 6/9/10, Individual #122 for a DRR completed 6/9/10, Individual #226 for a DRR completed 7/5/10, and Individual #298 for a DRR completed 7/5/10. ▪ For six of the DRRs reviewed (27%), the recommendations had no response, and it was not clear if the physician had reviewed the recommendations. This was the case for Individual #140 for a DRR completed 3/11/10, Individual #218 for a DRR completed 3/4/10, Individual #298 for a DRR completed 3/10/10, Individual #255 for a DRR completed 2/18/10, Individual #238 for a DRR completed 3/3/10, and Individual #295 for a DRR completed 3/4/10. It is imperative that there be a physician response, and a system in which there can be dialog between the pharmacist and the PCP. The PharmD brings important information to the physician for response, and the physician needs to respond to each of the recommendations. Consistency in where this information is recorded is also important. This also should be done using a team or collaborative approach, because each relies on the other for expertise. It was difficult to readily find follow-up to the many recommendations made by the PharmD. Perhaps it would be beneficial for regularly scheduled medical staff meetings to be held during which the DRRs could be reviewed by the PharmD, with response and orders written by the PCP at that time. This would allow the PCP to provide documentation for each of the recommendations either in the form of an order or a written reason for deferring a decision on that recommendation. It also would allow collaboration between the pharmacist and PCPs. There are other options for accomplishing this, but until the physicians respond in writing to each of the recommendations, compliance with this aspect of the SA will not be achieved.	
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	If the individual was on psychotropic medication, the psychiatry nurses completed the MOSES or DISCUS. If there were other indications for the implementation of these instruments, the nurses assigned to that building completed the rating instrument. The Pharmacy Department determined which individuals required the MOSES or DISCUS, and reviewed them for completion and as a part of the quarterly DRR process. In the sample of 22 DRRs reviewed, one individual, Individual #298, was found to have a past	Noncompliance

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	dyskinesia.	due DISCUS. The instrument was due to be completed on 2/12/10, and the date of the quarterly DRR was 3/10/10. The remaining 21 (95%) of the DRRs indicated that the MOSES and/or DISCUS had been completed in a timely manner. This aspect of timely completion of the MOSES and DISCUS approaches compliance. Each Drug Regimen Review form had three assessment indicators for MOSES, and three assessment indicators for DISCUS. These include the following: "MOSES required"; "MOSES if required, was it completed by RN?"; "MOSES if completed, were values reviewed by Pharmacist?"; and "DISCUS required"; "DISCUS if required, was it completed by RN?"; and "DISCUS if completed, were values reviewed by Pharmacist?" The Pharmacy Department has demonstrated its tracking of MOSES and DISCUS completion, and review by the pharmacist. However, although the pharmacist recorded the scores, there did not appear to be a section with interpretation of the findings. For example, it was not clear if there were any significant findings, or if the individual was stable based on review of the results from the preceding screening, etc. The collection of data was not complete without a final formal written statement by the pharmacist about these scores. Although pharmacy had been able to monitor the completion of the rating instruments by the nursing staff and/or psychiatry team, monitoring is more than simply recording if a form was completed, but it includes a review of the trend and when appropriate, communication with the psychiatrist, PCP, and nursing department to alert them of changes.	
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.	In the Pharmacy Policy and Procedure Manual, there was a policy entitled "Adverse Drug Reactions," with revision date of 5/26/10, and implementation date of 6/5/10. However, the pharmacy department has not reported any adverse reactions. Consequently, the policy remains untested. The lack of adverse drug reactions reflected well on the pharmacy database of medication allergies of individuals residing at CCSSLC, and the pharmacy review process of medications before they are dispensed. However, there will be an occasional unexpected adverse drug reaction, and the pharmacy staff need to be familiar with the process included in the policy. Periodic in-service training of pharmacy staff, as well as physicians and nursing staff by the pharmacy department will alert medical and nursing staff to this issue. Further defining and providing potential examples of "unusual or unusually severe" reactions should also be used to ensure that such an event will be properly captured in the data for adverse drug reaction. At this point, the Facility's ability to implement the policy remains unproven because there has not been an adverse drug reaction reported. Also, given the size of the SSLC, one would expect from one to three reports of adverse drug reactions per year. That none were reported could be interpreted as missed events that are not being captured by the system. This underscores the importance of providing in-services to the physicians and nursing staff	Not Rated

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		as to what constitutes a reportable adverse drug reaction so that under reporting does not occur.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	At the time of the site visit, no drug utilization evaluations had been completed. The Pharmacy Department stated that they were awaiting completion of a policy and guidance from the State Office. With the hiring of a clinical pharmacist, the complement of pharmacy staff in the department had the training and expertise to pursue drug utilization evaluations. The department is encouraged to proceed in piloting one or more DUEs. The first step would be to take the task to the Pharmacy and Therapeutics (P&T) Committee, to determine priority medications that should be evaluated, and what should be the focus of the evaluation for each of the priority medications. This step will take time to accomplish, and in the meantime pharmacy staff should pursue learning the DUE process (creation, development, implementation, monitoring, completion, data interpretation, and application to the individuals at CCSSLC.). As the SO determines a policy and procedure and detailed guidance, CCSSLC can adapt their pilot DUEs to be consistent with the expectations of the SO.	Noncompliance
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.	One of the first steps to ensure accurate medication variance information is documented and reported is the creation of guidance through policy and procedure. The CCSSLC Pharmacy Department had developed and implemented a policy for medication errors: Pharmacy Medication Error Reporting Policy Revised, dated 6/2/10. A similar policy was developed by the Nursing Department: Medication – Errors, implemented 1/1/10. The pharmacy policy was new, but the nursing policy has been in effect for longer than six months. The two policies complement and reinforce the other. Each provides guidance unique to their discipline. Data from September 2008 to August 2009, and data from September 2009 to August 2010 indicated lower than expected numbers for the size of the census at CCSSLC and the numbers of medication given to each individual. For the most recent yearly data ending August 2010, two units, Coral Sea and Pacific, had more reported errors than the other units. Interpretation of this information was not attached, and it was difficult to determine if these two units had more problems with medication errors than the other units, or were reporting it more accurately than the other units. This becomes more perplexing when compared to the yearly data ending August 2009, in which these two units were among the units that had the least number of medication errors, and two others, Atlantic and Tropical, had most reported medication errors. A second data set labeled “procedural,” recorded more errors than the prior data set for medication errors, but the meaning of these values was difficult to interpret. All the	Noncompliance

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		procedural errors were considered omissions, but the fact that the number of medication errors involving omissions was greater than the number of more global medication errors brought into question the validity of the information. On review of a sample of 10 medication error reports, one was Category A (neither error nor harm occurs, the circumstances or events only have the potential to cause an error), three were Category B (an error occurs, intervention occurs before being administered to or used by the individual, the error does not reach the individual), five were Category C (an error occurs, the error reaches the individual, the individual is not harmed by the error), and one was Category D (an error occurs, the error reaches the individual and he/she requires increased level of care, monitoring or observation following the error, the individual is not harmed by the error). Of these, there were three systemic issues that would have the potential to be discussed at either the Medication Error Committee or the Medication Administration Workgroup meetings. More specifically: ▪ On one medication error form, dated 5/4/10, an RN made a comment: "The appointment calendar system currently in use has resulted in several negative consequences." In this instance the appointment on the calendar had an incorrect date. A memo was sent out to correct the date of the appointment, but the electronic system did not remove the erroneous appointment date from the calendar. The individual had been given Ativan as a pre-treatment sedation medication on a day that he did not have an appointment. The error in this case would have been preventable had the calendar been accurate. ▪ In another error, medications from the April Medication Administration Record (MAR) were incorrectly transcribed to the May MAR. The comment by the RN was that it "takes two nurses to competently review the order to ensure nothing was missed. Staff on 10-6 usually reviews with 2 nurses but on this night the other nurse got called to a unit." This points out an area of vulnerability in the ability of nursing to provide quality review when they are called away, leaving one nurse to do the task. Ensuring the MARs are not transcribed when only one nurse is available would be one way to resolve this problem. There were other transcription errors, and this may have been the cause, but was not stated. Nursing would need to review deployment of their staff during the time the MARs were transcribed and reviewed to determine any pattern, as well as to investigate any other causes for the transcription errors. ▪ In another medication error, the respiratory therapy department was not notified of orders, and so those orders were not carried out. Nursing needs to review this area to determine if the communication of orders to respiratory therapy can be improved. These errors occurred on 5/3/10, 5/4/10, and 5/24/10.	

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		Minutes of the Medication Administration Workgroup were submitted for 2/26/10, 3/8/10, 3/22/10, 3/29/10, 4/19/10, and 5/3/10. The medication errors discussed above and their potential systemic caused would have been discussed in a meeting(s) after this time period. The minutes reviewed did identify some systemic issues, though. For example, the 3/22/10 meeting minutes included the following comments: "Continue to map out process on flow chart, from the time order is written until order completed and carried out. Too many variations. ..nurses are being set up for failure due to outdated processes, heavy work load, impossible time frames and out of date medication rooms." Some goals were listed: "major focus is safe nursing care," "stream line what doing," "too many extra steps been created over the years," and "make sure all units are doing the same thing." Despite the comments and observations stated on the medication error forms and comments in the minutes of this workgroup, there seemed to be no progress in researching these issues further, and crafting a protocol or pathway to begin to reduce the medication error rate. Similarly, Medication Error Committee minutes were submitted for January 28, 2010, February 2, 2010, March 30, 2010, and April 29, 2010. The meeting for May 27, 2010 was not held due to lack of a quorum. Several topics were discussed that had the potential to improve the medication error rate. In the January 28, 2010 meeting, there was a recommendation that all immunization orders be time limited. The committee identified the practice of the Campus Nurse relaying PCP orders to unit nurses as a routine that increased the risk of medication errors. The follow-up to address this issue was that the current policy did not allow for nurse-to-nurse orders from the PCP, and that this would be discussed at the Nursing Management meeting. The Committee also noted that different insulin pens were used at the Facility, and there was the need to develop competency-based training on the different types of pens. It was noted that this area needed Pharmacy to alert Nursing before new or different insulin pens were sent to the units. However, there was no evidence that there was follow through on any of these areas of concern. In the March 30, 2010 meeting, the nurse-to-nurse orders were further discussed. There were two areas identified by the committee that needed improvement: improve communication between nurses, and inform all nurses there is no rule regarding only RNs calling the PCP on-call. Also discussed at this meeting was the area of medication refusals. Areas identified as opportunities for improvement included ensuring the RN was notified of a every medication refusal, reminding all nurses to document refusals, and including this documentation in the integrated progress notes. It also was suggested that both the trade and generic names of medications be listed on the MAR. There was no further documentation at future meetings as to the conclusion of these practical ideas. There was no documented follow-through in either accomplishing them, or any feedback	

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		to the committee regarding the effectiveness of the recommended solutions. Additionally, both the March 30, 2010 and April 29, 2010 Medication Error Committee minutes indicated that there was underreporting of medication errors. The April 29, 2010 committee minutes stated: "Due to underreporting concerns, it is difficult, if not impossible, to analyze data." According to the January 28, 2010 Medication Error Committee minutes, it was recommended that the QE nurse, and Nurse educator observe up to eight nurse medication passes per month. The nurse managers were encouraged to observe one nurse medication pass per month. Given concerns related to underreporting, to determine the actual medication error incidence, it may require observations of several medication passes per shift each week. As pharmacy is responsible for developing and implementing an oversight system for medication errors and variances, and generating database information, pharmacy also should be expected to observe medication passes on the units. This would allow a discipline outside of nursing to observe the strategic issues and begin to assist the nursing department in this endeavor. Although a policy and procedure had been created to assist in tracking and resolving medication errors and variance, this was only the first step. According to the Medication Error Committee minutes, the system was still broken, medication errors were not being reported, and systems were not being improved.	

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

1. Pharmacists should review all new orders to identify and clarify ambiguous or confusing information before distribution to the units.
2. Information Technology or other computer support personnel at the State-level should determine if there are ways to integrate WORx and Avatar, as the lack of integration affects all 13 SSLCs in the state.
3. Broaden the scope of the Quarterly Drug Regimen Reviews to include medication review of all individuals prescribed medication(s), not just those prescribed psychotropic medication.
4. When the psychiatrist reviews a quarterly DRR, and medication changes are made, the PCP should be copied.
5. When an individual is discharged from the hospital, there should be a formal system to ensure any new medication allergies or serious side effects are communicated to the pharmacy department for inclusion into the database and computer-generated physician order forms.
6. As noted in the quarterly DRRs, there are still delays in completing MOSES and DISCUS. Pharmacy and nursing need to collaborate to create a system to ensure these assessments are completed in a timely manner.
7. Policies need to be developed to address coordination between medical and pharmacy with regard to 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; monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.

8. The current form entitled "Face-to-Face assessment, debriefing, and reviews for crisis intervention restraint" does not effectively utilize the resources of the pharmacy department, as the pharmacy review occurs several days to weeks after the event. Pharmacy should have input into alternative medications or alternative dosages of medications that are being considered when they are on-site. Additionally, there is the wealth of clinical information the pharmacy department brings to the team in determining side effect risks and future treatment alternatives.
9. The current form entitled "Face-to-face assessment, debriefing, and reviews for crisis intervention restraint" should be modified to reflect valuable clinical information that the pharmacy department should provide, including a log of prior chemical restraint usage, listing medication, dosage, time of day, effectiveness, reason, etc. This would be valuable in determining the dosage, or alternatives, especially to ensure that the dosage is lowered as much as possible.
10. Sharing information from pharmacy about QDRR recommendations with the physicians may best be accomplished at a medical staff meeting or forum where information and opinions can be discussed in a non-confrontational manner.
11. The current quarterly DRR system needs to be reviewed by the pharmacy and medical departments, and a system developed to ensure that physicians or other PCPs respond adequately to the recommendations by either following the recommendations, or providing written justification for not following the recommendations.
12. Although there is tracking of results with MOSES and DISCUS, there should be a formal written comment from the pharmacy concerning the interpretation of the scores from the tests.
13. To encourage accurate reporting, pharmacy staff should consider providing routine and periodic in-service training to nurses and physicians concerning the definition of an adverse drug reaction and what constitutes a reportable event.
14. The pharmacy department is encouraged to pilot drug utilization evaluations, beginning by choosing the medication and target issue and bringing these to the P&T Committee for review, and then conducting the evaluation and returning to the P&T Committee with the results. Such studies (for instance, are drug levels of a selected medication therapeutic across the campus and what percent exceed or are below the range, what are the side effect profiles of selected medications prescribed to the individuals on campus, i.e., how many individuals on Topamax have weight loss greater than 10% over 3 or 6 months) can provide value to the care of the individuals at CCSSLC, and as a State Office policy is developed, may be influential in its development or could later be adapted to the SO format.
15. Given concerns related to underreporting, to determine the actual medication error incidence, it may require observations of several medication passes per shift each week.
16. As pharmacy is responsible for developing and implementing an oversight system for medication errors and variances, and generating database information, pharmacy also should be expected to observe medication passes on the units. This would allow a discipline outside of nursing to observe the strategic issues and begin to assist the nursing department in this endeavor.
17. When the Medication Error Committee and/or the Medication Administration Workgroup identifies recommendations for improvements, a systematic approach should be used to ensure follow-through, and to ensure that the steps taken to remedy identified issues are effective. For example, action plans should be developed, including action steps, person(s) responsible, anticipated outcomes, and timeframes for completion. The Committees should then review and document progress on the completion of the action plans, as well as any changes made to the plans, if anticipated outcomes are not achieved initially.

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Person-Specific Monitoring in Dining Room, revised 6/29/10; o PNMP Monitoring and Coaching Report, revised 6/29/10; o Monthly Home Equipment Check Sheet, revised 6/29/10; o Monthly Person-Specific PNMP Check Sheet, revised 6/29/10; o Monthly Tool Instructions Person-Specific PNMP Check Sheet, Monthly Home Equipment Checklist, Meal Monitoring, Competency Tools and Plan of Improvement, dated 7/1/10; o PNMP Coordinator Data Sheet Physical/Nutritional Management Data with directors to PNMP Coordinators, not dated; o Presentation Book Section O, dated 7/12/10; o Therapy Staff with Current Caseloads, not dated; o Habilitation Therapies Department Directory, revised 7/12/10; o Habilitation Therapies Department Table of Organization, not dated; o CCSSLC-Identified Aspiration Risks, dated 7/14/10; o CCSSLC Enteral Diners/Aspiration Risks, dated 7/14/10; o CCSLC Enteral Diners, dated 7/14/10; o Agenda for New Staff Orientation; o Curricula for new staff orientation, including training materials used; o Schedule for ongoing in-service staff training; o Number of budgeted positions, number of staff and number of contractors; o Monitoring tools currently utilized by the facility's Quality Enhancement Department; o Survey Staffing Review for ICF/MR Facilities, dated 1/10; o CV's for PNMT members; o List of Continuing Education sessions/activities for PNMT members; o Minutes/Documentation of Attendance for PNMT meetings; o Minutes for NMT meetings; o Documentation of Attendance for HST meetings; o PNMT reports/minutes for 3/10, 4/10, and 5/10; o Nutritional Management Screening Tool, not dated; o List of Individuals with/without PNMPs, 7/10; o PNM Screening documents for 2010; o PNM Management Plan (blank); Mat Assessment for Seating and Positioning (blank); Wheelchair Evaluation and Work Order (blank); PNMP Clinic Minutes (blank); NM Screening Tool (blank), not dated; o List of PNM Assessments/Updates, 1/10 through 5/10; o PSPs for Individuals with current PNM Assessments, 12/09 through 3/10; o Completed PNMPs, 8/09 through 7/10;

	o Person-Specific PNMP Monitoring and Coaching Report; PNMP Check Sheet; Monitoring in Dining Room (blank), not dated; o List of Individuals for whom PNM monitoring tools were completed, 4/10 through 6/10; o Evaluation of Dysphagia-Karen Hardwick (1993); o Dining Plan (template), not dated; o Dining Plans-Enteral Feedings, 10/09 through 6/10; o Competency Based Training Sheets/Rosters, 2/10 through 6/10; o Wheelchair Use Report; Orthotics Usage; Modified Liquid Report; Enteral Dining Report; Protective Device Usage; Adaptive Equipment, 5/10 through 7/10; o Adaptive Dining Texture Report; Modified Liquids Report, 6/10; o Downgrade Diet and/or Fluid Consistency, 6/10; o BMI greater than or equal to 30, 5/09 through 5/10; o BMI less than or equal to 20, 5/09 through 5/10; o Unplanned Weight Loss greater than or equal to 10% in six months, 1/10 through 6/10; o Swallow Incidents/Choking for 12 months, 6/09 through 6/10; o Pneumonia Diagnosis for 12 months, 6/09 through 6/10; o Skin Breakdown, 1/10 through 6/10; o Risk Factor: Falls; Pneumonia; Aspiration; Constipation; Osteoporosis; Skin Breakdown, not dated; o Dental Database for poor oral hygiene, 1/10 through 6/10; o Gastrostomy/J-Tubes, not dated; o Modified Barium Swallow Studies for 12 months, not dated; o Meal Schedules; o PNMP Clinics Scheduled, 7/12/10 through 7/17/10; o Training Rosters/Competency Levels; New Employee Orientation Curriculum; Mechanical Lifts; Pivot Transfers; Repositioning from 10/09 through 5/10; o PNMP Competency Checklist-blank, dated 6/10; o Person-Specific PNMP Monitoring and Coaching Report; PNMP Check Sheet; Monitoring in Dining Room, dated 6/10; o Training Roster/Competency Levels for PNMP Training Sessions, 7/09 through 5/10; XII.30Training Roster/Competency Levels for PNMP Coordinators/Therapists, 4/10 through 6/10; o Individual record for Individual #246, Individual #136, Individual #207, Individual #161, Individual #68, Individual #113, Individual #325, Individual #223, Individual #375, Individual #244, Individual #66, Individual #52, Individual #263, Individual #58, and Individual #198, with the following requested records: OT/PT/SLP Assessments,; OT/PT/SLP Consultations for the past year; PSP; PSP Addendums for past year; PNMP current and revised PNMP for last year with pictures; PNMT Individual Record; Nutrition Assessment; PNMP Clinic Notes for last year; Individual specific consultations; Nursing Assessment; Medical Assessment; PNMP Management Data for May/June; Person-specific monitoring 2-10, Competency-based monitoring for staff; Competency-based staff training documentation Daily Schedule; HST Risk Assessment for all categories; and Wheelchair

	consultations; o Individual records for Individual #240, Individual #153, Individual #348, Individual #105, Individual #173, Individuals #357, Individual #67, and Individual #363 with the following requested records: OT/PT/SLP Assessments; OT/PT/SLP Consultations for the past year; PSP; PSP Addendums for past year; PNMP current and revised PNMP for last year with pictures; PNMT Individual Record; Nutrition Assessment; PNMP Clinic Notes for last year; Individual specific consultations; Nursing Assessment; Medical Assessment; PNMP Management Data for May/June; Person-specific monitoring 2-10, Competency-based monitoring for staff; Competency-based staff training documentation Daily Schedule; and HST Risk Assessment for all categories; and o Individual records for Individual #370, Individual #137, Individual #240, Individual #380, Individual # 209, Individual #183, Individual #340, Individual #239, Individuals #195, Individual #190, and Individual #113 with the following requested records: OT/PT/SLP Assessments; OT/PT/SLP Consultations for the past year; PSP; PSP Addendums for past year; PNMP with pictures and date of implementation; Pleasure/therapeutic feeding plan; Person-specific monitoring for May-June; Monthly monitoring for equipment for May/June; PNMP Management Data Sheets for May/June; PNMP Coordinator Data Sheet for May/June; Person-specific monitoring in dining room; Competency–based monitoring for staff; Competency-based staff training documentation; and Daily Schedule ▪ **Interviews with**: o Rosie Cortez, Director Habilitation Therapies and Occupational Therapy Director; o Tami Loudermilk-Flores, Occupational Therapist; o Tangila Phoenix, Certified Occupational Therapy Assistant (COTA); o Yvonne Cortez, COTA; o Dora Barbosa, Speech Assistant; o Norma Martinez, Speech Assistant; o Linda Merryman-Scifres, Speech Language Pathologist; o Marlene Perry, Speech Language Pathologist; o Angela Roberts, Audiologist; o Paul Osborne, Director of Physical Therapy; o Maria Garcia, Physical Therapist; o Janie Mendoza, Physical Therapist; o Allan Mendoza, Physical Therapist; o Fred Vera, Physical Therapy Assistant (PTA); o Debbie Salinas, PTA; o Joe Lopez, Lead OET Tech, Wheelchair Department; o Meeting to discuss the PNMT (NMT) with Iva Benson, Director; Mark Cazalas, Assistant Director of Programs; Polly Ramirez, Settlement Agreement Coordinator Becky McPherson, State Office; Linda Lothringer, Director of Settlement Agreement Compliance Unit; Debra Woodruff, State Office; and Karen Hardwick, Coordinator of Habilitation Therapies, on 7/14/10; and o Dana VerHey, QE Program Auditor

	▪ **Observations of**: o Unit Morning Meeting Ribbonfish, on 7/13/10; o Integrated Clinical Services Meeting, on 7/14/10; o Observations in the following residences: Pompano, Ribbonfish 2, and Ribbonfish 3; o Observation of meals in the following homes: Pacific Dining Room, Atlantic Dining Room, and Coral Sea Dining Room; o Personal Support Plan Meeting for Individual #136; and o Seating Assessment with Karen Hardwick, Coordinator of Habilitation Therapies and CCSSLC Therapy Staff
	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Although the POI reviewed for CCSSLC did not include this component, the POI for Section O identified compliance and/or non-compliance with identified indicators. CCSSLC identified compliance with some indicators in Section O. However, based on the Monitoring Team's review, the Facility was not in compliance with these components of the SA. Additional information and individual examples are contained in the section below that addresses Section O of the SA. Examples of indicators that were rated in compliance but non-compliance was found by the Monitoring Team included: ▪ The POI for Section O.1.4 documented compliance with the following indicator: "to identify all individuals for physical and nutritional risk, to recommend and formulate interventions, to review plans and provide follow-up and provide equipment for mobility and positioning." There was no evidence submitted to substantiate compliance for these indicators. Record review of 23 individuals by the Monitoring Team did not support that these individuals with complex physical and nutritional support needs had been identified by the Facility as at risk and/or referred to the Physical and Nutritional Management Team (PNMT). ▪ The POI for Section O.2.1 indicated compliance with the following indicator: "100% of records reviewed showed that a process was in place to identify individuals with PNM concerns." The comments section to justify compliance stated that: "documentation from all NMT discussion will be in the individual's unified record." This indicator was not congruent with identifying a "process is in place that identifies individuals with PNM concerns." Individual record review conducted by the Monitoring Team did not support that those individuals with PNM concerns were identified and reviewed by the PNMT (NMT). ▪ The POI for Section O.2.8 documented compliance for "100% of records review show that people who receive enteral nutrition and/or therapeutic or pleasure feedings are provided with PNMPs that include the components listed above." PNMPs for those individuals who receive enteral nutrition did not incorporate strategies for medication administration and oral hygiene consistently. ▪ The POI for Section O.2.11 stated: "100% of records reviewed show that PNMPs are reviewed annually at the PSP meeting and updated as needed." Individual record review for 23 individuals did not document that PNMPs were reviewed annually at the PSP meeting, because the components of the PNMP were not consistently integrated into the PSP. ▪ The POI for Sections O.3.1, O3.2, and O.3.3 documented compliance with "100% of records reviewed show that all individuals identified as being at risk (requiring PNM supports) are

	provided with a comprehensive PNM Plan (PNMP) and 100% of records reviewed show that as appropriate PNMP consists of interventions/recommendations regarding PNMP components as outlined in the SA." A review of PNMPs documented that multiple PNMPs were missing strategies for medication administration and oral hygiene. ▪ The POI for Sections O.4.6 and O.4.7 documented observations completed and records reviewed showed that individuals were in proper alignment and position, and records showed that staff who were responsible for ensuring correct positioning and alignment were trained and monitored for performance, respectively. Observations by the Monitoring Team did not support that individuals were consistently in optimal alignment and support. Competency-based staff training documentation was not available to document that staff had received and successfully passed competency-based training. ▪ The POI for Sections O.5.3 and O.5.4 documented compliance with competency-based training for direct support professionals on mealtime and positioning plans for new employees. As stated above, documentation was not presented to document staff had completed competency-based training for mealtime and positioning plans, and observations by the Monitoring Team did not support staff competency with mealtime and positioning plans. ▪ The POI for Sections O.6.1, O.6.2 and O.6.4 addressed a system for monitoring. There were no policies to define the CCSSLC monitoring system and that monitoring covers staff providing care in all aspects in which the person is determined to be at increased risk. ▪ The POI for Section O.7.2, O.7.4, O.7.5 and O.7.7 indicated the Facility was in compliance with the following: "a process is in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with health risk, individual's PNM status is reviewed regularly and plans updated when there is a change in status, and immediate interventions are provided when the individual is determined to be at increased risk of harm." A review of 23 individual records by the Monitoring Team did not identify a review of these individuals by the PNMT (NMT), establishment of a monitoring schedule for those individuals with complex physical and nutritional supports, and/or provision of immediate interventions for those individuals at risk of harm. ▪ The POI for Section O.8.5 acknowledged the presence of a policy that defined the frequency and depth of evaluations for individuals who receive enteral nutrition. However, a policy was not submitted that defined this process. ▪ The POI for Section O.8.6 indicated record compliance for individuals who were at an increased PNM risk and were provided with interventions to promote oral intake. The Monitoring Team's record review identified individuals who had received a gastrostomy and/or jejunostomy tube, but had not been referred/reviewed by the PNMT (NMT) to complete a comprehensive assessment to address their significant nutritional risk prior and/or after the placement of a feeding tube. CCSSLC had begun to implement a monitoring process regarding Sections O, P, and R. A Corrective Action Plan was developed for Sections O, P, and R. The Habilitation Therapies Director was responsible for monthly monitoring using the Draft Monitoring Tool SA - Section O. Per report, multiple therapists were also monitoring Section O, P, and R on a monthly basis. A policy notebook was to be established with two sections, one for State Office Policies and one for current and new CCSSLC policies, protocols and

	procedures. An analysis was to be completed to determine what policies, protocols, and procedures needed to be developed, revised and/or deleted. In addition, a database was in the process of being developed to ensure tracking of all applicable actions steps in Sections O, P, and R. The Habilitation Therapies staff were to be responsible for entering the data and presenting monthly analysis to the Performance Improvement Committee for review and recommendations. CCSSLS staff would be trained on revised and new policies and procedures. As discussed above with regard to Section E of the SA, the monitoring tools for Sections O, P, and R will need to be revised to facilitate monitoring by the Facility, include indicators that clearly define the expectations and ensure reliability across reviewers, and have corresponding instructions/guidelines developed.
	Summary of Monitor's Assessment: PNMT (NMT) did not meet regularly to address changes in status, assess clinical data, and/or review monitoring results. Documentation was submitted for only two meetings (3/24 and 3/30/10) conducted since the baseline review. During the CCSSLC July 2010 review, the Director, Assistant Director, Habilitation Therapies Director, State Office representatives, State Coordinator of Habilitation Therapy Services, Settlement Agreement Coordinator (SAC), and members of the Monitoring Team met to discuss the absence of PNMT (NMT) meetings, barriers to implementation and strategies to establish a PNMT with designated standing members. A Corrective Action Plan was developed during the week of the compliance review. Clinical instruction documentation was submitted for the Habilitation Therapies Department for multiple PNMP and Wheel Chair (WC) Clinic Teleconferences. There were no additional continuing education courses documented for therapy staff. PNMT standing members (not just therapists) should attend a variety of annual continuing education courses to bring diversity of knowledge and skills to the provision of supports to individuals with the most complex physical and nutritional supports needs. CCSSLC did not have a process in place that identified individuals with PNM concerns, and referred these individuals to the PNMT. Individuals identified as being at an increased risk level were not provided with a proactive comprehensive assessment, and treatment/intervention strategies and plans were not developed and implemented. Analysis and review of documentation and monitoring to determine the efficacy of supports provided at both the individual-specific and systemic levels was not being conducted. Review of the Facility's training curricula revealed that it did not include adequate PNM training in the following areas: ▪ Body mechanics; ▪ Handling techniques; ▪ Optimal alignment and support in seating systems and alternate positions; ▪ Mechanical lift transfers; ▪ Manual transfers approved by Facility policy; ▪ Mealtime positioning; ▪ Food and fluid consistency; ▪ Safe presentation techniques for food and fluid; and ▪ Physical and Nutritional Management Plans (PNMPs).

	Competency-based training was not being provided to staff providing supports to those individuals with the most complex health, physical and nutritional supports needs. The Facility had developed and implemented various PNM monitoring tools, but policies/procedures had not been developed to ensure monitoring consistency and inter-rater reliability. A review of Facility reports (Quality Improvement/Quality Enhancement, HST minutes, and Mortality Review Committee) did not show that a mechanism was in place that ensured timely data was provided to the PNM (NMT) that could be analyzed to identify and ensure the provision of supports to individuals with the most complex physical and nutritional support needs. The PNMT should establish thresholds to trigger further evaluation based on degree of and/or frequency of certain types of incidents, and/or key health care indicators. Individual-specific outcomes and criteria must be clearly recorded, utilized for monitoring, and analyzed to determine efficacy of the supports provided at both the individual-specific and systemic level. This information should be integrated into the Facility's Quality Assurance/Enhancement, Incident Management and Risk Management systems. In addition, PNMT members should be involved actively in internal mortality reviews as a learning process as well as a mechanism for improving supports to individuals with the most complex health, physical and nutritional support needs. The Facility did not evaluate individuals who were enterally nourished to ensure that the continued use of the tube was medically necessary. There was no Facility policy that addressed the assessment process of individuals receiving enteral nutrition to provide justification to support the appropriateness of receiving and continuing enteral nutrition, and/or strategies to transition an individual to oral intake, if appropriate.

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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	Due to the multiple requirements included in this provision of the SA, as well as the requirements of this overarching provision of the Settlement Agreement being further detailed in other components of Section O of the SA, the following summarizes the review of the requirements related to the Physical and Nutritional Management Team, including the composition of the team, the qualifications of team members, and the operation of the team. Each indicator of compliance is underlined, and the narrative that follows summarizes the Monitoring Team's findings. The assessment and planning processes in which the team is required to engage are discussed below in the sections of the report that address Sections O.2 through O.7 of the SA. <u>The PNM team consists of qualified Speech Language Pathologist (SLP), Occupational Therapist (OT), Physical Therapist (PT), Registered Dietician (RD), and, as needed, ancillary members [e.g., MD, Physician's Assistant (PA), Registered Nurse Practitioner (RNP)].</u> Based on a review of PNM Team meeting minutes (which the Facility refers to as the NMT), only two PNMT (NMT) meetings had been held since the baseline review,	Noncompliance

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	regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, physical therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in swallowing disorders. As needed, the team shall consult with a medical doctor, nurse practitioner, or physician's assistant. All members of the team should have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs.	including meetings on 3/24/10, and 3/30/10. There were no corresponding attendance records submitted. Without sign-in sheets, it could not be determined if attendance of even the two meetings had consisted of the appropriate members of the PNMT. As a result, the Facility had documented zero percent (0%) attendance level by PNM (NMT) Team members. Because a standing PNMP Committee had not been established, and attendance records for the two PNMT meetings did not include names of staff, the qualifications of the PNMT could not be reviewed or established. During the July 2010 review, the Director, Assistant Director, Habilitation Therapies Director, State Office Representatives, State Coordinator of Habilitation Therapy Services, SAC Coordinator, and members of the Monitoring Team met to discuss the absence of PNMT (NMT) meetings, barriers to implementation, and strategies to establish a PNMT with designated standing members. A Corrective Action Plan was developed during the week of the compliance review. This plan included the following: ▪ Core team members of the CCSSLC PNM Team were designated (Completion date 7/14/10); ▪ The State Coordinator of Habilitation Therapy Services conducted a PNMT meeting with core members, Habilitation staff and Administrative staff during which two individuals were reviewed (Completion date 7/14/10); ▪ NMT/Weight clinic would continue on a monthly basis until the PNMT meeting was fully implemented (Ongoing); ▪ PNMT Core Membership would meet with Medical and nursing staff and other discipline coordinators to determine criteria for individuals to be referred to the PNMT from HST and/or when there was a life changing event (Completion date 8/01/10); ▪ PNMT Core Membership would review current High Risk list of 64 individuals, and compare it to the PNMT Referral Protocol to determine which individuals would be referred to PNMT meeting (Completion date 8/1/10); ▪ Additional training in PNMT would be provided to PNMT Core Members and PST (Ongoing); ▪ A draft PNMT Meeting procedure would be developed (Completion date 8/1/10); ▪ Training on PNMT and PST on roles and responsibilities outlined in the PNMT Meeting procedure would be provided (Completion date 9/1/10); and ▪ Weekly PNMT meeting would begin (Completion date 9/1/10 and ongoing). The Curricula Vitae (CVs) and years of experience for the newly established PNMT members will be reviewed during the next compliance review. In addition, during the next review, a review will be conducted of PNMT (NMT) clinical	

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		instruction documentation to determine if adequate training and professional development has been provided related to physical and nutritional supports. For the July 2010 review, clinical instruction documentation was submitted for the Habilitation Therapies Department for multiple PNMP and WC Clinic Teleconferences (XII.5.a.). There were no additional continuing education courses documented for therapy staff. PNMT standing members (not just therapists) should attend a variety of annual continuing education courses to bring diversity of knowledge and skills to the provision of supports to individuals with the most complex physical and nutritional supports needs. <u>PNM team meets regularly to address change in status, assessments, clinical data, and monitoring results.</u> Based on a review of 15 individual records, none of them (0%) included documentation to support that the PNM (NMT) Team met regularly to address change in status, assessment, clinical data and monitoring results. The records reviewed included: Individual #246, Individual #136, Individual #207, Individual #161, Individual #68, Individual #113, Individual #325, Individual #223, Individual #375, Individual #244, Individual #66, Individual #52, Individual #263, Individual #58, and Individual #198. The individual record sample was drawn from lists of individuals at risk based on the following criteria: ▪ Individuals who had Emergency Room visits; ▪ Individuals who had hospitalizations; ▪ PNM (NMT) Team meeting minutes; ▪ Individuals with active pressure ulcer within the last six months; ▪ Individuals with severe dysphagia; ▪ Individuals with chronic constipation or who experienced fecal impaction within the last six months; ▪ Individuals with unexplained weight loss or Body Mass Index (BMI) ≤ 20; ▪ Individuals ≥ BMI of 30; ▪ Individuals who experienced a choking incident which required abdominal thrust within the last six months; ▪ Individuals with a diagnosis of aspiration pneumonia; ▪ Individuals who had experienced significant falls related to transfers and/or ambulation; ▪ Individuals with chronic respiratory infections; ▪ Individuals with chronic dehydration; ▪ Individuals with a diagnosis of osteoporosis and/or osteopenia; ▪ Individuals who experienced a fracture; and ▪ Reviewer observations of mealtime, positioning, transfers, medication	

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		administration, tooth brushing, personal care, and functional communication. Individual and additional examples of where the PNM (NMT) Team did not met regularly to address change in status, assessment, clinical data and monitoring results included: ▪ As noted above, the CCSSLC PNMT (NMT) did not meet regularly to address changes in status, assessment clinical data and monitoring results as documentation was submitted for only two meetings, on 3/24 and 3/30/10, since the baseline review. ▪ Individual #246 experienced a choking incident on 7/9/10. The SPL reviewed him on 7/10/10, and an OT on 7/11/10. Consultation recommendations did not refer Individual #246 to the PNMT (NMT). ▪ Individual #113 was identified as "at risk" for dysphagia (VI.3.e), but was not referred/reviewed by the PNMT (NMT). ▪ Individual #58 was hospitalized for a fever, Systemic Inflammatory Response Syndrome (SIRS), and aspiration pneumonia on 3/9/10, and was discharged on 4/6/10. The PNMT (NMT) discussed Individual #58 on 3/30/10, and documented "had an MBSS at the hospital and G-tube placement has been recommended and procedure will be done soon before he comes home. Continue Risk Level 1." The PNMT (NMT) did not meet again to complete a comprehensive assessment for Individual #58. ▪ Individual #375 was identified as having skin breakdown within the past 12 months (XII.24.h), but was not referred to or reviewed by the PNMT (NMT). In addition, Individual #375 was hospitalized for a fracture of her left femur, on 4/10/10, but was not referred to or reviewed by the PNMT (NMT). ▪ Individual #207 was identified as "at risk" for contractures, dysphagia, skin breakdown/decubitus ulcer, impaction/bowel obstruction/constipation, and dehydration. She was not referred to or reviewed by the PNMT (NMT). ▪ Individual #263 was identified as "at risk" for falls, but was not referred to/ or reviewed by the PNMT (NMT).	
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	<u>A process is in place that identifies individuals with PNM concerns.</u> Based on policy review (State and Facility) and record review, a process that identified individuals with PNM concerns was not defined sufficiently, as illustrated by: ▪ In 0 of the 15 records reviewed (0%), there was documentation of risk identification levels based upon physical and nutritional history, current status and/or specific criteria for guiding placement of individuals into specific risk levels. ▪ In 0 of the 15 records reviewed (0%), there was documentation of comprehensive assessment process leading to the development of measurable, functional outcomes for individuals at highest risk, which included analysis of discipline-specific assessments (OT, PT, SLP, nursing, medical, nutrition, and	Noncompliance

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	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.	psychology), PNMP Clinic results, PNM (NMT) Meeting Summaries, and individual-specific consultations. ▪ In 0 of the 15 records reviewed (0%), there was documentation of development of implementation strategies. ▪ In 0 of the 15 records reviewed (0%), there was documentation of competency-based training for individual strategies. ▪ In 0 of the 15 records reviewed (0%), there was documentation of a monitoring schedule for individuals at highest risk. ▪ In 0 of the 15 records reviewed (0%), there was documentation of a review process to determine the efficacy of individual strategies resulting in the attainment of identified outcomes. Examples of the lack of a sufficiently defined PNM process were: ▪ At the time of the review in July 2010, Individual #244 had a BMI score of 16.7 (XII.24.d) that documented her underweight status. PNMT (NMT) Minutes, dated 3/24/10, documented "in January and February she gained weight and is now EDWR [established desired weight range]. She does continue to refuse meals at dinnertime. RN: will work with staff on identifying if there is a pattern or certain foods that she does not like and report at next NMT." She was not reviewed at the next PNMT (NMT) meeting on 3/30/10. There was no documentation of a comprehensive assessment leading to the development of measurable, functional outcomes to minimize and/or reduce the identified health risk. ▪ Individual #173 was identified "at risk" for chronic respiratory infections. He was hospitalized on 1/8/10 for hypothermia/hypotension and aspiration pneumonia, and admitted to the Infirmary for aspiration pneumonia on 2/5/10). Individual #173 was not referred to or reviewed by the PNMT (NMT). <u>Individuals identified as being at an increased risk level are provided with a comprehensive assessment that focuses on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning during the course of the day and during nutritional intake by the PNM team.</u> Review of eight records involving individuals who had been identified by the Facility as being at high risk, including Individual #240, Individual #153, Individual #348, Individual #105, Individual #173, Individuals #357, Individual #67, and Individual #363 revealed the following: ▪ In 0 of the 8 records reviewed (0%), there was documentation of PNM (NMT) review/analysis of the findings of relevant discipline-specific assessment(s), PNMP Clinic results, PNMP, and relevant consultation(s) leading to the development of a comprehensive summary, addressing: o Physical health status;	

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		o Nutritional health status; o Oral care; o Medication administration; o Mealtime strategies; o Proper alignment; o Positioning during the course of the day; and o Nutritional intake. ▪ In 0 of the 8 records reviewed (0%), measurable, functional outcomes were identified. ▪ In 0 of the 8 records reviewed (0%), there was documentation of PNMPs developed with input from the PNM (NMT) for those individuals at highest risk ▪ In 0 of the 8 records reviewed (0%), there was congruency between Strategies/Interventions/Recommendations contained in the PNMP and the concerns identified in the comprehensive assessment. ▪ In 0 of the 8 records reviewed (0%), comprehensive summary results were integrated into the design of the appropriate PNM support plans as outlined in Section VI and VIII HCG, and SA O.3 through O.8. ▪ In 0 of the 8 records reviewed (0%), PNM (NMT) updates were provided as needed until the individual was discharged from the PNM (NMT) Team. Examples of where the PNM (NMT) did not provide individuals with a comprehensive assessment/summary, integration of summary into the PNMP, and/or updates were: ▪ Individual #105 was identified at high risk (High Risks by Type, dated 7/12/10) for GI and medical concerns. He was hospitalized for post operation respiratory distress, on 1/28/10, and respiratory distress/ALC/pneumonia, on 2/4/10. He was not referred to or reviewed by the PNMT (NMT), and no comprehensive assessment was completed and/or used to develop a PNMP. ▪ Individual #240 was identified at high risk (High Risks by Type, dated 7/12/10) for choking, medical concerns and aspiration. She was not referred to or reviewed by the PNMT (NMT), and no comprehensive assessment was completed and/or used to develop a PNMP. ▪ Individual #173 was identified at high risk (High Risks by Type, dated 7/12/10) for aspiration, choking and respiratory concerns. He was hospitalized for hypothermia/hypotension/aspiration pneumonia on 1/08/10). He was not referred to or reviewed by the PNMT (NMT), and no comprehensive assessment was completed and/or used to develop a PNMP. ▪ Individual #357 was identified at high risk for skin integrity (High Risks by Type, dated 7/12/10). She was not referred to or reviewed by the PNMT (NMT), and no comprehensive assessment was completed and/or used to develop a PNMP. ▪ Individual #348 was identified at high risk for injury, osteoporosis, constipation and polypharmacy. He was not referred to or reviewed by the PNMT (NMT), and	

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		no comprehensive assessment was completed and/or used to develop a PNMP. ▪ Individual #67 was identified at high risk for weight loss. She also experienced a choking incident requiring abdominal thrust on 4/16/10). She was not referred to or reviewed by the PNMT (NMT), and no comprehensive assessment was completed and/or used to develop a PNMP. ▪ Individual #153 was identified at high risk for choking and aspiration. He was not referred to or reviewed by the PNMT (NMT), and no comprehensive assessment was completed and/or used to develop a PNMP.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	<u>All persons identified as being at risk (requiring PNM supports) are provided with a comprehensive Physical and Nutritional Management Plan (PNMP).</u> Based on a review of a sample of 23 individual records, including for Individual #246, Individual #136, Individual #207, Individual #161, Individual #68, Individual #113, Individual #325, Individual #223, Individual #375, Individual #244, Individual #66, Individual #52, Individual #263, Individual #58, and Individual #198, Individual #240, Individual #153, Individual #348, Individual #105, Individual #173, Individuals #357, Individual #67, and Individual #363, individuals were not provided with a comprehensive PNMP. Although a number of the components of a comprehensive PNMP were present for many individuals, there were a number of components missing. More specifically: ▪ In 22 of 23 records reviewed (96%), positioning instructions for wheelchair and alternate positions instructions were included. ▪ In 22 of 23 records reviewed (96%), transfer instructions were included. ▪ In 22 of 23 records reviewed (96%), the mealtime/dining plan included oral intake strategies for mealtime and snacks ▪ In 21of 23 records reviewed (91%), the mealtime/dining plan included food/fluid textures. ▪ In 21 of 23 records reviewed (91%), the mealtime/dining plan included behavioral concerns related to intake. ▪ In 0 of 23 records reviewed (0%), strategies for medication administration were included. ▪ In eight of 23 records reviewed (35%), strategies for oral hygiene were included. ▪ In 23 of 23 records reviewed (100%), individual adaptive equipment was included. ▪ In 18 of 23 records reviewed (78%), bathing/showering positioning and instructions were included. ▪ In 21 of 23 records reviewed (91%), personal care instructions were included. ▪ In 23 of 23 records reviewed (100%), communication strategies were included. In addition, as noted above with regard to Section O.2 of the SA, comprehensive assessments had not been completed or incorporated into the PNMPs for individuals	

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		identified as being at high risk. As a result, the quality and comprehensiveness of the strategies included in the PNMPs reviewed may have been inadequate to meet the needs of the individuals for whom they have been developed. Examples of where individuals were not provided with a comprehensive PNMP included: ▪ None of the PNMPs incorporated strategies for medication administration. Multiple individuals' PSPs (i.e., Individual #240, Individual #153, Individual #105, Individual #173, Individual #363, and Individual #207) indicated that they were at risk of aspiration, but their PNMPs did not incorporate strategies for medication administration to minimize the risk of aspiration. ▪ PNMPs for Individual #240, Individual #153, Individual #348, Individual #105, Individual #173, Individual #357, Individual #67, Individual #207, Individual #375, Individual #263, Individual #52, Individual #66, Individual #325, Individual #68, and Individual #246 did not identify strategies for oral hygiene. <u>PNM plans were incorporated into individual's Personal Support Plans.</u> In 0 of 23 records reviewed (0%), PNMPs were incorporated into individual Personal Support Plans. In general, they were simply referenced or listed. There was not clear delineation, for example, of responsibility for data collection, monitoring, or review of the plans. The plans were not clearly integrated with other supports identified in the plans such as dental care, communication, community integration, etc. Examples of where individual PNMPs were not incorporated in PSPs included: ▪ Individual #153's PNMP was revised on 3/17/10 to include "give a 1 sip of fluid with every 1 bite of food (to clear his mouth and prevent choking). Give food very slowly to allow it to pass from esophagus to stomach." This revision was not documented in his PSP and/or a PSP addendum. ▪ Individual #348's PNMP was revised on 3/1/10, and 6/22/10. There were revisions in the area of assistive equipment, mobility, and transfers. These revisions were not incorporated into his PSP via addendums. ▪ Individual #105's PSP, dated 4/14/10, did not incorporate his PNMP that was revised on 3/12/10, and 4/2/10. It was unclear what was revised on his PNMP. <u>PNMPs are developed with input from the IDT, home staff, medical and nursing staff.</u> In 0 of 23 records reviewed (0%), PNMPs were developed with input from the PST with an emphasis on direct support professionals, medical/nursing staff, and behavioral staff (if appropriate). Examples of where individual PNMPs were not developed with input from the PST included: ▪ Individual #198's Occupational Therapy Evaluation, dated 4/27/10,	

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		recommended a high-sided plate to assist with scooping and promote independent with eating. This recommendation was not incorporated into his PSP via an addendum or his PNMP until 6/17/10, indicating that input was not sought from his team for over six weeks from the time the need was identified. ▪ Individual #58's PNMP was revised on 1/21, 4/27, 5/11, 5/14, and 5/26/10. The PNMP only documented the following change "ambulate in living and bedroom areas w/hard shell helmet, gait belt, and assistance of 1-2 staff as needed." There was no notation that this revision occurred on 5/26/10. The PSP, dated 1/21/10, did not address the preceding revision. His PNMP documented "he receives all nutrition, fluids and medications through g-tube (4/27/10), and there were no PSP Addendum(s) to address his PNMP revisions, and/or the placement of a g-tube. ▪ Individual #52's PSP Addendum, dated 2/19/10, documented a choking incident. An OT/PT consultation was recommended to evaluate his diet texture, and a Speech consultation to evaluate for communication book with Spanish translation for better communication. The OT/Speech consultation was completed on 2/18/10, and was signed by an Occupational Therapist and Speech Assistant. The consultation did not address his communication book. Individual #52 continued to receive one-to-one supervision during all meals/snacks (HRC approved on 9/4/10). There were no further PSP Addendums to discuss the implementation of additional strategies that would reduce the one-to-one level of supervision during meals. The PST was not adequately involved in the development of strategies to address his communication or mealtime needs. <u>PNMPs are reviewed annually at the PSP meeting, and updated as needed.</u> In 0 of 23records reviewed (0%), PNMPs were reviewed annually at the PSP meeting, and updated as needed. Examples of where individual PNMPs were not reviewed annually at the PSP and/or updated as needed included: ▪ Individual #263's PSP Addendum, dated 1/28/10, documented "three falls within the last 30 days." Individual #263's PSP, dated 12/29/09, recommended "a hospital bed with bedrails and a standard manual wheelchair with planar seat and back to be fabricated." His PNMP, dated 12/16/09, did not address these recommendations, nor did subsequent PSP Addendums. ▪ Individual #375's PNMP, revised 3/23/10 and 4/20/10, indicated that sections of the PNMP were to be placed on hold for assistive equipment, mobility, and standing, but these revisions were not incorporated in the PSP and/or a PSP addendum. ▪ Individual #66's PNMP, revised 4/23/10, documented the following assistive	

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		equipment: hospital bed, long handled sponge brush to aid in bathing hard to reach areas, toileting aid to assist with wiping during toileting, and pressure relief mattress. Her PSP, dated 3/3/10, and/or PSP addendums did not discuss the purpose and use of her assistive equipment. ▪ Individual #325's PNMP was revised on 6/21/10. It was unclear what the revision to his PNMP was. However, there was no PSP Addendum that discussed revisions to his PNMP. ▪ The nutritional focus of Individual #161's PNMP, dated 5/25/10, was to prevent complications from reflux and aspiration. His PSP, dated 5/25/10, identified water safety recommendations. These recommendations were not incorporated into his PNMP. <u>PNMPS are reviewed and updated as indicated by a change in the person's status, transition (change in setting) or as dictated by monitoring results.</u> In 0 of 23 records reviewed (0%), PNMPs were reviewed and updated as indicated by a change in the individual's status, transition (change in setting), or as dictated by monitoring results. Examples of when PNMPs were not reviewed and updated as indicated by a change in the individual's status, transition (change in setting), or as dictated by monitoring results included: ▪ Individual 161's Health Risk Assessment Tool-Aspiration/Choking, dated 4/19/10, documented that he received an MBSS on 02/08/10. Recommendations included "continue puree/pudding thick diet, strict aspiration precautions: slow rate and small bite. Monitor temperature, check chest for rattles, runny nose or watery eyes." His PNMP, dated 5/25/10, had not been updated to incorporate the recommendation for small bite, monitor temperature, check chest for rattles, runny nose or watery eyes. ▪ The last revision of Individual #67's PNMP was 12/17/09. A review of her PSP, dated 1/26/10 identified information that was not incorporated in her PNMP. For example the following information "place a foot stool to support her feet to encourage proper positioning" was not integrated into her PNMP. In addition, she experienced a choking incident, on 4/16/10, and her PNMP was not revised to reflect PSP Addendum recommendations dated 4/19/10. The PSP Addendum requested an OT consultation, but it was not completed. ▪ Individual #207's Physical/Occupational Therapy Evaluation, dated 7/23/09, documented a PT/OT consultation, dated 3/23/09 that indicated: "to schedule a MBSS due to [Individual #207's] coughing." The PT/OT evaluation did not discuss the results of the MBSS, nor did her PSP. As a result, it is not clear that the PNMP was appropriately modified to address any results of the MBSS. ▪ Individual #113's PNMP was revised on 11/09/09, 1/21, 2/12, and 4/26/10. A	

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		review of Individual #113's PSP Addendums did not reflect effective PNMP updates. For example, a PSP Addendum documented Individual #113 was not to attend swimming due to him having chronic nasal drainage and hypothermia. PSP Addendum, dated 12/18/09 documented "his diet and diet card have been changed and adjusted to offer these foods in attempt to reduce the meal refusal pattern, but his PNMP did not reflect such a revision in December 2009. The Level of Supervision sheet, dated 1/14/10 documented "new PEG placement and use of an abdominal binder." The PNMP did not document the use of an abdominal binder.	
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.	<u>Staff implements interventions and recommendations outlined in the PNMP and/or Dining Plan.</u> Thirty-six observations were completed of staff's implementation of dining plans and/or PNMPs. Overall, staff did not consistently implement interventions and recommendations outlined in the PNMP and/or mealtime plan. This had the potential to provoke swallowing difficulties and/or increased risk of aspiration. Issues were identified in the following areas: ▪ In 9 of 19 observations (47%), staff were following mealtime plans. ▪ In 0 of 7 observations (0%), staff were following wheelchair positioning instructions. ▪ In 0 of 5 observations (0%), staff were following alternate positioning instructions. ▪ In 0 of 5 observations (0%), staff were following transfer instructions, Examples of where staff did not implement interventions and recommendations outlined in the PNMP and/or mealtime plan included: ▪ In two observations of two PNMP Coordinators completing pivot transfer with two individuals, they did not allow the individuals to bear weight during the transfer, staff did not use good body mechanics, the individuals were not positioned correctly in their respective wheelchairs, nor were the seatbelts securing their pelvises to provide optimal alignment and support in their wheelchairs. ▪ Individual #136 was not positioned in his wheelchair to provide optimal alignment and support. Staff did not reposition him. ▪ Individual #67 was transferred from her wheelchair to a regular dining chair with a pivot transfer. She had no laces in her shoes, which placed her at risk of falling. The dining chair was placed directly in front of her wheelchair, which made it very difficult for her to pivot with her feet and placed her and the staff person at risk of falling. Staff did not allow her time to weight bear during the transfer. There were no instructions for a pivot transfer on her PNMP. ▪ Individual #139 was too far back from the table at mealtime, and was in a very	Noncompliance

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		poor position in her dining chair. There was no dycem mat under her divided plate. Staff did not reposition her, or place a dycem mat under her plate. ▪ Individual #200 was in poor position during mealtime, was too far away from the table, and had no armrests on his chair to provide support during mealtime. Staff did not reposition him during the meal. ▪ Individual #207 was in poor position and alignment during her meal. ▪ Individual #285 was sacral sitting (sitting on his tailbone) in his wheelchair, which placed him in poor alignment. His seatbelt was not securing his pelvis to provide support. ▪ Individual #2 was in poor alignment in her bed. <u>Staff understands rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the PNMP.</u> Based on limited interviews with direct support professionals, they were able to describe strategies included in PNMPs or dining plans, but could not consistently describe where to find the plan, or the schedule for implementation. More specifically: ▪ In 0 of 2 interviews with staff (0%), they were able to identify the location of PNMP and/or mealtime plan. ▪ In 2 of 2 interviews with staff (100%) , staff could describe individual-specific PNMP strategies. ▪ In 0 of 1 interviews with staff (50%), staff could describe the schedule for implementation of PNMP strategies. ▪ In 2 of 2 interviews with staff (100%, staff stated they had received individual-specific training for PNMP strategies Examples of direct support professionals who were not able to describe the following PNMP information: ▪ A staff person working with Individual #210 did not know the location of her PNMP in her All About Me Book.	
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	<u>Staff are provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff.</u> Review of the Facility's training curricula revealed that it did not include adequate PNM training in the following areas: ▪ Body mechanics; ▪ Handling techniques; ▪ Optimal alignment and support in seating systems and alternate positions; ▪ Mechanical lift transfers; ▪ Manual transfers approved by Facility policy; ▪ Mealtime positioning; ▪ Food and fluid consistency;	Noncompliance

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	responsible for implementing.	▪ Safe presentation techniques for food and fluid; and ▪ PNMPs. The following are examples illustrating that Facility training curricula did not provide foundational training: ▪ A review of New Employee Orientation Curriculum (no date) stated: "apply the basic principles of body mechanics to work-related tasks," but the curriculum did not present teaching strategies for the principles of body mechanics. ▪ In addition, there were no teaching strategies for handling techniques, optimal alignment and support in seating systems, and/or alternate positions. ▪ Further review of the New Employee Orientation Curriculum showed that it did not address teaching strategies for mealtime positioning, or safe presentation techniques for food and fluid. <u>Competency-based training focuses on the acquisition of skills or knowledge and is represented by return demonstration of skills or by pre/post test, which may also include return demonstration as applicable.</u> Based on a review of 23 records for staff competency-based training documentation, such training had not been completed. More specifically: ▪ In 0 of 23 staff training records (0%), staff completed pre/post tests for information-based learning. This included the records for: Individual #246, Individual #136, Individual #207, Individual #161, Individual #68, Individual #113, Individual #325, Individual #223, Individual #375, Individual #244, Individual #66, Individual #52, Individual #263, Individual #58, Individual #198, Individual #240, Individual #153, Individual #348, Individual #105, Individual #173, Individuals #357, Individual #67, and Individual #363. <u>All foundational trainings are updated annually.</u> Based on a review of staff development training schedules, staff training records and facility training reports, foundational trainings were not scheduled annually. Multiple new employee staff training records were submitted, but the Facility did not submit a report as requested that identified the number of new employees that had successfully completed PNM foundational training. The Monitoring Team was unable to determine if all new employees had foundational training in PNS. As stated above, new employee training did not provide comprehensive foundational training in PNS. Information on percent of staff with responsibility for the provision of direct supports who have completed competency-based training on foundational skills in PNM (Section XII.31) was not submitted. Moreover, in 0 of 23 staff training records for individuals reviewed (0%), staff had not	

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		completed competency-based performance check-off for foundational training. <u>Staff are provided person-specific training of the PNMP by the appropriately trained personnel.</u> Based on a review of staff PNMP training records documented competency-based person-specific training was not provided by appropriately trained personnel. This was illustrated as follows: o In 0 of 23 records reviewed (0%), PNMP coordinators had been provided instruction by licensed therapists and/or assistants. o In 0 of 23 records reviewed (0%), licensed therapists, assistants and/or PNMP coordinators had trained supervisors and/or other designated staff who would be responsible for implementation of PNMPs. o In 0 of 23 records reviewed (0%), licensed therapists, assistants, PNMP coordinators and/or competency-trained designated supervisors/home managers, etc. had provided instruction to direct support professionals. Examples of staff who were implementing PNMPs, but had not received person-specific training: ▪ Individual #240's PNMP identified the following supports to be provided by staff: bathing/toileting, transfer, dining plan. No competency-based staff training documentation was submitted. Her PNMP Handling section documented she was at risk of osteoporosis, but no handling instructions were provided for staff. The Facility identified Individual #240 at high risk (High Risk by Type, dated 7/12/10). ▪ Individual #153 was identified at high risk for choking and aspiration (High Risk by Type, dated 7/12/10). No competency-based staff training documentation was submitted. His PNMP did not identify risk indicators of choking and aspiration. ▪ Individual #348 was identified at high risk for osteoporosis, constipation and polypharmacy. No competency-based staff training documentation was submitted. Her PNMP, revised 6/22/10, did not identify staff handling techniques to minimize her risk of osteoporosis. ▪ Individual #173 was identified at high risk for aspiration, choking and respiratory concerns (High Risk by Type, dated 7/12/10. No competency-based staff training documentation was submitted. His PNMP required staff to provide support in the following areas: mobility, transfer, bathing, handling, meals provided with gastrostomy tube, and positioning. ▪ Individual #357 was identified at high risk for skin integrity (High Risk by Type, dated 7/12/10). It was unclear why she was not at high risk for weight as her BMI was 50.4. Clinically, body weight and thus the extent of obesity is classified by using the Body Mass Index. A BMI score over 50 placed her in the "super	

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		obesity" category, and placed her at extremely high health risk. No competency-based staff training documentation was submitted. ▪ Individual #67 was identified at high risk for weight loss (High Risk by Type, dated 7/12/10). Her PNMP Nutritional Focus was "modified diet texture to prevent choking." Her PNMP, revised 12/17/09, documented the following areas for staff support: transfer, bathing, positioning, handling, and feeding/nutritional instructions. No competency-based staff training documentation was submitted. ▪ Individual #363 was identified at high risk for weight loss. His PNMP, revised 5/7/10, documented staff supports were needed in feeding/nutritional instructions. No competency-based staff training documentation was submitted. <u>PNM supports 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.</u> In 0 of 23 staff training records reviewed (0 %), was there documentation that staff who provided assistance to individuals determined to be at an increased level of risk had successfully completed competency-based training. PNMP Competency for Staff (no date) presented 13 questions for staff to answer. Training documentation confirmed that staff verbally responded to questions. The 13 questions did not require a demonstration by staff. Examples of individuals determined to be at risk who were not assisted by staff who had received competency-based training included: ▪ The PNMP Competency for Staff checklist had been completed, but these questions were not specific to Individual #263's PNMP, dated 12/16/09. As noted above, the checklist did not require staff to demonstrate competency. ▪ Individual #52's PNMP was revised on 10/28/09 and 3/4/10. The revisions were "he required 1:1 supervision during all meals/snacks (HRC approved (3/4/10)," and "remind him to slow [down eating] food thoroughly (3/4/10). A PNMP Competency for Staff checklist was submitted with staff ID number, but no staff signatures were filled in nor was there a date on the form. A training form, dated 3/3/10, was submitted with 26 staff signatures, but there was no documentation of the type of training received on the form. The form checked off that staff responded verbally. There was no documentation of staff's competence through demonstration. ▪ Individual #66's PNMP was revised on 4/23/10, but it was unclear what was revised on her PNMP. Staff training documentation was not submitted. ▪ Individual #244's PNMP, dated 8/5/10, required staff support in the areas of mobility, transfer, bathing, oral care, handling, feeding/nutritional instructions, and positioning. There was no competency-based staff training record	

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		documentation. ▪ Individual #113 had been admitted to the hospital on 1/16/10, and discharged on 1/22/10 with a diagnosis of pneumonia. Individual #113's PNMP was revised on 11/9/09, 1/21, 02/21, and 4/26/10. Training records, dated 10/22/09 to 11/02/09, for "pump on back side" were submitted with 42 staff signatures. The purpose and content of the training was unclear. There was no competency-based staff training record documentation. <u>Staff are trained prior to working with individuals and retrained as changes occur with the PNMP.</u> Based on a review of 23 staff training in individual records, 0 out of 23 (0%) showed that staff were re-trained when changes occurred on the PNMP. Examples of staff not being retrained on revised PNMPs included: ▪ Individual #58's PNMP was revised on 1/21, 4/27, 5/11, 5/14, and 5/26/10. The only training form that was submitted was dated 12/16/09, with 15 staff signatures, but there was no indication of what was trained. ▪ Individual #246's PNMP was revised on 11/20, 12/12, 12/18 and 12/19/08; and 1/6, 4/22, 4/27, 7/2/09. His PNMP required staff supports in the areas of mobility, transfer, bathing/toileting, and dining plan. Individual #246 experienced a choking incident on 7/9/10. There were no competency-based staff training records submitted.	
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.	<u>A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.</u> Based on review of the Facility's policy, CCSSLC did not have an adequate policy defining the monitoring system for PNMPs. Such a policy should be developed to ensure that a system is in place to monitor staff implementation of PNMPs, including mealtime plans. At a minimum, such a policy should include: ▪ Definition of monitoring process to cover staff providing care in all aspects in which the person is determined to be at risk; ▪ Identification of monitors and their roles and responsibilities; ▪ Formal schedule for homes to be monitored on a quarterly basis, with an identified staff schedule; ▪ A re-validation of monitors on an annual basis by therapists and/or assistants; and ▪ Results of monitoring activities in which deficiencies are noted are formally shared for appropriate follow-up by the relevant supervisor. Information gathered during the review that did not support implementation of these monitoring indicators included:	Noncompliance

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		▪ As stated in the baseline report, the Physical and Nutritional Management Policy did not provide a formalized schedule for monitoring, training/validation procedures for supervisors, identification and definition of specific monitoring indicators for PNMPs, identified compliance levels expected, and/or the process to be followed if PNMPs were not being implemented as written. There were no revisions to this policy, nor did the Facility's POI address changes to monitoring. ▪ The following monitoring tools were presented: o *Person-Specific Monitoring in Dining Room* form - the top of the form stated: "The monitor is responsible for documenting the overall observations with regards to physical and nutritional management in the dining room. The results need to be forwarded to the Habilitation Therapy Director as well as the Unit Director for each particular home." The bottom of the form had a section to list problems found, resolution target date, and date resolved/signature. Monitoring Tool Instructions for this form (as of 7/1/10) provided administrative instructions for completion of the form. Individual monitoring indicators on the form were not defined to support monitoring consistency and inter-rater reliability. o *Physical/Nutritional Management Data* form – This form was to be completed by PNMP Coordinators for an identified shift to document identified activity performed and/or not performed. If the activity was not performed, the PNMP Coordinator was responsible for commenting on why the activity was not performed. During the compliance review, the Monitoring Team attended a PNMP Coordinator meeting during which their supervisor, who had completed a quality assurance review of completed Physical/Nutritional Management Data forms, presented a document that provided additional information for PNMP Coordinators to ensure consistency on completed forms. o *PNMP Competency for Staff* form – This form contained 13 questions for staff to answer. These questions were generic in nature and were not individual-specific to a dining plan. For example: • "If you run out of Thick-It, where do you get more? • If an individual is coughing during meals, who do you report it to? • Where do you find a PSP (Personal Support) book)? • What is a PSP book for? • Where are the PNMPs found? • What does prone mean? • What is a communication device? • What does elevated a minimum of 30° mean? • Name three positioning devices.	

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		• What is a gait belt? • If your client is excessively leaning to the right, despite being in a custom W/C, what do you do? • What do you do if a seatbelt is missing or broken? • If the bathing/lifting equipment is missing or broken, what do you do?" o *PNMP Monitoring and Coaching Report* form – This form stated: "the monitor is responsible for documenting the overall observation to physical management plans. The results will need to be forwarded to the Habilitation Therapy Director as well as the Unit Director for each particular home." The form had 20 questions. Questions on this form were similar to questions on PNMP Competency for Staff form discussed above, and were not adequate to determine that PNMPs were being implemented in a competent manner by staff. The Facility's POI for Section O.6 identified the following monitoring tools: "person-specific PNMP monitoring took, data sheets, and 2-10 monitoring tool," but a policy/procedure had not been developed for these forms. <u>Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities).</u> A review 23 individual records illustrated that 0 staff (0%) were being monitored in all aspects in which the individual was determined to be at increased risk. The following are examples of PNM activities that were not being monitored: ▪ Individual #357 was identified at high risk for skin integrity (High Risk by Type, dated 7/12/10). Her PNMP identified staff support for special considerations, mobility, transfers, bathing/toileting, skin integrity, positioning, and dining plan. There were no individual-specific PNMP monitoring(s) completed to review if her PNMP was being implemented to reduce her identified health risks. ▪ Individual #58 had been hospitalized for aspiration pneumonia on 3/9/10. Individual #58's PNMP documented staff supports in the areas of mobility, bathing, toileting, positioning, ambulation program, oral care, and feeding/nutritional instructions. There were no individual-specific PNMP monitoring(s) completed to review if his PNMP was being implemented to reduce his identified health risks. ▪ Individual #244's BMI was 16.7, which placed her at nutritional risk. Her PNMP, dated 8/5/10, documented that staff supports were required in the following areas: mobility, transfer, bathing, oral care, handling, positioning and feeding/nutritional instructions. There were no individual-specific PNMP	

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		monitoring(s) completed to review if her PNMP was being implemented to reduce her identified health risks. ▪ Individual #207 was at risk for contractures, dysphagia, skin breakdown/decubitus ulcer, impaction/bowel obstruction/constipation, and dehydration. Her PNMP, revised 10/16/09, documented the need for staff assistance in the following areas: mobility, transfer, bathing/toileting, special considerations, handling, positioning, and feeding/nutritional instructions. There were no individual-specific PNMP monitoring(s) completed to review if her PNMP was being implemented to reduce her identified health risks. <u>All members of the PNM team conduct monitoring.</u> Based on the record review of 23 individuals, for none (0%) had the PNM (NMT) Team completed the following: ▪ In 0 of 23 records reviewed (0%), PNM (NMT) Team members completed individual-specific monitoring. ▪ In 0 of 23 records reviewed (0%), monitoring was conducted on a frequent basis for those individuals at highest risk to ensure comprehensive summary strategies were implemented. ▪ In 0 of 23 records reviewed (0%), deficiencies that were noted during monitoring were corrected within an appropriate period of time. ▪ In 0 of 23 records reviewed (0%), issues that were noted during monitoring were followed by the PNM team and remained open until all issues had been resolved and appropriate trainings conducted. ▪ In 0 of 23 records reviewed (0%), results of monitoring activities in which deficiencies were noted were formally shared for appropriate follow-up by the relevant supervisor. <u>Mechanism is in place that ensures that timely information is provided to the PNM team so that data may be aggregated, trended and assessed by the PNM team.</u> A review of Facility reports, including those from Quality Improvement/Quality Enhancement, HST minutes, and Mortality Review Committee did not illustrate that a mechanism was in place that ensured timely data was provided to the PNM (NMT) that could be analyzed to identify and ensure the provision of supports to individuals with the most complex physical and nutritional support needs. The PNMT should establish thresholds to trigger further evaluation based on degree of and/or frequency of certain types of incidents, and/or key health care indicators. Individual-specific outcomes and criteria must be clearly recorded, utilized for monitoring, and analyzed to determine efficacy of the supports provided at both the individual-specific and systemic level. This information should be integrated into the Facility's Quality Assurance/Enhancement, Incident Management and Risk Management systems. In addition, PNMT members should be involved actively in internal mortality reviews as a learning process as well as	

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		a mechanism for improving supports to individuals with the most complex health, physical and nutritional support needs. The PNMT (NMT) did not meet on a regular basis as stated above with regard to Section O.1 of the SA. However, the limited PNMT (NMT) meeting documentation submitted reflected a review of individuals. There was no documentation to support submission and review of Facility reports, such as Quality Improvement/Enhancement reports, HST minutes and Mortality Review Committee reports. Such a review should have included analysis of the data, leading to the provision of enhanced supports to individuals with the most complex physical and nutritional support needs, and provision of training to PSTs who support them. <u>Immediate intervention is provided if the person is determined to be at risk of harm.</u> Based on review 23 records, the following examples illustrated that immediate intervention was not provided even when an individual was determined to be at risk of harm: ▪ Individual #246's PNMP, revised 7/2/09, dining plan indicated: "Texture: MBS results 4/27/09-Pureed with pureed breads. Encourage [Individual #246] to drink after every 2-3 bites. Fluids: thicken all fluids to nectar consistency." A Consultation Report, dated 7/9/10, documented a choking incident on Friday 7/9/10, when Individual #246 "took a bite of fajita and had difficulty swallowing it. Staff reports it was the chopped meal served by food services staff. According to staff he wheeled himself into the restroom and coughed out the meat himself." Consultation recommendations by OT, dated 7/11/10) were as follows: "1). Continue staff monitoring [Individual #246] throughout each meal for one more week and re-evaluate his status at that time; 2). Continue with chopped textured diet with cubed breads as long as he has staff support throughout the meal to keep reminding him to slow down, not to overfill spoon, and chew his food and not speak while his mouth is full; 3). Follow up and monitor him to see if he is indeed vomiting after meals. If he is we need to intervene by evaluating this; 4). OT provided him with a new diet card. It was missing today; and 5). [Individual #246] may need more staff support when he gets paid and goes and buys food, snacks with his money. He is on routine, so staff does not know what he is eating. This needs closer monitoring." It was unclear why Individual #246 was consuming a chopped diet when his dining plan as a result of a MBS prescribed a pureed diet with pureed breads. A PSP Addendum, dated 1/25/10, documented he is "on regular diet at this time." Individual #246 continued to be at risk of harm without resolution of his correct diet texture even after he experienced a choking incident. ▪ Individual #67 experienced a choking incident on 4/19/10 (PSP Addendum 4/19/10), but was not referred to and/or reviewed by the PNMT (NMT). The	

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		"PSP agreed to send consult to OT/PT to evaluate [Individual #67]," but there were no OT/PT consultations submitted. There were no revisions to her PNMP addressing her choking incident, and/or subsequent strategies to address her ongoing risk of choking. ▪ Individual #357's BMI was 50.4, which placed her in the "super obesity" range. She was at risk for multiple health concerns. Her PNMP did not address her weight risk status, nor did it address strategies for weight loss. The following identifies the health risks associated with this level of obesity: "Persons 45.4 kg (100 lb) or more above desirable weight have exponential increases in mortality and serious morbidity compared with normal persons. The presence of a complication or an independent coronary risk factor along with obesity increases the mortality further. Among the 'threshold conditions' that appear at a critical level of body weight (60% or more above desirable weight), the most important are sudden unexplained death, ventilatory disorders, circulatory congestion, and functional limitations in activities of daily living. Recent epidemiologic data on extreme obesity and data on cardiac dysfunction show impaired quality of life in young, morbidly obese patients." (Morbid Obesity and Related Health Risks. John G. Kral, MD, Ph.D.)	
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.	<u>A process is in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk.</u> Based on the review 23 individual records, in none (0%) did the PNM (NMT) Team document progress of individual strategies on a monthly basis to ensure the efficacy of identified strategies to minimize and/or reduce PNM risk indicators for those individuals with the most complex physical and nutritional support needs. In 0 out of 23 cases (0%) was documentation found to support that if strategies were not effective, strategies and PNMPs were revised. Examples of individuals that did not receive review of their progress by the PNM (NMT) Team were: ▪ The following individuals did not receive review of their progress by the PNMT (NMT): Individual #246, Individual #136, Individual #207, Individual #161, Individual #68, Individual #113, Individual #325, Individual #223, Individual #375, Individual #244, Individual #66, Individual #52, Individual #263, Individual #58, and Individual #198, Individual #240, Individual #153, Individual #348, Individual #105, Individual #173, Individuals #357, Individual #67, and Individual #363. Examples have been provided throughout this report in relation to Section O of the SA. <u>Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators.</u>	Noncompliance

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		Based on the review of 23 individual records, in none (0 %) did the PNMT document the progress of individuals with PNM needs on a quarterly basis to ensure the efficacy of identified strategies to minimize and/or reduce PNM risk indicators. In none of the 23 records reviewed (0%) was it documented that if PNMPs were found through this monitoring not to be effective, the PNMPs were updated.	
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.	<u>All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to PO status.</u> Based on the review of 11 individual records (Individual #370, Individual #137, Individual #240, Individual #380, Individual #209, Individual #183, Individual #340, Individual #239, Individuals #195, Individual #190, and Individual #113) who were enterally nourished, none (0%) of these individuals had received an annual assessment that addressed the medical necessity of the tube and potential pathways to by mouth (PO) status. Examples of individuals who received enteral nutrition and did not receive an annual assessment included: ▪ Individual #137's PSP, dated 7/8/10 did not reference or incorporate an assessment that documented the medical necessity of the tube, and potential pathways to PO status. ▪ Individual #240's PSP, dated 2/23/10, did not reference or incorporate an assessment that documented the medical necessity of the tube, and potential pathways to PO status. <u>People who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the components listed above wit regard to Section O.3 of the SA.</u> Based on a review of 11 PNMPs of individuals who received enteral nutrition and/or therapeutic/pleasure feedings, none (0%) were provided with PNMPs that incorporated the components listed with regard to Section O.3 above. Examples of individuals who received enteral nutrition but were not provided with a comprehensive PNMP included: ▪ Individual #370, Individual #137, Individual #240, Individual #380, Individual #209, Individual #183, Individual #340, Individual #239, Individuals #195, Individual #190, and Individual #113's PNMPs did not include strategies for medication administration. ▪ Individual #240, Individual #183, Individual #340, Individual #239, and Individual #195's PNMPs did not provide strategies for oral hygiene.	Noncompliance

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		The need for continued enteral nutrition is integrated into the PSP. Based on a review 11 individuals PSPs who received enteral nutrition, none (0%) clearly documented the rationale for the continued need for enteral nutrition. When it is determined that it is appropriate for an individual to return to oral feeding, a plan is in place that addresses the process to be used. Based on a review of 11 individual records who were identified as being fed enterally: ▪ Individuals within this sample were eating orally. Individual #370's Dining Plan (PSP Date 10/6/09) did not document the use of a feeding tube. ▪ Individual #113, Individual #134, and Individual #16's Dining Plans were submitted as individuals receiving therapeutic feeding. There was no further documentation submitted to substantiate a therapeutic feeding program. ▪ Individual #380 had a gastrostomy tube placement for medications/fluids/ nutrition as deemed necessary per medical staff. There was no plan to address the potential removal of the tube. ▪ Individual #340's PNMP, revised 6/18/10, and Individual #239's Dining Plan, Staffing Date 8/25/09, recommended oral stimulation at least once per day. Individual #340' Occupational/Physical Therapy Evaluation and Individual #239's Occupational/Physical Therapy Screening, dated 8/18/09, did not provide recommendations/strategies for oral stimulation. ▪ There were no recommendations for Individual #137, Individual #240, Individual #209, Individual #183, Individual #340, Individual #239, Individual #195, and Individual #190. A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT). Facility policies did not clearly define the frequency and depth of evaluations related to an individual receiving enteral nutrition. Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake. Based on a review of Individual #190's record, who had recently received a feeding tube: ▪ In 1 of 1 record reviewed (100%), the individual was referred to the PNM (NMT) for review and the development of a comprehensive assessment/summary. ▪ In 0 of 1 record reviewed (0%), the individual was provided interventions to promote continued intake. ▪ In 0 of 1 records reviewed (0%), monitoring was completed by the PNM (NMT) Team to support the efficacy of the interventions. Examples of individuals who did not receive these interventions prior to the placement	

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		of a feeding tube were: ▪ A Nutritional Management Team Report documented Individual #190 received a gastrostomy tube on 4/6/10. The Nutritional Management Team Report for Individual #190 documented meetings on 3/30/10, 4/23/10 and 5/28/10. No NMT minutes were submitted for these meeting dates. The PNMT (NMT) did not complete a comprehensive assessment to develop strategies to promote continued oral intake. Monitoring was not conducted by the PNMT (NMT). ▪ Individual #113's PNMP, revised 4/26/10, documented: "as of 1/10, [Individual #113] received a G-tube to be used as an alternate source of food, fluid and meds acquisition, if he refuses P.O. [anything by mouth]." Individual #113 was not referred to and/or reviewed by the PNMT (NMT) team. ▪ Individual #58's PNMP, revised 5/26/10, stated: "he receives all nutrition, fluids and medications through g-tube (4/27/10). He is to receive nothing by mouth." Individual #58 was not on the list for individuals who receive nutrition through non-oral methods. It was unclear from documentation submitted when he received his gastrostomy tube. He was not referred to and/or reviewed by the PNMT (NMT).	

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

1. The Facility established a dedicated PNMT with core team members during the on-site review. The plan that was developed during the week of the review to operationalize this team should be implemented, and adjustments made as necessary to ensure the full operation of a duly constituted PNMT.
2. The establishment of a dedicated PNM team will substantially increase caseloads for the remaining therapists and dietitians. The Facility should complete an analysis to determine the number of therapy and dietitian positions to support these professionals being active members of an individual's PST.
3. Additional opportunities should be provided for continuing education for PNMT members to support their responsibilities in working with individuals with complex physical and nutritional support needs.
4. Individuals with identified physical and nutritional support needs should have a timely, proactive comprehensive assessment completed; an appropriate PNMP developed and implemented; regular review, documentation, monitoring and analysis to determine the efficacy of the supports provided; and modifications to plans, as necessary.
5. Criteria should be defined for referral of individuals to the PNMT. Individuals at highest risk should be prioritized to receive a PNMT comprehensive assessment. Upon completion of the comprehensive assessment/summary the PNMT should develop and implement intervention plans, conduct individual-specific monitoring, develop and implement documentation guidelines, and complete a review and analysis to determine the efficacy of supports provided at both the individual-specific and systemic level(s).
6. The PNMT should establish thresholds to trigger further evaluation based on degree of and/or frequency of certain types of incidents, and/or key health care indicators. Individual-specific outcomes and criteria must be clearly recorded, utilized for monitoring, and analyzed to determine efficacy of the supports provided at both the individual-specific and systemic level. This information should be integrated into the Facility's Quality Assurance/Enhancement, Incident Management and Risk Management systems.
7. PNMT members should be actively involved in internal mortality reviews, as a learning process as well as an opportunity for improving supports

to individuals with the most complex health, physical and nutritional support needs.

8. PNMPs should incorporate strategies for individuals for oral intake for mealtime, snacks, medication administration, oral hygiene, as well as any other activities that present potential risks such as water activities.
9. Orientation training and annual refresher training should be revised to ensure the content is sufficient to provide staff with the knowledge and skills to support competency in the implementation of mealtime and positioning plans.
10. Staff performance check-offs should be developed and include demonstration of an understanding of position and alignment in wheelchairs, alternate positions and mobility systems; safe body mechanics; mechanical lift and two-person transfer; position and alignment at mealtimes; identification of food textures and fluid consistency; and safe presentation techniques for food and fluid.
11. Staff should be required to successfully complete a skill performance check-off to document staff competency with learning objectives. Job descriptions for direct support professionals should incorporate these training requirements, as well as their performance evaluations.
12. All policies related to mealtime monitoring should be reviewed to ensure identified performance indicators are effective in monitoring mealtimes, as well as to ensure continued staff competency with regard to knowledge and skills acquired in competency-based physical and nutritional support foundational training. Such policies need to define "regular" monitoring as required by the Settlement Agreement.
13. In addition, policies for monitoring staff's implementation of PNMPs should be reviewed and revised, and Facility procedures should be developed to ensure adequate monitoring as required by the SA and HCG.
14. Consideration should be given to establishing compliance benchmarks for mealtime monitoring results. Results falling below established benchmarks should require the development and implementation of person-specific, staff re-training and/or the development of an action plan to address systemic concerns.
15. Consideration should be given to the development of a reporting system that presents mealtime monitoring results, including status of action plans. This reporting system should be linked to the Facility's Quality Enhancement System.
16. Consideration should be given to the development and implementation of a competency-based training for dining room supervisors including roles and responsibilities before, during, and after mealtime.
17. Consideration should be given to the development and implementation of a competency-based training for mealtime monitors, as well as an on-going validation process for mealtime monitors. The goal would be to achieve accurate mealtime monitoring scoring and ensure a high-level of inter-rater reliability.
18. Policies also should define procedures to be followed by staff if a person is determined to be at risk of harm, such as a mealtime incident that involves choking requiring the Abdominal Thrust.
19. The interval of review and monitoring of individuals at various levels of risk should be clearly established as part of each individual's PNMP. Such monitoring should be completed according to schedule, and the results reviewed to identify in a timely manner individual, as well as systemic actions that need to be taken to correct deficiencies.
20. A procedure should be developed to ensure that individuals at risk of receiving enteral nutrition are referred to the PNMT.
21. Evaluation should be conducted of individuals who are enterally nourished to determine the appropriateness of receiving enteral nutrition, and, if not, to identify strategies to transition a person to oral intake, if appropriate.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Person-Specific Monitoring in Dining Room, revised 6/29/10; o Presentation Book Section P, dated 7/12/10; o Therapy Staff with Current Caseloads, not dated; o Habilitation Therapies Department Directory, revised 7/12/10; o Habilitation Therapies Department Table of Organization, not dated; o PNMP Coordinators and Therapists Home Assignments, not dated; o CCSSLC Habilitation Therapies Database; o PNMP Coordinator Monthly Check-Off Log for June 2010; o CCSLC Wheelchair Maintenance and Inspection Database; o Wheelchair Use Report-primary mobility for 6/10; o Wheelchair Use Report-transport for 6/10; o Other Ambulation Assistive Devices Use Report for 6/10; o Orthotics and/or Braces Use Report for 6/10; o List of Individuals with Decubitus/Pressure Ulcer from 3/10 through 5/10; o List of Individuals with Falling Incidents from 3/10 through 6/10; o PNM Maintenance Log Tracking Modifications made to Adaptive/Assistive Equipment from 1/09 through 6/10; o OT/PT Assessments template-blank, not dated; o Current OT/PT Assessments with corresponding PSPs from 2/10 through 6/10; o Adaptive Equipment List for 6/10; o PNM Spreadsheet-Nutritional Management Client Master List, not dated; o List of MBSSs-past 12 months; o Employee Orientation; Training Rosters from 6/09 through 6/10; o Training Rosters/Protocol for PNM Staff and Attendance Logs from 1/09 thru 12/09; o Communication Monitoring Forms; Activity Plan; Progress Notes from 2/08 through 1/10; o Competency-Based Monitoring in Dining Room; PNMP Check Sheet; Home Equipment List for 5/10; o List of Individuals Receiving Direct OT and/or PT Services and Focus of Intervention, not dated; o Individual records for: Individual #11, Individual #286, Individual #375, Individual #348, Individual #180, Individual #247, Individual #270, Individual #52, Individual #260, Individual #126, Individual #104, Individual #343, Individual #31, Individual #144, Individual #335, Individual #128, Individual #50, Individual #228, Individual #334, Individual #142, and Individual #22, including the following requested records: Dining Plan/Diet Card; OT/PT Assessment and Updates; PSP; PHMP revised and current with date of implementation; PSP; PSP with Addendums for the past year; OT/PT Consultations for the past year; Daily Schedule; OT/PT progress notes; Instructional Plans for

	goals/objectives; Activity Plans for goals/objectives; Treatment plans for goals/objectives; Competency-based training documentation for staff; Person-specific monitoring for May/June; Monthly monitoring for equipment for May/June; PNMP Management Data Sheet for May/June; PNMP Coordinator Data Sheet for May/June; PNMP Clinic results; 2-10 Monitoring Form; and Individual Habilitation Therapies Database ▪ **Interviews with**: o Rosie Cortez, Habilitation Therapies Director and Occupational Therapy Director; o Tami Loudermilk-Flore, Occupational Therapist; o Maria Garcia, Physical Therapist; o Nancy Droke, Occupational Therapist; o Paul Osborne, Physical Therapy Director, Physical Therapist; o Allan Mendoza, Physical Therapist; o Janie Mendoza, Physical Therapist; and o PNMP Coordinators (Jessica Perez, Loren R. Martinez, Crystal Salinas, Leticia Gonzales, John J. Medrano, Brenda Garza, Ruben Martinez, Gracie Rodriquez, Richards Martinez, and Sarah Rodela) ▪ **Observations of**: o Observations with therapists (OT, PT and COTA) in Pacific; and o Observations with therapists (OT and PT) in Coral Sea
	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Although the POI reviewed for CCSSLC did not include this component, the POI for Section P identified compliance and/or non-compliance with the identified indicators. CCSSLC's POI indicated that the Facility was in compliance with some of the indicators in Section P. However, based on the Monitoring Team's review, the Facility was not in compliance with these components of the SA. Status of compliance for each of the Settlement Agreement requirements, including individual examples supporting the determination of non-compliance is provided below. Examples of indicators that the Facility rated as being in compliance, but non-compliance was documented by the Monitoring Team were: ▪ The POI indicated the Facility was in compliance with Section P.1.5, P.1.6, P.1.8, P.1.9, P.1.10, P.1.11, and P.1.13 that require that individuals receiving services to be evaluated at least annually and upon change in status. A review of the individual record sample showed that comprehensive OT/PT assessments as defined in the Habilitation Therapies Handbook Physical and Nutritional Management (Revised 2009) had not been completed. Individuals received either an OT/PT update and/or a screening. In many cases, individuals had experienced a change in status (hospitalization, falls, fractures, skin breakdown, choking incident, etc.), but they were not reassessed to determine the impact of the change of status, and/or to develop interventions to minimize the significant health event. In addition, the OT/PT updates and/or screenings did not refer an individual for additional assessments. Assessments were not signed and dated by occupational and physical therapists, and it was not clear how these therapists had collaborated in the completion of an update and/or screening. ▪ The POI indicated the Facility was in compliance with P.2.2 and P.2.4 that required development

	and implementation of a plan within 30 days of assessment. The development of a plan within this indicator did not refer just to the development of a PNMP. These indicators also referred to therapy plans, intervention plans, and activity plans, which, in many cases, were not being developed. ▪ The POI indicated the Facility was in substantial compliance with P.3.1 and P.3.a/c/d that required staff implementation of OT/PT recommendations and competency-based training. Observation of staff implementing OT/PT recommendations showed a lack of competence. Competency-based training for staff was not documented for individual PNMPs. Six individuals were receiving OT/PT direct treatment and therapy/intervention programs had not been implemented for individuals living at CCSSLC. ▪ The POI indicated the Facility was in compliance with Section P.4.1 that required policies/procedures governing physical and occupational therapy, but commented that the policy will contain information about the monitoring process. These policies/procedures related to monitoring had not been developed. ▪ The POI indicated that the Facility was in compliance with Section P.4.2 that required that a system exist to evaluate routinely adaptive/assistive equipment. A review of completed monitoring forms for equipment did not address all components of the SA. Section P.4.6 indicated compliance with regard to the requirement that responses to monitoring findings be clearly documented from issue identification to resolution. Monitoring forms had been revised to address resolution of problems identified, but a review of completed monitoring forms showed that issues were identified without resolution. Policies/procedures had not been developed for these monitoring forms. ▪ The POI indicated that the Facility was in compliance with Section P.4.9 that required that person-specific monitoring be conducted and focus on plan effectiveness and how the plan addressed the identified needs. This indicator refers to PNMPs, as well as treatment/therapy, intervention and activity plans developed by OTs and PTs. The Monitoring Team found that monitoring was not occurring for the latter.
	Summary of Monitor's Assessment: Clinical instruction for OTs, Certified Occupational Therapy Aides (COTA), PTs and PTAs documented attendance for PNMP and WC Clinic Teleconferences. There were no additional continuing education courses documented for therapy staff. Therapy staff should be attending a variety of annual continuing education courses to bring diversity of knowledge and skills to the provision of therapy supports for individuals living at CCSSLC. The current caseloads for occupational and physical therapists will not allow therapists to be active members of the individuals' PSTs, and will present significant challenges in meeting the standards set forth in the SA and HCG. At the time of the review, six of 293 individuals (2%) living at CCSSLC were receiving direct OT/PT services. Three of these individuals were members of the individual record sample, but no direct therapy/treatment plans were submitted for these individuals. Although requested, OT/PT comprehensive evaluations were not submitted. As a result, the Monitoring

	Team was not able to determine if OT/PT comprehensive evaluations had been completed as required. Many of the individuals reviewed had documented needs related to movement, mobility, range-of-motion, independence, and regression of functional skills, but active OT/PT treatment or participation in an OT/PT program was not documented. Furthermore, with the absence of a comprehensive OT/PT evaluation, the OT/PT Updates did not provide an adequate assessment process to identify an individual's functional skills, interests and preferences through observation and clinical assessment. Likewise, individuals for whom OT/PT screening results identified potential needs for therapy were not consistently provided with comprehensive assessments. Observation of PNMP Coordinators completing stand pivot transfers for two individuals identified potential safety issues for the PNMP Coordinator and/or the individual. Individuals were not provided the opportunity to weight bear during the transfers. PNMP Coordinators did not position the individual correctly in their seating systems. Per report, PNMP Coordinators had been provided competency-based training, but observations identified concerns with regard to their competency. PNMP Coordinators should be required to successfully complete competency-based physical assistance and mealtime supports training with specific learning objectives and identified competencies. It is essential that PNMP Coordinators are competent in the performance of their duties, because these staff are responsible for service delivery, as well as monitoring of direct support professionals. A Facility policy did not exist that clearly defined the details of the monitoring system including frequency, and implementation.

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a	<u>The Facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience.</u> Based on a review of CVs for each therapy clinician and assistant and interviews with therapy staff, there was documentation of appropriate qualifications for licensed OTs, PTs and assistants. However, there was not sufficient evidence of specialized training and/or continuing education in the last 12 months. Per report and document review, OTs, COTAs, PTs, and PTAs were licensed to practice in the state of Texas. Clinical instruction for OTs, COTA, PTs and PTAs documented attendance for PNMP and WC Clinic Teleconferences. There were no additional continuing education courses documented for therapy staff. Therapy staff should be attending a variety of annual continuing education courses to bring diversity of knowledge and skills to the provision of therapy supports for individuals living at CCSSLC. Current therapy caseloads for Occupational Therapy and Physical Therapy were as	Noncompliance

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	clinically justified manner.	follows: **Pacific Residences (78 Individuals)** 1 Occupational Therapist 1 Certified Occupational Therapist Assistant 1 Physical Therapist **Atlantic Residences (66 Individuals)** 1 Occupational Therapist, who was the Habilitation Therapy Director and Occupational Therapy Director 1 Physical Therapist 1 Physical Therapy Assistant **Coral Sea Residences (83 Individuals)** I Occupational Therapist 1 Certified Occupational Therapy Assistant 1 Physical Therapist, who was the Physical Therapy Director **Tropical Residences (66 Individuals)** 1 Certified Occupational Therapy Assistant I Physical Therapist 1 Physical Therapy Assistant At the time of the review, there were five approved Occupational Therapy positions at CCSSLC for three Occupational Therapists and two Certified Occupational Therapy Assistants. There were four approved Physical Therapy and two Physical Therapy Assistant (PTA) positions. The current Habilitation Therapy Director/Occupational Therapy Director carried a caseload of 66 individuals in addition to administrative and supervision duties for the Speech/Audiology Director, Physical Therapy Director, and Supervisor of PNMP Coordinators. The Physical Therapy Director carried a caseload of 83 individuals in addition to administrative duties and supervision of five Physical Therapists and two Physical Therapy Assistants. In addition, he supervised three Orthopedic Equipment Assistants. The current caseloads for occupational and physical therapists will not allow therapists to be active members of the individuals' PSTs, and will present significant challenges in meeting the standards set forth in the SA and HCG. At the time of the review, six of 293 individuals (2%) living at CCSSLC were receiving direct OT/PT services. In the Atlantic residences, there were five individuals (Individual #133 to manage swelling of lower extremities, Individual #348, Individual #375, Individual #18, and Individual #144 to become independent and with ambulation). Individual #245 in Coral Sea residence was being provided wound care to promote healing. Three of these individuals (Individual #348, Individual #375 and Individual	

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		#144) were members of the individual record sample for Section P of the SA. No direct therapy/treatment plans were submitted for these individuals. Twenty-one (21) records were reviewed, including those for: Individual #11, Individual #286, Individual #375, Individual #348, Individual #180, Individual #247, Individual #270, Individual #52, Individual #260, Individual #126, Individual #104, Individual #343, Individual #31, Individual #144, Individual #335, Individual #128, Individual #50, Individual #228, Individual #334, Individual #142, and Individual #22. Of the 21 individuals for whom these needs were identified (0%) were receiving active OT and/or PT treatment or participating in an OT/PT program as documented by the absence of OT/PT treatment programs with corresponding documentation (i.e., OT/PT progress notes). Although requested, OT/PT comprehensive evaluations were not submitted. As a result, the Monitoring Team was not able to determine if OT/PT comprehensive evaluations had been completed per OT/PT Evaluation instructional guidelines contained in the Habilitation Therapies Handbook Physical Nutritional Management (Revised 2009), and the requirements of the SA. A review of 21 individual records did not document active OT/PT treatment or participation in an OT/PT program, and many of these individuals had documented needs related to movement, mobility, range-of-motion, independence, and regression of functional skills. OT/PT Updates were completed for the following individuals: Individual #334, Individual #128, Individual #335, Individual #104, Individual #126, Individual #52, Individual #270, Individual #348, and Individual #286. OT/PT updates reviewed did not consistently follow the OT/PT Update format. Because comprehensive OT/PT evaluation were not provided, relevant assessment information was not available to identify individual strengths, abilities and preferences leading to the development of measurable, functional outcomes for individuals. Instructional guidelines were not provided for the OT/PT Evaluation Update. Furthermore, the OT/PT Updates, with the absence of a comprehensive OT/PT evaluation, did not provide an adequate assessment process to identify an individual's functional skills, interests and preferences through observation and clinical assessment. The assessment should include an analysis of findings to provide a rationale for recommendations and skill acquisition intervention strategies. OT/PT Screening(s) and/or Screening Updates were completed for the following individuals: Individual #22, Individual #142, Individual #228, Individual #50, Individual #144, Individual #343, Individual #260, Individual #247, Individual #180, Individual #375, and Individual #11. These screenings identified potential needs for therapy. *Occupational/Physical Therapy Services* policy, dated 10/7/09, stated:	

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		"individuals identified with therapy needs must receive a comprehensive, integrated occupational and physical therapy assessment that will be completed within 30 days of identification of the needs." Per policy and the SA, these individuals should have received a comprehensive OT/PT assessment, but did not. The following are examples of individuals with identified needs without OT/PT intervention: ▪ Individual #128's OT/PT Screening, dated 10/20/09, did not assess her identified needs related to movement; mobility; range-of-motion; independence and regression of functional skills. Individual #128 had experienced skin breakdown, spiral fracture of distal left tibia and fibula with medial angulation, and hospitalization for post-external fixator surgery. ▪ Individual #31 had experienced falls (PT Consultation Report 6/14/10, and PSP Addendum 6/23/10), but he did not have an OT/PT screening and/or comprehensive assessment to identify his needs related to movement; mobility; range-of-motion; independence, and regression of functional skills. ▪ Individual #247 was admitted to the hospital on 5/18/10 for respiratory distress and a diagnosis of pneumonia. He was not receiving active OT/PT treatment or participating in an OT/PT program to address his potential for regression of skills due to health risk indicators. ▪ Individual #270 was admitted to the infirmary on 6/25/10 for post hospitalization pneumonia and UTI (urinary tract infection), but did not receive referral for a comprehensive OT/PT assessment to identify his functional skills, strengths and potentials related to movement, range of motion, independence and regressions of functional skills. Individual #270 had received an OT/PT Screening, dated 11/24/09, which did not assess his identified needs related to movement; mobility; range-of-motion; independence, and regression of functional skills. ▪ Individual #52 experienced a choking incident on 2/18/10 (Personal Support Plan Addendum 2/19/10). He did not receive a comprehensive OT/PT assessment to address this change in status. He had received a PT Screening Update, dated 8/12/09, but this screening did not comprehensively address his identified needs related to movement; mobility; range-of-motion; independence and regression of functional skills. <u>All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission.</u> No individuals were admitted to CCSSLC within the last six months.	

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		All individuals identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification. Based on a review of nine OT/PT screenings, none of the nine individuals (0%) had received an OT/PT comprehensive assessment within 30 days. These nine individuals should have received a comprehensive OT/PT assessment to establish a baseline of their functional skills, interests and preferences, and that identifies an individual's strengths and potentials for skill acquisition, if appropriate. If receiving services, direct or indirect, the individual is provided a comprehensive OT and/or PT assessment every 3 years, with annual interim updates or as indicated by a change in status. Based on record review of three individuals receiving direct and/or indirect OT/PT services), 0 of these three individuals (0%) reviewed had received a comprehensive OT/PT assessment within the last three years. At a minimum, the comprehensive OT/PT assessment should address the following elements: a. Movement; b. Mobility; c. Range-of-motion; d. Independence; and e. Functional Status across each of these areas. Based on record review of 15 individuals (Individual #128, Individual #335, Individual #104, Individual #52, Individual #270, Individual #348, Individual #286, Individual #31, Individual #22, Individual #142, Individual #343, Individual #247, Individual #180, Individual #375, and Individual #11) who had experienced a change in health or physical status, none of 15 individuals had received a comprehensive OT/PT assessment within 30 days or sooner as indicated to address health and/or safety. Individuals determined via comprehensive assessment to not require direct or indirect OT and/or PT services receive subsequent comprehensive assessments as indicated by change in status or PST referral. Based on record review, 15 of the 21 individuals who did not receive OT/PT supports and services had experienced a change in health or physical status. Of these 15 individuals, none had received a comprehensive OT/PT assessment within 30 days or sooner as indicated to address health and/or safety. Findings of comprehensive assessment drive the need for further assessment such a	

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		wheelchair/seating assessment. No comprehensive OT/PT assessments were completed so this was not assessed. Examples of OT/PT updates/screenings that did not contain probes for additional assessment: ▪ Individual #286, Individual #375, Individual #180, Individual #247, Individual #270, Individual #260, Individual #126, Individual #104, Individual #144, Individual #128, Individual #50, Individual #228, Individual #334, Individual #142, and Individual #22 OT/PT updates and/or screenings did not request a wheelchair/seating assessment. ▪ Individual #128 experienced a status changes (i.e., pressure sores/skin breakdown, and hospitalization for external fixator surgery) as documented in her OT/PT Screening, dated 10/20/09. Her orthopedic physician recommended physical therapy. An OT/PT comprehensive assessment was not completed, and there was no documentation for the provision of physical therapy. ▪ Individual #335's OT/PT Screening Update, dated 10/29/09 documented "there were 13 falls this year." An OT/PT comprehensive assessment was not completed to address his change in status. ▪ Individual #52 experienced a choking incident on 2/18/10 (PSP Addendum) requiring two abdominal thrusts. The PST requested an OT/PT consultation to evaluate him on diet texture. No OT/PT consultation was completed. An OT/PT comprehensive evaluation was not completed to address this significant health event. ▪ Individual #247 was admitted to the infirmary on 6/15/1, after being discharged from a hospital stay from 5/18/10 to 6/15/10 with a diagnosis of pneumonia. There was no OT/PT assessment to address this significant health event. Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions. None of the 21 OT/PT updates and/or screenings reviewed (0%) addressed each medical issue and health risk indicator identified via a plan, support or service, or if not, provided sufficient rationale why not. Evidence of communication and or collaboration is present in the OT/PT assessments. Based on record review, 0 of 21 OT/PT assessments (0%) included signatures and date of both OT and PT. Based on record review, 0 of 21 OT/PT updates and/or screenings (0%) were	

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		comprehensive with content from each discipline as indicated. Based on review, 0 of 21 OT/PT assessments (0%) included evidence of active collaboration between OT and PT. It was difficult to determine the level of collaboration between the OT/PT in the updates and/or screenings reviewed.	
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.	<u>Within 30 days of the annual PSP, or sooner as required for health or safety, a plan has been developed as part of the PSP.</u> As noted above, comprehensive assessments were not provided. However, based on screening results, updates, PNMPs and associated instructional plans, Activity Plans, Treatment plans, etc., and clinician progress notes, for the 21 individuals reviewed, none (0%) of those receiving OT/PT services, were plans developed within 30 days of the date of the assessment/update. Based on record review, none of the 21 records (0%) contained OT/PT treatment plans, instructional plans, and/or activity plans that had been developed within 30 days. <u>Within 30 days of development of the plan, it was implemented.</u> As noted above, no treatment, instructional and/or activity plans were identified in any of the records reviewed. <u>Appropriate intervention plans are: integrated into the PSP, individualized, based on objective findings of the comprehensive assessment with effective analysis to justify identified strategies, and contain objective, measurable and functional outcomes.</u> Intervention plans for the sample were outlined in the PSP and listed as actions and/or training objectives for none of 21 individuals reviewed (0%). As noted previously, a number of the individuals had outstanding needs for which plans should have been developed and included in PSPs, or justifications provided for plans not being developed. Because none of the records reviewed included intervention plans, it could not be determined if plans: ▪ Were based on objective findings in the comprehensive OT/PT assessment or update with analysis to justify specific strategies ▪ Included goal statements that were measurable and functional ▪ Specified frequency of implementation; ▪ Specified criteria for data collection and data collection format; and ▪ Identified staff responsible for implementation.	

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		Interventions are present to enhance: movement; mobility, range of motion; independence; and as needed to minimize regression. As noted above, no intervention plans were present in the records reviewed. There fore, it could not be determined if they appropriately addressed the following: ▪ Movement; ▪ Mobility; ▪ Range-of-motion; ▪ Independence; and ▪ Minimize regression. The plan addresses use of positioning devices and/or other adaptive equipment, based on individual needs and identified the specific devices and equipment to be used. Based on reviews of PNMPs and other positioning plans for 1 of 16 individuals, the rationale for the positioning plans was clearly stated in the OT/PT assessment or update. Based on reviews of PNMPs and other positioning plans for 16 individuals, equipment was specified and identified in a photograph(s) for 14 of 16 PNMPs reviewed (88%). Of note, Individual #142 had a sidelying photograph and this position was integrated into her PNMP, revised 5/26/10. Her head was in hyperextension in the photograph, which placed her at risk of aspiration. Positioning photographs should be critically reviewed to ensure the individual is in optimal alignment and support in the seating system, as well as alternate positioning. On at least a monthly basis or more often as needed, the individual's OT/PT status is reviewed and plans updated as indicated by a change in the person's status, transition (change in setting), or as dictated by monitoring results. Based on review of OT/PT documentation, there was no evidence that each individual was reviewed at least monthly for their OT/PT Status whether they had a PNMP, had experienced a change in status and/or were receiving direct services (three individuals within the sample).	
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	Staff implements recommendations identified by OT/PT. Based on observations of OT/PT interventions, all PNMPs or other intervention plans were implemented as written for 0 of 2 individuals (0%). More specifically, observation of PNMP Coordinators completing stand pivot transfers for two individuals identified potential safety issues for the PNMP Coordinator and/or	Noncompliance

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	have successfully completed competency-based training in implementing such plans.	the individual. Individuals were not provided the opportunity to weight bear during the transfers. PNMP Coordinators did not position the individual correctly in their seating systems. Per report, PNMP Coordinators had been provided competency-based training. Observations by the Monitoring Team did not show that PNMP Coordinators had achieved competency in the provision of foundational physical and nutritional support service delivery. PNMP Coordinators should be required to successfully complete competency-based physical assistance and mealtime supports training with specific learning objectives and identified competencies. Such training should include foundational knowledge and skills related to the appropriate implementation of physical assistance supports including, but not limited to: risk indicators and problem-solving; position, alignment and support; proper body mechanics for lifting; provision of adequate support during transfers; physical assistance strategies for use with seating, mobility devices, orthotics, etc.; 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 and rationale; understanding a swallow study; presentation and alignment strategies to support safe swallowing during oral hygiene, bathing, swimming and medication administration; and techniques to promote optimal levels of independence and skill acquisition. This training should include written tests and skills-based performance check-offs. Therapists need to conduct ongoing observations/audits to ensure that PNMP Coordinators are performing their duties as required. It is essential that PNMP Coordinators are competent in the performance of their duties, because these staff are responsible for service delivery, as well as monitoring of direct support professionals. <u>Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations.</u> Based on review of training rosters and in-service outlines, direct support professionals, PNMP Coordinators and therapy aides were not identified as competent to implement OT/PT interventions and supports as outlined in the PNMPs, and other activity plans. Specifically, for none of 21 individuals reviewed in the sample (0%) was documentation of adequate individual competency-based staff training submitted.	
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	<u>System exists to routinely evaluate: fit; availability; function; and condition of all adaptive equipment/assistive technology.</u> Reviews were completed of PNMP monitoring for the last quarter, PNMP Clinic Reviews, and maintenance logs for 21 individuals listed with adaptive equipment/assistive technology in the OT/PT database and/or individual record documentation. The *Monthly Person-Specific PNMP Checklist* form was completed for 18 of 21	

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	physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	individuals in the sample. The form tracked the following: **Bed** ▪ Bed information (Brand and Serial Number); ▪ Mattress (Type and Condition); and ▪ Elevation (Head, foot, controls work, and elevation guide in place). **Wheelchair** ▪ Type; ▪ Cleanliness; and ▪ Repairs needed. **Assistive Equipment** ▪ Type; ▪ Condition; ▪ Is it being used; and ▪ Problems identified. **Communication** ▪ Type; • Condition; • Is it being used; and • Problems identified. **Dining Equipment** ▪ Type; ▪ Condition; ▪ Is it being used; and ▪ Staff concerns. This form did not address routine evaluation of fit and/or function (i.e., determination of if the equipment was functional to the individual). Staff notations were made for equipment not being used by staff (e.g., Individual #142 Monthly Person-Specific PNMP Check Sheet -06/27/10), but this was not documented in the section entitled List of Problems Found and Date Resolved/Signature. Monitoring Tool Instructions (as of 7/1/10) were provided for *Person-Specific PNMP Checksheet* and *Monthly Home Equipment Checklist* forms. The Monitoring Team reviewed completed forms, which illustrated that instructions were not consistently followed. For example: ▪ "PNMP Coordinators will immediately seek resolution to any problem identified, and they will document the problem/resolution/target date/supervisor noted at the bottom of the form. Even if there are no problems identified they must still sign and date the bottom of the form. Multiple forms were not signed and dated by the PNMP Coordinators.	

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		In addition, there were no instructions for completion of the individual indicators on the form. The absence of indicator instructions will not provide consistent documentation of requested information. The following shows the results of the review of forms submitted for the 21 individuals included in the sample. Evaluation was documented for: ▪ Fit for 0 of 21 individuals in this sample (0%); ▪ Availability for 14 of 21 individuals in this sample (67%); ▪ Function for 0 of 21 individuals in this sample (0%); and ▪ Condition for 14 of 21 individuals in this sample (67%). PNMP Clinic documentation was provided for four of the 21 individuals in the sample, but this did not document fit and/or function. The Plan of Improvement Section P.4.2 documented compliance, but stated that a system to evaluation fit, availability, function and condition of all adaptive equipment was "currently under development." As noted previously, the Monitoring Team did not substantiate compliance in this area. <u>A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.</u> Based on review of the State and/or Facility's policy, a system was not in place to monitor staff implementation of PNMPs and other OT/PT interventions. Such a system should have included: ▪ Definition of monitoring process; ▪ Identification of monitors (licensed professional for OT/PT intervention plans) and their roles and responsibilities; ▪ Formal schedule for monitoring to occur; ▪ Process for monitors to be re-validated on an annual basis by therapists and/or assistants; and ▪ Description of how when results of monitoring activities, noted deficiencies, they are formally shared for appropriate follow-up by the relevant supervisor As stated above in Section 0.6 there were multiple monitoring forms, but policy/procedures had not been developed to define the monitoring process and address the components above. <u>On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs.</u> A policy did not exist that clearly defined the details of the monitoring system including frequency, and implementation. Such a system should require that the program author review intervention plans monthly, including observation of staff implementation of the	

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		plans. Based on a review of 21 individual records, there were no intervention plans submitted, nor was documentation submitted that PNMPs were reviewed on a monthly basis. <u>For individuals at increased risk, staff responsible for positioning and transferring them receive training on positioning plans prior to working with the individuals. This includes pulled and relief staff.</u> As noted above, issues related to the competencies of PNMP Coordinators, who have responsibility for working with the individuals with the most complex needs and monitoring other staff's competence, were identified by the monitoring team, particularly with regard to transferring individuals. It is essential that these staff consistently demonstrate competence in these areas. <u>Responses to monitoring findings are clearly documented from identification to resolution of any issues identified.</u> As noted above, a system for monitoring had not been developed and memorialized in policy. <u>Safeguards are provided to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available.</u> There was evidence in OT/PT documentation that equipment prescribed was available for 14 of 21 records (67%) reviewed. Based on monitoring forms reviewed from 14 of 21 records (67%) , monitors documented that appropriate adaptive equipment and assistive technology supports were immediately available to all individuals in the sample. <u>Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses the identified needs.</u> As noted above, a system for monitoring had not been developed and memorialized in policy. <u>Data collection method is validated by the program's author(s) .</u> As noted above, a system for monitoring had not been developed and memorialized in policy.	

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

1. The Facility should complete an analysis to determine needed OT/PT therapy positions to support these professionals being active members of individuals' PSTs.
2. Therapy staff should be provided opportunities to attend a variety of annual continuing education courses that would bring diversity of

knowledge and skills to the provision of therapy supports for individuals living at CCSSLC.

3. Comprehensive OT/PT evaluations need to be completed for individuals living at CCSSLC.
4. Occupational/Physical Therapy assessments should include an analysis of findings that provide a rationale for recommendation(s) and intervention strategies. Functional outcomes need to be identified clearly, and monthly documentation needs to be utilized to justify initiation, continuation of, or discontinuation of OT/life skill supports recommendations.
5. PNMP Coordinators should receive competency-based physical assistance and mealtime supports training with specific learning objectives and competencies identified. Such training should provide foundational knowledge and skills related to the appropriate implementation of physical assistance supports, including but not limited to: risk indicators and problem-solving; position, alignment and support; proper body mechanics for lifting; provision of adequate support during transfers; physical assistance strategies for use with seating, mobility devices, orthotics, etc.; 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 and rationale; understanding a swallow study; presentation and alignment strategies to support safe swallowing during oral hygiene, bathing, swimming and medication administration; and techniques to promote optimal levels of independence and skill acquisition. This training should include written tests and skills-based performance check-offs.
6. Therapists should conduct ongoing observations/audits to ensure that PNMP Coordinators are performing their duties as required.
7. Positioning photographs should be critically reviewed to ensure the individual is in optimal alignment and support in the seating system, as well as alternate positioning.
8. Policies/procedures should be developed for the OT/PT monitoring system with identified performance indicators that are defined clearly. This system should include, but not be limited to a systematic and routine review of the components of PNMPs and related equipment; OT/PT instructional/intervention programs and equipment; staff utilization of the equipment; fit, function, availability and use of adaptive equipment; and staff competency with PNMPs, therapy instructional/intervention plans as well as activity plans. There should be established thresholds for staff re-training; identification, training and validation process for monitors to achieve accurate scoring; and inter-rater reliability methodologies.

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents:** o CCSSLC Dental Database 2010 Jan – Jun: Refused; o CCSSLC Dental Database 2010 Jan – Jun: No Shows; o CCSSLC Dental Database 2010 Jan – Jun: Cancellation; o Missed Dental Appointments - [week of 2/22/10]; o Missed Dental Appointments [week of 3/1/10]; o Missed Dental Appointments [week of 3/8/10]; o Missed Dental Appointments [week of 3/15/10]; o Missed Dental Appointments [week of 3/22/10]; o Missed Dental Appointments [week of 3/30/10]; o Missed Dental Appointments [week of 4/5/10]; o Missed Dental Appointments [week of 4/12/10]; o Missed Dental Appointments [week of 4/19/10]; o Missed Dental Appointments [week of 4/29/10]; o Missed Dental Appointments [week of 5/3/10]; o Missed Dental Appointments [week of 5/10/10]; o Missed Dental Appointments [week of 5/20/10]; o Missed Dental Appointments [week of 6/1/10]; o Missed Dental Appointments [week of 6/7/10]; o Missed Dental Appointment Totals 2/25/10 through 6/12/10, per building; o Individuals Identified for Preventative Dental Work; o Individuals Identified for Restorative Dental Work; o CCSSLC Dental Database 2010 Jan- Jun: Restoration; o Individuals Identified to Have Required Emergency Dental Treatment; o Individuals Identified to Have Required Extractions; o CCSSLC Dental Database 2010: Annual Due; o Dental Procedure: Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia - Anesthesia Policy; o Dental Procedure: Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia – Criteria for Use; o Dental Procedure: Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia – Anesthesia Medical Clearance; o Dental Procedure: Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia – Dentist Anesthesiologist; o Dental Procedure: Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia – Anesthesia Surgery; o Dental Procedure: Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia – Anesthesiology Personnel;

	○ Dental Procedure: Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia – Pre-operative Sedation prior to TIVA or MAC Sedation; ○ Dental Procedure: Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia – Anesthesia Recovery; ○ Dental Procedure; Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia – REACT Scoring System; ○ Dental Procedure: Parenteral Sedation Intravenous (IV) (TIVA or MAC) Anesthesia - Vital Signs Flow Sheet; ○ Dental Procedure: Missed and Refused Appointment; ○ Dental Procedure: Monitoring or Pre-Post Dental Sedation; ○ Dental Procedure: Consultations - Dental; ○ Dental Procedure: Protective Supports and/or Sedation (pending committee approval); ○ Dental records for the following individuals: Individual #144, Individual #72, Individual #277, Individual #134, Individual #41, and Individual #140; ○ Atlantic Unit: scheduled on Campus medical and dental appointments for the day: 3/30/10, 4/5/10, 4/29/10, 5/3/10, 5/25/10, 5/27/10, 6/2/10, and 6/3/10; ○ Pacific Unit: scheduled on campus medical and dental appointments for the day: 4/8/10, 4/9/10, 4/12/10, 4/14/10, 4/15/10, 4/20/10, 5/3/10, 5/11/10, 5/13/10, 5/27/10, and 6/1/10; ○ Copy of packet of information from dental department record for individuals undergoing TIVA procedure: Individual #15, and Individual #294; and ○ List of medications used during TIVA ▪ **Interviews with**: ○ Dr. Enrique Venegas, Dental Director; and ○ Kathy Roach, Dental Hygienist
	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Although the POI reviewed for CCSSLC did not include this component, the Facility assessed almost all areas of the POI related to Section Q of the SA as being in noncompliance. The Facility had listed a substantial compliance finding for the indicator related to refusal of appointments. However, the documentation reviewed by the Monitoring Team suggested noncompliance. This is discussed further in the Assessment of Status Section. Other areas that the Facility assessed as being in compliance, included: 1) emergency dental services being provided promptly and effectively; and 2) sedation being documented when given. This was consistent with the Monitoring Team's findings. The Facility also assessed that the IDT can currently access the annual summary of the dental records. However, better communication was needed in other areas of dental care. Although there was a detailed annual summary provided to the team, access was limited by the need to retrieve information directly from the dental office. In addition, the dental office provided little information in the record other than that a visit occurred. A more informative progress note would resolve this problem. Overall, with regard to the requirement in the SA regarding dental care, the department had approached these areas from several different perspectives as indicated in their POI. The Dental Department was at the

	beginning stages of developing and implementing systems to improve the care provided.
	Summary of Monitor's Assessment: One of the essential steps in providing quality dental care is having an adequate complement of dental personnel. In this regard, the dental department had made great strides over the past several months. At the time of the review, they had two full-time dentists, and two full-time dental hygienists. One of the dental hygienists was working directly with individuals and staff in the homes on dental hygiene. This is a positive step in providing preventative care. Based on the data provided, during the past year, 60 individuals (approximately 20 percent of the individuals residing at CCSSLC) received no dental care and/or no annual dental exam. They were either unable to cooperate with treatment or did not show for the appointment. Missed appointments were a significant issue with approximately 20 to 30 percent of appointments being missed. Although a policy had been developed to address this issue, there was not yet a systematic approach to identifying the underlying issues impacting this complex problem using a team approach, and developing and implementing plans to address the potential causes. When plans to address underlying issues are implemented, there should be improvement over time, and eventually the missed appointment rate would be expected to improve. Since the baseline visit, thorough policies had been developed and implemented with regard to the use of Total Intravenous Anesthesia, particularly with regard to dental work. Based on a review of records, the preparation for the use of anesthesia, monitoring during the procedure, and post-operative care were thorough and well documented. This represents a valuable addition to the spectrum of dental services provided through the dental department to allow for the provision of quality dental care. Policies allowed for TIVA to be used both to address individuals' behavior (e.g., refusal) to have dental work completed, as well as to allow the completion of extensive dental work that would be painful. An area still requiring attention was with regard to the development of desensitization plans and other strategies to overcome individuals' refusals to allow dental care to be completed, and/or for it to be completed with the least amount of sedation necessary. It did not appear that the Dental Department and Psychology Department had begun to collaborate with individuals and their teams to develop such plans.

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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,	The provision of adequate dental care involves a number of factors. Each of the following factors is discussed in further detail below: adequate staffing of the Dental Department; management of missed appointments; routine, restorative, and emergency dental care; and use of dental anesthesia. <u>Adequate Staffing of the Dental Department</u> One of the essential steps in providing quality dental care is having an adequate	Noncompliance

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	consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards.	complement of dental personnel. In this regard, the dental department had made great strides over the past several months. They had started with a part-time dentist position, which was increased to a full-time position. Approximately one year ago, a second FTE was made available, and a second dentist had been recruited. A full-time dental hygienist had been supplemented by an additional full-time dental hygienist. With the presence of a second dental hygienist, progress was anticipated in providing preventive care. According to the Dental Director, the focus of the second dental hygienist was teaching and training of individuals and the direct support professionals in the homes concerning effective tooth brushing. This important assignment should provide improved dental hygiene. The Dental Department had no immediate plans to implement a tracking system to determine improvement in oral health with this additional staff member. It is suggested that an Oral Health Index rating database be developed and implemented to track the effectiveness of these efforts. It is anticipated that this index would improve over serial quarters of time, indicating substantial progress in preventive care. Given that this process of in-home toothbrush training is new, it will require time for the dental hygienist to determine what the most effective ways are of approaching each individual, because levels of understanding and levels of tactile defensiveness will vary. The dental hygienist is encouraged to create, with the assistance of the dental department, a competency-based training program for the direct support professionals. This will increase the likelihood that when the hygienist is not in the building, the trained staff will continue to direct the individuals in correct tooth brushing techniques. In beginning, to meet the dental needs of this population, it is important that a second dentist be on site full time. This is the first step in attaining timely care for preventive dental visits, routine care, as well as appropriate urgent and emergent dental care. A second dentist also frees the Dental Director to begin to collaborate with other departments in multi-disciplinary areas where cooperation and planning is needed. Until now, the role of the Dental Director had been hampered by having responsibility for providing clinical dental care to all individuals served by CCSSLC, leaving little to no time for important administrative issues to be resolved. With the addition of the second full-time dentist, the Dental Director should have time to address other issues that require attention. <u>Management of Missed Appointments</u> One of the measurements of timeliness and efficiency of routine dental care is a system that has a low rate of "no show" appointments for routine care. At the time of the review, it was estimated that individuals were not keeping 20 to 30% of scheduled visits. The Dental Department was beginning to break these missed appointments into categories,	

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		which is the first step in resolution of this problem. They also tracked these missed appointments by sending out notices to the QMRP and case manager of individuals who missed appointments, as well as the Unit Director, Medical Director, and Dental Director. For those that had missed three appointments, there was some informal inquiry as to the reasons. However, there did not appear to be a systematic procedure in following through on this important step of beginning the inquiry process. With a second dentist in place, the Dental Director is encouraged to meet with representatives of other departments to begin to solve this complex problem using a team approach. When plans to address underlying issues are implemented through the PST process, there should be improvement over time, and eventually the "no show" rate would be expected to improve. At the time of the review, the Dental Department had delineated the reasons for breaking the dental visit appointments into three categories: cancellations, refusals, and no show. The POI highlighted several categories that had not been included in this categorization process, such as staffing issues (staff unable to leave the unit to bring individual, sick call-ins, etc.), transportation issues (van not available or not working, etc.), and dental clinic issues (sick call-ins by dental staff, scheduling issues, etc.). Additional comments made suggested other factors needed to be considered, such as the individual was ill at the time of the appointment, there was a conflict with an off-campus appointment, or the individual was on furlough. An additional factor to be tracked is the category of refusals due to tactile defensiveness, which is discussed elsewhere. The positive step taken by the dental department was that it had begun to take a serious stance in determining the cause of so many missed appointments. The challenge was that a new database had been started of June 1, 2010, and data was just beginning to be entered. From data shared during interviews with the Dental Director, there were 204 "no shows" for the prior six-month period of January to June 2010. The dental department saw eight to ten individuals per day. Based on the "no show" rate, 20% of the scheduled appointments did not occur. Based on eight cases per workday, this was the equivalent of the loss of two workdays each month, at a time when there were significant dental needs for the individuals served by CCSSLC. The Dental Department also supplied a list of missed dental appointments per week. The number of refusals varied between three and eight. For example, week of 2/22/10, there were eight missed appointments, week of 3/1/10, there were six missed appointments, week of 3/8/20, there were six missed appointments, week of 3/15/10, there were six missed appointments, week of 3/22/10, there were three missed appointments, week of	

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		3/30/10, there were seven missed appointments, week of 4/5/10, there were six missed appointments, week of 4/12/10, there were seven missed appointments, week of 4/19/10, there were five missed appointments, week of 4/29/10, there were four missed appointments, week of 5/3/10, there were four missed appointments, week of 5/10/10, there were four missed appointments, week of 5/20/10, there were nine missed appointments, week of 6/1/10, there were nine missed appointments, and the week of 6/7/10 , there were four missed appointments. This confirmed the prior information that about two full days of dental services were lost per month due to a variety of reasons ending in a missed appointment. The Dental Department had been able to track the number of missed dental appointments per home. There were three outliers. This included 19 from Pompano and 19 from Sailfish, as well as 11 from Kingfish 3. However, no next steps were identified to address these issues. Reducing the "no show" rate is an important need that will take a long-term, systems approach to resolve, and will require an interdisciplinary approach. For buildings in which there was a higher than expected "no show" rate, a member of the dental department may need to meet periodically with the PST to develop a plan of implementation to improve this statistic. The dental policy "Missed or Refused Dental Appointments" noted several steps by which the Unit of the individual, as well as the team members were notified of a missed appointment. Specifically, step #5 stated: "List will be reviewed and discussed in the Unit's next morning meeting." In reviewing documentation to determine what the units' responses were to missed appointments, some examples were identified that called into question the accuracy of the data being maintained by the Dental Department and/or the units. The etiology of the discrepancies is unknown. However, until such discrepancies are corrected, it will be difficult to fully implement the dental policy for missed or refused appointments. The dental database may not be including cancellations, which may be creating some of the discrepancies, although the information presented to the reviewer did include all three categories – no show, refused, and cancelled. The following are some examples of the discrepancies: ▪ In the Atlantic Unit, on 3/30/10, under the "scheduled on campus medical and dental appointments for the day," under the section "did appointment take place as scheduled?" Individual #132 was listed as "yes." However, in the dental department's "Missed Dental Appointments," Individual #132 was listed on 3/30/10 as having missed the appointment. According to the dental policy, the unit should have discussed the missed appointment at the next morning meeting, but it was entered as a successful appointment. ▪ On 4/5/10, one entry for the Atlantic Unit stated that Individual #140 did not complete a dental appointment as scheduled, but in a subsequent entry for 4/5/10, the column was labeled as a successful appointment. However, it was	

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		not listed under the 'Missed Dental Appointments' from the dental department. Under the annual list of appointments, Individual #140 was not listed as having had an appointment that day, so confirmation could not be made that the appointment existed. The appointment may have been categorized other than an annual. ▪ On 6/2/10, according to the Unit report, Individual #118 refused the dental appointment. The Dental Department listed this individual as a "no show," and not as a refusal. Good communication would improve the accuracy of the information and provide valuable information as to the reasons for refusal. ▪ The Pacific Unit listed Individual #58 as requiring sedation and having the dental appointment cancelled on 4/8/10. This individual was not on the missed dental appointment list generated by the Dental Department. In this instance, it was not clear that cancelled appointments were included in the weekly dental appointment roster, yet cancellations were included in the earlier missed appointment information. The Unit report additionally did not indicate if the individual received the sedation or not. ▪ On 4/9/10, the unit report indicated Individual #378 missed a dental appointment, and did record a reason: he was scheduled at 9:45 a.m., but was taken at 10:15 a.m. This individual was not listed in the weekly roster from the Dental Department. ▪ On 4/12/10, Individual #91 had a successful dental appointment, according to the Unit report. However, the weekly dental record indicated this individual did not show for the appointment. ▪ On 4/14/10, the Unit report indicated Individual #19 and Individual #131 both did not keep dental appointments because they were cancelled. It was not clear if the unit cancelled the appointment or the dental department. These names were not listed on the weekly missed dental appointment. Clarification is important to determine if cancelled appointments originate from the Dental Department or from the unit in determining if these were considered missed appointments. If the Dental Department cancels appointments due to internal departmental unexpected developments, this should still be considered as some category of un-kept appointment, because it delays dental care. It also would provide data to ensure that the Department is meeting its scheduled appointments as much as possible. It would also be important to know if cancellations by the Dental Department are a sizeable percentage of appointments not completed. ▪ Individual #131 again appeared on the Unit 4/15/10 report as missing a dental appointment due to a cancellation, but this was not listed on the weekly dental missed appointment roster. The reason for the cancellation was not given, but needed to be pursued to determine the cause, refusal, conflict, etc. ▪ On 4/20/10, the Unit report indicated that Individual #128 had a dental	

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		appointment, but there was no information concerning whether the appointment was completed. The Dental Department weekly missed dental appointment list indicated this individual as a "no show." ▪ Also listed as a "no show" was Individual #146, but this was not listed in the Unit morning report. ▪ On 5/3/10, the Unit report indicated Individual #200 completed a dental appointment, but the Dental Department missed dental appointment roster included him as a "no show." ▪ On 5/11/10, the Unit report indicated Individual #363 had a dental appointment for 5/13/10, but the follow-up reports did not indicate whether it was completed. The Dental Department listed him as a refusal. ▪ On 5/27/10, Individual #65 was unable to have the dental appointment due to the sedation not being ordered. The Dental Department missed dental appointment list categorized her as a "no show." Either misinformation circulated from the Unit, or the data from the dental department was in error. In the first example, the Unit was not following the dental policy. In the other instance, the quality and reliability of either the unit information or the dental data was questionable. Such discrepancies make it difficult to determine a baseline and to make decisions about improvement plans and future goals. Based on interviews, the Dental Department did not have much communication with other areas of the Facility, including the unit administrations. It would be important for the Dental Department to know the outcome of the unit discussions when there was a missed appointment. In one instance, it was recorded that the "home wasn't aware of the appointment." That would be valuable information for the dental department to know, because it would allow them to research the reason for the lack of knowledge, and reduce the chance of reoccurrence. It is important that the dental department close the loop on the policy for missed appointments. They should request follow-up in writing as to the cause, and if there is no response, then meet with the unit administration to follow up. The Dental Department may improve the show rate at appointments if they are diligent in reviewing each missed appointment case to determine how the next visit can be successful. The following provide some examples of where this could have occurred, but did not: ▪ The dental department listed Individual #357 and Individual #132 as having missed dental appointments on 5/25/10. The Unit report indicated that Individual #357 refused the appointment and the sedation. There was no list provided that showed that Individual #132 ever had a dental appointment for that date. There was no communication between the dental department and the unit when the latter case occurred. The dental department had the appointment	

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		in their system, but the unit appeared to have no record of the appointment, and there was no discussion of this. The dental department needs to seek closure to determine why the unit did not have this individual listed for an appointment. ▪ On 5/27/10, the Unit report indicated both Individual #224 and Individual #34 refused dental appointments. The missed dental appointment list confirmed this. This would have been an opportunity for the Dental Department to communicate with the unit to determine the reason for the refusal, and to request the next step (e.g., behavioral clinician consultation, changing the time of day of the appointment to meet the needs of the individual, etc.). This should be done while the information is current to gain as much detail as possible. ▪ On 6/3/10, the Unit report indicated Individual #300 kept the dental appointment, but the dental department listed this Individual as having missed an appointment. If the Dental Department had expected a response in writing back from each missed dental appointment, the department would have discovered that the visit was listed as completed, and explored the reason for the misinformation. ▪ On 6/1/10, the Unit report indicated that Individual #215 did not complete a dental appointment because his name was not on the calendar. The dental department had this individual on the "no show" missed appointment list. The dental department needs to clarify the precise reason for the many missed or un-kept appointments in order to improve on the "show" rate. Routine, Restorative, and Emergency Dental Care From the data provided by the Dental Department, a number of individuals had been unsuccessful in completing an annual exam/treatment despite repeated appointments. These 60 individuals (approximately 20 percent of the population residing at CCSSLC) received no dental care and/or no annual dental exam, according to the data received, during the past one year. They were either unable to cooperate with treatment or did not show for the appointment. Information concerning appointments dated back to 8/09. During this time the following individuals were unable to be successfully assessed for an annual dental examination, despite several appointments being made: Individual #215 (2 appointments), Individual #145 (2 appointments), Individual #379 (2 appointments), Individual #15 (4 appointments), Individual #334 (3 appointments), Individual #147 (4 appointments), Individual #182 (1 appointment), Individual #343 (3 appointments), Individual #1 (3 appointments), Individual #132 (5 appointments), Individual #295 (5 appointments), Individual #83 (3 appointments), Individual #200 (3 appointments), Individual #323(3 appointments), Individual #67 (2 appointments), Individual #273 (3 appointments), Individual #205 (2 appointments), Individual #217 (2 appointments), Individual #362 (2 appointments), Individual #176 (3 appointments), Individual #9 (4 appointments),	

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		Individual #103 (3 appointments), Individual #159 (4 appointments), Individual #174 (3 appointments), Individual #246 (6 appointments), Individual #369 (4 appointments), Individual #206 (4 appointments), Individual #280 (4 appointments), Individual #294 (2 appointments), Individual #326 (3 appointments), Individual #268 (2 appointments), Individual #287 (1 appointment), Individual #284 (2 appointments), Individual #23 (4 appointments), Individual #348 (3 appointments), Individual #158 (2 appointments), Individual #175 (2 appointments), Individual #102 (2 appointments), Individual #371 (3 appointments), Individual #74(2 appointments), Individual #376 (3 appointments), Individual #356 (2 appointments), Individual #198 (3 appointments), Individual #336 (4 appointments), Individual #333 (4 appointments), Individual #363 (4 appointments), Individual #111 (2 appointments), Individual #193 (5 appointments), Individual #228 (3 appointments), Individual #166 (3 appointments), Individual #240 (2 appointments), Individual #258 (4 appointments), Individual #283(2 appointments), Individual #84 (3 appointments), Individual #187 (3 appointments), Individual #42 (2 appointments), Individual #375 (2 appointments), Individual #290 (2 appointments), Individual #281 (2 appointments), Individual #2 (3 appointments), and Individual #314 (2 appointments). Additionally, the dental department provided an oral hygiene rating. The baseline number was difficult to interpret, because it may represent the rating based on those who were able to complete an exam (either annual or partial serial visits to complete an annual exam). Of 681 rated visits (there were slightly less than 300 individuals served by the Facility), 130 were rated as having "very poor" oral hygiene, and 195 were rated as having "poor" oral hygiene. It is not clear whether the 60 individuals who did not complete any visit were assumed to be of very poor hygiene, or were not counted in this oral hygiene rating but it is obvious the task is enormous. It was also apparent the Facility had not been able to meet the basic dental needs of preventive and routine maintenance care of many individuals. Although this represents an enormous challenge, it also represents an enormous opportunity now that an additional dentist and dental hygienist have been added to the department. The data for the categories of dental work was confusing and difficult to interpret. For instance, from a quick count, there were 171 individuals who received preventative dental work for the first six months of 2010. However, the Dental Director stated that depending on the cooperation of the individual, at times, only one quadrant of the mouth could be examined or treated. Therefore, an annual preventive visit or six-month preventive visit might require from one to four office visits. This was not reflected in the information provided. Considering there were nearly 300 individuals serviced by CCSSLC, this could represent a need for 300 annual visits, or 1200 annual visits. Additional information from the dental department is required to interpret these statistics. However, 171 individuals out of approximately 300 total census (57%) had some degree of preventive dentistry during the prior 6 months.	

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		Further, the quality of the information being entered into the database may need to be reviewed. For instance, Individual #297 on 1/20/10, Individual #168 on 1/8/10, Individual #114 on 2/25/10, Individual #329 on 1/25/10, and Individual #191 on 2/4/10 were on the emergency dental treatment list. For these same dates, they also were listed on the preventative dental work list. Generally, preventative dental work is a visit associated with maintenance care, not emergency dental work. Additionally, several extractions were also listed on the Preventative Dental Work list, including for Individual #99 on 1/26/10, Individual #139 on 1/25/10, Individual #209 on 1/12/10, and Individual #357 on 1/11/10. There was no indication these were part of Total Intravenous Anesthesia cases, but if they were, a footnote or other descriptor should have been entered into the information. Again, extractions are usually not considered preventative care, and in the above cases of extractions and emergency dental work, the accuracy of the statistics concerning preventative dental work raises questions. It is important to review the quality of the data being entered. This may reflect the need for training for the database entry personnel. This information, when accurate, is a powerful guide for planning and funding, and it is critical that accuracy is ensured. The following issues related to the data provided confused interpretation further: ▪ Two separate lists of individuals identified for restorative dental work were provided (Individuals Identified for Restorative Dental Work, and CCSS Dental Database 2010 Jan – Jun: Restoration). During interviews, the Dental Department acknowledged that the information was not considered accurate because there were two different database systems. On comparing the two restorative dental work lists, there were a number of discrepancies. The Dental Director estimated that five to six fillings were completed each month, which would make the "CCSS Dental Database 2010 Jan-Jun: Restoration" the more accurate of the two lists. However, to be in compliance will require data collection demonstrating timeliness of restorative procedures. Documenting the visit where an oral exam determines the dental pathology and needs, translating this into a dental care plan, and monitoring to completion, will provide the necessary information for the SA. Timing of the visits to ensure there is not inordinate delay in completing the components will assist in measurement of compliance. Determining a timeline goal for completion of restorative work as outlined in the dental care plan will allow measurement of timeliness as an important factor for compliance in the SA. The same data collection will be necessary in tracking tooth extractions and dental emergencies (when was the issue of pain identified on the unit, when was the dental office called, the appointment made, the findings of the exam, when was the extraction or other emergency procedure completed, any post-operative visit or exam to ensure closure of the problem), with dates included to record timeliness. As recorded in	

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		this document, the various lists provided by the dental department only led to confusion and the meaning of the lists can be interpreted in various ways. Determining future goals of the dental department will require accurate and complete data, and the above information would assist in determining the strengths and needs of the department. ▪ From the preventative dental work list, it was observed that there were no entries after early or mid-March, suggesting the data was extremely incomplete. ▪ Additionally, from the list entitled Individuals Identified to Have Required Extractions, it was noted that the only extractions were for those individuals with a surname starting with the letter "R," and also that the only extractions occurred in January. This appeared to be a significantly incomplete list. Adjustments to the needs of the individual appeared to be made routinely. For instance, if an individual had a recent pneumonia, within three weeks of the dental visit, they were to be rescheduled. If an individual had the onset of a seizure, the Dental Department stopped the dental work, waited, and monitored. If the seizure occurred shortly before the appointment, the Dental Department rescheduled the visit. If the individual had dysphagia, the individual was kept upright, and fluids were minimized. A throat pack was often used. A continuous spray of water occurred at the same time as suctioning to prevent any aspiration. Also, the water volume in the spray could be adjusted. If necessary, only one quadrant of the mouth at a time was examined and treated. <u>Use of Dental Anesthesia</u> As part of the spectrum of dental care, the Department had a consultant dental anesthesiologist available to complete on-site dental care under conscious sedation. Policies had been written and were in force. Implementation of these policies is discussed in further detail below. Creation and implementation of policies had been a critical positive step. A list of potential medications used while under TIVA was submitted by the Dental Department, and included: Halcion, Fentanyl, Demerol, Versed, Propofol, Ultiva, Glycopyrolate, Ketamine and Flumazenil. The Dental Department had done an excellent job of creating policies; training Dental Department staff; communicating with other departments, including the individual's PSTs concerning TIVA, training nursing and other department staff concerning expectations, and requiring timely evaluations and consents prior to a TIVA procedure. Known risks had been methodically minimized. According to the Dental Director, a procedure involving TIVA had clear documentation, including physician notes, dental department notes, medications used, and monitoring and documentation while under anesthesia and in recovery. The dentist anesthesiologist initialed lab values. If the dental anesthesiologist's exam on the day of TIVA indicated concerns, such as low oxygen saturations, or breathing abnormalities, TIVA was not	

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		performed. Monitors were in place for the procedure. Post anesthesia, a Respiration, Energy, Alertness, Circulation, and Temperature (REACT) score was used to monitor the individual. The individual remained in the dental clinic until stable. The dental anesthesiologist continued to monitor the individuals in the dental office until they were stable using dental anesthesiology criteria. The individual was then transferred to the infirmary for monitoring for a minimum of two hours. Vital signs were checked frequently, and logged on a vital sign sheet. An RN remained in the room with the individual until he/she was discharged from the infirmary. The anesthesiologist did not leave campus until recovery was considered acceptable, and physiologically the individual had demonstrated stability. There was a back-up plan for unstable conditions. As individuals who had undergone anesthesia received nothing by mouth (NPO), and dehydration might be an issue, when vitals signs did not indicate prompt recovery, the dentist anesthesiologist might place an intravenous (IV) catheter, and order fluids. The dentist anesthesiologist was always available by phone. There had been no complications to date. TIVA was available at the Facility beginning approximately one year ago. As mentioned, not all those who arrived at the dental department with appropriate screening actually underwent TIVA. One of the last steps in the decision-making was the dental anesthesiologist's examination, and initial monitoring. The following are examples of how the close monitoring identified individuals for whom this was not appropriate, and evidence that the system for monitoring during the initial steps was effective in ensuring the health and safety of the individual. ▪ In the case of Individual #240, she had an appointment with TIVA scheduled on 6/9/10. However, the RN at the infirmary stated that: "the dental procedure was not done due to oxygen levels dropped to the 80s. Her last VS reported were T 98.5 (temporal), p 77, R 18, SAO2 96%, BP 114/82." ▪ Individual #310 was scheduled for TIVA on 3/23/10, but it was learned he had been served breakfast. According to the TIVA policy and procedure, his appointment was canceled and he was rescheduled for the next day. Separately, the unit and nursing department need to develop systems in which such events do not occur. Two dental records were reviewed to determine completeness of documentation: initial assessment, consents, procedural monitoring, pre- and post-operative care. ▪ Individual #15 underwent TIVA on 6/8/10. As part of this documentation, the following were reviewed: the annual medical summary; comprehensive exam dated 1/5/10; current medication list updated on 3/23/10; current treatments and diet updated on 4/1/10; an explanation of TIVA by the dentist, dated 4/20/10; signed consent by the guardian on 5/15/10; medical consultation clearance request dated 4/6/10, with medical clearance/accepted for TIVA on	

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		4/10/10; pre-operative TIVA orders dated 6/4/10; anesthesia record dated 6/8/10, including history, allergies, updated medication list, pre-operative status, fluids used, catheter size, estimated blood loss, start and termination time, problems encountered, post-operative patient status and vital signs; monitors used; and detailed monitor chart for anesthesia. Post-operative care included a vital sign flow sheet that was completed every 15 minutes for the first hour, every one half hour for an hour, then every hour until the evening on which the procedure was completed. Vital signs included temperature, pulse, respirations, blood pressure, O2 saturation and REACT score. There were no missing entries. A RN/LVN Restraint Physical/Mental Evaluation form was completed. A dental note was written the day of the procedure. The Annual Dental Summary recorded the procedures completed ("comprehensive examination completed, deep pocket scaling and root planing prophylaxis - full mouth, x-ray series of full mouth"), and listed recommendations and treatment outlined ("daily oral hygiene brushing should be maintained to keep tissue healthy. Continue with Annual Examinations and Prophylaxis with sedation when requested. No restorative work indicated at this time."). The typed-written annual dental summary was an excellent communication tool for the PST to review, and implementation of recommendations was expected. Post-operative orders were typed, and there was an integrated progress note written. ▪ Individual #294 also had TIVA on 6/8/10. The packet of information included: prior dental department notes; 9/15/09 annual medical assessment and comprehensive exam; current medication list with allergies updated 4/10/10; updated medication addendum, dated 5/8/10; laboratory data through 11/13/09; diet fluids and supplemental feeding listed as of 7/16/09; explanation of TIVA by the dentist, dated 5/25/10; request for consultant clearance on 4/6/10; review note by medical director, dated 4/9/10; consultant clearance, dated 4/10/10; pre-operative orders written on 6/4/10; completed anesthesia record, including history of allergies, assessment of pre-operative status, fluids used, catheter size, estimated blood loss, start and stop time, problems encountered, post-operative patient status, post-operative vital signs, and monitors used; completed anesthesia monitoring chart; completed post-operative vital signs flow sheet; completed RN/LVN Restraint Physical/Mental Evaluation form; dental progress note, dated 6/8/10; completed annual dental summary with TIVA sedation procedures, and recommendations and treatment outlined; post-operative orders; and integrated progress note completed on 6/8/10. In both these cases involving the use of TIVA, the charting was thorough, and updated communication to the team through the annual dental summary was excellent. The preparation for TIVA, monitoring during the procedure, and post-operative care were	

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		thorough and well documented. This represents a valuable addition to the spectrum of dental services provided through the dental department in order to provide quality dental care.	
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.	The following areas are discussed in further detail below: development and implementation of dental policies and procedures, provision of adequate dental records, desensitization programs and strategies to overcome refusals, and tracking and assessment of sedating medications. Development and Implementation of Dental Policies and Procedures To the credit and diligence of the Dental Department, they have created and implemented a number of policies. During the last monitoring site visit, there was concern raised about the use of conscious sedation at the Facility. Since that time, a number of policies were created to ensure quality and standardization of care in a high-risk area of dentistry. The Dental Department continued to use the services of a dentist anesthesiologist who is trained and licensed in this specialty. With this additional resource, a policy statement and related procedures have been created and implemented effective March 23, 2010. These include: ▪ Parenteral Sedation intravenous (IV) (TIVA or MAC) Anesthesia: Anesthesia Policy; ▪ Parenteral Sedation intravenous (IV) (TIVA or MAC) Anesthesia: Criteria for Use; ▪ Parenteral Sedation intravenous (IV) (TIVA or MAC) Anesthesia: Anesthesia Medical Clearance; ▪ Parenteral Sedation intravenous (IV) (TIVA or MAC) Anesthesia: Dentist Anesthesiologist; ▪ Parenteral Sedation intravenous (IV) (TIVA or MAC) Anesthesia: Anesthesia Surgery; ▪ Parenteral Sedation intravenous (IV) (TIVA or MAC) Anesthesia: Anesthesiology Personnel; ▪ Parenteral Sedation intravenous (IV) (TIVA or MAC) Anesthesia: Pre-operative sedation prior to TIVA or MAC Sedation; ▪ Parenteral Sedation intravenous (IV) (TIVA or MAC) Anesthesia: Anesthesia Recovery; ▪ Parenteral Sedation intravenous (IV) (TIVA or MAC) Anesthesia: REACT Scoring System; and ▪ Parenteral Sedation intravenous (IV) (TIVA or MAC) Anesthesia: Vital Signs Flow Sheet. Additionally, these policies also had been implemented: ▪ Monitoring of Pre-Post Dental Sedation, implemented 3/5/10;	Noncompliance

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		▪ Missed or Refused Dental Appointments, implemented 3/5/10; and ▪ Dental Consultations, implemented 4/6/10. A policy entitled Protective Supports and/or Sedations had been drafted, but the implementation date was pending. At the time of the review, the Dental Department did not use mechanical or physical restraints such as wristlets. Chemical restraints were used, and there was also manual redirection, and support of the hands and head. Additionally, policies on the following topics are suggested: Reduction of chemical restraint use (with log), and dental desensitization plan. <u>Provision of Adequate Dental Records</u> There was a form that was sent back to the building for placement in the record, for members of the PST to review, and to facilitate the implementation of dental recommendations. This one-page form, the annual dental summary, was an important start in educating the PST about the current status of dental health and the unmet needs of the individual. The recommendation section had begun to be utilized, and the Dental Department should see the completion of the recommendation section of this form as imperative to instructing the PST with regard to the requirements of oral health for the individual. Several dental records were reviewed and each had a copy of the summary that was forwarded to the building. The dental record also included the backup information and details important for dentists and dental hygienists to share within their department and field of expertise. Records reviewed included those for Individual #144, Individual #72, Individual #277, Individual #134, Individual #41, and Individual #140. Communication back to the dentist remained problematic. For instance: ▪ Although the annual dental summary for Individual #41 included the recommendation: "Brushing must be conduced 3 times a day and especially before bedtime", when asked if this was being completed, neither the Dental Director nor dental hygienist knew the answer. ▪ In another case, in which sipping sugar laden fluids has been detrimental to oral health for Individual #140, the recommendation to replace the fluids with water was written in a recommendation from September 2009. Recently, the Dental Department has seen her with water and not sugar rich fluids. In this case, the recommendation appeared to have been acted upon by the PST and implemented. The dental team was surprised to see the water, indicating the PST had not updated them concerning progress with the dental recommendation. Clearly, the dental department needs to be better integrated into the PST process and communication system. In addition, there remained room for improvement in communication originating from	

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		the dental office to the unit and PST, and for adequately recording information with regard to individuals' dental treatment. For example: ▪ On 4/28/10, Individual #380 underwent TIVA in the dental office. The nursing note that evening at 7:50 p.m. stated: "we couldn't find Individual #380's meds and MAR after she came back from TIVA Dental. As a result, Remeron was held as there is none in the …cart, but other meds were given." This suggested the need for further coordination in the post-operative steps. Although this was probably a transfer issue, the Dental Department needs to take ownership and ensure every aspect of the procedure (pre and post) is seamless. On the same date, the Dental Department wrote a note in the interdisciplinary progress record: "Dental appointment with TIVA Sedation. Refer to Dental Progress note for details." This note had little content as to what procedure was accomplished, and expanding this information briefly would have been valuable. The IDT and unit did not have ready access to the dental department records if there were a question, especially after hours. An improved post-operative note is essential for adequate communication. ▪ Similarly, Individual #67 had completed a dental appointment on 6/2/10. The only dental note in the integrated progress note section stated: "dental appt for dental prophylaxis cleaning with sedation. Refer to dental progress notes for details." This did not supply the information needed by the PST. Also, Individual #67 had been scheduled for a dental appointment on 2/12/10, but it was canceled because she had been taken to breakfast, and sedation orders were canceled. Give the high no show rate in the Dental Department, the Department and nursing should meet to determine ways to monitor when such events occur, and develop strategies to reduce this as a reason contributing to the no show rate. ▪ Individual #52 completed dental work on 2/22/10, but the integrated progress note again contained the same note with little information provided to the unit. A note that read: "Dental appointment for dental restoration. Refer to dental progress notes for details" was not helpful in providing adequate information to the unit. More detailed information should be documented in the progress notes for all departments to read. ▪ The recording of dental visits and dental health status was difficult to determine based on review of Individual #228's record. On 7/19/09, she was scheduled for a dental appointment on 7/21/09. It was not clear this appointment occurred. On 10/7/09, an appointment for dental cleaning was made for 10/15/09, but this was subsequently canceled. On 10/19/09, a dental visit was cancelled due to illness in the home. She had a dental visit on 2/23/10, and the progress record indicated: "seen in dental for prophylaxis. See dental progress	

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		notes for details." On 7/6/10, her record indicated that she was to have a dental appointment for dental cleaning on 7/8/10, but the only information reported was by nursing that the individual received Atarax. There was no information submitted by the Dental Department. The dental section of the personal support plan indicated that the oral health rating (OHR) is very poor, and she needed better brushing. Overall, the unit would have difficulty determining her current dental health. The Dental Department needed to write progress notes with significant content, particularly because her OHR was considered very poor. ▪ In 3/10, TIVA was cancelled for Individual #87 when review of the medical record indicated the need for a cardiology update consultation. It was rescheduled and completed on 4/27/10. However, the integrated progress note referred the reader to the dental notes for details. On the positive side, it was noted in the case of Individual #207, who had a TIVA procedure on 10/28/10, that there was the request to learn of "any other procedures which needed to be done while under sedation, such as nail trimming, ear irrigation, eye or ear exams, etc." This is a sign of a unique communication and a collaborative approach. <u>Desensitization Plans and Strategies to Overcome Refusals</u> Chemical restraints were used in the Dental Department, but no mechanical or physical restraints such as wristlets were used. There was assisted redirection of hands and head as needed. Desensitization programs had not begun. The Dental Department was able to readily identify several names of individuals who had tactile defensiveness, but did not seem to have a process for obtaining assistance in developing programs to address these individuals' needs. The Psychology Department usually would be the lead department in this endeavor, but progress had not been made, and there were no minutes of meetings submitted that would indicate this had been a priority. Implementation of desensitization plans might reduce by a sizeable percentage, the number of individuals needing sedation, or would greatly reduce the amount of sedation required. At the time of the review, environmental factors were being adjusted, such as introduction of low lighting, soft music, a fish aquarium, and a television. Comprehensive desensitization plans will require considerable patience, often involving a several step plan. For example, it would include Dental Department visits to the home for tooth brushing and examination, then multiple trips to the dental office to become familiar with sitting in the dental chair, having lights focused on the individual's face, and lastly small advancements in evaluation of the mouth with instruments and familiarity with	

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		noises of dental instruments. The implementation of this process will require meticulous documentation of every trip made, and whether or not progress was made. It will require an individual with some experience in a successful program to create and implement a program at CCSSLC. In the meantime, the Dental Department is encouraged to place in the annual dental summary recommendation space, information that an individual might benefit from a desensitization program and ensure the psychology department receives a copy of this form. At the time of the review, the Dental Department did not appear to be part of the team that discussed desensitization. <u>Tracking and Use of Sedating Medications</u> Besides dental treatment in the office at CCSSLC and through the dentist anesthesiologist who provided TIVA on site, there was also a contract with a local oral surgeon, who completed procedures in his office for specific treatments, such as difficult extractions. The dental department submitted a list of those individuals who required sedation in preparation for the dental visit. For the 2010 month of January – 15, February – 10, March - 22, April - 25, and May - 23. This was a total of 95 sedations for five months, an average of 19 per month. This could be used as a baseline from which to determine if any desensitization procedures were effective in this population at CCSSLC. The dental department should ensure that an up-to-date list of medications administered and their dosages, dates, effectiveness, as well as the dental procedure, are in the individuals' records in an on-going log entry form. Decreasing a medication dosage and recording effectiveness will be essential in minimizing sedative use in preparation for the dental visit. The pharmacy department also should have a similar list from their internal information, and should be a resource for alternatives in medication administration. For those needing antibiotic prophylaxis or sedation, the RN in the home unit was responsible for ensuring the order was filled, and that any consents for sedation, annual exam and treatment, dental pre-treatment sedation medication, etc. were obtained. Such consents were generally current. When consent was not obtained or antibiotics not administered, the individual was not seen in the Dental Department, but the appointment was rescheduled. It is suggested that the Dental Department meet with the Nursing Department to review times when antibiotics were not given as ordered, sedation was not given, and/or consent not present to determine any causal factors that could be eliminated to minimize the need for rescheduling.	

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

1. The Dental Department is encouraged to develop a database to track the Oral Hygiene Index of individuals being taught tooth brushing by the dental hygienist, to determine the positive impact of such a program over serial quarters of the year.

2. The dental hygienist is encouraged to develop a competency-based training program for the direct support professionals concerning tooth brushing. Such training should be designed to ensure that staff are able to assist and monitor proper tooth brushing during times when the dental hygienist is not in the home, in order to enhance the continuity in the implementation of these important preventive activities.
3. A team approach should be utilized to analyze the data related to the "no show" appointment rate for individuals, identify potential causes, and develop action plans to address identified issues. Such a team should include members of the Dental Department, as well as Unit staff. Resulting action plans should include action steps, anticipated outcomes, person(s) responsible, and timeframes for completion. They should be monitored for completion, and modified, if they are not effective at addressing the underlying issues.
4. The data categories related to missed appointments should be similar in all reports so as to prevent difficulty in interpretation.
5. The Dental Department needs to precisely determine the cause of each missed or un-kept appointment in order to begin to improve the 'show' rate. The Dental Department should request a written response from the unit for each missed appointment when the reason is not clear. Such reasons should be entered into the dental database.
6. Every missed appointment should be considered an opportunity for the dental department to work with the unit to improve communication and assist in improving the "show" rate.
7. Cancellations of appointments by the dental department should be tracked, because this reflects on delay in treatment and provides a measure of departmental efficiency.
8. It is recommended that the Dental Department identify a goal over the next 24 months to reduce the number of individual unable to successfully complete an annual exam. The Department should then work with other related departments, such as psychology, to develop and implement a plan to meet this goal.
9. The Dental Department should address/clarify the many overlapping and confusing statistics to allow the development a long-range plan (e.g., one visit should not be double coded as both preventive and emergency visits unless footnotes clarify specific circumstances).
10. To ensure that the data maintained by the Dental Department can be used to ensure the appropriate provision of dental treatment to individuals at CCSSLC, the Dental Department should review their database entry system, and take any actions necessary to increase accuracy.
11. The Dental Department should complete the annual dental summary recommendation section to ensure adequate communication of individuals' needs to their PSTs.
12. The Dental Department should become better integrated into the PST, particularly with regard to communication regarding progress being made or not being made on the implementation of dental recommendations.
13. The Dental Department should provide more informative notes in the integrated progress note section of the record following the use of TIVA and other dental procedures.
14. The annual dental summary recommendation section should include a recommendation for those who may benefit from dental desensitization or other strategies to reduce refusals and/or minimize the need for chemical sedation, but for whom such plans do not currently exist.
15. The Psychology Department should receive a copy of the annual dental summary, especially if the recommendation states that the individual may benefit from dental desensitization or the development of other strategies to reduce refusals and/or minimize the need for chemical sedation.
16. Policies on the following topics are suggested: Reduction of chemical restraint use (with log), and dental desensitization plan.
17. The Dental Department needs to be part of the interdisciplinary team that develops dental desensitization program or other strategies to reduce refusals and/or minimize the need for chemical sedation.
18. The dental department should ensure that an up-to-date list of medications administered and their dosages, dates, effectiveness, as well as the dental procedure, are in the individuals' records in an on-going log entry form. Decreasing a medication dosage and recording effectiveness will be essential in minimizing sedative use in preparation for the dental visit. The pharmacy department also should have a similar list from their internal information, and should be a resource for alternatives in medication administration.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Master Speech List, no dated; o Presentation Book Section R, dated 7/11/10; o Therapy Staff with Current Caseloads, not dated; o Habilitation Therapies Department Directory, revised 7/12/10; o Habilitation Therapies Department Table of Organization, not dated; o People with Alternative and Augmentative (AAC) Systems, not dated; o Speech and Language Update format, not dated; o Speech and Language Screening format, not dated; o Initial Speech Language Evaluation format, not dated; o Five current AAC and SLP assessments conducted by each therapists and corresponding PSPs; o Communication Equipment Monitoring form, not dated; o Communication Monitoring Activity Plan XV.6, not dated; o Augmentative Communication Monitoring Activity Plan, not dated; o Completed Communication Equipment Monitoring Forms for past month; o Communication Book for Individual #278, and Individual #113, not dated; o CCSSLC Augmentative Communication Systems List, not dated; and o Individual records for Individual #145, Individual #278, Individual #297, Individual #154, Individual #251, Individual #3, Individual #294, Individual #110, Individual #221, Individual #185, Individual #128, Individual #320, Individual #136, Individual #69 and Individual #2, which included requests for SLP Assessment and Updates, PNMP with date of implementation and pictures; Communication programs; daily schedule; person-specific monitoring; PSP, PSP Addendum(s), BSP, SLP Consultations, Competency-based staff training documentation, person-specific monitoring for May-June, Monthly monitoring equipment for February to June, 2-10 Monitoring forms, Individual Habilitation Therapies Data Base, SLP Progress notes, Monthly PSP reports for communication objectives, Quarterly SLP reports for communication objectives and Communication Dictionary ▪ **Interviews with**: o Linda Merryman-Scifres, Speech-Language Pathologist; o Marlene Perry, Speech/Language Pathologist (Consultant); o Carol Thompson, Speech/Audiology Director, Speech Language Pathologist ; and o Dora Barbosa, Speech Assistant ▪ **Observations of**: o Observations in the following areas: Tropical, Coral Sea, Atlantic, Ribbon Fish Vocational Building, Adult Life Skills Building
	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the

	steps the Facility took to assess compliance. Although the POI reviewed for CCSSLC did not include this component, the POI for Section R indicated that CCSSLC was in compliance with some indicators in Section R. However, based on the Monitoring Team's review, the Facility was not in compliance with these components of the SA. Additional information and individual examples are provided within the section of this report that addresses Section R of the SA. Examples of indicators rated in compliance, but non-compliance was documented by the Monitoring Team included: ▪ The POI indicated that the Facility was in compliance with Section R.1 with regard to recruitment of SLPs, professional contractors to be used until permanent employees could be hired, and limiting the use of professional staff for activities other than those for which they were hired. No supporting documentation in the presentation book substantiated compliance with these indicators. The Corrective Action Plan for required SLP/Communication Human Resource Needs, dated 4/20/10, indicated that "screening results will be reviewed to determine if present number of SLPs on staff are able to carry out recommendations; to determine if further assessment needs to be more comprehensive and if present number of SLPs on staff are able to carry them out and continue to monitor use of contract SLPs being utilized to meet the demands of communication needs." The completion date for these actions steps was January 1, 2011. It is of concern that an additional six months will be needed to determine if CCSSLC has sufficient SLPs on staff, and if assessment need to be more comprehensive. The baseline review in January 2010 confirmed there were not sufficient SLPs on staff, and over 90% of the individuals residing at CCSSLC were not receiving communication services. These action steps will not be completed until January 2011, which means that individuals with significant communication needs will continue to wait to receive needed services. CCSSLC continues to be in non-compliance with providing adequate numbers of SLPs and communication supports to the individuals living at CCSSLC. ▪ The POI for the indicators in Sections R.2.1, R.2.2, R.2.3, R.2.4, R.2.6, R.2.7, R.2.10, and R.2.11 were noted to be in substantial compliance. The Monitoring Team found these indicators to be in noncompliance. SLP Updates and/or Screenings were submitted in the individual record sample for Section R. No comprehensive SLP assessments were submitted. A review of SLP updates did not follow the Speech Language Evaluation format identified in the Habilitation Therapies Handbook Physical and Nutritional Management (Revised 2009). Individuals had had a SLP screening without a follow-up comprehensive SLP evaluation. Indicators R.2.3, R.2.4, R.2.6, R.2.7, R.2.10, and R.2.11 referred to the development of a database, which would not meet the intent of these indicators and substantiate compliance with these indicators. ▪ The POI for Sections R.3.5 and R.3.6 indicated that the Facility was in substantial compliance because Alternative and Augmentative Communication (AAC) devices were portable and functional in a variety of settings. Observations by the Monitoring Team did not find that what few AAC devices there were on campus were portable, and functional in multiple environments. There were many individuals living at CCSSLC who had not been assessed to determine their functional skills, interests, and preferences leading to the identification of strengths and potentials for functional communication skill acquisition. The POI indicated substantial compliance with Section R.2.14, which addressed generic AAC devices being available in common areas. Observations by the Monitoring Team showed that generic devices were absent in many common areas at CCSSLC. In those areas where generic AAC devices were mounted, they were not accessed or used by

	individuals or staff, and in some cases, the generic devices were inaccessible as furniture was placed in front of the devices. ▪ The POI indicated that the Facility was in compliance with Section R.4.1 and R.4.4 that address a communication monitoring system, and that validation checks are built into the monitoring process and conducted by the plan's author. There was limited monitoring of individual communication devices. Only seven communication equipment monitoring forms were submitted for the last month, and this system had not been formalized in policy. The monitoring that was conducted did not address the implementation of the device and the effectiveness of the device.
	Summary of Monitor's Assessment: The Speech Therapy Director had a caseload of 149 individuals in addition to administrative and supervisory duties as a Director. The current caseloads for Speech Language Pathologists and Speech Assistants will not allow therapists to be active members of the individual's PST, or provide functional communication supports. Clinical instruction for SLPs and Speech Assistants consisted of attendance at PNMP and WC Clinic Teleconferences. There were no additional continuing education courses documented for the SLPs and Speech Assistants. Therapy staff should be attending a variety of continuing education courses to bring diversity of knowledge and skills to the provision of therapy supports to individuals living at CCSSLC. Continuing education did not provide ongoing specialized training to enhance skill development in augmentative and alternative communication. The SLP Master Speech List for CCSSLC identified individual initial evaluation dates, and annual screening dates. An initial review of these Master Lists gave the impression that SLP evaluations, updates and screenings had been completed, and it had been determined that individuals were not in need of and/or appropriate for communication supports, including alternative and/or augmentative communication systems. This impression was incorrect. The Master Speech List identified individuals who had had an evaluation and/or annual screening, but these evaluations were not sufficient to identify individuals who would benefit from the use of alternative or augmentative communication systems. Per observation and record review, there were many individuals who would benefit from the use of alternative or augmentative communication systems, including systems that could be integrated with behavioral supports or interventions. The Facility needed to prioritize who would benefit from a comprehensive SLP evaluation, for example, individuals with Behavior Support Plans for whom an inability to communicate impacts their behavior. A review of individuals' evaluation updates and/or screenings did not support that SLPs were collaborating with psychology staff to assess and explore functional communication strategies for individuals involved in challenging behaviors. Procedures needed to be developed to define the SLPs' role in working with individuals with challenging behaviors, including collaboration with the individuals' psychologists and PSTs. There were only three individuals on campus with electronic AAC devices. When, the Speech Assistant and a member of the Monitoring Team went to observe these three individuals, their devices were broken, not

	working, and/or not available. The Adult Education Area and Vocational Annex did not have generic AAC devices. Eight of the nine homes that were visited had generic AAC devices present in the common areas, but it was noted that furniture and/or carts were covering the communication systems in Ribbonfish 2, Ribbonfish 4, Seahorse, and Sanddollar. Multiple observations in all nine homes demonstrated that staff did not utilize common area AAC devices. There were no policies/procedures submitted to define the SLP monitoring process that supported data consistency and inter-rater reliability. A review *Communication Equipment Monitoring Forms* from July 2009 to June 2010 documented that staff were not being monitored in all aspects of AAC utilization.

#	Provision	Assessment of Status	Compliance
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.	Each indicator of compliance is underlined, and the narrative that follows summarizes the Monitoring Team's findings. The Facility provides an adequate number of speech language pathologists or other professionals [i.e. Assistive Technology (AT) specialists] with specialized training or experience. Training should include augmentative and assistive communication. Current therapy caseloads for Speech Language Pathologists and Speech Assistants were as follows: **Pacific Residences (78 Individuals)** 1 Speech Language Pathologist **Atlantic Residences (66 Individuals)** 1 Speech Language Pathologist Consultant (20 hours per week) 1 Speech Assistant **Coral Sea Residences (83 Individuals)** I Speech Language Pathologist who also served as the Speech Therapy Director 1 Speech Assistant **Tropical Residences (66 Individuals)** I Speech Language Pathologist who also served as the Speech Therapy Director The Speech Therapy Director had a caseload of 149 individuals in addition to administrative and supervisory duties as a Director. At the time of the review, the caseloads for speech language pathologists and speech assistants would not allow therapists to be active members of the individual's PST, or provide functional communication supports.	Non-compliance

#	Provision	Assessment of Status	Compliance
		None of the 15 records reviewed (0%) indicated individuals with identified language difficulties were receiving active Speech Treatment, or participating in a Speech program. The records reviewed included those for: Individual #154, Individual #278, Individual #2, Individual #297, Individual #251, Individual #185, Individual #69, Individual #110, Individual #320, Individual #128, Individual #145, Individual #136, Individual #221, Individual #3, and Individual #294. Examples of Individuals with identified speech or language difficulties not receiving services included: ▪ Individual #278's PNMP, revised 5/26/10, communication section indicated that she made her wants and needs known with gestures, vocalizations, and facial expressions. Individual #278 had a communication system of eight symbols through which she was given opportunities for making choices regarding a variety of items she enjoys manipulating. Her SLP Evaluation, dated 10/26/07, did not address the communication system identified in her PNMP. Individual #278 did not have a communication program. Individual #278's PSP Behavior Services section, dated 11/4/09, recommended consideration of training to improve expressive communication skills. Her Behavior Support Plan was developed without collaboration with a SLP. Individual #278 engaged in self-injurious behavior such as pulling or scratching on skin or fingernails that resulted in bleeding and/or resulted in the need for medical intervention. The BSP identified the use of a picture book that would identify her needs. Individual #278 had communication abilities and needs, but was not receiving services/supports from a speech language pathologist. ▪ Individual #251's BSP described her disruptive behavior when she was frustrated or angry as yelling, swearing, spitting, threatening, hitting, kicking and flopping to the floor from her wheelchair. A SLP was not involved in collaboration with the development of her BSP. Individual #251 needed an effective way to communicate her frustration and anger. ▪ Individual #3 did not have a comprehensive SLP assessment to identify his functional skills, interests and preferences leading to the identification of strengths and potentials for the development of functional communication. ▪ The Monitoring Team observed Individual #294 while she was shredding paper. Individual #294 did not have an effective way to communicate with the Monitoring Team. Her SLP Update, dated 2/4/10, documented "verbal speech and language skills are effective for her needs. She is not in need of alternate or augmentative communication." It was unclear how this determination was made, because the SLP Update did not document an assessment of her abilities with alternate/augmentative communication devices.	

#	Provision	Assessment of Status	Compliance
		The document entitled Survey Staffing Review for ICF/MR Facilities, dated 1/29/10, indicated licenses were current for two full-time Speech Language Pathologists, and one Contract Speech Language Pathologist. Clinical instruction for SLPs and Speech Assistants consisted of attendance at PNMP and WC Clinic Teleconferences. There were no additional continuing education courses documented for the SLPs and Speech Assistants. Therapy staff should be attending a variety of continuing education courses to bring diversity of knowledge and skills to the provision of therapy supports to individuals living at CCSSLC. Continuing education did not provide ongoing specialized training to enhance skill development in augmentative and alternative communication. <u>Communication Aide Devices and Speech Generated Devices (simple and complex) are provided to individuals based on need and not staff availability. All individuals in need of AAC, receive AAC. SLPs actively participate in all facets of care in which communication is relevant.</u> Based on a review of 15 records, none (0%) of the individuals who were identified with severe expressive or receptive language were receiving supports designed to improve or augment existing language. Based on a review of 15 records of individuals with identified speech/language and behavioral difficulties, none (0%) had Speech Language Pathologist(s) actively involved in their care. An example of an individual with difficulties with communication as well as behavior not receiving active SLP collaboration included: ▪ Individual #297's most recent SLP Evaluation was completed on 2/16/05. An implementation plan, dated 2/24/10, for an electronic augmentative communication device (Vantage) included the following stated objective: "[Individual #297] will create functional messages using Core Vocabulary on her voice output electronic communication aid/device to communicate with others with 80% accuracy for 4 sessions." A review of SLP documentation and progress notes did not document the evaluation criteria for data collection and recording. There were no therapy sessions documented for March. Individual #297 attended 3/5 therapy sessions in April, 2/9 sessions in May (three of the therapy sessions the SLP was not available, the individual moved to new home during one session, and there were two "no show" by Individual #287), and 0/7 therapy sessions in June (two "no shows," and device was broken for other five therapy sessions). It was unclear without a comprehensive SLP assessment focusing on augmentative communication how Individual #278's communication device was selected.	

#	Provision	Assessment of Status	Compliance
		The Monitoring Team observed Individual #297 with a Speech Assistant. Her communication device was not working during this observation. Neither the Speech Assistant nor staff were not able to correct the problem. The Speech Assistant contacted the SLP by phone for assistance. The device continued to not function. The implementation plan criteria for program change stated if Individual "demonstrates maintenance or regression for three consecutive months, the objective will be evaluated for possible modification, or reasons for the need to continue will be addressed in monthly progress not narrative." The implementation plan had not been revised even though Individual #297 consistently did not attend therapy sessions, and was not making progress. The SLP was not integrated with the development and implementation of the BSP.	
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.	<u>All individuals in need of AAC are identified as being in need of AAC.</u> The SLP Master Speech List for CCSSLC identified individual initial evaluation dates, and annual screening dates. An initial review of these Master Lists gave the impression that SLP evaluations, updates and screenings had been completed, and it had been determined that individuals were not in need of and/or appropriate for communication supports, including alternative and/or augmentative communication systems. This impression was incorrect. The Master Speech List identified individuals who had had an evaluation and/or annual screening, but these evaluations were not sufficient to identify individuals who would benefit from the use of alternative or augmentative communication systems. Per observation and record review of 15 individuals, there were many individuals who would benefit from the use of alternative or augmentative communication systems, including systems that could be integrated with behavioral supports or interventions. The SLP evaluation should address, at a minimum, diagnoses and/or description of significant health care issues; health risk indicators; functional communication; receptive and expressive language skills; voice and articulation; functional reading skills and literacy; and the assessment, selection and training for augmentative and alternative communicating aids and devices, impact of health care issues on performance and therapeutic intervention, description of current therapeutic supports including assistive technology and AAC devices, and baseline measurements. The evaluation should include an analysis of the findings to provide a rationale for recommendations and intervention strategies. The Facility needed to prioritize individuals who would benefit from a comprehensive SLP evaluation. An important group to be prioritized, that would significantly benefit learning functional communication skills, would be individuals with a Behavior Support Plan. Twelve of the 15 individual records reviewed documented the presence of a	Noncompliance

#	Provision	Assessment of Status	Compliance
		Behavior Support Plan. There were no formal communication programs developed to assist staff and individuals with strategies to support functional communication. Zero of 15 records reviewed (0%) indicated individuals identified with severe expressive/receptive language had AAC investigated and assessed. Examples of individuals diagnosed with severe language difficulties where AAC was not assessed or investigated, included: ▪ Individual #69's SLP Annual Summary, dated 8/5/09, did not follow the Speech-Language Evaluation format (Habilitation Therapies Handbook Physical and Nutritional Management Revised 2009). The SLP Annual Summary did not assess his functional skills, interests, and preferences through clinical assessment. The summary documented: "[he] uses verbal words and phrases accompanied by gestures and signs to communicate with others. Verbal utterances, however, are often unintelligible." Individual #69 was involved in communication therapy for a number of years to learn to use a communication book. He was placed on communication monitoring plan for the past two years to assess and ensure use of the book on an ongoing basis. Individual #69 did not receive a comprehensive SLP evaluation that provided an analysis of assessment data to identify his strengths and potentials leading to the development of strategies for the development of functional communication. Progress notes for Communication Monitoring Activity Plan were only submitted for 8/20/08, 9/11/09, 10/09, 11/09, and 12/09. ▪ Individual #136 was observed during his annual PSP meeting. A comprehensive SLP assessment was not submitted. His Speech and Language Update, dated 6/10/10, did not present assessment findings for augmentative/alternative communication systems. His update in the section labeled Augmentative/ Alternative Communication section documented: "[he] had had his communication board for several years. The board is comprised of symbols depicting his wants and needs, and is updated and/or modified periodically when a need is noted, or requested by staff." Individual #136 and staff did not access his communication board during the PSP meeting. This observation illustrated that his communication board was not functional for him or for his staff. There were no progress notes to document changes to his communication board. A consultation was requested by his QMRP to add additional icons to indicate to staff when he wished to exit or enter the patio. The icon was needed to prevent further injury to his hands and arms when entering and exiting patio doors. The consultation documented the addition of icons. Direct support professionals were in-serviced on new icons, but no documentation was submitted for competency-based staff training.	

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		All people have received a communication screening or assessment within 30 days of admission, readmission or change in status. Examples of individuals who did not receive a timely assessment included: There were no new admissions to CCSSLC since the baseline review. Communication Assessment addresses: ▪ Both verbal and nonverbal skills; ▪ Expansion of current abilities; ▪ Development of new skills; ▪ Whether the individual requires direct or indirect Speech Language services; and ▪ The need for further assessment in Augmentative Communication. In the 15 records reviewed, the Communication Assessment assessed the following areas: ▪ In 0 of 15 records reviewed (0%), the assessment addressed verbal and nonverbal skills. ▪ In 0 of 15 records reviewed (0%), the assessment addressed expansion of current abilities. ▪ In 0 of 15 records reviewed (0%), the assessment addressed development of new skills. ▪ In 0 of 15 records reviewed (0%), the assessment addressed whether the individual required direct or indirect Speech Language services. ▪ In 0 of 15 records reviewed (0%), the assessment addressed the need for further assessment in Augmentative Communication. For persons receiving behavioral supports or interventions, the Facility has a screening and assessment designed to identify who would benefit from AAC. Note: this may be included in the PBSP. A policy did not exist that demonstrated identification of behavioral difficulties and communication difficulties. The *Communication Services* policy, dated 10/07/09, Section II.D Assessment stated: "Assessments will consider the behavioral issues and provide recommendations, including recommendations regarding communication systems involving behavioral supports or interventions." The policy did not provide additional information beyond this statement. A review of individuals' evaluation updates and/or screenings did not support that SLPs were collaborating with psychology staff to assess and explore functional communication strategies for individuals involved in challenging behaviors. Procedures needed to be developed to define the SLPs' role in working with individuals with challenging behaviors, including collaboration with the individuals' psychologists and PSTs.	

#	Provision	Assessment of Status	Compliance
		<u>Communication programs are integrated into the PBSP as indicated.</u> Twelve (12) of the 15 individuals reviewed had PBSPs, but there were no communication programs developed by the SLP for these individuals. Examples of individuals with identified communication difficulties whose plans were not integrated in the PBSP included: ▪ Individual #145's BSP, dated 11/1/09, documented that she would "display disruptive behavior when she is frustrated, when unable to reach her mother or she does not take her home when she expects and when she is denied something she wants." The BSP teaching rationale stated that her disruptive behavior was related to her inability to communicate. The strategy presented was for Individual #145 to use a communication board to express her feelings. A SLP attended the BSP meeting, but there did not appear to be collaboration, because systems that were discussed in the Speech and Language Evaluation, draft dated 7/16/10, were not integrated into the BSP. ▪ Individual #69's BSP was discussed at his PSP meeting, and a SLP was in attendance. A Speech and Language Screening, dated 6/27/09, had been completed, but a comprehensive SLP assessment had not. The absence of a comprehensive SLP assessment resulted in the SLP and his PST members not having information that would describe his strengths and potential for functional communication skill acquisition. <u>Policy exists that outlines the assessment schedule and staff responsibilities.</u> A policy did not exist that outlined the assessment schedule and staff responsibilities. The Communication Services policy, dated 10/7/09, Section II. Assessments stated: "comprehensive communication assessment will be completed according to the schedule set forth in the Communication Master Plan, or as indicated by need." CCSSLC did not have a Master Communication Plan for the prioritization and implementation schedule for SLP assessments. Procedures needed to be developed to provide consistency in the implementation of SLP assessments. At the time of the review, SLP evaluations reviewed did not follow the established format in Habilitation Therapies Handbook Physical and Nutritional Management (Revised 2009).	
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	<u>Rationales and descriptions of interventions regarding use and benefit from AAC are clearly integrated into the PSP.</u> None of the 15 records reviewed (0%) had a clear rationale and description of communication interventions integrated into the PSP. Examples of PSPs in which communication was not adequately integrated included:	Noncompliance

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	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.	▪ Individual #297 used a Vantage Plus AAC electronic device. There was no communication program written and integrated into her PSP to support utilization of her device across all environments. Her PNMP did not address staff strategies to assist her in the use of her electronic device. ▪ Individual #154's PSP, dated 4/28/10, had a training objective to utilize the communication board to make a choice. This objective did not have a communication program written by the SLP, and integrated in her PSP to assist staff in the implementation of her communication device. <u>Communication information is not only present in the PSP, but integrated into the daily schedule.</u> None of the 15 records reviewed (0%) had communication interventions and methods to improve communication integrated into the daily schedule. <u>AAC devices are portable and functional in a variety of settings.</u> None of the three individuals with an AAC component (0%) included AAC devices that were functional in a variety of settings (i.e., mealtime, work, and activities of daily living). Two of the electronic devices were mounted to wheelchairs, but the third device was in the Habilitation Therapies Department. The Speech Assistant and a member of the Monitoring Team went to observe the three individuals on campus with AAC devices that were broken, not working and/or not available. The following are examples of communication devices that were not functional for the individuals: ▪ Per report, Individual #154's communication device had been broken twice and had been sent out for repairs for over two months. ▪ Individual #251's device was at Habilitation Therapies and not accessible in her home. ▪ Individual #297's electronic device was not functioning during the observation. The Speech Assistant and/or staff were not able to solve the problem and correct the malfunction. The Speech Assistant called the SLP at Habilitation Therapies to obtain direction, but her suggestions were not successful in getting the device to work. <u>AAC devices are individualized and meaningful to the individual.</u> None of the 15 records reviewed (0%) had communication programs that were functional and meaningful to the individual and improved his/her daily living. <u>Staff are trained in the use of the AAC.</u> None of the records reviewed for the three individuals with electronic devices (Individual #297, Individual #154, and Individual #251) included competency-based	

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		staff training documentation. Moreover, there were no formal communication programs documented in the 15 records reviewed, even though three individuals had electronic devices (Individual 297, Individual #154 and Individual # 251). <u>General AAC devices are available in common areas.</u> The Adult Education Area and Vocational Annex did not have generic AAC devices. Eight of the nine homes observed (89%) had general AAC devices present in the Common areas. However, it was noted that furniture and/or carts were covering the communication systems in Ribbonfish 2, Ribbonfish 4, Seahorse, and Sanddollar. Multiple observations in all nine of the homes illustrated that staff did not assist individuals to utilize the AAC devices found in the common areas.	
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.	<u>Monitoring system is in place that: tracks the presence of the ACC; working condition of the AAC; the implementation of the device; and effectiveness of the device.</u> The following SLP monitoring forms were submitted: ▪ *Communication Equipment Monitoring Form* (no date); ▪ Communication Monitoring Activity Plan (no date); and ▪ Augmentative Communication Monitoring Activity Plan (no date). Communication Equipment Monitoring Forms were submitted for the following individuals: ▪ Individual #117 was monitored on a monthly basis from 12/09 to 6/10. The monitoring form documented that Individual #117 preferred to "use his own speech," but no recommendations were made to change his communication system. ▪ Individual #222's monthly monitoring forms documented his device was not used in July, August and September 2009, and rarely used in March, April, May, and June 2010. There were no changes made to address the lack of use of his communication device. ▪ Individual #154's monitoring forms documented three months in a row that the device needed new batteries. It was unclear why direct support professionals did not replace the batteries. Individual #154 had an inoperable device until the monitor replaced the batteries during a monthly monitoring visit. ▪ Individual #69's monitoring form documented that pictures were placed in his book during a monthly monitoring visit in November 2009, but staff were not in-serviced until January 2010. The monitoring form documented that Individual	Noncompliance

#	Provision	Assessment of Status	Compliance
		#69 "rarely" used his device from September 2009 to June 2010, but no changes were made to address this concern. There was no staff signature with a date on the form. There were no policies/procedures submitted to define the monitoring process for these forms. A review of Facility monitoring reports from July 2009 to June 2010 for seven individuals documented that staff were not being monitored in all aspects of AAC utilization. This included: ▪ In 7 of 7 reports reviewed (100%), the presence of the ACC was documented. ▪ In 7 of 7reports reviewed (100%), the working condition of the AAC was addressed. ▪ In 0 of 7 reports reviewed (0%), the implementation of the device was addressed. ▪ In 0 of 7 reports reviewed (0%), the effectiveness of the device was documented. <u>Monitoring covers the use of the AAC during all aspects of the person's daily life in and out of the home.</u> In reviewing Facility monitoring reports from July 2009 to June 2010 for seven individuals, it was unclear if staff were monitoring AAC during all aspects of the person's daily life. The monitoring forms did not document if the monthly monitoring took place in a variety of environments to support facilitation of the device across multiple settings.	

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

1. The current caseloads for speech language pathologists and speech assistants will not allow therapists to be active members of the individuals' PSTs or provide functional communication supports for individuals. The Facility should complete an analysis of required duties to establish realistic caseloads for SLPs to allow them to become functioning, active members of individuals' PST and to identify a reasonable caseload for Speech Assistants.
2. SLPs should be attending a variety of continuing education courses to bring diversity of knowledge and skills to the provision of therapy supports to individuals living at CCSSLC.
3. The SLP evaluation should address, at a minimum, diagnoses and/or description of significant health care issues; health risk indicators; functional communication; receptive and expressive language skills; voice and articulation; functional reading skills and literacy; and the assessment, selection and training for augmentative and alternative communicating aids and devices, impact of health care issues on performance and therapeutic intervention, description of current therapeutic supports including assistive technology and AAC devices, and baseline measurements. The evaluation should include an analysis of the findings to provide a rationale for recommendations and intervention strategies.
4. The Facility should prioritize who would benefit from a comprehensive SLP evaluation. An important group to be prioritized would be individuals with a Behavior Support Plan.
5. Procedures should be developed to define the SLPs' role in working with individuals with challenging behaviors, including collaboration with the individuals' psychologist and PSTs to develop functional communication programs.

6. The Facility should consider identifying a home to pilot the development and implementation of functional communication systems across all environments. This would promote interdisciplinary planning, development and implementation of an environment that supports and encourages functional communication throughout the 24-hour day.
7. Policies/procedures should be developed for the communication monitoring system with identified performance indicators that are defined clearly. This system should include, but not be limited to, a systematic and routine review of the components of the functional communication programs and equipment; staff utilization of generic AAC devices; fit, function, availability and use of AAC devices; and staff competency with functional communication devices and programs. There should be established thresholds for staff re-training; identification, training and validation process for monitors to achieve accurate scoring; and inter-rater reliability methodologies.

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:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o CCSSLC Vocational Assessment (blank rubric); o CCSSLC Vocational Profile (blank rubric); o Completed Vocational Assessment and Vocational Profile for Individual #13; o Individuals employed on and off campus (VIII.18) – summarizing each individual's average hours worked (12/09 through 5/10), including the job setting; o Revised Skill Acquisition Plan for Individual #318; o Personal Support Plan, including Community Integration Assessment, for Individual #18; o Specialized Training Survey, including summary of results; o Person Directed Planning and Active Treatment – Implementing and Documenting Active Treatment Programs, draft policy, revised 7/14/10; o Habilitation, Training, Education, and Skill Acquisition – Ensuring Facility Engagement; draft dated 7/8/10; o Five Minute Engagement Monitoring Form; o Person Support Planning Worksheet; o Summary of findings from team reviews of Barriers to Attending Day Programs Away from the Homes - for individuals in Atlantic, Tropical, Coral Sea, and Pacific Units; o Example of graphed data from a hypothetical skill acquisition plan; o Facility Community Action Plan, dated March 2010; o Summary of Community Outings per residence for the past six months (VIII.19); o Listing of Individuals with Skill Acquisition Plans in the Community Settings (June, 2010); o Personal Support Plans, Personal Focus Worksheet: Individualized Assessment Screening Tool, and Positive Adaptive Living Skills (PALS), when available, for: Individual #186, Individual #172, Individual #297, Individual #218, Individual #296, Individual #275, Individual #246, Individual #369, Individual #27, Individual #20, Individual #226, Individual #7, Individual #87, Individual #300, Individual #165, Individual #69, Individual #191, Individual #312, and Individual #95; o PSP Monthly Reviews for last six months (or less) as provided for: Individual #186, Individual #172, Individual #297, Individual #27, Individual #7, Individual #300, Individual #165, Individual #69, Individual #191, Individual #312, Individual #226, Individual #275, Individual #20, and Individual #246; and o Onsite chart reviews of: Individual #165, Individual #226, Individual #277, Individual #300, Individual #296, Individual #7, Individual #315, Individual #317, and Individual 46 ▪ **Interviews with**: o Bruce Boswell, Director of Day Programs and Active Treatment, Nelda Gonzalez, QMRP Coordinator, and Rachel Rodriquez, QMRP Educator, on 7/12/10;

	○ Dr. Robert Cramer, Director of Behavioral Service and Chief Psychologist, on 7/13/10; ○ Bruce Boswell, Director of Day Programs/Active Treatment, on 7/15/10; ▪ **Observations of**: ○ Observation and discussion with staff members at the Personal Focus Meeting for Individual #181, on 7/14/10; ○ Observation and discussion with staff members at the treatment team meeting for Individual #7, on 7/15/10; ○ Onsite direct observation, including interaction with direct support professional, and other professionals including residence coordinators, psychologists, psychology assistants, home team leaders and assistants, active treatment supervisors, active treatment specialists, and community integration specialists, and/or QMRPs were conducted throughout the morning, day and/or evening hours at the following residential and day programming, and habilitation sites: ▪ Apartment 510 (Sailfish), on 7/12/10; ▪ Apartment 511 (Pompano), on 7/12/10 and 7/15/10; ▪ Apartment 517 (Angelfish), on 7/12/10; ▪ Apartment 516 (Sanddollar), on 7/12/10; ▪ Apartment 515 (Seahorse), on 7/12/10; ▪ Apartment 522A (Kingfish 1), on 7/13/10; ▪ Apartment 522D (Kingfish 4), on 7/13/10; ▪ Adult Life Skills Building (512), on 7/13/10 and 7/15/10; ▪ Vocational Building (513), on 7/15/10; ▪ Apartment 524D (Ribbonfish 4), on 7/13/10; ▪ Apartment 524A (Ribbonfish 1), on 7/13/10 and 7/14/10; ▪ Apartment 518 (Starbright), on 7/14/10 and 7/15/10; ▪ Apartment 524C (Ribbonfish 3), on 7/14/10; ▪ Apartment 514 (Dolphin), on 7/14/10; and ▪ Apartment 522C (Kingfish 3), on 7/15/10
	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Although the POI reviewed for CCSSLC did not include this component, the POI did contain action steps, required evidence, facility target dates, full SA implementation dates, judgment on current non-compliance (N) or substantial compliance (S), and additional comments. The majority of target dates identified on the POI were for at least 10 months or more from the current review and the assessment of most sections was noted to be dependent upon the development or revisions of policies or procedures, the outcome of various pilot projects, and receipt of official policies or further information/clarification from the State Office. According to the current POI, CCSSLC indicated that it was in non-compliance with all Sections within Habilitation, Training, Education, and Skill Acquisition Plans (S.1-S.3). This finding was consistent with the Monitoring Team's review.

	Summary of Monitor's Assessment: In general, progress was observed in many areas of habilitation, training, and skill acquisition programs. It was evident that staff had begun the challenging process of improving the services and supports at CCSSLC as they progress toward compliance with the Settlement Agreement (SA). Although changes were observed since the baseline review, many areas still required additional resources and effort to adequately address components of the SA. Indeed, discussions and interactions with many administrative, clinical and direct support professionals reflected an acknowledgement of and sincere investment in the continued work that will be required to progress toward compliance. Since the baseline review, CCSSLC had made progress by developing several draft polices, revising assessment and skill acquisition formats, and by initiating new quality improvement systems, including the development of two oversight committees. The Monitoring Team looks forward to reviewing the Facility's progress as they begin implementing and monitoring these new methodologies and procedures. At the time of the review, residents typically had multiple skill acquisition programs developed to address identified needs and, ultimately, to promote and maintain adaptive behavior. The current format of these plans had not changed significantly over the past six months and, as a result, many of the concerns identified then continued to be problematic. However, a new skill acquisition plan format had been developed, based on previous recommendations as well as feedback from within the Facility, and was being piloted. A process for prioritizing skill acquisition programs should be developed and implemented, as well as highlighting how individual preferences were incorporated into the teaching strategies. Progress also had been made in the area of data collection. Graphing of skill acquisition data had recently been introduced. The use of visual analysis to examine performance over time will hopefully assist PST members in evaluating interventions and recommending modifications. The adequate recording of weekly data and summary of monthly data, however, continued to be inconsistently observed. Continued efforts to improve engagement and active treatment had also been occurring. A daily integrated schedule and a draft policy, including a new methodology for measuring engagement in residential and work settings, had been developed. During the recent visit, engagement across residential programs was estimated at 64%, showing a need for improvement. In addition, a policy targeting active treatment was recently revised and new active treatment program coordinators were hired in an effort to support more teaching and functional activities both on and off campus. This was good news as little formal or incidental teaching was observed within the residential programs. During the baseline visit, concerns were raised about the adequacy of the vocational assessment as well as the limited opportunities for some individuals to access day or vocational programming both on and off campus. Since then, a new more comprehensive vocational assessment had been developed, and was being piloted. In addition, several on campus settings had been opened allowing individuals alternative programming options during the day until additional community-based work sites became available. Training of staff continued to be an area of great concern. Baseline reviews and more recent observations

	continued to produce mixed findings regarding staff knowledge of and competencies in implementing skill acquisition plans. Since baseline, staff members had clearly advocated for more opportunities for training. As a result, staff were surveyed and topic areas for training had been identified. The Monitors look forward to reviewing the content and process of these new trainings as well as any related outcomes during the next visit. Lastly, it appeared that efforts to integrate individuals more fully into the community had continued. This included development of policy and assessments targeting community inclusion, as well as the acquisition of additional vehicles. Since the baseline visit, the number of skill acquisition programs implemented in the community appeared to have increased while, unfortunately, the number of individuals in community-based supportive employment has remained the same.

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S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	During the baseline reviews, it was determined that, in addition to the skill acquisition objects (SAOs) that prescribed teaching strategies in the PBSP to promote replacement behaviors, there were two other types of objectives currently being implemented, these included Specific Performance Objectives (SPOs) and Staff Service Objectives (SSOs), respectively. The SSOs were not considered skill acquisition programs, but the SPOs were. At that time, QMRPs were responsible for developing, implementing and monitoring each individual's SPOs and SSOs. Based on recent discussions with the Director of Day Services and Active Programming, the format of these programs as well as how they were being developed, implemented, and monitored would soon change (these changes are described below). Of the 20 sampled Personal Support Plans currently available for review (the PSP was incomplete or not provided for Individual #226 and Individual #300, respectively, and were not reviewed), 100% referenced SAOs, SPOs and/or SSOs that were implemented to address needs identified through one or more of the many assessments that were completed or reviewed as part of the PSP process. In general, findings and recommendations from these assessments were summarized within the PSP and corresponding action plans were developed to address identified needs. Action plans typically detailed or referenced corresponding SPOs or SSOs that were continued (if all ready in place), or developed and implemented. The rationale for each skill acquisition program should be identified or highlighted within the actual program, including what assessment(s) was the basis for current strategies. Such rationales were already provided for SAOs within PBSPs. As discussed below with regard to Section S.2 of the SA, a number of assessments typically were being completed to facilitate the adequate completion of each individual's annual PSP. These included, for example, the PFW, PALS, ICAP (at least every three	Noncompliance

#	Summary of Provision	Assessment of Status	Compliance
		years), and a more recently developed community integration narrative section, a number of which were assessments designed to identify an individual's goals, strengths, needs, likes/dislikes, etc. When completed adequately by professionals who are familiar with and have a positive relationship with the individual served, these assessments are likely to promote the development of individualized skill acquisition plans. Findings from the current review indicated that these assessments were being completed for the majority of individuals sampled. However, for some individuals, the completion of these assessments and how the results were utilized appear to less than adequate. More specific information about this is provided below with regard to Section S.2 of the SA. Although the completion of the above assessments as well as other aspects of the PSP process certainly promoted the identification and discussion of the individual, including individual preferences, it was still unclear whether or not individual preferences ultimately helped determine and shape which SPOs were developed and implemented. It was also unclear how PSTs prioritized the many assessment recommendations that ultimately resulted in the development of SPOs or SSOs. In addition, it was unclear how the PST selected either the SPO or SSO format to address a particular need, especially when, in some cases, it appeared that skill training was still necessary. For example, it was curious that an SSO was developed and implemented for Individual #191 to address a serious and challenging behavior (elopement), rather than an SPO, which were typically more comprehensive and structured skill training programs. As CCSSLC reviews and proceeds with anticipated changes to the PSP, including revisions to how skill acquisition programs are developed, implemented and monitored, a system needs to be developed and implemented to ensure these programs are prioritized, and individual preferences are addressed, including ensuring that this process is conspicuous. It appears that most individuals had, on average, approximately six skill programs (with a range of four to 10). Review of the 18 sampled SPOs suggested that the format remained relatively consistent with those sampled during the baseline visit (SAOs are discussed above with regard to Section K.9 of the SA). In general, SPOs continued to include the goal, information detailing the schedule of implementation, information on data collection, the staff responsible for implementation, materials needed, opening statement, instructions including an initial instruction (teaching steps) or any special instructions, and information on reinforcement. In addition, plans typically included one or more training objectives with specific success criteria, as well as tables in which to record performance data for the current month (i.e., per trials) and year-to-date monthly data totals (since implementation). In general, as described above, the general format of the SPOs did not appear to have changed since the baseline review. This was consistent with recent verbal reports from staff. Given that, it was not surprising that the current concerns regarding the SPO format remained similar to those presented during baseline reviews. The following concerns were noted, and examples of these are provided below:	

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		▪ None of the SPOs reviewed appeared to contain teaching steps based on a formal task analysis. ▪ When teaching steps were provided, they often were very brief and/or not sufficiently descriptive. ▪ In addition, operational definitions of targeted responses were not typically found. That is, although one or more behavioral objectives were stated in all plans, the responses they targeted were not formally operationally defined. In some cases, examples of the targeted skill were provided, but these were not always clear or conspicuous. ▪ Information on reinforcement delivery was often lacking, especially specification around differential reinforcement based on quality of performance. ▪ In most cases, SPOs were only scheduled to be completed daily or at naturally occurring times, and data was only collected once, or at most, twice a week. With data collected only once a week, it is unclear how authors of these plans could ensure that the plan was being implemented as scheduled. ▪ Responses following incorrect responses were typically not described. ▪ Plans for maintenance and generalization were not typically described. Reviewed plans, for example, did not appear to be based on specific task analyses. That is, although plans had instructions that contained multiple steps, these did not reflect the specificity generally found within a task analysis. At the time of the review, instructions in SPOs appeared rather vague and, consequently, were likely to lead to inconsistency across staff. For example: ▪ Individual #296 was on the second objective of his laundry SPO, but the first objective that he had mastered was not included in the instructions. ▪ Individual #226 had an SPO to wash and dry her hands, but there were no steps or specific instructions on how she should wash her hands (e.g., use soap or hot water, scrub for a certain amount of time, etc.). ▪ Two close approximations of task analyses included information provided within the SPOs for hygiene and denture care for Individual #7 and Individual #186. All of the sampled SPOs identified a response or skill that was the target for acquisition or modification. However, these responses varied greatly in how well they were described or defined. Indeed, operational definitions in SPOs were typically not found. For example: • Individual #297 had an SPO to improve work attendance, and the teaching strategies involved praising her when she arrived on time. The duration of work attendance or what she was required to do at work was not described beyond her objective that simply stated that she "… will attend work." In addition, an additional SPO for hair styling similarly did not define the skill beyond "… will	

#	Summary of Provision	Assessment of Status	Compliance
		independently brush her hair." Although 100% of the SPOs reviewed had instructions for teaching the skill, the instructions were often vague, incomplete and/or did not match the current objective. For example: ▪ Individual #172 had an SPO designed to teach him the purpose, including the name of the medication, the reason and the possible side effects, of taking his medication. The initial opening statement " … do you want to take your medication?" did not appear to be the best question given the information that the team wanted to elicit. In addition, although the instructions suggested using "… parallel talk and explain the importance and reason of taking the medication …", parallel talk and reasons why the medication was important to take were never defined or described. ▪ Similar findings for medication SPOs were found for Individual #312 and Individual #296. More specifically, the SPO goal for Individual #312 targeted learning to verbalize "… when and why he takes his medication" and, although the name and side effects were described, specific information regarding "when" and "why" he took the medications were not described. The SPO for Individual #296 instructed staff to encourage him to " … tell you the name of the medication," but the listed objectives targeted " ... stating the color of the medication" and "… state why he takes his medication." Although 100% of the sampled SPOs identified the use of positive reinforcement, usually verbal praise and/or campus bucks, either in a "reinforcement" section or under materials, very few of the plans adequately described when or how to specifically utilize reinforcers. For example: ▪ SPOs for some individuals identified the reinforcer, but did not describe when it should be delivered (e.g., hand washing, medication, social skills, budgeting, and laundry SPOs for Individual #369, Individual #172, Individual #312, Individual #191, and Individual #296, respectively). ▪ In some cases, only a general instruction encouraging staff to "… reinforce (name) for doing a great job" was found (e.g., purchasing, money management, medication, diet/exercise, and morning routine SPOs for Individual #172, Individual #312, Individual #297, Individual #275, and Individual #191, respectively). Subsequently, many well-meaning staff might reinforce effort regardless of accurate completion or successful completion of criterion, which might not result in the learning that the author of the plan expected. All teaching strategies clearly should identify specific reinforcers, perhaps emphasizing the use of more individualized preferred items or activities, and provide guidance regarding when and how these identified reinforcers should and should not be used. It	

#	Summary of Provision	Assessment of Status	Compliance
		was unclear from these SPOs how reinforcers were initially identified, and/or how their continued value was assessed. Regular preference assessments should be conducted for each individual residing at CCSSLC. In addition, although a few plans specifically stated what to do when a correct response was demonstrated (e.g., staff should praise Individual #297 when she arrives on time at work), none of the reviewed SPOs clearly described procedures (error correction, reintroduce the trial, etc.) following an incorrect response. Clear descriptions should be provided of what action staff should take to correct incorrect responses. The potential for progress on these plans appeared restricted by the limited number of teaching trials that were offered per month. In general, most plans prescribed daily or, in a few cases, weekly implementation with performance data collected either once or twice a week. For example: ▪ Individual #369 had two SPOs (i.e., teaching purchasing and laundry skills) that were only scheduled for completion once a week. This limited opportunity to practice and receive feedback was not likely to support learning. When appropriate, individuals should be offered frequent opportunities to practice new skills each day. Consideration should be given to how the overall goal of the SPO actually related to the specific skill being trained. More specifically, some goals did not appear to closely relate to the identified teaching objectives. For example: ▪ Individual #369 had a SPO targeting hand washing, and yet the goal of the program was to improve vocational skills. ▪ Also, an SPO for Individual #275 described a goal to "…learn about what triggers her anger," and yet the objective measures how well she "…states appropriate ways to respond to situations that makes her angry." Similarly to baseline visits, observations during the July 2010 site visits evidenced a continued effort to promote engagement in recreational, leisure and other activities, including opportunities for community outings, across all residential programs. The Monitoring Team measured engagement across many residences at multiple times across days and times of day. Engagement was measured by briefly observing the individuals who were engaged at the moment, and the number of staff available at that time. The definition of engagement was very liberal and included active (e.g., painting, coloring, building models, playing Wii, etc.) and passive forms (e.g., listening to music, watching TV, listening to a story being read, etc.) of engagement. See the table below for specific information on observed level of engagement (individuals engaged: total number of individuals) in relation to staff-to-individual ratios across residential programs.	

#	Summary of Provision	Assessment of Status	Compliance
		Engagement Observations	

Location	*Engaged*	*Staff-to-individual ratio*
Sailfish	2:2	3:2
Angelfish	1:1	1:1
Angelfish	4:4	--
Sand Dollar	1:3	1:3
Sand Dollar	1:5	--
Sand Dollar	2:2	1:2
Seahorse	2:3	1:3
Kingfish 4	1:5	1:5
Ribbonfish 4	3:4	1:4
Ribbonfish 4	4:4	1:4
Ribbonfish 1	3:8	1:8
Ribbonfish 1	3:3	1:3
Ribbonfish 1	3:5	1:5
Starbright	1:1	2:1
Starbright	2:2	3:2
Dolphin	2:2	1:2
Dolphin	2:2	2:2
Dolphin	1:2	1:2
Pompano	4:7	--
Kingfish 3	1:2	1:2

Overall engagement was 64%. An engagement level of at least 75% would be a typical target for a facility like CCSSLC. In general, direct observations suggested that many staff worked hard to keep individuals engaged by offering a lot of choices and consistent encouragement. At times, it appeared that engagement was limited due to the staffing ratios. However, all the interactions observed between staff and individuals were very respectful, positive, and considerate.

Direct observation suggested that engagement continued to be facilitated by monthly schedules posted in the residential programs. In addition, a draft policy (i.e., Habilitation, Training, Education, and Skill Acquisition – Ensuring Facility Engagement, dated 7/8/10) intended to promote more engagement across all residences and day and vocational programming was developed recently. This policy included the regular monitoring of engagement using the new "5 Minute Engagement Monitoring Form," and prescribed the collection and monthly summary of engagement data. According to staff report, this new monitoring form was being piloted. According to this draft policy, engagement criteria had been identified as 80% and 60% within day programs and residences, respectively.

#	Summary of Provision	Assessment of Status	Compliance
		When engagement falls below these levels, the Active Treatment Engagement Team is required to meet and develop additional training or resources. Completed engagement tools, as well as monthly reports will be reviewed during future Monitoring visits. A new document, called the "Integrated Daily Schedule', had been developed to facilitate active treatment, and had been implemented for individuals living at CCSSLC. It was unclear how long these documents had been implemented, but they were found in several PSP books during brief onsite random chart reviews (for Individual #46, Individual #165, Individual #277, Individual #296, and Individual #317), as well as in sampled documentation during off-site reviews (for Individual #7). Subsequent reviews will need to investigate how closely individuals and staff adhere to this schedule, and whether or not staff members believe the schedule promotes greater engagement and overall active treatment. Requested documentation on completed community outings also suggested an effort to ensure that each individual had access to the community. This documentation reflected considerable variability in the number of outings individuals participated in per month across residences. In addition to listing settings, the number of outings by individual and by residence should be summarized. This could include the average number of outings per week or month for each individual and residence. As found during the initial baseline visit, the current day and vocational habilitation and sheltered work programs on campus appeared to offer individuals opportunities for consistent work. At that time, many of the individuals served by CCSSLC expressed great pride in the work that they do each day. In addition, the Facility appeared to offer some opportunities for individuals to work on and off campus in enclave or supported employment positions. However, during this initial review, concerns were noted with regard to: 1) the goals and objectives that individuals' PSPs included with regard to day and/or vocational activities; and 2) the provision of day program options for people with more complex needs. According to the Director for Day Services and Active Treatment, previously reported concerns regarding the vocational assessment, including the development of adequate goals and objectives within day and/or vocational activities, had been examined and steps had been taken and/or were planned to address inadequacies. One major component within this amelioration process included the revision of the previous vocational assessment. A new more structured and comprehensive assessment, called the Vocational Assessment, had been developed. In addition, a supplement to this document, called the Vocational Profile, had also been developed. CCSSLC staff were piloting both draft assessments as PSP meetings were scheduled. At the time of the review, only one completed vocational assessment had been completed and was	

#	Summary of Provision	Assessment of Status	Compliance
		available for review. These assessments, completed for Individual #13, certainly provided more detailed information than the previous vocational assessment. The vocational assessment process is discussed in further detail in the section below that addresses Section S.2 of the SA. The utility of the new Vocational Assessment will only be optimized if its findings are well integrated within adequate, meaningful and functional skill acquisition programs. According to the Director of Active Treatment and Day Services, identified concerns with skill acquisition programs (SPOs) during the baseline review had also been examined. Reportedly, a newly revised format as well as a new process, for their development, implementation, and monitoring, had been developed and recently initiated. The revised skill acquisition plan rubric (e.g., for Individual #318) appeared to address previously identified concerns, and included more objectives that were measurable, operational definitions of behavioral targets, specific consequences for correct and incorrect responses, including differential reinforcement, and plans for maintenance and generalization of the acquired skill. These changes were concurrent with revisions within the CCSSLC policy on Person Directed Planning and Active Treatment: Implementing and Documenting Active Treatment Programs, revised 7/14/10. These qualitative changes in policy, content and process are likely to have profound effects on the nature of skill acquisition programs in day and vocational settings. Future reviews will be needed to assess the resulting outcomes of these changes on individual programming. At the baseline review, it was identified that a number of individuals did not leave their residential building during the day to attend a day program elsewhere on campus. For many individuals, this limitation did not appear to be as a result of medical restrictions. Since that time, teams were developed to review the barriers to attending day programs away from individuals' homes. According to the summaries dated July 2010, these reviews were completed for homes on Atlantic, Tropical, Coral Sea, and Pacific. These reviews identified a number of individuals who had medical conditions that would either prohibit them from leaving the residence (i.e., 11 individuals at Coral Sea) or that would necessitate additional supports while away from their homes (i.e., 25 individuals at Pacific would require an onsite LVN support to provide nutrition via G-tube). Transportation as well as adequate programming space also were identified as barriers for individuals residing at Coral Sea and Pacific residences. Five individuals at Atlantic and Tropical were identified as "reluctant" to leave the residence. Specific reasons for their reluctance were not provided for four of the five individuals. It appeared that further investigation for these identified individuals was necessary. Overall, it appears that, other than the 11 individuals at Coral Sea, the identified barriers could be addressed through the investment of additional resources, and some plans were underway.	

#	Summary of Provision	Assessment of Status	Compliance
		As presented below with regard to Section S.3 of the SA, progress had been made in improving transportation availability. In addition, efforts continued to be made in developing space on campus for individuals to participate in day/vocational programs. At the baseline visit, some individuals had begun to attend a day program in the newly designed area of the rehabilitation building. Since that time, new programming space had been developed in the Pacific residence, and the Bike Shop on campus recently opened. According the staff report, the number of individuals supported in these programs continued to increase (18 additional individuals since June). Although residents of Pacific did not technically attend day programming out of the residence, and the bike shop will only be able support a limited number of individuals, attempts were being made to offer alternatives settings for day programming until more ideal environments were identified. According to the Director of Day Service and Active Treatment, efforts to identify and secure community based work sites was ongoing. For the 11 individuals at Coral Seas, the medical reasons prohibiting their involvement in off-site day/vocational programs should be clearly identified and justification provided in their PSPs. Plans also should be developed to assist, as appropriate, individuals in overcoming such obstacles. PSTs should review such reasons and justifications regularly, as well as progress made in assisting individuals to overcome such obstacles.	
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.	As reported during the baseline review, the Personal Focus Worksheet: Individualized Assessment Screening Tool was supposed to be discussed and completed annually prior to the PSP meeting for each individual served at the Facility. The PFW was being completed in an attempt to identify important individual goals, interests, likes/dislikes, achievements and lifestyle preferences to assist with the PSP planning process. It also functioned as the primary screening device that assisted with the identification of additional necessary assessments. In the sample of 22 records reviewed, 16 (73%) had completed PFWs, although one of the assessments was not dated (for Individual #95) and, interestingly, two PFWs were completed for Individual #7 within one month of each other. PFWs were unavailable, however, for Individual #186, Individual #218, Individual #20, Individual #300, Individual #165 and Individual #69. It was unclear how these completed assessments were summarized within the PSP. The Positive Adaptive Living Skills assessment was also supposed to be completed for each individual concurrent with their annual PSP meeting. This assessment evaluated a substantial number of skill areas and offered additional information on individuals' preferences, strengths, skills, and needs. Of the individuals sampled, 21 out of 22 (95%) evidenced completion of a recent PALS assessment. Two of these reports, however, were not adequately dated (i.e., Individual #165 and Individual #300). In some reports, the	Noncompliance

#	Summary of Provision	Assessment of Status	Compliance
		PALs assessment appeared to be well summarized and, given the comments regarding the findings, meaningful in identifying needs (e.g., for Individual #275 and Individual #297). Indeed, an additional document summarizing the PALS was developed and appeared useful for Individual #191. Within other PSP reports, however, the PALs assessment did not appear to be well summarized or effectively utilized in determining areas for treatment or skill programming (e.g., Individual #95, Individual #186 and Individual #218). Curiously, dates listed in some PSPs did not match those listed on provided copies of recent PALS assessments (e.g., for Individual #7, Individual #27, Individual #191, and Individual #297). Overall, the majority of reviewed PSPs appeared to contain assessments that were completed within the last 12 months. There were, however, PSPs that listed assessments completed in excess of 12 months prior to the meeting date. For example, the PSP for Individual #186 listed several assessments (e.g., rights, functional living skills, self-administration of medication, Socially Responsible Behaviors classes) that were dated more than 12 months earlier. In addition, some assessments did not appear to be completed or available to the PSP team even though they appeared to be important. For example, the psychiatric and pharmacy assessments were missing for Individual #275 and Individual #297 who were receiving psychotropic medication. And, although dates were reported for other required assessments or the assessments appeared to be completed but not included in the PSP, the findings and related recommendations of assessments were not presented (e.g., ICAP assessments for Individual #20, Individual #172, and Individual #218). As presented earlier with regard to Section K.6 of the SA, it was curious that some assessments were completed just days following the annual meeting and, consequently, were not included in the PSP (e.g., ICAP report for Individual #95) According to recent verbal reports, a new narrative section within the PSP, called the Community Inclusion Assessment, had been developed and implemented (staring in March 2010) to supplement the identification and discussion of an individual's strengths, needs, and preferences in an effort to overcome barriers to community integration. The addition of this new assessment was outlined in the new Facility Community Activity Plan. Of the four PSPs completed since March (within the sample), this new section was found in two (50%) PSPs (for Individual #87 and Individual #95). These reports appeared to be an initial step toward identifying desired community involvement, as well as potential barriers limiting each individual's successful integration. As reported during the baseline review, a new PSP process was initiated in December 2009 and, at that time, many of the QMRPs did not have substantial opportunities to become familiar with the new format. Since that time, a new QMRP educator had been hired to facilitate more effective training.	

#	Summary of Provision	Assessment of Status	Compliance
		In addition, since the baseline review, a survey of CCSSLC staff was also completed to identify topic areas for further training. Staff were asked to identify training(s) that were of interest to them from a number of selections or indicate additional training ideas. According to provided documentation, 70 staff from a diversity of departments responded to the survey. Over half of those surveyed indicated support for trainings in the areas of Autism, skill acquisition programming , and PSP facilitation training. Subsequently, upcoming trainings, among others, for QMRPs as well as other PST members will target roles of PSP members and team leader/facilitation training for QMRPs. At this time, the format and process of these trainings (i.e., who will conduct the trainings, when they will be completed, etc) was unclear. A number of changes to the PSP process and format had occurred over the last year, and more changes were anticipated. A significant recent change, involving the revised role of the QMRP and the newly created active treatment program coordinators, will likely impact the PSP process, including the development, training, and monitoring of the skill acquisition programs. Indeed, the current roles of the QMRPs will likely change dramatically. According to verbal report from the Director of Day Programs and Active Treatment, a new CCSSLC PSP committee had been established to review PSP policy and format, including the specific roles of PST members, and potentially review subsequent PSPs to ensure consistency. This was an area that will need to be reviewed in further detail in future reviews. As identified during the initial baseline review, the vocational assessment formats did not adequately address individuals' strengths, needs and preferences. That is, the form appeared rather subjective and only offered a surface review of an individual's vocational history, preferences, and potential. Since the baseline review, a new vocational assessment entitled the CCSSLC Vocational Assessment had been developed. This revised rubric was a comprehensive eleven-page structured assessment that prompted respondents to answer items across a number of skill areas, as well as questions regarding personal preferences and individual characteristics. A supplemental assessment, called the Vocational Profile, prompted respondents to provide relevant information through a number of open-ended questions. At the time of the review, these assessments were being piloted. The results of the pilot will be reviewed in further detail at the next review.	
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		

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	programs of training, education, and skill acquisition to address each individual's needs. Such programs shall:		
	(a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and	As previously presented with regard to Sections K.5 and S.1 of the SA, skill acquisition programs, including SAOs and SPOs, appeared to target needs identified by assessments. However, it was not clear how these needs were identified as priorities given the numerous areas of need that often were identified in the assessments. As a result, it could not be determined if individuals prioritized needs were being met. As noted above as well, there were a number of problems noted with regard to the quality of the interventions developed, as well as the integrity and consistency of their implementation that negatively impacted the effectiveness of the interventions. At the baseline review, it was identified that skill acquisition programs (SAOs) were based on psychological assessments or behavioral services evaluations. Since December, a more comprehensive assessment format, the Structural and Functional Behavior Assessment, had been utilized. This appeared to have been an improvement because recent review of skill acquisition strategies within PBSPs indicated better identification of replacement behaviors than previously observed. As found during baseline visits, discussions with direct support professional and direct observation during on-site visits produced mixed results in estimating the degree of treatment integrity of skill acquisition plans. More specifically, some staff reported accurate information regarding skill training programs (i.e., correctly identifying target and replacement behaviors, and prescribed strategies to discourage or promote these responses). Other direct support professional, however, were unsure of identified targets or replacement behaviors or the strategies used in response to their occurrence (or lack of occurrence). Indeed, some direct support professional appeared very reluctant to answer questions or demonstrate skill acquisition programming without first consulting (or having at-hand) relevant documentation (e.g., PBSPs or SPOs). These observations suggested continued inconsistency across staff in the degree of knowledge regarding skill acquisition programming for individuals living at CCSSLC (for additional information, see Section K.11). As observed during baseline visits, little formal or incidental teaching was observed at the residential programs. Engagement in leisure or recreational activities, however, was frequently observed during site visits (see Section S.1 for more information). As identified during the previous baseline review and discussed above with regard to Section S.1 of the SA, specific evidenced-based teaching strategies, including task analysis, chaining procedures, differential reinforcement, sufficient opportunities to	Noncompliance

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		respond, operational definitions of target behaviors and/or error correction procedures were not typically found in skill acquisition programs. Although these continue to be areas of concern, progress was observed in the identification of behavioral objectives and data collection procedures. More specifically, behavioral objectives were identified in 100% of the skill acquisition programs reviewed. In addition, progress in graphing monthly data from SAOs and SPOs had been observed. That is, review of provided sampled documentation revealed that graphing of replacement behaviors associated with SAOs outlined in PBSPs was found in 93% of PSP Monthly Behavioral Services; while review of available documentation revealed graphing of SPO data in 67% of PSP Monthly reviews. Brief on-site reviews as well as off-site document reviews continued to reveal concerns with consistency of data collection, including regular monthly reviews. Based on these brief record reviews, missing data was observed for Individual #300 (i.e., SPO data for months of January and February, May and June), Individual #315 (i.e., weekly SPO data for tooth brushing and relaxation SPOs in July 2010), Individual 296 (i.e., missing 50% of weekly data for tooth brushing, shaving, and oral hygiene SPOs), and Individual #369 (i.e., missing July hand washing SPO data sheets for Individual #369). One relatively consistent finding was the lack of consistency in recording monthly totals, in year-to-date tables, on monthly SPO data sheets making ongoing performance monitoring difficult. With regard to the functionality of interventions and strategies in the community, concerns were noted with regard to some of the practices at CCSSLC. For example, low expectations were set with regard to individuals' participation in day/vocational programs. There appeared to be an emphasis on individuals' choice in the matter. While choice is a very important factor, this view is not consistent with the principle of normalization, or from the perspective of the training being provided to individuals that is functional in community settings. Just as children and adolescents are expected to attend school, adults are expected to engage in day and vocational activities, until they reach the age of retirement. As individuals now living at CCSSLC transition to community settings, this will be the expectation. An expectation should be set that adults of working age participate in full days of programming and/or vocational opportunities. Of course, this will need to be balanced with individual needs, but teams should look at this objectively. Modifying the current expectations will require a collaborative approach, including individuals' teams, psychology staff, and day/vocational staff. It will require continued efforts to ensure that meaningful day program and vocational opportunities are provided to individuals that incorporate their preferences and strengths.	
	(b) Include to the degree practicable training	At the time of the baseline review, it appeared that, according to discussions with QMRPs and direct support professionals, most individuals did not have opportunities to engage	

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	opportunities in community settings.	in skill acquisition programs in community settings. This finding corresponded with the lack of SAOs or SPOs, in sampled documentation, that were implemented within community settings. Since baseline, however, it appeared that progress had been made in promoting and supporting skill acquisition in community settings. Indeed, review of sampled documentation reflected a number of plans that identified community-based stores or other environments as settings for the completion of skill training programs. SPOs targeting purchasing (money management), for example, included special instructions for staff to encourage its completion either on campus or when in the community (e.g., Individual #172 and Individual #297). In addition, two similar SPOs for different individuals target making or indentifying correct change at the corner store or other community setting (e.g., money management SPOs for Individual #312 and Individual #246, respectively). This observed increase, based on sampled SPOs, reflected verbal reports by the Director of Day Programs and Active Treatment indicating that at least eight percent (8%) of all residents at CCSSLC had skill acquisition programs designed to be implemented in community settings. This estimate appeared roughly accurate according to provided documentation that listed 22 individuals who have skill acquisition programs specifically targeting implementation in community settings. The setting in which these skill acquisition program were designed to be implemented should be identified clearly. These improvements in the integration of skill programming into the community also potentially reflected the additional development of the Facility Community Action Plan (dated March 2010) that promoted the expectation that each individual residing at CCSSLC would have monthly learning opportunities in community settings, unless contraindicated by the PST. This plan outlined the use of community calendars by residential and day program staff, as well as the Community Inclusion Assessments that were being completed (since March 2010) as a component within each PSP. In addition to these efforts, the Socially Responsible Behaviors and Atlantic Life Skills classroom staff members were responsible for indentifying community settings that would accommodate skill acquisition plans. Taken together, these changes appeared to be supporting more integration of skill programming into community settings. Future reviews will need to closely examine summary data illustrating the nature (number of individuals, types of programs, specific community settings, etc.) of these opportunities and any related skill programming outcomes. At the time of the baseline review, it was determined that a limited number of individuals (approximately seven to twelve) held supported employment positions within community-based sites, including janitorial and lawn services for state and private business and residences. Based on verbal reports and summary data on individuals employed on and off campus (between 12/09 and 5/10), the number of individuals in	

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		community based supportive employment positions (nine) had not significantly changed. One of the primary challenges to community integration identified during the baseline visit was the limited availability of transportation. As more individuals have goals and objectives that require community participation, increasing numbers of vehicles (transportation) will be needed. Verbal reports indicated that CCSSLC had been able to purchase four additional vans that were expected to be available in September 2010. CCSSLC also appeared to be making progress in negotiating with the public transportation system in Corpus Christi to increase the availability of public transportation options to the individuals served. In the meantime, individuals should be taught the skills necessary to be successful in the community, including perhaps skills required to negotiate public transportation systems. Because the demand for additional transportation is likely to continue to outpace supply, staff members are encouraged to continue to consider other creative options to resolve this increasing need.	

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

1. The rationale for each skill acquisition program should be identified or highlighted within the actual program. This information should include which assessment(s) identified the specific need, as well as how individual's preferences were considered. In addition, this information should be conspicuously placed (perhaps at the top) of each skill plan/document.
2. As CCSSLC reviews and proceeds with anticipated changes to the PSP, including revisions to how skill acquisition programs are developed, implemented and monitored, the Facility should provide guidance to teams on the process to be used in prioritizing skill acquisition programs, and how individual preferences need to be addressed and incorporated, including ensuring that this process is conspicuous.
3. Within the PSP document, teams should describe how the PST identified (or ranked) which needs or recommendations would be addressed through skill acquisition programming. This should include providing a rationale for differentiating between those needs addressed through SPOs and SSOs, if these types of plans remain in effect.
4. If already not in place, a grid should be developed containing the last date of completed assessments (e.g., PALS, PFW, ICAP, etc.) typically utilized within the PSP process. Such a grid would facilitate efficient monitoring of required and/or optional assessments as well as help ensure their timely completion. In addition, this grid would support both internal (QE) and external (Monitoring teams) review of the PSP process.
5. Efforts should continue to provide intensive and on-going training on the development, implementation, and monitoring of skill acquisition plans to PSP members with these responsibilities. It is clear that the roles of various PSP members are likely to change and this training may, for example, be most beneficial for the Active Treatment Program Coordinators as well as Psychologists and Assistant Psychologists. Training should address writing operational definitions and behavioral goals, as well as evidenced-based teaching strategies, including task analysis, chaining procedures, error correction procedures, differential reinforcement, reinforcement strategies, and/or prompting hierarchies and fading.
6. Efforts to provide additional and requested trainings (e.g., QMRP facilitator training, evidenced-based treatment for individuals with Autism) to support professional development should continue.
7. Collaborative efforts across disciplines (e.g., psychology and active treatment services) should continue to ensure that each discipline's strengths are utilized to improve current supports and services. For example, as discussions continue with regard to revising skill acquisition programs, contributions from both psychology and day services will likely facilitate a better outcome.

8. Efforts to expand meaningful day and vocational programs should continue. The teams of individuals currently not attending a day or vocational program away from their residential unit should identify what the barriers are for participation in an off-unit program. Unless there is clinical justification for an individual remaining on the unit, individuals should attend off-unit day and vocational programs. This should include reexamining the potential barriers for individuals who were 'reluctant' to leave their residential programs.
9. For the 11 individuals at Coral Sea identified as not being able to participate in off-site day programming, the medical reasons prohibiting their involvement should be identified clearly and justification provided in their PSPs. Plans also should be developed to assist, as appropriate, individuals in overcoming such obstacles. PSTs should review such reasons and justifications regularly, as well as progress made in assisting individuals to overcome such obstacles.
10. If not already completed, consideration should be given to evaluating if all assessments are needed, or if the required assessments could be reduced to those that provide the most meaningful and useful information.
11. Graphing progress on skill acquisition programs should continue for all individuals. Generally accepted graphing conventions should be used (see recommendations in Section K).
12. The pilot of the new Vocational Assessments should continue, and consideration should be given to collecting, summarizing and reviewing feedback from individuals utilizing the assessment method.
13. The pilot should continue of the new 5-minute engagement assessment, and consideration should be given to collecting, summarizing and reviewing feedback from individuals utilizing this new assessment method.
14. Efforts should continue to utilize and revise the new skill acquisition format. Consideration should be given to collecting, summarizing and reviewing feedback from individuals utilizing the new format. Because Psychologists are likely to benefit from this review, perhaps scheduling reviews of programs at upcoming BSC meetings would be helpful to those who are developing, implementing, and monitoring their use.
15. Efforts should be made to ensure that overall goals of SPOs relate to the specific skills being taught.
16. Efforts should be made to integrate or completion skill acquisition programs in day program or vocational settings. It appeared that the majority of current skill acquisition programs are completed in residential programs.
17. Regular preference assessments should be conducted in an attempt to identify more individualized reinforcers.
18. An expectation should be set that adults of working age participate in full days of programming and/or vocational opportunities. Of course, this will need to be balanced with individual needs, but teams should look at this objectively. Modifying the current expectations will require a collaborative approach, including individuals' teams, psychology staff, and day/vocational staff. It will require continued efforts to ensure that meaningful day program and vocational opportunities are provided to individuals that incorporate their preferences and strengths.
19. Creative efforts should continue to increase the availability of transportation to facilitate individuals' participation in community skill acquisition programs, as well as community integration in general. Every effort should be made to ensure that such activities occur individually or with small groups of individuals and staff, and in a normalized fashion.
20. Efforts should be made to summarize community outing data. This should include the average number of outings per week (or month) for each individual and residence.
21. As increasing numbers of individuals begin to complete skill acquisition programs in the community, efforts should be made to conspicuously indicate on program documents where this program should be implemented.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o List of Individuals Assessed for Placement since 7/1/09; o List of Individuals Recommended by His/Her Team for Community Placement since 1/1/10; o List of Individuals Referred for Placement, dated 6/9/10; o List of Individuals who Have Requested Placement since 1/1/10; o List of Individuals with Discharge Planning between 1/1/10 and 6/1/10; o List of Individuals who have had Community Placements since 1/1/10, undated; o List of Individuals who Have Been Transferred pursuant to an Alternative Discharge since 1/1/10; o DADS Policy Number 018, entitled "Most Integrated Setting Practices", dated 10/30/09; o CCSSLC Policy, Section G.7, entitled "Community Referral", dated 3/16/09; o CCSSLC Policy, Section G.8, entitled "Community Placement, dated 3/16/09; o CCSSLC Policy, Section G.9, entitled "Discharge", dated 3/16/09; o Information related to Provider Fair held on 11/19/09; o CCSSLC Community Tour Activity since 1/1/10; o Community Living Options Information Process (CLOIP), undated; o Explanation of Mental Retardation Services and Supports, dated 4/08; o Making Informed Choices: Community Living Options Information Process, dated 4/08; o Making Informed Choices: Community Living Options Information Process for Legally Authorized Representatives of Residents in State Schools, dated 12/07; o List of Post-Move Monitor Responsibilities, undated; o List of Alleged Offenders Identified to Move to Mexia SSLC, not dated; o List of Post Placement Monitoring Dates, dated 6/2/10; o Last six months of auditing forms completed by the Admissions Placement Coordinator (APC) or QE Program Compliance auditors for Section T; o Blank Mental Retardation Authority (MRA) Continuity of Care: Pre-Move Site Review Instrument for the Community Living Discharge Plan, dated 12/09; o Exhibit C from DADS Policy #018.1: Living Options Discussion Record, dated 3/31/10; o Blank copy of Community Integration Discussion Record, dated 2/25/10; o Blank copy of Living Options Discussion Record, revised 2/25/10; o Completed Living Options Discussion Meeting Monitoring Checklist (11); o Materials used by State Office to provide training on Most Integrated Setting to CCSSLC staff; o PSPs, including related assessments for: Individual #11, Individual #365, Individual #88; o Community Living Discharge Plans (CLDPs), including individuals' most recent PSPs and related assessments for Individual #1, Individual #125, Individual #337, Individual #85,

	Individual#217, and Individual #29; o Post-Move Monitoring documentation for the following individuals: Individual #108, Individual #258, Individual #374, Individual #265, Individual #249, Individual #362, Individual #29, Individual #217, Individual #80, Individual #192, Individual #85, Individual #1, and Individual #125 ▪ **Interviews with**: o Dora Flores, Admissions/Placement Coordinator (APC); o Sandra Vera, Post-Move Monitor (PMM) ▪ **Observations of**: o Post-Move Monitoring visits for Individual #108, and Individual #1
	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Although the POI reviewed for CCSSLC did not include this component, the POI correctly identified that overall CCSSLC was currently not in substantial compliance with the requirements of Section T of the SA. The POI indicated compliance with some of the indicators within this section, including: ▪ The indicators related to CLDPs being developed in timely manner, and including the necessary components. However, as is illustrated below, many CLDPs were being developed within a couple of weeks of an individual's discharge, making adequate planning and implementation difficult. In addition, protections, supports and services were not yet being defined adequately in CLDPs. ▪ The indicators related to comprehensive assessments being completed/updated within 45 days of individuals' transitions. Again, the Monitoring Team did not find consistent documentation of this. Based on interviews with staff and review of documents, CCSSLC had begun to pilot a tool(s) to measure compliance with Section T. As is described in further detail below with regard to Section T.1 of the SA, the QE Department was working with the Admissions Placement Coordinator to modify the tools used by the Monitoring Team to be more useful to the Facility.
	Summary of Monitor's Assessment: Individuals' PSPs continued to not consistently identify all of the protections, services and supports that need to be provided to ensure safety and the provision of adequate habilitation. It is essential as teams plan for individuals to move to community settings that PSPs provide a comprehensive description of individuals' preferences and strengths as well as their needs for protections, supports and services. The Facility continued to be at the initial stages of identifying obstacles to movement to the most integrated setting appropriate to the individual's needs and preferences, as well as strategies to overcome such obstacles. With regard to the timeliness of the Community Living Discharge Plans (CLDPs), it appeared that the last couple that were developed prior to the Monitoring Team's review were developed in a more timely manner. The CLDPs reviewed included a number of action steps related to the transition of the individuals to the community. However, many of them did not clearly identify the specific steps that the Facility would

	take to ensure a smooth and safe transition, and were not sufficiently detailed or measurable. The CLDPs reviewed included essential and non-essential supports. However, it appeared that the Facility continued to be at the beginning stages of refining this process. Teams did not consistently identify all the essential supports that the individual needed to transition safely to the community, nor did teams adequately define the essential supports in measurable ways. Post-move monitoring had been completed in a timely manner for most of the individuals who had transitioned to the community. With regard to the content of the checklists, the checklists all utilized the format attached to the SA as Appendix C. Each of the items on the checklists had been addressed. It would be helpful, however, if additional information was provided with regard to the methodology used to conduct the reviews and the information gathered with regard to each indicator. The post-move monitoring identified some issues with regard to the provision of services at the community sites, and these items appeared to be addressed appropriately with provider agencies.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of the State, the resources available	As reported in the baseline report, on 10/30/09, DADS issued a policy entitled "Most Integrated Setting Practices." This State policy accurately reflects the provisions contained in Section T of the Settlement Agreement. The policy's stated purpose is to "prescribe procedures for encouraging and assisting individuals to move to the most integrated setting in accordance with the Americans with Disabilities Act and the Untied States Supreme Court's decision in Olmstead v. L.C.; identification of needed supports and services to ensure successful transition in the new living environment; identification of obstacles for movement to a more integrated setting; and, post-move monitoring." The policy includes components to ensure that any move of an individual to the most integrated setting is 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, and that the transfer is consistent with the individual's PSP. During future reviews, the Monitoring Team will continue to evaluate the State and the Facility's implementation of this policy. With regard to the availability for funding for community transition of individuals from CCSSLC, funding availability was not cited as a barrier to individuals moving to the community. No one appeared to be on a waiting list, and transitions were occurring at a reasonable pace. In fact, the State's expectation was that once a referral was made, the transition to the community should occur within 180 days. Permission needed to be sought for any transitions that were anticipated to take longer than the 180-day	Noncompliance

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	to the State, and the needs of others with developmental disabilities.	timeframe. At the time of the review, individuals' PSPs did not include determinations by professionals with regard to whether community placement was appropriate. Although Community Living Options Discussion Records included a statement of the team consensus, the professionals on the team did not consistently make specific recommendations. For example: ▪ The team did not make any independent recommendation in the case of Individual #355. Although Individual #355 who was her own guardian indicated interest in a group home, her grandmother wanted her to remain at a SSLC. The team concluded without any specific discussion of its concerns that the "most appropriate living option" was CCSSLC. ▪ Individual #88's team concluded in the Living Options Discussion Record that CCSSLC was the "most appropriate living option at the current time. Individual #88's guardian was opposed to community placement, and the team listed concerns about behavior including physical aggression, programmatic refusal, SID, and spurious allegation. It was unclear, though, if the professionals on the team believed Individual #88 was appropriate for community placement, and if not, what specific supports were available at CCSSLC that were not available in a more integrated setting in the community. The professional teams supporting individuals at CCSSLC should independently make recommendations regarding individuals' appropriateness for transition to the most integrated setting, appropriate to meet their needs. Such recommendations should be presented to the entire team, including the individual and LAR, for consideration. Based on team discussion, including any opposition from the individual or his/her LAR, the entire team then should make a decision regarding any potential referral for community transition.	
T1b	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall review, revise, or develop, and implement policies, procedures, and practices related to transition and discharge processes. Such policies, procedures, and practices shall require that:	Based on interview and review of documentation, CCSSLC had not modified any of its policies with regard to transition of individuals to the most integrated setting appropriate to their needs. During the baseline review, CCSSLC provided a copy of the DADS policy on Most Integrated Setting Practices, and indicated that CCSSLC was adopting the DADS policy as the Facility policy. However, at the time of the July 2010 review, the CCSSLC Policy Manual had not yet been updated to reflect this. The Facility policy manual contained a number of policies related to the community placement process. Specifically, the Facility Policy Manual included policies on: 1) Community Referral; 2) Community Placement; and 3) Discharge. Although these policies provided some valuable guidance with regard to the community placement and discharge processes, they did not address all of the provisions of the SA. Some of the items that were missing, included:	

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		▪ The PST's role in the identification of obstacles to the individual's movement to the community, and an action plan to overcome such obstacles; ▪ Provision of education to individuals and their LARs to assist them in making informed choices; ▪ A detailed description of the Community Living Discharge Plan development process; ▪ A description of the post-move monitoring process; and ▪ A description of the discharge process to be used for individuals for whom alternate discharges are implemented.	
	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.	As was discussed in the baseline report, and is discussed in a number of places throughout this report, individuals' PSPs do not consistently identify all of the protections, services and supports that need to be provided to ensure safety and the provision of adequate habilitation. Some of these issues relate to thorough and adequate assessments not being completed (e.g., nursing, psychiatry, physical and nutritional management, and communication), services and supports not being adequately integrated with one another (e.g., psychology and psychiatry, psychology and dental/medical, and occupational and physical therapy), and/or adequate plans not being developed to address individuals' preferences, strengths and needs (e.g., nursing, psychiatry, psychology and habilitation, physical and nutritional supports, and communication). It is essential as teams plan for individuals to move to community settings that PSPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports and services. This is important for two reasons, including: 1) as individuals and their guardians are considering different options in the community, it is important for them as well as potential providers to have a clear idea about what protections, supports and services the individual needs to ensure that perspective provider agencies are able to support the individual appropriately; and 2) as the process progresses, the PSP will be the key document that is used to ensure that essential supports are identified and in place prior to an individual's move. If all of the necessary protections, supports and services are not outlined in the PSP, it will be much more difficult to ensure the individual's safe transition. As noted above with regard to Section F of the SA, the PSP format was undergoing additional changes that were expected to address a number of issues, including the identification of obstacles to transition to the community, and the development of strategies to overcome them. Facility staff recognized that this was an area that continued to need improvement. Since the baseline review, a new tool called the Community Integration Discussion	Noncompliance

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		Record had been implemented at CCSSLC. The tool provided a format on which teams were asked to list of number of items related to areas such as community functional living skills, community employment, and community leisure. In each of these areas, teams were asked to identify individuals' preferences, strengths/skills, and needs, as well as the barriers and obstacles to community transition. This was being completed in addition to the Living Options Discussion Record. Although this form would appear be a helpful tool for teams, review of individuals' PSPs did not consistently find that use of the tool resulted clearly identified obstacles or strategies to overcome them. For example: ▪ For Individual #11, his team described his employment as shredding paper, and indicated that he worked better in a small, quiet area. His needs were "A job coach who will be patient with [Individual #11] and will engage him in his job." Barriers were listed as "Currently, [Individual #11] is living at CCSSLC." This did not describe supports that needed to be found, or were unavailable in the community. ▪ Individual #355's Community Integration Discussion Record indicated that she would prefer to live in a group home. It appeared from documentation she was her own guardian, and her grandmother was very involved in her life. One barrier that was listed was: "Currently [Individual #355] has some issues with anger that may hinder her out in the community." This did not describe a support that needed to be found or was unavailable, for example, adequate behavioral supports or psychiatric supports. Another barrier that was listed was: "Grandmother would rather have her placed as SACCLC [San Angelo SSLC] rather than out in the community." The team identified as the supports needed to overcome barriers: "To bring grandmother into consensus if and when PST feels [Individual #355] would be successful in transitioning to the community." The team provided no specific reasons for not believing she would be able to successfully transition, and no plan was developed to address any actual barriers. ▪ The Community Integration Discussion Record for Individual #9 identified as barriers and obstacles that he was "non-verbal," "blind," and "requires 1:1 staff." It was unclear why his team viewed these as barriers, because many people who do not communicate verbally, are blind, and/or require one-to-one staffing live successfully in the community. Another obstacle that was listed was transportation due to trouble getting him into a van. However, his team had not concretely defined the type of van or type of assistance that would need to be identified for him to successfully transition. The supports needed to overcome the barriers were listed as: "Staff that is familiar with [Individual #9] and his communication. No plan for identifying such supports was provided.	
	2. The Facility shall ensure the provision of adequate	As reported after the baseline review, CCSSLC has engaged in a number of activities to provide education about community placements to individuals and their families or	Noncompliance

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	education about available community placements to individuals and their families or guardians to enable them to make informed choices.	guardians to enable them to make informed decisions. This has taken a number of forms, including: ▪ On November 19, 2009, a provider fair was held. It appeared from the sign-in sheets that it was well-attended by providers, individuals, their families, and Facility staff. According to the Admissions/Placement Coordinator (APC), approximately 25 providers were in attendance. These providers offer services in a variety of counties. ▪ Visits to community group homes and day programs continued to occur, and were open to individuals, families/guardians, or staff who want to attend. Such visits offered individuals and their families the opportunity to obtain first-hand knowledge of what community supports are available, to meet provider staff, and potentially other people with whom they could have the opportunity to live or work. ▪ Individuals and their guardians also were provided information through the Mental Retardation Authority (MRA) Community Living Options Information Plan (CLOIP) process. This occurred regularly as part of the individual planning process. In addition, it was reported that the MRAs also had met with PST members in meetings designed specifically to provide information about services and supports that are available in the community. ▪ CCSSLC is fortunate to have a number of staff, including the Admissions/Placement Coordinator and Post-Move Monitor who had experience working in the community system. This allowed the APC, for example, to assist in answering questions about the community that individuals, families/LARs, or other staff may have. Efforts were being made to ensure that Facility staff had current knowledge of supports and services that were available in the community. For example, within three (3) months of any new staff member starting work at CCSSLC, they were required to go visit a group home and day program in the community. The most challenging area with regard to education of individuals and families is individualizing this process, and documenting that individuals and their guardians are making informed decisions. The Living Options Discussion Records reviewed did some of this, but they tended to make general statements about review of information from the MRA. This process will be facilitated as teams begin to better define obstacles to movement, and begin to talk in greater depth about the options available in community settings to meet individuals' specific needs in comparison with services and supports available at the Facility. The Facility is encouraged to continue offering a variety of educational options to individuals and families, and to expand these options to creatively meet the needs of various individuals and guardians. During the baseline review, the Monitor briefly	

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		discussed with the Admissions/Placement Coordinator activities that have been successful in other jurisdictions. For example, as individuals successfully transition to community settings, with their and their guardians' permission, newsletter articles could highlight such success stories. At times, it might be helpful to match individuals and/or guardians who have gone through the process with individuals and/or guardians who are considering a placement referral. This allows someone with first-hand knowledge about the process, including the challenges as well as the successes to share information and provide support.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	The SA anticipated that the Facility would require 18 months to complete this activity. However, to assess the Facility's progress, the Monitoring Team requested as part of its document request a list of individuals who had been assessed for placement since July 1, 2009, pursuant to the new or revised policies, procedures, and practices related to transition and discharge practices. The list provided appeared to be a list of all individuals who had had an annual staffing meeting since 1/1/09. As is discussed above with regard to Section T.1.a of the SA, the individuals' PSPs that were reviewed do not document an independent assessment by the professionals on the team of the individuals' appropriateness for transition to the most integrated setting appropriate to meet their needs. The Facility's POI documented that compliance had not been attained for this requirement, and indicated that the CCSSLC policy would be reflective of State Office policy, and that training of staff was going to be completed.	Noncompliance
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the individual is accepted for, and the individual or LAR agrees to service in, that setting, then the IDT, in coordination with the Mental Retardation Authority ("MRA"), shall develop and implement a community living discharge plan in a timely manner. Such a plan shall:	Community Living Discharge Plans were reviewed for six (6) individuals. This sample was drawn from the list of 13 individuals whom the Facility identified as having had a CLDP developed since January 1, 2010. With regard to the timeliness of the Community Living Discharge Plans, it appeared that many were developed only a few weeks prior to the individual's discharge, making adequate transition planning difficult. The only one that was developed approximately six weeks prior to her transition was for Individual #1. Others were much shorter periods of time. For example: ▪ It appeared that the CLDP was developed for Individual #85 less than 10 days before he moved. The CLDP was developed on 4/7/10, and he moved on 4/26/10. ▪ Individual #125's CLDP was developed on 5/17/10, and he transitioned on 6/1/10. The Monitoring Panel will discuss the expected criteria for timeliness of CLDPs further,	Noncompliance

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		and would like to discuss this with the State and DOJ in further detail. However, briefly, ensuring adequate transition planning will require looking at the entire transition process from start to finish. Part of the problem at this time is that teams are only beginning to define important and critical supports and services (called essential and nonessential supports in the CLDP process) at the time the CLDP is developed. If this process started earlier, specifically when the PSP is developed (especially for those individuals who are referred during the annual PSP), then the CLDP would flow from the essential and non-essential supports that already had been identified. Although some Living Options Discussion Records have included a reiteration of supports needed by individuals once they move, these have not been comprehensive and often consist of a listing of the supports being provided at the SSLC. PSTs should be discussing the configuration of supports and services that the individual needs no matter where those services and supports are provided. The Living Option Discussion records could identify if there are additional things that need to be in place for community living, or specific items that are "givens" at the Facility, such as a fenced in yard, but teams should not be reiterating supports and services that are already identified in an individuals' PSPs. Generally, individuals' needs do not change drastically, and the supports and services that are provided at the Facility also need to be provided in the community. However, there needs to be time to figure out how such supports and services will be provided when the individual moves, who will be responsible, etc. This is what the CLDP should lay out, in addition to specific transition activities to ensure the individual is comfortable with moving, staff are trained, etc. At this point, because the teams are starting over with a blank slate, two weeks is clearly inadequate. Even if the PSPs provided better direction, two weeks would be inadequate. Generally, transition planning should start at least at the point of referral. This would allow for transition activities such as visits to providers and the supports needed with that process to be defined, and the individualization with regard to numbers of visits to potential providers, training to be defined of provider staff, regardless of who the provider is, etc. to be defined and implemented. Finally, starting over in the CLDP process in terms of defining needed supports also means that supports and services that individuals need are being missed or not adequately defined.	
	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.	The Community Living Discharge Plans reviewed included a number of action steps related to the transition of the individuals to the community. However, many of them did not clearly identify the specific steps that the Facility would take to ensure a smooth and safe transition, and were not sufficiently detailed or measurable. As is described in further detail in the section of this report that addresses Section T.1.e of the SA, the CLDPs also did not consistently identify the essential supports required by the individuals. The following provide examples of some of the concerns noted with regard to the CLDPs reviewed with respect to defining the role of the Facility staff in the transition process:	Noncompliance

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		▪ Individual #29's PSP and CLDP described past behavior in the community that had resulted in his placement at CCSSLC. However, his CLDP did not describe the process through which Facility staff would share their knowledge about him and his PBSP to community staff who would become responsible for his treatment. For example, no action steps were identified with regard to community staff shadowing CCSSLC staff at the Facility, Facility staff providing competency-based training to the community staff, or Facility Psychology staff sharing information with the new psychologist responsible for taking over his treatment in the community. ▪ The narrative portions of Individual #85's CLDP clearly outline a number of behavioral issues that had the potential of placing him and others at risk. However, the essential support section of his plan did not set forth a plan detailing how his behavior supports would be seamlessly transitioned to a community provider. More specifically, the roles of CCSSLC's psychology, psychiatry, and direct support professional staff were not defined in terms of sharing information, and/or providing competency-based training or technical assistance to the community provider staff. There was mention of in-service training, but it was not clear what this would entail, making it difficult to measure.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	Based on the sample reviewed, Teams generally identified target dates for the completion of actions steps included in CLDPs. However, teams did not consistently identify the specific person(s) responsible for action steps included in CLDPs for which Facility staff or others were responsible. Terms used to identify responsibility frequently were "HCS [Home and Community-Based Services] provider" or "CCSSLC PST." These were not sufficient to identify the specific staff responsible.	Noncompliance
	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.	Based on review of six CLDPs, four of the six (67%) included documentation that the plans had been reviewed with the individual and/or the LAR. For the plans for Individual #217 and Individual #1, it did not appear that they were in attendance at the meeting, and it was not clear why.	Noncompliance
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	It is unclear what process is in place to ensure that written updates to assessments are completed within 45 days prior to the individual's leaving the Facility. As is illustrated below, although it appeared assessments were reviewed, documentation could not be found that any changes were memorialized in writing, or if there were no changes that this was committed to writing by each staff person responsible for the particular assessment. The following are examples:	Noncompliance

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	individual's leaving.	▪ Individual #29 transitioned to the community on 3/11/10. It appeared from the documentation provided that the most recent assessments were from his PSP meeting that was held in July 2009. ▪ Individual #217's CLDP documented many assessments that were months old. For example, Individual #217 had a number of physical and nutritional support needs. However, when she was discharged on 3/22/10, her most recent OT/PT update was dated 11/9/09. A process should be considered, particularly with regard to the transition of medical and other clinical information, for a summary to be developed, including but not limited to the individual's current status, any outstanding issues (e.g., tests due, issues for which resolution has not been reached), as well as any critical information about the individual's treatment (e.g., allergies, past history of medication use, etc.). This would facilitate the transition of this information to community medical care providers.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	The CLDPs reviewed included essential and non-essential supports. However, as reported after the baseline review, it appeared that the Facility was at the beginning stages of refining this process. Teams did not consistently identify all the essential supports that the individual needed to transition safely to the community, nor did teams adequately define the essential supports in measurable ways. Moreover, the plans did not consistently identify preferences of the individuals that might affect the success of the transition. This makes it difficult for thorough and meaningful monitoring to occur prior to and after the individual's transfer to the community. Likewise, teams did not consistently identify non-essential supports or do so in measurable ways. The following provide examples of issues identified with regard to the identification of measurable essential and non-essential supports: ▪ Individual #29 had a history of assaultive behavior that resulted in charges being filed, but dropped because it was determined he was incompetent to stand trial. This precipitated his admission to CCSSLC a few years ago. While at CCSSLC, he had a PBSP that addressed aggression and inappropriate social behavior. He also was prescribed psychotropic medication. Neither psychological supports nor psychiatric care were specifically identified as essential supports in his CLDP. His PBSP was mentioned in the essential support system in a list of items on which staff needed to be provided in-service training. The in-service training was not defined in a measurable way. For example, there was no indication as to whether staff would need to demonstrate competence in the implementation of the plan. Given his past history, this would appear to be an essential component of his CLDP. Although the plan stated that work was important to him, day services were listed as non-essential supports that did not have to be in place at the time of his transition. ▪ Individual #217 had a PNMP, including a dining plan, and used a number of	Noncompliance

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		pieces of adaptive equipment. Although there was mention in her 2/23/10 CLDP of the need for the adaptive equipment, there was no mention of her PNMP, or the need for her to have follow-up by therapists, such as a Registered Dietician, OT, or PT. ▪ As noted previously, Individual #85's CLDP in the narrative section identified the need for adherence to a PBSP as well as safety measures. Emphasis was placed on the need for these supports due to behaviors that potentially could place him and others at risk of harm. It would be assumed that this PBSP would need to be carefully monitored by staff with expertise in the provision of behavior supports to individuals with developmental disabilities. However, no such monitoring or follow-up was required as an essential support, not were the qualifications of anyone providing such supports defined. It would be important for such a support to be defined as "essential" to ensure that adequate transition could occur between the community psychologist and CCSSLC staff, and for such services to be in place prior to Individual #85's transition back to the community. ▪ Similarly, Individual #337 transitioned to a foster care situation with his mother with support from an agency. Although in-service training on the PSP and PBSP by the "CCSSLC PST" was listed under essential supports, no definition was provided of who would specifically conduct the training, who would be trained, or of what the training would consist (e.g., competency-based training, training on-site in his new setting or at the Facility, etc.). In addition, the psychological supports to be provided to Individual #337 were not defined at all in his CLDP. There did not appear to be a plan to ensure that there was oversight of the PBSP. Unfortunately, within weeks of his transition to the community, Individual #337 engaged in behavior that resulted in harm to member of his family, and charges had been pressed against him. The allegation was that he cut his mother with a knife. His PBSP at CCSSLC included aggression as a target behavior, and aggression had been a behavior that he had exhibited while in the community prior to his admission to CCSSLC. Therefore, even though he was transitioned to a family home, his CLDP should have included clear action steps to ensure that his PBSP continued to be implemented, and that there was adequate oversight of the PBSP by the community agency that was supporting the foster care program. ▪ Individual #1's CLDP provided more detail with regard to supports that needed to be in place, such as the need for one-to-one supervision for certain activities, monitoring for pica, the provision of a specialized diet, and specific medical activities. This type of detail was helpful in ensuring she had the supports she needed. This CLDP needed to be enhanced by further defining other services, for example, further defining the day supports Individual #1 should be provided, stating in measurable terms the oversight that was necessary for her PNMP, defining in measurable terms the type of training that needed to occur to ensure	

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		staff were competent in the delivery of her supports and services. With regard to Monitoring by the MRA or other means to ensure essential supports are in place prior to an individual's transition, this appeared from the records reviewed to be a general safety assessment as opposed to an individualized assessment based on the essential supports identified by the team. The only assurances that the MRA staff completing the "Pre-Move Site Review Instrument for the Community Living Discharge Plan" had that the essential supports were in place appeared to be based on a "meeting with the site administrator/manager." The form included two related questions, including: 1) "Did the site administrator/manager have a copy of the consumer's draft Community Living Discharge Plan and know the outcomes important to the consumer or legally authorized representative"; and 2) "Did the site administrator/manager verify services and supports could be provided that are necessary to assist the consumer in achieving the outcomes?" (Emphasis added.) Responses to these questions do not represent adequate proof that the essential services required by the CLDPs are in place. None of these forms for the sample reviewed provided any additional documentation to show that the MRA representatives had actually confirmed that the individualized essential supports were in place.	
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.	Facility staff reported honestly that they were still in the process of developing quality assurance processes to ensure that community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible. They had begun to pilot use of the forms developed by the Monitoring Teams, but were still in the initial stages of this. Both the Admissions Placement Coordinator and QE Program Compliance auditor had completed some, and were comparing results to ensure inter-rater reliability. The QE Department also was working with the APC to modify the tools used by the Monitoring Teams.	Noncompliance
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	Based on interview, the Facility had not yet been entering data with regard to obstacles into a database to allow it to be aggregated. As noted above, the obstacles that teams were identifying were not yet adequately defined.	Noncompliance

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	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.		
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services	In response to the Monitoring Team's request for the Community Placement Report, the Facility provided a copy of the "Current Referrals for Community Placement." This does not meet the requirements included in the provision of the SA, which requires a list of both those placed, as well as those referred with a description of the services they require.	Noncompliance

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	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.		
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	Timeliness of the Checklists Post-move monitoring documentation was provided for 14 individuals. One individual was not monitored due to his incarceration. For the remaining 13 individuals, 34 reviews should have been completed. Of the 34 required visits, 29 (85%) had been documented as having been completed on time; one was not dated (3%); and the remaining four (12%) were late or not provided. In addition, based on the documentation, it could not be determined if visits had been made to both the residential and day sites of the individuals. A number of notes indicated that an interview occurred at the day program with the individual. In order to adequately ensure that all essential and non-essential supports are in place, visits should be conducted in whatever settings protections, supports and services are being provided. Content of Checklists: With regard to the content of the checklists, the checklists all utilized the format attached to the SA as Appendix C. Each of the items on the checklists completed had been addressed. It would be helpful, however, if additional information was provided with regard to the methodology used to conduct the reviews and the information gathered with regard to each indicator. For example, it was unclear from the monitoring checklists if onsite visits were conducted, which documents were reviewed, and if staff and/or the individuals were interviewed. Other than a "yes" or "no" response, no additional information was provided to substantiate that essential and non-essential supports were in place. The primary reasons for conducting post-move monitoring are to identify if all protections, supports or services that the individual requires are in place, and, if any issues are identified, to take action to correct them. Generally, it appeared that issues were being identified, and followed through to conclusion. Notes identifying actions taken were documented on the forms.	Noncompliance

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T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	During the week of the on-site review, a member of the Monitoring Team accompanied the Post-Move Monitor and the APC on two post-move monitoring visits for Individual #1, and Individual #108. The Post-Move Monitor followed the format, asked many good questions, reviewed documentation, and conducted observations. As noted above, it will be important for these activities to be thoroughly documented on the monitoring forms. Some items that should have been confirmed through direct observation were not. For example: ▪ Individual #1 was supposed to have a ground diet, as well as one-to-one supervision when she was walking, eating, and showering, and she needed a number of pieces of adaptive equipment. Although questions were asked regarding many of these items, it was not clear that checks to ensure that all of these were implemented or in place. For example, although a snack was served during the review, it would have been beneficial for the review to occur during a mealtime to ensure that the diet plan was followed, and all the proper adaptive equipment was used and was in good working order. When the PMM identified concerns with regard to the delivery of services as outlined in the CLDP, she addressed these appropriately with the provider. For example: ▪ Individual #108 had not been receiving counseling services or Narcotics Anonymous support. The PMM brought this to the attention of the provider agency, and even when she met with resistance, explained the importance of it in a way that resulted in the provider agreeing to pursue it. As is discussed above with regard to Section T.1.e, one of the reasons that the clear and complete identification of essential and non-essential supports is of utmost importance, is to facilitate the post-move monitoring process. Without clear definition of the supports and services needed, monitoring to ensure the individual has what he or she needs is difficult: For example: ▪ This was illustrated with regard to Individual #108. He clearly stated to the Post-Move Monitor that he was bored at his day program, and that it was too loud. His CLDP provided very little detail regarding the expectations for him for work or day activities. Specifically, it stated: "Job training through the local ISD, Day hab programming when school is not in session." Without further definition, the PMM could only recommend that the provider seek other alternatives for him.	Noncompliance

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T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based	CCSSLC had not had any alternate discharges since January 1, 2010. Although CCSSLC submitted the names of two individuals, these individuals did not meet the criteria for this requirement, because both were transitioned to other State Supported Living Centers.	Not Rated

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	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.		

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

1. The professional teams supporting individuals at CCSSLC should independently make recommendations regarding individuals' appropriateness for transition to the most integrated setting, appropriate to meet their needs. Such recommendations should be presented to the entire team, including the individual and LAR, for consideration. Based on team discussion, including any opposition from the individual or his/her LAR, the entire team then should make a decision regarding any potential referral for community transition.
2. CCSSLC should modify its Facility-level policy and procedure manual to reflect the DADS policy on Most Integrated Setting Practices. Consideration should be given to customizing the policy to ensure its usefulness to Facility staff. For example, the current Facility policies provide lists of items that should be sent with the person on the date of discharge as well as records that should be transferred. This is valuable information that the Facility may want to consider continuing to use as it revises its policies to be consistent with the DADS policy.
3. The Facility is encouraged to continue to offer a variety of educational opportunities with regard to community options to ensure that individuals and their guardians make informed decisions regarding movement to the community. CCSSLC also should continue to add creative and individualized educational activities to meet the needs of various individuals and families/guardians. Consideration should be given to developing a written plan that identifies the actions that will be taken, persons responsible and timeframes for completion.
4. As teams begin to better define obstacles to movement, and begin to talk in greater depth about the options available in community settings to meet individuals' specific needs in comparison with services and supports available at the Facility, this discussion should be memorialized in the Living Options Discussion Records to document that individuals and their families are making informed decisions with regard to an individuals' living options.
5. Consideration should be given to beginning the process of developing the CLDP much sooner in the process to ensure that a comprehensive plan is developed, and that there is time to implement an adequate transition process.
6. Essential and non-essential supports need to be better defined in Community Living Discharge Plans. Likewise, the role of the Facility staff in the transition and discharge process needs to be better defined.
7. If the MRAs are going to continue to be responsible for ensuring that essential supports are in place before the individual departs from the Facility, then the process for confirming this needs to be substantially improved. As required by the Settlement Agreement, the State needs to ensure that supports considered to be essential to the individual's health and safety are verified as being present. This will require more than conversations with staff, but will entail onsite monitoring, review of documentation, observations, as well as interview. Documentation should include verification of each and every essential support identified in the CLDP, as well as the methodology used to verify their existence.
8. A process should be considered, particularly with regard to the transition of medical and other clinical information, for a summary to be developed, including but not limited to the individual's current status, any outstanding issues (e.g., tests due, issues for which resolution has not been reached), as well as any critical information about the individual's treatment (e.g., allergies, past history of medication use, etc.). This would facilitate the transition of this information to community medical care providers.
9. Clear expectations should be established with regard to the frequency and types of visits that need to be completed, the process that needs to

be used for monitoring, and the documentation that needs to be maintained.

10. In order to adequately ensure that all essential and non-essential supports are in place, visits should be conducted in whatever settings protections, supports and services are being provided.
11. Post-Move Monitoring Checklists should include: 1) a description of the monitoring methodology (e.g., documents reviewed, people interviewed, observations made); and 2) information to substantiate conclusions that essential and non-essential supports are in place and/or steps being taken by the provider agency to ensure that such supports and services are provided.
12. The action plans that are part of Post-Move Monitoring checklists should be more focused on resolving the issues identified.
13. Staff responsible for the completion of post-move monitoring activities should complete competency based training on the completion of monitoring reviews, including the methodology, proper documentation, and the development and implementation of action plans to address issues identified.

SECTION U: Consent	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o List of Individuals without Legally Authorized Representative, dated 6/22/10; o List of Individuals' Legal Status; o CCSSLC Policy #C.7: Obtaining Guardian Consent Prior to Non Routine Medical Appointments, dated 10/31/08; o CCSSLC Policy C.9: Obtaining Consent for Medication for Behavior Management, dated 1/21/09; o Texas Guardianship Statute - Probate Code, Chapter XIII. Guardianship, Sections 601 through 700; o Texas Health and Safety Code, Title 7. Mental Health and Mental Retardation, Subtitle D. Persons with Mental Retardation Act, Chapter 591. General Provisions, Subchapter A. General Provisions, Section 591.006. Consent; o Texas Health and Safety Code, Title 7. Mental Health and Mental Retardation, Subtitle B. State Facilities, Chapter 551. General Provisions, Subchapter C. Powers and Duties Relating to Patient Care, Section 551.041. Medical and Dental Care; and o Texas Health and Safety Code, Title 7. Mental Health and Mental Retardation, Subtitle D. Persons with Mental Retardation Act, Chapter 592. Rights of Persons with Mental Retardation, Subchapter A. General Provisions, Section 592.054. Duties of Superintendent or Director ▪ **Interviews with**: o Daniel Dickson, Quality Enhancement Director
	Facility Self-Assessment: The Facility's POI recognized that it was not in compliance with the requirements of Section U of the Settlement Agreement. This was also reflective of interviews with staff, and was consistent with the Monitoring Team's findings.
	Summary of Monitor's Assessment: Although CCSSLC had identified a list of 215 individuals who did not have the support of guardians, Facility staff recognized that this was an area in which they needed to make additional efforts. Staff also indicated that DADS Central Office was still in the process of developing a policy on guardianship and consent that was expected to provide guidance to the Facilities with regard to the implementation of this SA requirement. Some of the concerns related to the current process included the following: 1) the process that teams were using to determine an individual's ability to provide informed consent was vague and did not appear to be based on specific assessment tools; and 2) identification of concerns related to an individual's ability to make informed decisions did not result consistently in recommendations for either supports and services to increase the individual's decision-making capacity or to pursue guardianship.

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U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with 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.	As reported after the baseline review, although Corpus Christi SSLC had some of the preliminary processes in place to identify the need for individuals to pursue the guardianship process, the Facility had not met the requirements of this provision of the Settlement Agreement. Facility staff continued to recognize this as an area in which they need to make additional efforts. Staff also indicated that DADS Central Office was still in the process of developing a policy on guardianship and consent that is expected to provide guidance to the Facilities with regard to the implementation of this SA requirement. Specifically, CCSSLC provided the Monitoring Team with a list of individuals who did not currently have LARs. This list included the names of all of the individuals without a LAR. There were 215 names on the list, representing approximately 73% of the individuals served by CCSSLC. Staff explained, however, that they had not yet begun to prioritize a list of individuals who lack both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision, as required by the SA. As part of the annual individualized planning process, individual teams at CCSSLC were identifying whether an individual had a Legally Authorized Representative or not. It appeared that individual teams reviewed the Rights Assessment that is completed prior to each individual's annual Personal Support Plan meeting, and made some basic determinations regarding whether an individual was able to make informed decisions, and/or if supports were necessary to ensure that the individual's rights were maintained with respect to decision-making. As noted with the baseline review, some of the concerns related to the current process include the following: 1) the process that teams were using to determine an individual's ability to provide informed consent was vague and did not appear to be based on specific assessment tools; and 2) identification of concerns related to an individual's ability to make informed decisions did not result consistently in recommendations for either supports and services to increase the individual's decision-making capacity or to pursue guardianship. Each of these concerns is discussed in further detail below: <u>Process Used to Determine Individuals' Capacity to Make Informed Decisions:</u> Section J of the "Rights Assessment" discussed the ability of the individual to give or withdraw informed consent. For each individual, "[b]ased on assessments and the annual review process, the PST [determines] that he/she in **unable** to give informed consent in the areas noted below." Areas that may be identified by the team include medical, programmatic, financial, restrictive/intrusive practices, media/photo, and release of	Noncompliance

#	Provision	Assessment of Status	Compliance
		records. It is unclear which formal assessments, if any, teams utilize to reach conclusions regarding individuals' ability to provide informed consent in the various areas identified in the "Rights Assessment" document. <u>Recommendations to Increase Decision-Making Capacity or Pursue Guardianship</u>: Even when teams identified concerns with regard to an individual's ability to provide informed consent, there did not appear to be an expectation that this would result in a plan to either provide supports to increase the person's capacity, or to pursue guardianship as an alternative. For example, some individuals may be able to give or withdraw informed consent with additional education or when information is provided in alternative formats. Facility staff interviewed recognized guardianship as a restrictive procedure that, at times, is necessary to protect an individual who has limited ability to make informed decisions. Likewise, the Texas Guardianship Statute recognizes guardianship as a restrictive procedure that requires due process. The statute also offers limited guardianship as a less restrictive option to full guardianship. Therefore, it is important that assessments of an individual's capacity to provide informed consent detail the areas in which they are able to make informed decisions as well as those areas in which they cannot make such decisions. Further, it is important for such assessments to identify if there are supports or resources that could enable a person to make informed decisions, or increase their capacity to make such decisions.	
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	Based on interview with Facility staff, no progress had been made since the baseline review with regard to the identification of guardians for individuals who needed them. A position for a Human Rights Officer was in the process of being filled, and it was anticipated that the person in this position would be responsible for assisting in this process. However, there were no known guardianship resources available in the area. For example, Facility staff did not know of any nonprofit guardianship entities to which referrals could be made. As noted above, the list of individuals requiring guardians included 215 names. Although as also discussed above complete assessments had not been done to identify individuals who may be able to make decisions with supports other than full guardianship, substantial guardianship resources will be needed to address these individuals' needs for guardians. The Texas Guardianship Statute identified a number of pieces of information that the court may consider in making its decision regarding the need for guardianship and, if needed, the type of guardianship that will be ordered (i.e., full or limited guardianship). For example, guardian ad litems, attorney ad litems, and/or investigators may be	Noncompliance

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	organizations, and other entities seeking to advance the rights of persons with disabilities.	appointed to assist the court in evaluating the need for guardianship as well as the type of guardianship needed. In addition, it appeared that it was possible for other interested parties to be involved in guardianship proceedings. For example, people who must be noticed regarding guardianship proceedings include family members as well as the facility director of the facility currently supporting the individual. Given the knowledge that individuals' teams have regarding their strengths, needs and preferences, teams could potentially provide valuable information both in terms of written reports as well as verbal information regarding individuals who become the subject of guardianship proceedings. As the State finalizes its policy on consent and guardianship, it should define the potential roles of SSLC staff in the process.	

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

1. As the State finalizes the policy on consent and guardianship, it should consider including in the policy the following:
    a. An assessment process that clearly identifies an individual's specific capacities as well as incapacities related to decision-making. Such a detailed assessment would potentially be helpful in a guardianship proceeding in which decisions need to be made regarding full versus limited guardianship;
    b. An assessment process that identifies potential supports or resources that would either allow an individual to make informed decisions or increase his/her ability to make informed decisions over time (e.g., education, information provided in alternative formats, etc.);
    c. A standard tool/process for identifying priority with regard to the need for guardianship; and
    d. Definition of the role of State and Facility staff in the guardianship process, including potentially completing assessments for use in guardianship proceedings, participating in guardianship proceedings, and assisting in the identification of potential guardians for consideration by the Court.
2. Once the State policy is finalized, the State should provide key Facility staff with training on its implementation.
3. Once the State policy is finalized, CCSSLC should develop a policy on guardianship to reflect the State policy.
4. Based on any additional information provided in State policy regarding prioritization for guardianship, CCSSLC should review the list that identifies individuals who need the support of a guardian, and prioritize the list.
5. The State should consider seeking or providing funding for a guardianship program in the Corpus Christi area that would be responsible for the identification, training, and oversight of guardians, such as those programs that are available in other parts of the state.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o CCSSLC Draft Filing and Retention Schedule, revised 6/16/10; o CCSSLC Draft Active Record (POR – Problem Oriented Record) Check-out Process: The Process Using a Special Binder in Each Active Record Area, revised May 2010; o CCSSLC Policy #V.1: Draft Organizing, Training on and Maintaining "Individual Notebooks," dated 5/19/10; o Draft Maintenance of Individual Records Table of Contents, revised 6/21/10; o Active Record Order and Guidelines, revised 5/21/10; o Active Record Order and Guidelines, revised 6/11/10; o Completed Active Record Review Sheets for May and June 2010, and part of July 2010; and o CCSSLC Policy #A.1: Policy and Procedure Guidelines, revised 7/1/10 ▪ **Interviews with**: o Elena Menchaca, Unified Records Coordinator; o Lily Rodriguez, Unified Records Coordinator; and o Daniel Dickson, Quality Enhancement Director
	Facility Self-Assessment: The Facility was in the process of revising the POI to provide a description of the steps the Facility took to assess compliance. Although the POI reviewed for CCSSLC did not include this component, the POI correctly identified that overall CCSSLC was currently not in substantial compliance with the requirements of Section V of the SA. The POI indicated compliance with some of the indicators within this section, including: ▪ The indicators related to the existence of an active record, individual notebook, and master record for each individual. Although these did appear to exist, they did not yet meet the requirements of Appendix D of the SA, and less than half had been converted over to the new Table of Contents required by State Office. ▪ The indicator related to quality assurance procedures being completed on at least five records. The Monitoring Team found that at least five reviews were being completed, but the reviews related to the quality of the records were not being completed using a tool that had been determined to adequately capture quality issues. As discussed below, inter-rater reliability had not yet been established, and questions arose about some of the validity of the data. ▪ The indicators related to corrective actions being taken when deficiencies were noted. Based on discussions with the QE Director, it appeared that the corrective action processes were in the beginning stages of development. Notifications were occurring of problems with individual files, but there was no process to close the loop to ensure problems were resolved, and trends were not yet being identified and addressed through the development and implementation of action plans. Based on interviews with staff and review of documents, CCSSLC had begun to conduct regular reviews of individuals' records. As is described in further detail below with regard to Section V.3 of the SA, the QE

	Department was working on combining a tool that had previously been used for record review with the one used by the Monitoring Teams. The Facility recognized that in addition to reviews of the presence of items in records, it also needed to assess quality of items. With regard to the development of policies and procedures, the Facility's implementation of a revised policy that established a Policy and Procedure Committee should assist the Facility in assessing its status with regard to the policies required by the SA, and for ensuring the quality of those policies.
	Summary of Monitor's Assessment: Since the baseline visit, the State issued the new Table of Contents (TOC) for the active records. Based on interview with CCSSLC staff, the Facility developed an action plan to address the conversion of the records from to old to the new TOC. This process began in late March 2010. At the time of the review, 125 records had been converted, representing approximately 43 percent of the records at the Facility. This was a substantial accomplishment in a short time. As is discussed throughout this report, policies and procedures necessary to implement the SA were in various stages of development. A positive development at CCSSLC since the baseline visit was the development and implementation of the CCSSLC Policy and Procedure Guidelines policy. This policy set forth a process for the development and review of policies and procedures. It required that the Policy and Procedure Committee review and approve all draft policies. CCSSLC was conducting reviews of at least five records each month. The system for doing this, and particularly the processes for identifying trends that needed to be addressed and putting plans in place to address problematic trends, were in the beginning stages of development. There continued to be issues related to missing documents, and/or the quality of information included in individuals' records. These will need to be corrected in order to ensure that records can be adequately used for making treatment decisions.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	Since the baseline visit, the State issued the new Table of Contents for the active records. Based on interview with CCSSLC staff, the Facility developed an action plan to address the conversion of the records from to old to the new TOC. This process began in late March 2010, and involved staff from the records management unit meeting with residential unit staff at their morning meetings to review the changes that were going to occur. The Unified Records Coordinators in conjunction with the File Clerks were working on the conversion process. At the time of the review, 125 records had been converted, representing approximately 43 percent of the records at the Facility. The records that had been converted were those in the Atlantic Unit, and half of the Coral Sea	Noncompliance

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		Unit (i.e., Sanddollar). This was a substantial accomplishment in a short time. The deadline for the conversion of the rest of the records was 10/15/10. A significant change with regard to staffing that had occurred since the baseline visit was that the file clerks had begun to report to the Director of QE, as did the Unified Records Coordinator. Four medical clerk positions were being added. These positions would report to the Medical Department, but would assist in the filing process. This complement of staff should assist with both the conversion process, as well as the ongoing maintenance of records. One of the issues identified was with regard to the filing of the notes of Registered Dieticians. At the time of the review the RDs indicated that they were keeping notes in their own files, as opposed to having them filed in the Active Records. This was discussed with the records management staff who indicated that no tab was included for these in the TOC distributed by the State. Likewise, as is discussed above with regard to Section M.1 of the SA, the Respiratory Therapist was not including notes in the Active Record. These issues should be reconciled to ensure that information that is necessary for the proper care and treatment of individuals is available in the record. With regard to the security of records as referenced in Appendix D of the SA, it was the expectation that records were maintained in a locked file cabinet to which staff in the homes had access. The Facility had drafted an Active Record Check out procedure. This procedure would go into effect any time an individual's active record needed to leave the unit, for example, for off campus medical appointments, or for a PSP meeting. Implementing such a system will assist in maintaining control over the security of the records. As detailed below with regard to Section V.3 of the SA, a number of quality issues related to the content of the active records were being identified internally. This process of reviewing records regularly, and identifying areas needing improvement will assist the Facility in ensuring that each individual has a unified record that are consistent with Appendix D of the SA.	
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 is discussed throughout this report, policies and procedures necessary to implement the SA were in various stages of development. A positive development at CCSSLC since the baseline visit was the development and implementation of CCSSLC Policy #A.1, revised 6/8/10 and 7/1/10, entitled Policy and Procedure Guidelines. This policy set forth a process for the development and review of policies and procedures. It required that the Policy and Procedure Committee review all draft policies. This Committee was comprised of the Director, the Assistant Director of	Noncompliance

#	Provision	Assessment of Status	Compliance
	as necessary to implement Part II of this Agreement.	Programs, the Settlement Agreement Coordinator, and the Quality Enhancement Director. Based on interview with staff and review of the policy, the Committee was responsible for reviewing any draft policies to ensure adherence to State Office requirements as well as Settlement Agreement, and regulatory requirements. As appropriate, the Committee made recommendations to the policies' authors, and approval for policies was provided when all recommendations had been addressed. This process should be very helpful as the Facility moves through the process of finalizing the many policies currently under development or revision.	
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 shall monitor all deficiencies identified in each review to ensure that adequate corrective action is taken to limit possible reoccurrence.	CCSSLC was conducting reviews of at least five records each month. The system for doing this, and particularly the processes for identifying trends that needed to be addressed and putting plans in place to address problematic trends, were in the beginning stages of development. The reviews of records were being conducted on a couple of levels, and different tools were being used to conduct the reviews. The following describes what the process was at the time of the Monitoring Team's July 2010 visit: ▪ The Unified Record Clerks were conducting monthly reviews of individual notebooks and unified records to ensure that proper content was present, as well as some basic quality issues, such as if signatures were present, if dates were correct, etc. A review of the completed forms since May 2010 showed that these were being completed, and issues identified. Based on staff interview, this information was entered into the computer, and the data generated was sent to the QE Director, the Unit Director, and the Residential Coordinator. The expectation was that corrections would be made, but staff forthrightly reported that a system was not in place to ensure that this happened. ▪ Program Compliance Auditors also were completing approximately 16 audits a month of individuals' records. Two different tools had been in use, including one that was about 70 questions long, and the other being the tool developed by the Monitoring Teams. The QE Director had identified the need to consolidate the two tools into one. The reviews showed many missing documents. Of the sample submitted for review, seven from June 2010 that had been completed by the Unified Records Coordinators of the active records were computer-generated, and tabulated to allow review of percentages of documents present that should have been. Scores ranged from 43% to 65% compliance with the records requirements. An additional sample of five reviews of individual notebooks showed scores ranging from 56% to 80% compliance. As this process unfolds, it will be important to ensure that those conducting the audits have been properly trained, and that there is adequate inter-rater reliability. In	Noncompliance

#	Provision	Assessment of Status	Compliance
		conducting a review of a sample of the completed forms, some potential scoring issues were noted. For example, on many of the forms, the auditors had identified that a Reiss Screen was present, but a psychiatric assessment was missing. Without having the entire individuals' records to review, it could not be determined if the individuals should have had both, but the repetitive nature of this coding across many individuals, called into question whether the auditors understood that a Reiss Screen might have been sufficient, and it would not be expected that every individual would have a psychiatric assessment. Trending of information gathered from such reviews also had not yet occurred, but the QE Director indicated that there were plans to do so. This will provide important information, and should result, as appropriate, in action plans to address areas of concern.	
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.	During the review, the following issues were noted with regard to the availability and quality of the records, and the impact on the ability of staff to utilize records in making medical treatment and training decisions: ▪ With regard to medical records, in reviewing records onsite, it was noted that significantly fewer documents had to be obtained from the units compared to the baseline review. There was some occasional confusion regarding finding sequential progress notes since only some of the medical records had been transitioned to include the most current note at the beginning of the progress note section. However, all progress notes were found to be available in the medical records. However, there were problems finding the PSPA's and HST minutes in the records for a number of individuals. ▪ Recording of data is a key part of recordkeeping, and the integrity of such data collection is key to the clinical decision-making process. In reviewing the collection of data for Positive Behavioral Support Plans and skill acquisition goals, it was determined that staff were not consistently and timely documenting data. Likewise, as noted with regard to Section M.1, nursing staff were not consistently documenting information in integrated progress notes, including hospitalizations of individuals, and results of hospitalizations. ▪ As noted above with regard to Section V.1 of the SA, Dietary and Respiratory Therapy notes were missing from individuals' records. ▪ As was discussed with regard to Section Q of the SA, the Dental Department maintained some records that were not incorporated into the individuals' active or unified record.	Noncompliance

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

1. The Table of Contents for the Active Record should be reviewed to ensure that information from Registered Dieticians, as well as Respiratory

Therapists is appropriately included.
2. CCSSLC should continue to convert records to the new Table of Contents for the Active Record.
3. The State and Facility should consider recommendations regarding policies and procedures that are offered throughout this report as they develop and/or finalize policies and procedures.
4. Quality Enhancement monitoring tools and procedures should be finalized and implemented to allow regular review of records, analysis of data, and action steps/plans to address individual as well as systemic issues as they are identified.
5. The staff responsible for conducting record audits should be provided with necessary training, and inter-rater reliability should be established.
6. Documents should be filed in a timely manner in the medical records so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services.
7. As is specified in other sections of this report, improvements should be made with regard to the quality of the data and other information that is entered into individuals' records.

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative or Augmentative Communication
ABA	Applied Behavior Analysis
AED	Antiepileptic Drugs
AEM	Antiepileptic medication
A/N/E	Abuse/Neglect/Exploitation
AP	Alleged Perpetrator
APC	Admissions/Placement Coordinator
ARNP	Advanced Registered Nurse Practitioner
BACB	Behavior Analyst Certification Board
BCABA	Board Certified Assistant Behavior Analyst
BCBA	Board Certified Behavior Analyst
BSC	Behavior Support Committee
BID	Twice a Day
BiPAP	Bilevel Positive Airway Pressure
BM	Bowel Movement
BMI	Body Mass Index
BSC	Behavior Support Committee
BSE	Behavior Services Evaluation
BSP	Behavior Support Plan
CBC	Complete Blood Count
CCSSLC	Corpus Christi State Supported Living Center
CD	Compact Disc
C-Diff	Clostridium difficile
CDC	Centers for Disease Control
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CMP	Comprehensive Metabolic Panel
COTA	Certified Occupational Therapy Aide
CRIPA	Civil Rights of Institutionalized Persons Act
CT	Computed Tomography
CV	Curricula Vitae
DADS	Texas Department of Aging and Disability Services
DAP	Description, Assessment and Plan
DART	Data, Action, Response, and Treatment
DCP	Direct Care Professional
DDAVP	Desmopressin
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DOJ	United States Department of Justice

DRR	Drug Regimen Reviews
DSM	Diagnostic and Statistical Manual
DUE	Drug Utilization Evaluation
DVD	Digital Video Disc
EDWR	Established Desired Weight Range
ER	Emergency Room
F	Fahrenheit
FAI	Functional Assessment Interview
FAST	Functional Analysis Screening Tool
FBA	Functional Behavioral Assessment
FTE	Full-time Equivalent
GERD	Gastroesophageal Reflux Disease
GI	Gastrointestinal
G-tube	Gastrostomy feeding tube
GJ-tube	Gastrostomy/Jejunostomy or transgastric feeding tube
HCG	Health Care Guidelines
HCS	Home and Community-Based Services
HIV	Human Immunodeficiency Virus
HRC	Human Rights Committee
HST	Health Status Team
IC	Infection Control
ICAP	Inventory for Client and Agency Planning
ICF/MR	Intermediate Care Facilities for persons with Mental Retardation
ID	Identification
ID/DD	Intellectual Disabilities/Developmental Disabilities
IDT	Interdisciplinary Team
IMC	Incident Management Coordinator
IMRT	Incident Management Review Team
IOA	Inter-observer Agreement
IQ	Intelligence Quotient
ITTP	Individual Treatment Training Plan
J-tube	Jejunostomy feeding tube
LAR	Legally Authorized Representative
LVN	Licensed Vocational Nurse
MAR	Medication Administration Record
MAS	Motivation Assessment Tool
MBS(S)	Modified Barium Swallow Study
MD	Medical Doctor
mg	Milligrams
MH	Mental Health
MOSES	Monitoring of Side Effects Scale
MR	Mental Retardation

MRA	Mental Retardation Authority
MRSA	Methicillin-resistant Staphylococcus aureus
NA	Sodium
NM	Nutritional Management
NMT	Nutritional Management Team
NP	Nurse Practitioner
NPO	Nothing by Mouth
O2	Oxygen
OCD	Obsessive Compulsive Disorder
OHR	Oral Health Rating
ORIF	Open reduction internal fixation
OT(R)	Occupational Therapist
PA	Physician Assistant
PALS	Positive Adaptive Living Skills
PBSP	Positive Behavior Support Plan
PCP	Primary Care Physician
PMAB	Prevention and Management of Aggressive Behavior
PMM	Post Move Monitor
PNMT	Physical Nutritional Management Team
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PNMT	Physical and Nutritional Management Team
PO	By mouth
POI	Plan of Implementation
PPD	Purified Protein Derivative
PRN	Pro re nata (as needed)
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PSR	Psychiatric Services Review
PST	Personal Support Team
PT	Physical Therapist
P&T	Pharmacy and Therapeutics
PTA	Physical Therapist Aide
PFW	Personal Focus Worksheet
REACT	Respiration, Energy, Alertness, Circulation, and Temperature
RD	Registered Dietician
RNP	Registered Nurse Practitioner
ROM	Range of Motion
RT	Respiratory Therapist
QA	Quality Assurance
QE	Quality Enhancement
QMRP	Qualified Mental Retardation Professional

RN	Registered Nurse
SA	Settlement Agreement in U.S. v. Texas
SAC	Settlement Agreement Coordinator
SAO	Skill Acquisition Objective
SFAR	Structural and Functional Assessment Report
SFBA	Structured Functional Behavior Assessment
SIB	Self-Injurious Behavior
SIRS	Systemic Inflammatory Response Syndrome
SLP	Speech and Language Pathologist
SPCI	Safety Plans for Crisis Intervention
SPO	Specific Program Objective
SSLC	State Supported Living Center
SSO	Staff Service Objective
STD	Sexually-transmitted disease
UGI	Upper Gastrointestinal
UNT	University of North Texas
TID	Three times a day
TIVA	Total Intravenous Anesthesia
TOC	Table of Contents
TST	Tuberculin Skin Test
UA	Urinalysis
UTI	Urinary Tract Infection
VNS	Vagus Nerve Stimulator
WBC	White Blood Count
WC	Wheel Chair