**United States v. State of Texas**

**Monitoring Team Report**

**Corpus Christi State Supported Living Center**

**Dates of Review:** July 11th through 15th, 2011

**Date of Report:** September 19, 2011

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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, 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, and are intended to inform the parties of the Facilities' status of compliance with the Settlement Agreement. 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 and medical care, nursing, psychology, habilitation, protection from harm, individual planning, physical and nutritional supports, occupational and physical therapy, communication, placement of individuals in the most integrated setting, consent, and recordkeeping.

In order to provide a complete review and focus the expertise of the team members on the most relevant information, team members were assigned primary responsibility for specific areas of the Settlement Agreement. It is important to note that the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members shared information as needed, and various team members lent their expertise in 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 review of CCSSLC, 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 Settlement Agreement.

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 11 through 15, 2011, 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 Monitoring Team 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 (CLDPs), 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.

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 Settlement Agreement 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 Settlement Agreement and each of the chapters of the HCG, the report includes the following sub-sections:

(a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;
(b) **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 Settlement Agreement. 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 Settlement Agreement, 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 Settlement Agreement, 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 Settlement Agreement 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") will be 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 Settlement Agreement identifies the requirements for compliance. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the Settlement Agreement. 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 Settlement Agreement. The recommendation sections for some provisions include a subsection of additional suggestions for the Facility. These are presented in an effort to assist the Facility in prioritizing activities as the Facility staff work towards achieving substantial compliance with the provision.

**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

During this most recent review, it was clear that the staff at CCSSLC had taken many steps to address issues that had been identified during previous reviews, and to comply with the Settlement Agreement. In talking with direct support professionals, they often commented that the additional training had been helpful, the addition of more active treatment was beneficial, and positive changes had been made with regard to their schedules, and more reasonable overtime practices. These improvements had continued to strengthen the team at CCSSLC.

Also of note, with the leadership of the Facility Director, CCSSLC had recognized the importance of integrating protections, supports, and services. One of the ways in which this was evidenced was through Performance Evaluation Teams (PET) that brought together discipline leaders and other staff charged with the responsibility to meet monthly, conduct self-assessments, and draft corrective action plans for presentation to the QA/QI Council. This philosophy of working together as a team in a truly integrated fashion should assist the Facility in moving forward quickly towards compliance.

The team at CCSSLC recognized that it still had significant work ahead to comply fully with the Settlement Agreement, and, most importantly, to improve the protections, supports, and services being offered to individuals living at the Facility. As discussed while the Monitoring Team was on site, at this point in the life of the Settlement Agreement, focused efforts need to be placed on some of the key requirements where adequate progress has not been seen. It also is important to sustain efforts in areas in which progress has begun, but further action is needed to reach compliance. The Monitoring Team encourages the Facility to continue to approach the many challenges ahead through a team approach, and with the same energy and commitment that have resulted in the many successes thus far.

As with previous reviews, the Monitoring Team would like to thank the management team, all of the staff, and the individuals who live at CCSSLC for their assistance during the on-site monitoring visit, as well as in preparation before the visit, and the production of many documents after the visit. Everyone with whom the Monitoring Team spent time during the on-site review was helpful in providing valuable information to assist the Monitoring Team in reviewing the Facility's status with regard to the Settlement Agreement.

**Positive Practices:** The following is a brief summary of some of the positive practices that the Monitoring Team identified at Corpus Christi State Supported Living Center:

Restraints

- The Restraint Review Committee process and minutes were designed to review restraint use monthly, including the results of monitoring audits, plan addendums, checks on clinical reviews, as well as individuals with more than three restraints in 30 days, and a review by unit. The Committee made recommendations for follow-up.
- Progress was noted in getting restraint monitors in place within 15 minutes of the beginning of a restraint.
- Progress was noted in obtaining the pharmacist's reviews of chemical restraints in a timely manner, and helpful suggestions were noted in the reviews.
- The process for reviewing restraint documentation had been revised and a helpful chart had been created to illustrate how the documents move through the system. This process should enhance the quality of the documents and their usefulness in guiding changes to individual programs.
- A "Do Not Restrain" List has been created and posted in living unit offices to alert staff to individuals who have limitations on the use of restraint.

Abuse, Neglect and Incident Management

CCSSLC had demonstrated significant progress toward compliance in the area of protection from harm in the previous review, with thirteen of the 22 indicators in the section found to be in substantial compliance. Based on this review, twelve of the 22 indicators were found to be in substantial compliance. The principle change was in training of investigators. Highlights of their progress included:

- Policies and procedures had been established to address reporting and investigation of unusual incidents, and to require reporting of abuse, neglect, and exploitation.
- Procedures were in place to discourage retaliation against reporters of abuse as evidenced by Zero Tolerance posters in all residences and day services locations. Actions were being taken to address any allegations of retaliation, and staff interviewed clearly stated that they could report retaliation to the Director or to Office of Inspector General (OIG).
- Actions to protect individuals who were involved in unusual incidents or abusive situations were taken quickly. Staff alleged to have been abusive or neglectful were routinely put on temporary work reassignment to remove them from direct contact with individuals served.
- Staff knew that they were expected to report abuse. They could describe the steps required and routinely referred to their badges to get the number to call. When asked what would happen if they failed to report, they said that the individual would be at risk and they would be fired.
- There was evidence of cooperation with DFPS investigations and with investigations by law enforcement and the Office of the Inspector General.

Quality Assurance

- CCSSLC had adopted policies and procedures to guide the development of its quality assurance program, and was beginning to implement them. A Quality Enhancement Plan was in place. The plan set out the audit tools to be used for each section of the Settlement Agreement with corresponding expectations for the samples to be

drawn, the persons responsible for auditing, reporting, and analyzing the resulting data, and creating corrective action plans. Although refinements continued to need to be made to the monitoring tools and processes, there was substantial progress in this area.

- CCSSLC continued to report trend data monthly and to analyze that data on a quarterly schedule for some key areas, such as restraints, abuse allegations, incidents, and injuries, and risks had been added to the list. 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 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.
- The Quality Assurance/Quality Improvement Council had been organized to develop, revise, and implement quality assurance procedures. The Performance Implementation Team (PIT) had been reorganized to focus on quality improvements in the units and in service delivery disciplines, though it was not clear the unit teams were in operation.

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

- Since the last review, QMRPs had undergone additional training on meeting facilitation, and consultants for the State had begun to train teams on the philosophical and historical context of individual planning, as well as on some of the logistics of the development of sound plans. Both the QMRP Coordinator and the State consultants had begun to provide technical assistance to teams at CCSSLC during annual planning meetings. Based on the meetings observed while the Monitoring Team was onsite, these efforts had begun to show positive changes with regard to facilitation skills, more productive meetings, and a more person centered focus. As would be expected, significant changes had not yet occurred in the PSP documents themselves.
- The Facility continued to develop its quality assurance system related to the PSP process. The QA Department continued to monitor PSP meetings, as well as PSP documents and implementation. Data had begun to be analyzed, and two areas had been selected in which to develop and implement corrective action plans. Although the system needed continued refinement, these developments were positive.

<u>Integrated Clinical Services</u>

- In preparation for the annual PSP, the Medical and Dental Departments revised the schedule of due dates of the annual exam, and the pharmacy aligned the quarterly drug regimen review (QDRR) in order for updated information to be available to the PST at the time of the annual review.

<u>Minimum Common Elements of Clinical Care</u>

- A number of initiatives were beginning, such as the development of the quarterly medical summary. This document required the PCP to conduct a quarterly review of medical care to ensure that recent events and lab were reviewed periodically and health assured. It was in the early stages of implementation. Both the medical and dental assessments had begun to include components of levels of risk for various health categories, as well as recommendations concerning community placement.

At-Risk Individuals

- The Facility had concentrated on implementing the integrated risk rating form. The State Office Discipline Coordinator and consultants had assisted in mentoring the PSTs to develop quality ratings with adequate rationale to justify the rating. Based on the Monitoring Team's observations of PSPs during the onsite review, the PSTs had made some progress regarding the At-Risk process. However, there had been no improvements found affecting the clinical outcomes for individuals designated to be at risk.

Psychiatric Care and Services

- The Psychiatric Reviews included extensive input from Psychology and Nursing staff.
- During the last year, the Facility also hired a locum tenens Psychiatrist, who was on site at CCSSLC for approximately six weeks, during which time he focused on completion of the individual comprehensive psychiatric evaluations (CPEs). He was scheduled to return again in the near future for another two months. The Consulting Psychiatrist also had been completing CPEs for individuals who had been newly admitted, so that they were performed in a timely manner. The recent CPEs that the Consulting Psychiatrist and the locum tenens Psychiatrist had completed complied with both the format and content specified in the Settlement Agreement. At the time of this review, the Psychiatry Department reported that new CPEs, which followed this outline, had been completed for 50 of the 140 individuals who were receiving psychotropic medication.
- The Psychiatry Department, working in conjunction with the Psychology Department, also had made significant progress in relation to the screening of individuals who did not receive psychotropic medication to ascertain if they had any signs of undetected mental illness. Those individuals who were identified as being in need of a mental health evaluation were then referred for a formal CPE.

Psychological Care and Services

- A majority of behavioral services staff continued to improve in their development of professional competencies, as they progressed through the necessary coursework toward the BCBA certification. In addition, some of the more advanced students had started to obtain the necessary supervision. The recent hiring of a BCBA as the Director of Behavioral Services, as well as contracting with a second BCBA should support the continued improvement of behavioral services.
- Progress in the area of peer review was also noted as the internal peer review process had been revised to expand its oversight of additional behavioral services (e.g., counseling services, monthly reviews, etc.) and an additional external peer review process had been initiated.
- Progress was observed in the area of psychological assessments. Behavioral services staff continued to complete comprehensive SFBAs, and a process to conduct standardized tests of intelligence was initiated. Although improved, concerns remained regarding the adequacy of SFBAs and counseling treatment plans.

Medical Care

- The Facility had high compliance rates of completing preventive tests, such as colonoscopies and mammograms.

- Non-facility medical peer review had begun, with one visit completed, during which five percent of the medical records were reviewed. The medical QI component had developed many aids for the PCPs (several lists) to improve compliance, and tracked five percent of the records of each PCP on a monthly basis.

Nursing Care

- CCSSLC's nursing staff had essentially remained stable since the last review, and had continued not to need the services of agencies to augment the nursing staffing coverage. The Chief Nurse Executive had reallocated a full-time Nurse Manager position to the Quality Assurance Department. Also, a part-time position was added and filled for Nursing Education. The Facility also had recently hired a full-time RN for the Infection Control Nurse position. Additionally, a full-time RN position was assigned as the dedicated nurse on the Physical and Nutritional Management Team.
- Since the last review, the Facility had continued to implement a number of interventions to address the Facility's Medical Emergency Response systems. In addition, onsite observations of staff on two units found that the nurses observed were able to appropriately demonstrate the use of the emergency equipment.
- The data summary generated from the Facility's training database for the Health Monitoring tools was very promising. This type of presentation format should allow the Nursing Department, as well as other departments to determine what specific areas are operating well and those that are problematic, as well as the ability to follow the progress of these items on a monthly basis. This type of format also lent itself to developing focused plans of correction that could address the specific problematic items.

Pharmacy Services and Safe Medication Practices

- The Pharmacy Department was compliant with Section N.7, which addressed the implementation of regular drug utilization evaluations (DUEs). The DUE system appeared to be mature and results had pragmatic application to clinical practice.
- In addition, the Pharmacy Department was implementing a quality improvement (QI) system to ensure medication orders were meeting the Settlement Agreement requirements. This new internal QI system indicated progress with regard to Section N.1, and had the ability to verify and document sustained improvement necessary for compliance.
- Progress was made in creating a system in which there was agreement between the Pharmacy and the Psychology Departments concerning the number of stat medications given, with timely written response from the Pharmacy Department.

Physical and Nutritional Supports

- The Physical and Nutritional Management Team (PNMT) members during the course of providing supports to individuals also identified systemic concerns that needed to be addressed. The PNMT is commended for this approach. This revealed that CCSSLC's PNMT understood their role as not only providing supports to individuals on their caseload, but also the importance of resolving systemic issues that impacted the health and safety for individuals campus-wide. For example, the PNMT identified infection control issues related to

respiratory equipment, and developed a monitoring form for documentation of cleaning. These systemic issues should be raised with the Risk Management, as well as Quality Assurance Departments.

- The PNMT PT was the PNMT Chairperson, and was fully dedicated to the PNMT. The addition of nurse dedicated to the PNMT also was a positive improvement.
- The Habilitation Therapy Director is commended for her leadership in beginning the process for the development and implementation of performance check-off objectives for competency-based training.

Physical and Occupational Therapy

- The OTs and PTs attended a variety of continuing education courses and conferences, which included Wheelchair and Bed Positioning for the Geriatric Patient; a Neuro Rehabilitation Conference; Managing Dysphagia: Essential Assessment, Diagnosis and Treatment Strategies; Beckman Oral Motor Assessment and Interventions; and Meeting the Needs of Latino Children with Communication Disorders.

Dental Services

- There was continued tracking of refusals and "no shows," with increased communication and response from the residences, including development of Personal Support Plan Addendums (PSPAs) in response to repeated refusals.
- A tracking log was developed for emergency visits.
- A member of the Dental Department attempted to attend each PSP meeting.

Communication

- The Monitoring Team commends the HT Department for implementing monitoring of communication devices consistently, but as stated in the previous report, there was no Facility policy developed for communication devices and AAC devices.

Habilitation, Training, Education, and Skill Acquisition Programs

- The quality of skill acquisition plans had continued to improve. This improvement was likely due to the ongoing refinement of the skill plan format, continued trainings and oversight on the development, implementation, and monitoring of skill plans, as well as continued refinement of the PSP process. Previously observed concerns regarding the adequacy of elements of skill plans, however, continued to be noted.
- Improvement in on-campus settings for day and vocational programming, as well as the continued emphasis on community integration was also noted.
- Overall, improvement in integrating individuals more fully into the community, including opportunities for formal skill training, continued to be noted. Ongoing monitoring appeared effective in prompting corrective action, when community integration supported through the day programs recently decreased.

Most Integrated Setting

- Post-move monitoring had been completed in a timely manner for all of the individuals who had transitioned to the community. The Post Move Monitor's comments often provided a thorough description of the methods used

to evaluate the item and the findings (e.g., interviews, document reviews and observations). However, some concerns were noted with the thoroughness and/or completeness of the monitoring for some individuals.

Consent

- The Facility had developed a Social Supports Questionnaire to assist in screening individuals, and determining the priority level for individuals needing guardians. Although these efforts were positive steps in beginning to involve individuals' teams in the screening and prioritization processes, a more comprehensive screening process, as well as more objective criteria for prioritization should be developed and implemented to meet the Settlement Agreement requirements.

Recordkeeping and General Plan Implementation

- As the State issued modifications to the Table of Contents for the Active Record, the Facility had developed and implemented plans to make revisions to the active records across campus. CCSSLC continued to maintain Individual Notebooks (I-Books).
- The Facility had developed an Active Records Documentation Log. It identified typical items to be filed for each discipline. The log allowed a record to be maintained of when departments submitted documents, and when they were filed.
- CCSSLC was conducting reviews of at least five records each month. 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.

**Areas in Need of Improvement:** The following identifies some of the areas in which improvements are needed at Corpus Christi State Supported Living Center:

Restraints

- In general, the Facility had systems in place for restraint reporting, monitoring, and review processes. However, concerns were noted in regard to the adequacy with which staff described the antecedent- and consequence-based interventions that were used prior to the implementation of restraint. It was not clear in all cases reviewed that staff implemented specific strategies from PBSPs in an effort to reduce target behavior and prevent the use of restraint. It was difficult to tell if, even when those strategies were employed, that they worked.
- The inadequacy or inconsistency of PSTs in examining potentially biological/medical, psychosocial, and environmental factors related to restraint as well as in reviewing and potentially revising SFBAs and PBSPs following more than three restraints in any 30-day rolling period was also noted as a concern.
- It was noted that some staff were not able to hold a restraint once it was applied, sometimes resulting in multiple attempts. When a restraint must be used, it is important to do it correctly and effectively to ensure staff

and the individual remain safe, and that there are no unintended consequences of strengthening the challenging behavior. Training will need to be reviewed and revised to address this.

- Discussion with the Restraint Reduction Committee leader revealed that efforts were underway to look more closely at the root causes of restraint use. This effort can only succeed if staff who complete forms and restraint monitors who review them look for indications of what happened in the individual's life just before the escalation of behavior problems that led to restraint. It is not enough to say that the person kicked a door or threw a rock at staff. To define a strategy for preventing restraint, one must know what happened that led to the kicking or the throwing.
- While documentation indicated that no one was restrained in a community setting, the police restrained one individual. The Facility should review how staff deal with challenging behavior in a public place to minimize the need for police action that may inadvertently place an individual at risk.

Abuse, Neglect and Incident Management: To continue its progress toward full compliance with Section D, the Facility will need to:

- Fine-tune its processes to make them timely, provide for documentation of supervisory reviews of investigations, and ensure that investigators are fully trained in the requisite investigatory skills, as well as skills in working with people with developmental disabilities.
- Revise the Plan of Implementation (POI) Action Plan for the audit of injuries to include a semi-annual review of injuries experienced by each individual, and determine whether there is a need to have any of the injuries or series of injuries reported for investigation as possible abuse or neglect.
- Follow-up on recommendations from investigative reports, and record the result on the Unusual Incident Report. The recommendations should be specific. Phrases such as "ADOP (Assistant Director of Programs) will follow up" are not sufficient.

Quality Assurance

- The next steps for CCSSLC's quality assurance initiatives will include refining and implementing the corrective action plan process, managing the data system to collect information generated by the monitoring activities, and developing a set of key criteria to measure progress on service outcomes.
- As the Facility moves forward in developing its self-assessment processes, in addition to the important narrative information included in the POI, the Facility should include data, including the results of the analyses of the data, to substantiate its findings of either substantial compliance or noncompliance. This data would potentially come from a variety of sources, including, for example, the results of monitoring activities, and outcome data being collected and analyzed by various departments. Such data should be quantitative as well as qualitative in nature. This data should be a core component of what the Quality Assurance/Quality Improvement Council reviews, and the analysis of this data should form the basis for the actions that the Council implements, monitors, and revises, as appropriate, to effectuate positive changes in the lives of individuals the Facility supports.

Integrated Protections, Services, Treatments and Supports

- As noted in many sections of this report, comprehensive, thorough, and adequate assessments were missing in many areas, including but not limited to nursing, speech and communication, psychiatry, skill acquisition and day/vocational, and physical and nutritional supports. Adequate assessments are the foundation for good individualized planning.
- Attendance of the full array of staff necessary to provide input into the interdisciplinary process was not consistently seen.
- Action plans largely addressed skill acquisition plans, but not other supports, services, treatments, or strategies. Focused effort was needed to improve the scope of action plans, as well as to ensure they were measurable.
- The State and the Facility will need to ensure that person-centered concepts are incorporated with the need to develop comprehensive, integrated plans. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility, should figure out ways to have adequate, technical team discussions, while focusing on the individual and his/her preferences, strengths, etc.

Integrated Clinical Services

- Policies such as the acute medical problem policy and tracking of diagnostic tests and consults provided detailed guidance to direct support professionals, as well as the Nursing, Medical, and Dental Departments in ensuring timely, efficient, and effective health care integrating the roles of several departments. All of the policies were implemented within a few weeks to months of the Monitoring Team's visit and would require time to ensure compliance. In addition, these policies appeared to be independent of one another and it was not clear how they interfaced or potentiated the ultimate goal of integration. Each was presented as an "island," rather than an essential part of a whole.
- Although improvement was noted with Primary Care Practitioners signing consultation reports, the documentation did not include whether or not to adopt the recommendations, or whether to refer the recommendations to the individual's team for integration with existing supports and services.

Minimum Common Elements of Clinical Care

- The morning medical meeting was a routine part of the PCPs and Nursing Department's schedule. This was a forum for asking and researching critical clinical concerns. The potential of this meeting had not been accomplished, but the group was progressing toward the goal of ensuring timely integration of care.
- Clinical indicators were not identified. The Facility was expecting completion of clinical pathways in the near future, which would provide assistance with regard to many of the provisions within Section H, including the development and implementation of clinical indicators.

At-Risk Individuals

- A specific focus had been placed on aspiration pneumonia, particularly with regard to the development of action plans. However, the action plans for individuals designated as being at high risk due to aspiration pneumonia

were found to be generic and clinically inadequate. No Integrated Risk Action Plans had been developed for individuals who were designated as high or medium risk for other health indicators other than aspiration.

Psychiatric Care and Services

- Polypharmacy continued to be an issue, and was being reviewed regularly in the Polypharmacy Committee Meetings.
- An area that continued to require additional attention was the documentation to empirically demonstrate that the prescribed psychotropic medications were effective. This was especially relevant for those individuals who were receiving multiple psychotropic medications, as it becomes much more difficult to substantiate the efficacy of individual medications, as the number of medications prescribed for a specific individual increases.
- Another factor that will continue to need attention is the identification of the linkage between the psychiatric diagnosis and the identified target behaviors of the prescribed psychotropic medications. The dual classification of behaviors as being both targets of the psychotropic medication, and as being present on a learned basis or as a response to environmental factors, also continued to be problematic.
- Although the Psychiatry Department at CCSSLC had definitely made progress in meeting some of the provisions of the Settlement Agreement since the last review, a fundamental issue remained. The Facility relied on only 12 hours per week of psychiatric consultation time to manage the psychotropic medication for 140 individuals, some of whom had very complex psychiatric presentations.

Psychological Care and Services

- Substantial concerns remained regarding the nature of data collection, data reliability, data display, and the utilization of data in PST decision-making.
- Limited progress was observed in the area of PBSPs, since the previous review. Although a comprehensive process was in place to ensure the quality and timeliness of PBSPs, the quality of the plans remained inadequate. It continues to be anticipated that, as professional competencies in ABA develop through coursework and supervised training, the quality of the PBSPs will continue to improve over time.
- Concerns continued to be noted with regard to the limited progress in monitoring and ensuring adequate competency-based training to direct support professionals, as well as treatment integrity of behavioral programming.

Medical Care

- The morning medical meeting had the needed components to support the provision of quality medical care, but members need to be challenged to ask critical questions and raise clinical concerns. For those admitted to the hospital or sent to the ER, the question that should be addressed until closure is what are the steps that need to be taken to prevent a recurrence of the hospitalization or ER visit.
- An improved medical database was needed, an essential step in creating a medical QI program. Many of the diagnostic categories had conflicting information and/or incomplete information.

- The clinical mortality reviews needed further work to ensure that they raised important issues and corresponding recommendations.
- The Medical Department's involvement in transition planning was not adequate, and there was no system to track and prevent poor clinical outcomes for those transitioning to the community.

Nursing Care

- Consistent with the past three reviews, significant problems were found regarding the quality of the nursing care and documentation regarding acute illnesses, the nursing assessments, and Health Management Plans. Although a number of Health Monitoring tools for Acute Illness/Injury, Urgent Care, and Documentation had been completed, the Facility had not implemented any systemic changes, which resulted in any measurable changes regarding the nursing documentation and clinical outcomes for individuals that experienced an acute change of status resulting in an Infirmary admission, and/or hospitalization. The Facility should address urgently and aggressively the lack of the implementation of nursing protocols to guide nursing care, as well as the lack of development of appropriate Health Management Plans, and the associated documentation.

Pharmacy Services and Safe Medication Practices

- The Quarterly Drug Regimen Review (QDRR) was revamped, and additional sections were included for each individual recommendation. However, based on the Monitoring Team's review, for 18% of the recommendations, the PCPs had provided no response, which both Pharmacy and Medical Departments should track. Additionally, although questions were added in the QDRR related to anticholinergics and benzodiazepines, the questions did not address the requirements of the Settlement Agreement.
- Medical errors/variances remained a challenge, but the Pharmacy Department had assisted with root cause analysis in two cases. Omissions of medications required continued investigation.

Physical and Nutritional Supports

- Areas requiring continued improvement included: the PNMT process for reviewing the Integrated Risk Rating Form; completion of the comprehensive assessment and action plan; competency-based training and performance check-offs; individual-specific monitoring; documentation in Integrated Progress Notes; the PNMT's involvement with individuals who experience hospitalizations; as well as in developing transition plans, and discharge planning.
- Based on a review of a sample of Aspiration Pneumonia Enteral Nutrition (APEN) evaluations, they did not evaluate the medical necessity of the tube, and/or determine if a less restrictive approach to receiving enteral nutrition was possible and, if appropriate, recommend the development and implementation of a plan to return an individual to oral eating.

Physical and Occupational Therapy

- Numerous issues were noted with regard to the assessment process, as well as the provisions of therapeutic supports. Direct and indirect therapy interventions were not analyzed, during the assessment and/or update process, or in clinical progress notes to determine if progress was being made and/or if changes needed to be

instituted. Justification for therapy interventions was not outlined in the analysis of findings section of the assessments to provide a rationale for functional recommendations, measurable outcomes, and intervention strategies.

- In addition, therapy programs were not integrated into individuals' PSPs in the form of skill acquisition programs or staff service objectives. Therapy plans were not integrated through skill acquisition programs, and reinforced through the use of informal therapy supports throughout the 24-hour day.
- Monthly and/or quarterly documentation was not consistently found to justify the initiation, continuation, and/or discontinuation of programs implemented by the PNMP Coordinators.

Dental Services

- The oral hygiene ratings indicated some overall regression across campus, with challenges in those individuals with noncompliant behaviors. There also was continued training needs for direct support professionals. The Dental Department created a training program for new employees and a separate education program for current employees.
- Efforts to develop and implement interventions to minimize the use of sedating medications, including the development of desensitization plans remained in their infancy.

Communication

- Staffing was potentially one factor that resulted in the inadequate provision of speech and communication supports to individuals at CCSSLC. In sum, therapists were not active members of the PSTs, as evidenced by the SLPs' absence from annual PSP meetings, insufficient time to provide direct therapy, the lack of development and integration of therapy recommendations into formal skill acquisition programs, the lack of development of instructional programs for PNMP Coordinators and/or staff, and the insufficient development of informal strategies to reinforce assessment recommendations and measurable outcomes.
- The CCSSLC Speech Department should conduct a critical review of the current status of the SLP assessment completion rates for individuals within the priority levels to assess the projected completion dates in reference to the Settlement Agreement timelines for Section R. In addition, the completed SLP assessments did not meet the requirements for the Settlement Agreement with specific emphasis on augmentative/alternative communication.

Habilitation, Training, Education, and Skill Acquisition Programs

- Previous Monitoring Team reports raised concerns about the adequacy of some of the assessments utilized (e.g., PALs, PFA, Vocational, etc.). Although similar concerns were currently noted with the PFA, improvement in the vocational assessment was noted. However, inconsistencies and concerns within these assessments evidenced a need for further refinement. The opportunities and processes for situational assessments needed particular focus.

- Training of staff continued to be an area of concern. Previous reviews and more recent observations continued to produce mixed findings regarding staff knowledge of and competencies in implementing and monitoring the integrity of skill acquisition plans.
- Although improving, notably at Miracle Field, opportunities for off-campus supported employment continues to increase at a slower than desired rate.

Most Integrated Setting

- At the time of the review, although assessments prepared for annual PSP meetings had begun to include the assessor's recommendation regarding transition to the community, individuals' PSPs did not include a summary or conclusion with regard to the professional team members' determination with regard to whether or not community placement was appropriate.
- Since the previous review, six individuals had transitioned to the community. Of these six individuals, four had experienced significant adverse outcomes within the first 90 days of transition. One had died; three had experienced a total of four psychiatric hospitalizations, most of which also involved police contact and/or arrest; and one had engaged in unauthorized departures from his community home, which placed him as well as community members at significant risk of harm. Based on a review of the CLDPs for these individuals, as well as the post-move monitoring information, significant concerns were noted with regard to the transition plans, as well as the quality of supports community providers offered to these individuals.

Consent

- DADS State Office was still in the process of finalizing policies on guardianship and consent that were expected to provide guidance to the Facilities with regard to the implementation of this Settlement Agreement requirement. Although CCSSLC staff reported that progress was being made, the final policies had not been issued. This resulted in minimal progress being made at the Facility level.
- Since the last review, no guardians had been identified for individuals who needed them. CCSSLC had made efforts to identify potential guardianship resources, but, at the time of the review, no viable resources had been identified. It will be essential that adequate resources be identified to address this need.

Recordkeeping and General Plan Implementation

- 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.
- The final phase of the record conversion process involved the conversion of individuals' historical files to the Master Record format State Office issued, which the Facility continued to work towards.

## V. Status of Compliance with the Settlement Agreement

| **SECTION C: Protection from Harm-Restraints** | |
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| 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:<br>• **Review of Following Documents**:<br>• CCSSLC Policies #C.2, C.4, C.11 and C.12;<br>o CCSSLC Plan of Improvement, dated 6/29/11;<br>o Presentation Book, Opening Visit Presentation Notes, and POI for Section C, completed by Erin Willis;<br>o Summary behavioral sciences database (excel spreadsheet) of Individuals with Desensitization Plans, dated 7/12/11 and 7/15/11;<br>o Psychological and Behavior Services – Meeting minutes for Desensitization Plan Workgroup, dated 2/9/11 and 2/23/11;<br>o Behavior Support Committee (BSC) Weekly Minutes, including discussion/review of revised desensitization plans, dated 5/10/11;<br>o Desensitization Plans, as provided, for: Individual #231 and Individual #174;<br>o Training Roster for Desensitization Plan, dated 6/21/11;<br>o Email and attached Dental Anxiety Screening Checklist, dated 7/2/11;<br>o CCSSLC Restraints – Quarterly Trending Reports, from 12/1/10 to 2/28/11, and 3/1/11 to 5/13/11, dated 3/13/11 and 6/9/11, respectively;<br>o Summary of individuals with a diagnosis of pica or who have had an incident of swallowing an inedible object;<br>o Summary of individuals noted to have caused the highest number of injuries for reporting period, dated 6/6/11;<br>o Summary of individuals with highest number of injuries for reporting period, dated 6/6/11;<br>o DADS TX: Prevention and Management of Aggressive Behavior (PMAB) Basic Course Due/Delinquent, as of 6/1/11;<br>o Individuals Restrained During Time Period Between 1/8/11 and 7/8/11;<br>o Restraint Reduction Committee minutes for: 2/11 (no specific date), 4/15/11, and 5/26/11;<br>o Settlement Agreement Cross-Referenced with ICF/MR Standards: C – Protection From Harm – Restraints Guidelines, revised 12/10;<br>o CCSSLC: Do Not Restrain List, dated 6/30/11;<br>o Restraint Reduction Committee Monthly Minutes, for 4/15/11 and 5/26/11;<br>o Performance Evaluation Team Presentation for Section C for 5/23/11 (Review Month March 2011), and 5/25/11 (Review Month April 2011);<br>o Sample #C.1 was chosen from the list of individuals restrained as a crisis intervention between 1/1/11 and 6/31/11, in the Quarterly Trending Report – Restraints for 6/1/11 to 6/30/11. There were 118 personal restraints and 24 chemical restraints for a total of |

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| | 142 restraints listed in the report. The Sample of 37 restraints included the following individuals with restraints on the dates specified:<br>▪ Individual #191: 2/15/11 at 5:35 p.m.; 2/27/11 at 10:40 p.m., 10:50 p.m. and 11:23 p.m.; 3/12/11 at 7:52 p.m.; 3/20/11 at 9:43 p.m.; 4/28/11 at 4:54 p.m.; 5/11/11 at 10:30 p.m.; and 5/12/11 at 4:15 p.m.;<br>▪ Individual #7: 3/2/11 at 3:45 p.m.; 3/7/11 at 8 p.m.; 3/9/11 at 1:50 p.m., 3/10/11 at 8:20 p.m., and 9:25 p.m.; 3/19/11 at 11:44 p.m., 3/30/11 at 8:46 am; and 5/13/11 at 8:30 p.m.;<br>▪ Individual #133: 2/10/11 at 3:15 p.m. and 3:35 p.m.; 4/17/11 at 4:58 p.m. and 4:58 p.m.; 4/22/11 at 7:52 p.m., 7:55 p.m., and 7:58 p.m.; 5/3/11 at 9:44 p.m., and 9:44 p.m.; 5/16/11 at 8:40 p.m. and 9:40 p.m.; and 5/29/11 at 3:20 p.m.;<br>▪ Individual #105: 4/14/11 at 4:26 p.m.; 5/3/11 at 5:54 p.m.; and 5/23/11 at 5:44 p.m.;<br>▪ Individual #114: 5/21/11 at 7:23 p.m.;<br>▪ Individual #218: 4/30/11 at 3:47 p.m.;<br>▪ Individual #88: 5/2/11 at 8:19 a.m.; and 5/12/11 at 8:30 a.m.; and<br>▪ Individual #312: 4/11/11 at 6:45 p.m.;<br>o Sample #C.2: The following documentation was obtained for a sample of 37 staff hired between 4/1/11 and 6/1/11:<br>▪ The date hired and the position title from the new hire lists provided in response to Document Request II.13:<br>▪ DADTX: Course Due/Delinquent through 6/1/11 for the PMAB basic course; and<br>▪ Acknowledgement of Responsibility for Reporting Abuse, Neglect and Exploitation, for all new hires;<br>o Sample #C.3: Individual #182 and Individual #190 were listed as having medical and protective restraints during June 2011 on the Monthly Trending Report. The physicians' orders, restraint checklist, monitoring documentation and Face-to-Face reports were requested for both individuals. The Facility provided the restraint checklists, but the rest of the documentation was not submitted;<br>o Sample #C.4: For 20% of the 21 instances (N = 4) on the list provided by the Facility (II.07.a) who were restrained with chemical restraint other than pre-sedation since the last monitoring review, including Individual #133 on 4/17/11 at 4:58 p.m. and on 5/16/11 at 9:40 p.m.; Individual #7 on 3/10/11 at 9:25 p.m.; and Individual #191 on 5/12/11 at 4:15 p.m.;<br>o Sample #C.5: Based on documentation provided by the Facility, no restraints had occurred off the grounds of the Facility in the last six months;<br>o Positive Behavior Support Plans (PBSP), Safety Plan for Crisis Intervention (SPCI), PSP, PSP addendums, PSP Monthly Behavioral Services Reviews, as provided, for: Individual #7, Individual #133, and Individual #191; and<br>o For Section C.4, Positive Behavior Support Plans (PBSP) for: Individual #275, Individual #268, Individual #7, Individual #9, Individual #335, Individual #109, Individual #16, Individual #200, Individual #58, and Individual #186. |

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| | • **Interviews with**:<br>o Erin Willis, Chair of the Restraint Reduction Committee and Lead for Section C of the Settlement Agreement;<br>o Dr. Robert Cramer, Clinical Psychologist; Bruce Weinheimer, State Office Coordinator, and Erin Lewis on 7/11/11;<br>o Robyn Palmer Blue, M.A., BCBA, and Judy Sutton, M.A., BCBA, incoming Director of Behavioral Services, on 7/14/11;<br>o Dr. Robert Cramer, Clinical Psychologist, and Judy Sutton M.A. BCBA, incoming Director of Behavioral Services, on 7/14/11;<br>o Bruce Boswell, Active Treatment Director and Interim Acting Chief of Behavioral Services, and Judy Sutton M.A. BCBA, incoming Director of Behavioral Services, on 7/14/11;<br>o Quality Assurance Monitors that monitor restraints; and<br>o Twenty staff members in various units.<br>• **Observations of**:<br>o All residences;<br>o Vocational Buildings, including buildings: 510, 513 and 512;<br>o Atlantic Unit Management Team Meeting, at 9 a.m. on 7/14/11; and<br>o PSP meetings for Individual #228 and Individual #353. |
| | **Facility Self-Assessment**: Based on a review of the Facility's POI with regard to Section C of the Settlement Agreement, the Facility found that it remained out of compliance with five out of the eight indicators. The POI indicated that the Facility was in substantial compliance on Sections C.2, C.6, and C.8. The Monitoring Team concurred with the findings of substantial compliance on provisions C.2, but found CCSSLC out of compliance with Sections C.6 and C.8.<br><br>In the previous monitoring report, the monitors wrote: "As the Facility moves forward in its self-assessment efforts, an adequate sample size should be selected for review, and the Facility should ensure that the quality of efforts as well as the quality of the documentation is evaluated thoroughly." The Facility had demonstrated significant progress toward that goal. The Facility's auditing data was included throughout Section C of the POI, and in a number of cases, it directly related to the provision of the Settlement Agreement to which it applied. However, refinement of the process was still necessary. For example, the Facility found itself out of compliance with Section C.5. Although this was consistent with the Monitoring Team's findings, the data the Facility included in the POI seemed to indicate compliance had been achieved. This appeared to be due at least in part to the narrow focus of data, as opposed to the more comprehensive review needed to determine compliance. For example, for Section C.6, the data the Facility included in the POI only addressed a few of the components of the requirements of this provision. Because Section C.6 references Appendix A, many data points need to be reviewed in order to determine compliance. The summary of the Facility's data only addressed a few, including, for example, one-to-one supervision, and breaks for mealtimes and bathroom use. As a result, the Facility found itself to be in compliance, but the Monitoring Team did not.<br><br>Four action plans were included in the POI, of which three were reported to be complete. |

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| | **Summary of Monitor's Assessment:** The Monitoring Team noted significant activity directed toward reducing the need for restraint and managing how restraints were used. The reinvigoration of the Restraint Reduction Committee with a clear mission to review restraint use and make recommendations was a positive step.<br><br>The process for assessing the use of restraints has progressed with policy amendments and development of a flow chart to clearly show the steps and responsibilities in the flow of the Restraint Checklist. The involvement of the Chair of the Restraint Reduction Committee in rigorously auditing restraint forms and using that information to make changes, and to evaluate compliance with the Settlement Agreement was a significant step forward.<br><br>In general, the Facility had systems in place for restraint reporting, monitoring, and review processes. However, concerns were noted in regard to the adequacy with which staff described the antecedent- and consequence-based interventions that were used prior to the implementation of restraint. It was not clear in all cases reviewed that staff implemented specific strategies from PBSPs in an effort to reduce target behavior and prevent the use of restraint. The Facility had made progress in addressing previous concerns with regard to restraint monitors being in place within 15 minutes, and the pharmacist reviewing medications used as chemical restraints. |

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td>C1</td><td>Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in</td><td>Based on information the Facility provided in the document entitled "Individuals Restrained During Time Period report, between 1/8/11 and 7/8/11," and the data in the Quarterly Restraint Trending Reports for June 2011, the following data is available:<br><br>
<table>
<tr><th></th><th>July – December 2010</th><th>January – June 2011</th></tr>
<tr><td>Individuals who were the subject of restraint</td><td>162</td><td>110</td></tr>
<tr><td>Number of restraints that occurred (personal, chemical, pre-treatment sedation)</td><td>416</td><td>451</td></tr>
<tr><td>Personal restraints (crisis intervention per Safety Plan and Emergency)</td><td>131</td><td>118</td></tr>
<tr><td>Chemical (Emergency only)</td><td>21</td><td>24</td></tr>
<tr><td>Medical and Protective Restraints</td><td>264</td><td>309**</td></tr>
</table>
** Of the 309 Medical and Protective Restraints, Individual #190 accounted for 105 restraints, classified as Medical/Protective on the Monthly Trend Reports, and another 147 appeared to be pre-treatment sedation for medical purposes.<br><br>The Quarterly Trend Reports were useful in looking at the "big picture" of whether restraint use overall was increasing or declining. The corresponding data in "Individuals</td><td>Noncompliance</td></tr>
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| | the Facilities' policies shall be used. | Restrained During Time Period" was somewhat less dependable, since it used different terminology for types of restraint and reasons for restraint (such as "programmatic restraint".) The Quarterly Trend Reports used terms that were familiar to the Facility, and should be comparable over time.<br><br>A sample, referred to as Sample #C.1, was selected. This included eight individuals involved in 37 episodes of restraint, representing 26% of personal and chemical emergency and programmatic restraint records over the six-month period from 1/1/11 through 6/30/11. This sample was selected to ensure that some of the individuals with the highest numbers of restraint were included and to examine how multiple restraints on a single day were documented. The individuals in this sample and the dates of restraint are specified in the "documents reviewed" section above.<br><br><u>Prone Restraint</u><br>Based on Facility policy review, prone restraint was prohibited. A review of the data presented in the Quarterly Trend Report indicated that no prone restraint was used. Based on staff interview, staff knew that prone restraint was forbidden, and that while an individual was in restraint, if he moved into a prone position, staff must either turn him to his side or stop the restraint.<br><br>Based on a review of the restraint records for individuals in Sample #C.1, zero (0%) showed use of prone restraint.<br><br><u>Other Restraint Requirements</u><br>Based on document review, the Facility policies stated that restraints may only be used if the individual posed an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner; and could not be used as punishment, for convenience of staff, or in the absence of or as an alternative to treatment.<br><br>Restraint records were reviewed for Sample #C.1, including the restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review:<br>▪ In 34 of the 37 records (92%), there was documentation indicating that the individual posed an immediate and serious threat to self or others. For Individual #105 on 4/14/11 at 4:26 p.m., it was not clear that the threat was immediate and serious. According to the Restraint Checklist, he was attempting to punch staff and had picked up a rock and a garden rake and had attempted to throw the rake. His Safety Plan called for staff to move away from him and it was not clear that they did, or whether there might have been other individuals at risk. In a second episode of restraint involving the same individual on 5/3/11 at | |

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| | | 5:54 p.m., it was not clear that staff had attempted to move away from the individual's gravel throwing, or whether the behavior was endangering peers who could not move away. On 2/15/11 at 5:35 a.m., Individual #191 said he had knives in his pockets. It was not clear whether he had the knives, what kind of knives they might have been, or whether he attacked staff with them. The restraint monitor should question staff more closely about exactly what happened, how much of the danger was real, and what else might have been done to avert the danger.<br>▪ For the 37 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that in 37 (100%), there was some documentation that indicated that restraints were not being used for the convenience of staff or as punishment.<br>▪ In 36 of the 37 records (97%), there was some evidence that restraint was used only after a graduated range of less restrictive measures had been tried in that boxes were checked on the form and there were at least a few notes about what had been done to avoid restraint. In one case it was not clear whether all options had been exhausted or considered in a clinically justifiable manner. On 4/11/11 at 6:45 p.m., Individual #312 was upset when he could not keep his boy scout uniform. He escalated from self-injurious behavior of some kind (not documented) to aggression toward staff (not specified) to threatening to kill himself with a sharp object that he had found (again unspecified.) It was not clear that the suicide threat was real or that he had an object that could actually cut him. Nor was it clear whether staff had followed the Safety Plan procedure of asking him whether he "wanted to make up."<br><br>Facility policies identified a list of approved restraints.<br>▪ Based on the review of 37 restraints, involving eight individuals, 37 (100%) were approved restraints, or PMAB-approved restraint techniques.<br><br>As noted earlier in this section, Individual #190 was restrained more than 100 times during the January to June period. Although she was not included in the sample, Restraint Checklists, Doctor's orders and Debriefing forms were requested. It was not possible to verify the reason for the restraint, although staff indicated in interview that the restraint was an abdominal binder, put in place at night to prevent Individual #190 from removing her J-tube. The Restraint Checklists recorded the restraint as a mechanical restraint (abdominal binder). The reason for the restraint was "behavior/SIB" and "Protective to prevent SIB." The type of restraint was recorded as crisis intervention pursuant to a Safety Plan. Checks for circulation by direct support professionals were recorded every half hour, and checks for toileting were made regularly. There were no checks by nurses. The restraint was in place most nights from approximately 10 p.m. to 6 a.m. This case raises several issues that need clarification: | |

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| | | ▪ The Safety Plan and PSP should specify how this restraint was to be used, whether it was medical or crisis intervention, who authorized its use, and any alternatives to monitoring, such as not needing a nurse to check the person in restraint.<br>▪ It mattered whether or not the restraint was medical, because if the restraint was mechanical for a crisis intervention, it was in conflict with Facility Policy #C.2 which provided a list of approved restraints that did not include abdominal binders. If the restraint was mechanical as a medical restraint, the abdominal binder was permitted according to Facility Policy C.8.<br><br>While none of the individuals in the Sample #C.1 was restrained with an unapproved restraint, Individual #190 might have been, depending on the type of restraint that was being used. The Facility should review all the documentation related to this individual's restraint use and confirm that the restraint is being used in accordance with policy.<br><br>An additional sample of three individuals' records was reviewed, including the restraint records, PBSPs, and SPCIs for Individual #7, Individual #133, and Individual #191.<br>▪ In two (66%) of the three records reviewed, there was documentation to show that restraint was not used in the absence of or as an alternative to treatment. That is, information provided on Restraint Checklists suggested that interventions prescribed within PBSPs and/or SPCIs were attempted prior to restraint. However, in all of the sampled records, more specification would facilitate greater understanding of the events leading and following restraint, as well as support implications for future assessment and intervention.<br><br>Examples in which adequate treatment was present included:<br>o The restraint record, dated 3/30/11, 8:46 a.m., for Individual #7 indicated that staff attempted multiple interventions to avoid restraint. According to recorded checkmarks on the Restraint Checklist, these included: prompting replacement behaviors, interventions in PBSP and SPCI, verbal prompts, redirection, PMAB protection skills, and the removal of a dangerous object. Written descriptions on the checklist indicated that staff "…intervened per PBSP/Safety plan, prompted replacement behaviors, used VR/GR/PR [verbal redirection, gestural redirection, physical redirection] (unsuccessful) …" More specification, instead of general statements, would likely assist the PST in examining the situation and in refining potential hypotheses regarding underlying function, as well as identifying unsuccessful as well as potential promising future strategies.<br>o The restraint record, dated 4/22/11, 7:58 p.m.) for Individual #133 indicated that staff attempted multiple interventions to avoid restraint. | |

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| | | According to recorded checkmarks on the Restraint Checklist, these included: prompting replacement behaviors, prompted coping skills, interventions in PBSP and SPCI, verbal prompts, redirection, PMAB protection skills, moved others away and moved furniture. Written descriptions on the checklist indicated that staff used "…VR, GR, PR attempted. Prompted interventions and replacement behaviors in PBSP and SPCI." In this case, it was difficult to determine which coping skills, replacement behaviors, and/or interventions were attempted and were unsuccessful. For example, it was unclear which, if any, alternative responses were unsuccessful. As outlined in the PBSP, these included, for example, talking to someone, walking away, counting to ten, manipulating a stress ball, thinking positive things, and/or planning a more preferable activity. More specification, instead of general statements, would likely assist the PST in examining the situation and in refining potential hypotheses regarding underlying function, as well as identifying unsuccessful as well as potential promising future strategies.<br><br>An example in which adequate treatment was not provided included:<br>o The restraint record, dated 5/12/11, 4:15 p.m., for Individual #191 indicated that staff attempted multiple interventions to avoid restraint. According to recorded checkmarks on the Restraint Checklist, these included: prompting replacement behaviors, coping skills, interventions in PBSP, verbal prompts, redirection, change in environment, moved other(s) away, and traded out staff. Written descriptions on the checklist indicated that staff prompted the individual to "stop," removed others from his proximity, changed out staff, and provided counseling. These listed interventions (i.e., verbal redirection to "stop," providing additional space, and providing counseling) were consistent with the prescribed strategies outlined within the current PBSP, dated 3/31/11. However, a significant step was missing within the prescribed strategies leading to restraint. According to the current SPCI, staff should have initially implementing less restrictive (as written) PMAB physical restraints (i.e., hand-over-hand, basket hold or follow-down personal restraint) prior to using chemical restraint. The SPCI clearly stated that "… if [Individual #191] is in restraint for 15 minutes and continues to be in restraint make a request for a chemical restraint." According to the restraint report, no physical restraints were implemented prior to the use of chemical restraint. In addition, ambiguity within definitions of target responses as well as inconsistency across the SCPI and PBSP appeared to warrant further revision. More specific information is provided with regard to Sections C.7.a – C.7.g of the Settlement | |

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| | | Agreement.<br><br>As noted above, it was not consistently clear that individuals posed a danger to self or others, that less restrictive alternatives were followed, that only approved restraints were used, or that restraints were not used in the absence of adequate treatment. As a result, a finding of noncompliance has been made. | |
| C2 | Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others. | The 27 restraint records involving eight individuals who were physically restrained in Sample #C.1 were reviewed. The remaining 10 in Sample #C.1 were chemically restrained, so the exact time of "release from restraint" cannot be calculated. Of the 27, 26 records for seven individuals had Safety Plans that defined the use of restraint:<br>▪ For the 26 restraint episodes where individuals had Safety Plans, in 25 (96%), the documentation was sufficient to determine the individual had been released when no longer a danger to self or others. Specifically:<br>o Twenty included sufficient documentation to show that the individual was released from restraint according to the criteria set forth in the Safety Plan.<br>o In one episode of restraint (Individual #312, on 4/11/11 at 6:45 p.m.), it was not clear whether the expired Safety Plan was in effect or not. However, the individual appeared to have been released promptly.<br>o In four episodes, the restraint application was abandoned because staff could not maintain the hold.<br>o However, in one episode of restraint (Individual #191 on 4/28/11 at 4:54 p.m.), it was not clear whether the restraint was stopped as soon as the individual no longer presented a danger. On the Restraint Checklist, it appeared that the restraint was stopped. However, the Face–to–Face/Debriefing form indicated the restraint was not stopped timely, but without explanation. While it appeared that the Debriefing form might have been an error, there was no way to be certain.<br>▪ In the one episode of restraint where the individual did not have a Safety Plan (Individual #114), he was released from restraint when he was no longer a danger to himself or others.<br><br>In some episodes of restraint, the individual was released and restrained again in quick succession. Individual #133 was restrained with a hand-over-hand restraint on 4/22/11 at 7:52 p.m., and released after three minutes. At 7:55 p.m., she received a chemical restraint and at 7:58 p.m., she was again restrained with a hand-over-hand restraint, and released after one minute, when staff could not maintain the restraint. It appeared that she was released as soon as possible from the first restraint, and the fact that she had to be restrained again suggested that staff were being careful to release as quickly as possible. However, these episodes raised the issue of whether staff are being trained well | Substantial Compliance |

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| | | enough in the use of restraints. When a restraint is used, the staff must know how to sustain it to avoid subjecting the individual to multiple restraint attempts and increasing the possibility of injury to both the individual and the staff.<br><br>In addition, a review of the list of individuals restrained between 1/8/11 and 7/8/11 revealed that fewer than 20 episodes of restraint (other than protective restraints for one individual) lasted more than 10 minutes. Based on a list the Facility provided of recent restraints, out of 243 episodes of restraint (495 reduced by 147 for pre-treatment sedation and the 105 protective restraints for one individual) that would be approximately eight percent<br><br>The POI indicated that Facility reviews of 24 restraint checklists in April, and 28 in May revealed that all individuals were released as soon as they no longer posed a danger to themselves or others.<br><br>Based on the review of the sample data, the overall use of restraint, and the consistency of the Facility's own reviews with that of the Monitoring Team, the Facility was found to be in substantial compliance with this provision. To maintain substantial compliance, the Facility will need to attend to the issues of training, documentation and continue its record of releasing individuals from restraint promptly. | |
| 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 | Based on document review, the Facility policies stated that restraints may only be used if the individual posed an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner; and could not be used as punishment, for convenience of staff, or in the absence of or as an alternative to treatment. The Facility policies required training of staff prior to using restraints on individuals<br><br>CCSSLC Policy #C.2 was revised 5/25/11 to provide for a Restraint Restriction List of individuals who cannot be restrained, who have limitations on use of restraint, and who have Safety Plans. The list was to be displayed in each residence in the attendant's station. Policy #C.2 included a list of approved restraints. CCSSLC Policy #C.4 was revised on 5/25/11 to improve the completion and routing of Restraint Checklists and Face-to-Face Debriefing Forms. CCSSLC Policy #C.12 was revised to modify the completion and routing of chemical restraint consult forms. These changes appeared to present a clear pathway for these forms to travel, and one that would assure timely review, and identification and correction of any problems with the use of the forms or any issues raised within the forms.<br><br>Review of the Facility's training curricula revealed that it included adequate training and competency-based measures in the following areas: | Noncompliance |

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| | restraint techniques; and adequate supervision of any individual in restraint. | ▪ Policies governing the use of restraint;<br>▪ Approved verbal and redirection techniques;<br>▪ Approved restraint techniques; and<br>▪ Adequate supervision of any individual in restraint.<br>However, based on the findings with regard to Section C.2, additional training was needed in the techniques of maintaining a restraint when necessary.<br><br>Sample #C.2 included 37 staff members hired since 4/1/11. A review of the training records for these 37 staff indicated that one appeared on the "Course Due/Delinquent List" of 7/11/11 (Employee #0000223663) for PMAB Basic, which covered the fundamentals of preventing, avoiding, and using restraint. This employee was a nurse.<br><br>The delinquency report listed all staff who as of 7/11/11 were supposed to have had PMAB Basic training or to have been retrained on an annual basis. This report showed that 27 people, or about three percent of the approximately 1000 staff at the Facility, were late with their annual training or had not received training.<br><br>As the Facility noted in its Plan of Improvement, there had been some important policy changes, but they were too recent to evaluate completely. In addition, the training of staff still needed to be improved.<br><br>As noted above with regard to Section C.1 of the SA, 97% of the restraint records reviewed showed that restraint was only used after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. However, in order to ensure that the least restrictive method is utilized, individuals' BSPs must be followed, and the preventative steps outlined in BSPs must be implemented. | |
| 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 | Based on a review of 37 restraint records (Sample #C.1), in 34 (92%) there was documented evidence that restraint was used as a crisis intervention.<br><br>In review of eight Behavior Support Plans for the eight individuals in Sample C.1, in eight (100%), there was no evidence that restraint was being used for anything other than crisis intervention (i.e., there was no evidence in these records of the use of programmatic restraint.) In addition, Facility policy did not allow for the use of restraint for reasons other than crisis intervention.<br><br>However, the report entitled Individuals Restrained During Time Period Between 1/8/11 and 7/8/11 included a category called programmatic restraint. According to the State's comments on the last Monitoring Team's draft report, the term "programmatic" was used mistakenly, and had been replaced to read: "Crisis Intervention as Specified in the Safety Plan." The State clarified that CCSSLC did not use programmatic restraint. Some entries | Noncompliance |

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| | eliminate the need for restraint. | in the report had been modified to the "Safety Plan" terminology, but not all.<br><br>All 37 restraint records reviewed (100%) included evidence that the restraint used was not in contradiction to the individuals' medical orders according to the "Do Not Restrain" list. Several individuals appeared on the Do Not Restrain list. However, the list was specific about the restriction on use of restraint. In cases where any question arose, there was a doctor's order for the type of restraint that could be used.<br><br>Individual #133 on 4/22/11 was involved in a series of restraints including chemical restraint following an incident in a store. Individual #133 became loud, violent, stubborn and unwilling to cooperate with staff. Police were summoned to remove her from the store and resorted to handcuffing her in a prone position and dragging her from the store. This was not reported as restraint because police, not staff, were restraining her. The Facility should develop strategies for community-based incidents such as these, to avoid staff employing restraint if possible, but preferring staff employing the restraint as opposed to the police, whenever possible. This might require coordination with the local police department(s). Individual #133 was on the Do Not Restrain list to limit restraints to those that would not put her in a follow down or side lying position due to medical considerations. Prone restraint was prohibited as well because of the possible negative effects on breathing. The Facility should review this incident and decide on some strategies to use in similar situations that will arise in the future.<br><br>In review of 10 Behavior Support Plans, in 10 (100%), there was no evidence that restraint was being used for anything other than crisis intervention (i.e., there was no evidence in these records of the use of programmatic restraint). In addition, Facility policy did not allow for the use of restraint for reasons other than crisis intervention.<br><br>Documentation provided prior to the onsite visit (i.e., initial document request #TX-CC-1107-II.19) indicated that no new dental desensitization plans had been implemented since 10/15/11. At the time of the Monitoring Team's previous review, review of sampled desensitization plans noted that the plans appeared to be almost identical, suggesting little individualization in their development and implementation. In addition, most of the plans appeared to target choice making, and not necessarily skills typically associated with relaxation or calm responding. The Monitoring Team believed that, at that time, the homogeneous objectives and "cookie cutter" strategies lacked sufficient detail (i.e., clear objectives, individualized methodology and reinforcers, differential reinforcement), and consequently, were unlikely to be effective.<br><br>Documentation provided during the most recent onsite visit, however, indicated some progress in revising desensitization plans. This included the development of a multi-disciplinary Desensitization Workgroup that had met repeatedly since the last | |

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| | | Monitoring visit in an attempt to improve treatment plans. These efforts led to the revision of desensitization plans for Individual #174 and Individual #231. Review of these plans, however, did not evidence a significant improvement from previous plans. Similar to last time, the plans appeared very similar and lacked significant components of effective skill acquisition plans (the section of this report that addresses Section S.1 of the Settlement Agreement provides more details). Recent verbal reports, as well as documentation provided indicated that behavioral services staff, active treatment staff, and the contracted BCBA consultant continued to work to improve these plans by attempting to make them more individualized (i.e., planned use of the dental anxiety checklist), more naturalistic (i.e., planned use of environments more similar to the dental office), and by ensuring they had elements critical to effective teaching (i.e., planned integration of skill acquisition format/methodology into these plans).<br><br>In order for compliance to be achieved in this section, CCSSLC needs to make significant improvements in the quality and implementation of desensitization plans and/or other strategies to minimize or eliminate the need for restraint. CCSSLC also needs to develop strategies for community-based behavior incidents to ensure that individuals on the Do Not Restrain list are not restrained. | |
| 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 | The training curricula for the course, Applying Restraint Devices (RES0110MR) was provided for this review. A review of the course outline and materials revealed an initial class and annual refresher class for all staff with responsibilities that could include the use of restraint. It was noted that the course:<br>▪ Stressed the need to know the signs of respiratory or circulatory distress and what to do when they were observed;<br>▪ Emphasized that mechanical restraints could be used only when ordered by a physician or prescribed in a behavior support plan*;<br>▪ Contained examples of restraints and tested knowledge of them;<br>▪ Demonstrated safe holding of limbs and torso;<br>▪ Did not describe the physical restraints commonly used at CCSSLC. However, they were covered in the PMAB course, which was also required for restraint monitors.<br><br>*The course referred to the Behavior Support Plan as the place where mechanical restraints might be ordered. The current policy (i.e., definitions in CCSSLC Policy #C001) defined a Safety Plan as the place where a restraint might be prescribed along with instructions on how to avoid using the restraint.<br><br>The training materials for local classes for restraint checklist monitors, and the training for proper documentation for emergency chemical restraints and medical/dental restraint were provided along with the postings and sign-in sheets for classes in February | Noncompliance |

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| | order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required. | and June of 2011. However, a complete list of restraint monitors and their training was not provided.<br><br>Based on a review of 37 restraint records (Sample #C.1), a face-to-face assessment was conducted and documented on the form entitled "Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint:"<br>▪ In 0 out of 37 incidents of restraint (0%) was documentation available to show that an adequately trained staff member had monitored the individuals. While the form was completed in all 37 cases, there was no documentation available to verify that the staff monitoring the restraints had been trained as restraint monitors;<br>▪ In 36 out of 37 instances (97%), the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint (i.e., Individual #312 on 4/11/11 at 6:45 p.m.). This was an improvement from 70% at last monitoring review.<br>▪ In 37 instances (100%), the documentation showed that an assessment was completed of the application of the restraint.<br>▪ In 37 instances (100%), the documentation showed that an assessment was completed of the circumstances of the restraint.<br>▪ The following concerns related to the documentation were noted:<br>o Sometimes the restraint monitors entered comments such as "Individual was upset about upcoming to PSP" (Individual #191 on 2/15/11 at 5:35 a.m.), or "individual said he needed an adult diaper" (Individual #191 on 5/12/11 at 4:15 p.m.). Somewhere in the documentation it would have been better to record what it was about the upcoming PSP that bothered Individual #191 as well as how staff addressed the individual's concerns, because that could lead to concrete actions to reduce that anxiety. It would have been better to record why Individual #191 thought he needed an adult diaper as well as how staff addressed the individual's concerns, so that actions could be directed at the cause of whatever issue might have been worrying him and/or the response to similar requests.<br>o While there was some progress in staff writing comments on the restraint checklist and the Face-Face assessment, some terminology was not specific enough to be useful in understanding what happened and whether restraint was necessary. Terms like "aggressed toward staff" required more detail. Was the individual kicking and punching, brandishing a lamp as a weapon, flailing his arms or shouting obscenities? If the staff member who completed the form did not make the comments clear enough, the restraint monitor who completes the Face-to-Face/Debriefing form should clarify the details | |

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| | | Based on a review of 37 restraint records for eight individuals for restraints that occurred at the Facility, there was documentation that a licensed health care professional:<br>▪ Conducted monitoring at least every 30 minutes from the initiation of the restraint in 31 (84%) of the instance of restraint. Records that did not contain timely documentation of this included: Individual #7, on 1/16/11, 3/2/11, 3/9/11, 3/19/11, and 3/30/11; and Individual #105, on 5/23/11.<br>▪ Monitored and documented vital signs in 29 (78%). Records that did not contain documentation of this included: Individual #7, on 1/16/11; Individual #191, on 3/12/11; Individual #133, on 4/22/11 for three episodes, on 5/3/11 for two episodes; and Individual #105, on 5/3/11. (Restraint Checklists that were marked "refused" for respirations were scored as noncompliance for this indicator.)<br>▪ Monitored and documented mental status in 29 (78%). Records that did not contain documentation or appropriate documentation of this included: Individual #7, on 1/16/10, and 3/10/11 (no description of "aggressive"); Individual #133, on 4/22/11, three episodes marked as refused for mental status, and on 5/3/11 two episodes; and Individual #105, on 5/3/11.<br><br>Overall, there was noted improvement in the documentation by nursing regarding restraints. From discussions with the Psychiatric Nurses and review of the Facility's raw data from the Restraint-Nursing Review monitoring tools from October 2010 through June 2011, the Facility had been regularly auditing the nursing documentation for some of the episodes of restraint each month. However, from discussions with the Chief Nurse Executive (CNE) and the Psychiatric Nurses, no collaboration or communication had occurred between them regarding the findings of the audits. Consequently, there had been no analysis of the data generated regarding nursing documentation addressing restraint. The Facility should ensure that the data and findings of the restraint audits conducted by the Psychiatric Nurses are provided to the Nursing Department for review, and plans of correction are developed for any problematic areas noted.<br><br>Sample #C.3 was selected from the list of individuals who had medical/protective restraint between 1/1/11 and 6/31/11. The physicians' orders, restraint checklist, monitoring documentation, and Face-to-Face reports were requested for both individuals. Restraint checklists were received, but the rest of the documentation was not submitted. From the records received it was found that:<br>▪ Individual #190 was restrained for medical/protective reasons 36 times in June 2011, and a total of 105 times since January 2011. Restraint Checklist were partially filled out, usually for an abdominal binder for reasons of self-injurious behavior (SIB), and documented that the restraint was used pursuant to crisis | |

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| | | intervention as specified in a Safety Plan. Checks for circulation were done every 30 minutes as required. Releases for toileting were documented. The length of time in restraint exceeded the standard 30 minutes, so a physician's order should be in place, but it was not clear that it was. Other portions of the Restraint Checklists were incomplete, and no Face-to-Face and debriefing forms were in evidence.<br>▪ Individual #182 was restrained on 6/3/11 at 12:00 p.m. for sedation in order to complete her medical exam. The Restraint Checklist indicated a light conscious sedation to allow for a bone density scan. A similar Restraint Checklist was done on 6/20/11 at 8:00 a.m. to allow for the completion of a medical exam.<br><br>It was not clear that the restraint for Individual #190 met the definition of medical restraint included in the Settlement Agreement. Individual #190 had been restrained over 100 times for behavioral reasons. She should have had a Behavior Support Plan, and a Safety Plan. According to CCSSLC Policy #C0100, the maximum time in mechanical restraint for crisis intervention prior to attempting release is 55 minutes. Release must be for a minimum of five minutes. If, however, this was a medical restraint, then the length of time would be as specified by the physician. If requirements to complete other restraint documentation, such as the Face-to-Face report are going to be waived, there must be a written explanation and justification for doing so.<br><br>Individual #190 appeared on the Do Not Restrain list as not to be restrained physically under any circumstances, which may explain why the abdominal binder was being used.<br><br>To come into substantial compliance with this provision, the Facility needs to provide evidence that all staff who perform the duties of restraint monitor are qualified to do so. Efforts to provide additional training to staff who fill out restraint checklists and debriefing forms should continue to ensure that the progress made can be sustained. Of particular importance is the need to continue to work with staff to provide information about precursors to behavior that necessitates restraint. Progress had been made, but more is needed. The Facility should ensure that restraints classified as "medical" meet the definition in the Settlement Agreement, and ensure that restraints listed as medical/protective have proper documentation to support alternative schedules of monitoring and time in restraint. | |
| 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 | A sample (Sample #C.1) of 37 Restraint Checklists for individuals in non-medical restraint was selected for review. The following compliance rates were identified for each of the required elements:<br>▪ In ten of the 37, the restraint was chemical, and one-to-one supervision was not required. In the remaining 27 (100%), continuous one-to-one supervision was provided; | Noncompliance |

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| | 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. | ▪ In 37 (100%), the date and time the restraint was begun was documented;<br>▪ In 37 (100%), the location of the restraint was documented;<br>▪ In eight (22%), information about what happened before, including the change in the behavior that led to the use of restraint was adequate. Examples included:<br>o A positive example: For Individual #114 on 5/21/11 at 7:23 p.m., staff documented that the individual was upset by a peer who refused to share his cigarettes, providing a clear understanding of what happened before the behavior that led to restraint.<br>o Likewise, with Individual #133 on 4/17/11 at 4:58 p.m. when staff documented that the individual became upset because a male peer would not talk to her, leading to the restraint.<br>o A less positive example: For Individual #105 on 4/14/11 at 4:26 p.m., staff did not record the precursor to rock-throwing, but the Face-to-Face assessment did record he was upset at being redirected by staff from banging his head against a pillar.<br>o An example of not getting the needed information recorded was for Individual #105 on 5/3/11 at 5:54 p.m., when the restraint checklist indicated he was "upset." The question that needed an answer was what caused the individual to be upset.<br>▪ In 37 (100%), the actions taken by staff prior to the use of restraint were documented by checking the applicable boxes on the checklist. However, to permit adequate review per Section C.8, some narrative was needed. It was not possible to tell from the box checks what order the interventions were employed, or whether the staff were able to follow the directions in the Safety Plans as they were written. It will be important that training on the checklist emphasize that some narrative is needed, and that it must not repeat what is already in the checked boxes.<br>▪ In 37 (100%), the specific reason for the use of the restraint was indicated with at least a checkmark in a relevant box. In 37 (100%), there was an additional comment in the "Describe Events…" box that described more precisely the reason for the restraint was such as "destruction of others property," or "throwing rocks," or "biting and banging head."<br>▪ In 37 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint was documented;<br>▪ In 37 (100%), the names of staff involved in the restraint episode were listed;<br>▪ Observations of the individual and actions taken by staff while the individual was in restraint, including:<br>o In 37 (100%), the observations documented every 15 minutes and at release. Most restraints in the sample were brief and most were monitored more frequently than every 15 minutes.<br>o In 37 (100%), the specific behaviors of the individual that required | |

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| | | continuing restraint.<br>o In 37 (100%), the care provided by staff during the restraint, including opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan, although this was not an issue since the range of time in restraint in this sample, excluding individuals restrained chemically, was one to 23 minutes. One episode was recorded as 62 minutes (Individual # 7 on 3/30/11 at 8:46 a.m.). However, it appeared from the record of the restraint that the individual was in and out of restraint during that time, with one period of nine minutes when she was released during the 62 minutes.<br>▪ In 27 of 27 episodes of physical restraint (100%), the level of supervision provided during the restraint episode was identified;<br>▪ In 27 of 27 episodes of physical or mechanical restraint (100%), the date and time the individual was released from restraint was provided; and<br>▪ In 27 (100%), the results were documented of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects.<br><br>In a sample of 37 records (Sample #C.1), restraint debriefing forms, entitled "Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint," while present in 100% of the records, had not always been completed correctly or completely. The specific improvements as well as concerns noted are described below.<br><br>Improvements noted included:<br>▪ Information on the debriefing forms clarified missing elements from the Restraint Checklist, such as identifying the precursor to the behavior that led to restraint.<br>▪ The chemical restraint portion of the form was completed for most chemical restraints and a pharmacy note was done. A good example of a note on a pharmacy review was Individual #133 on 5/16/11 at 8:40 p.m., where the pharmacist noted that the same emergency chemical restraint was ordered for the fifth time in about a month and recommended review of the maintenance medication.<br>Concerns noted included the following:<br>▪ For at least 13 forms, there were no indications of review by the Unit Incident Management Review Team (UIMRT) or the Incident Management Team (IMT) recorded on the debriefing form;<br>▪ For Individual #7 on 3/10/11 at 9:25 p.m., the person administering the chemical restraint and the restraint monitor appeared to be the same person.<br>▪ Sometimes boxes were checked and no comment was entered. Examples included checking the box for concerns with "safety of all" (Individual #191 on | |

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| | | 2/27/11 at 10:50 p.m.), or checking restraint not stopped when individual no longer a danger (Individual # 191 on 4/28/11 at 4:54 p.m.). When the restraint monitor checks a box that is not the expected one, an explanatory comment should be entered.<br>▪ On one form for Individual #312 on 4/11/11 at 6:45 p.m., the debriefing was on an old form.<br>▪ One form for Individual #133 on 4/22/11 at 7:58 p.m. did not have the chemical restraint portion of the form completed.<br>▪ Three separate restraints were recorded on three separate debriefing forms for Individual #133 on 4/22/11 at 7:52p.m, 7:55 p.m., and 7:58 p.m. with the second being a chemical restraint. There was a debriefing form for each event, which was the initial form with additions for the second two restraints. Together the three were awkward to follow, but made sense. The Facility might want to consider how to reduce the paperwork where restraints resulting from the same initial event, happen in quick succession.<br><br>Sample #C.4 was selected using the list the Facility provided called "Individuals Restrained During Time Period Between 1/1/11 and 6/31/11." A sample of 20% of the 21 individuals restrained with chemical restraint other than pre-treatment sedation on the list was selected and included: Individual #133 on 4/17/11 at 4:58 p.m. and on 5/16/11 at 9:40 p.m.; Individual #7 on 3/10/11 at 9:25 p.m.; and Individual #191 on 5/12/11 at 4:15 p.m.<br><br>This sample of four individuals who were the subject of a chemical restraint were reviewed. In four (100%), there was documentation that prior to the administration of the chemical restraint, the psychologist was consulted. The direct contact was between the licensed health care professional (a nurse) and the psychologist, who assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met. In three of the four cases, it was not clear who the psychologist was that was contacted. In one case, both names were on the "Name of Nurse/physician, consulting psychologist," which was helpful in establishing who it was that made contact.<br><br>The Facility remained out of compliance with this provision, although many of the details needed on the Restraint Checklists and Chemical Restraint forms were in place. The Facility still needs to record the reviews by the Unit Team and the Incident Management Team on the Face-to-Face Assessment, Debriefing and Reviews for Crisis Intervention Restraint forms (i.e., 04282009R). Overall, the quality of the Restraint Debriefing and Face-to-Face forms should be improved. Staff should complete forms accurately, and fill in all information, particularly explanatory comments and dates of review. In addition, there should be documentation of direct contact between the licensed health care | |

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| | | professional and the psychologist prior to administration of chemical restraint. | |
| C7 | Within six months of the Effective Date hereof, for any individual placed in restraint, other than medical restraint, more than three times in any rolling thirty day period, the individual's treatment team shall: | | |
| | (a) review the individual's adaptive skills and biological, medical, psychosocial factors; | According to the Restraint Quarterly Trending Reports, dated 12/1/10 to 2/28/11 and 3/1/11 to 5/31/11, 67, 26, and 74 restraints occurred within the first, second and third quarters of 2011, respectively. Documentation reflected that approximately 25 individuals were involved in these reported restraints. Of these individuals, three individuals (Individual #7, Individual #133, and Individual #191) were selected for further review (reflecting a sample of 12%). According to most recent quarterly report, these three individuals were within "the top five" of those identified with the most restraints. In addition, Individual #7 was identified as having the most frequent pica related incidents (although, inexplicably, she did not have a diagnosis of pica), Individual #191 was identified as one of individuals with the highest number of injuries, and Individual #133 was one of the individuals noted to have caused the highest number of injuries.<br><br>According to provided documentation, restraints were reported for sampled individuals on the dates in 2011 listed below. For clarification, repeated dates reflect multiple restraints on the same day, and dates in [brackets] reflect PSPA meetings where PSTs, in some cases, appeared to meet in response to the "more than three restraints in a rolling 30-day period" criterion:<br>• Individual #7: 1/16, 3/2, 3/7, 3/9, 3/10, 3/10, [3/15], 3/19, 3/30, and 5/13;<br>• Individual #133: 2/10, 2/10, 2/10, [2/11], 4/17, 4/17, 4/22, 4/22, 4/22, 5/3, [5/4], 5/16, 5/16, [5/17], 5/29, and [6/1];<br>• Individual #191: 2/15, 2/27, 2/27, 2/27, [2/28], 3/12, 3/20, 4/28, 5/11, 5/12, and [5/13].<br><br>One restraint for each of the selected individuals from the above dates was randomly selected. This included: 1) Restraint Checklist, dated 3/30/11 (8:46 a.m.) for Individual #7; 2) Restraint Checklist, dated 4/22/11 (7:58 p.m.) for Individual #133; and 3) Restraint Checklist, dated 5/12/11 (4:15 p.m.) for Individual #191. In addition to the specific Restraint Checklists, Face-to-Face Assessment Debriefing and Reviews for Crisis Intervention Restraint forms were reviewed for Individual #7, Individual #133, and Individual #191 on those specified dates as well. In addition, the PSP, PSP addendums, | Noncompliance |

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| | | SFBAs, PBSPs, SPCIs, and PSP Monthly Behavioral Services Reviews, as provided, were reviewed. The results of this review are discussed below with regard to Sections C.7.a through C.7.g of the Settlement Agreement.<br><br>According to the POI, since the last Monitoring visit, oversight was provided to PSTs that were meeting and completing the Personal Support Plan Addendum (PSPA) template (i.e., when the criterion of "more than three restraints in a rolling 30-day period" was met). This oversight identified PSTs that were not utilizing the template as well as prompting, when necessary, the revision of several documents (e.g., SFBA, PBSP, and SPCIs). Within the current sample, it was noted that two of the more recent PSPA meetings utilized this new format. That is, the new template was used for Individual #191 (PSPA dated 5/13/11) and Individual #133 (PSPA dated 5/4/11). However, other PSPAs did not appear to utilize the new format. This included, a PSPA for Individual #7 (dated 3/15/11), and multiple PSPAs for Individual #133 (dated 5/17/11 and 6/1/11).<br><br>Of the three individuals sampled, one (33%) of the individuals' teams met to discuss the selected restraints. The following are examples of where teams completed this adequately:<br>▪ Evidence provided indicated that the PST for Individual #133 met multiple times (i.e., on 2/11/11, 5/4/11, and 5/17/11) to discuss the three or more restraints that occurred across multiple 30-day rolling periods. The selected restraint (dated 4/22/11) was discussed by the PST during the PSPA meeting dated 5/4/11.<br><br>The following is an example of where a team failed to do this adequately:<br>▪ Documentation indicated that the PST for Individual #7 met on 3/15/11, and discussed three restraints that occurred between 3/7/11 and 3/10/11. These three included chemical restraints on 3/7/11 and 3/10/11, as well as a physical restraint on 3/9/10. However, it did not appear that, at that time, the PST discussed additional restraints (i.e., physical restraints on 3/2/11 and 3/10/11) or other subsequent March restraints (i.e., dated on 3/19/11 and 3/30/11).<br>▪ Although documentation indicated that the PST for Individual #191 met on 5/13/11 to discuss the three restraints that occurred between 5/11/11 and 5/12/11(i.e., including the sampled restraint on 5/12/11), there was no evidence that similar meetings followed other, previous restraints (i.e., that met the more than three restraints in a rolling 30-day day period) that occurred between February and March 2011. More specifically, it appeared that the PST should have met in late February to address the four restraints that occurred between 2/15/11 and 2/27/11, and/or met in mid-March to address the five restraints that occurred between 2/27/11-3/20/11. | |

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| | | The PST for Individual #7 did not meet to discuss the restraint selected (dated 3/30/11). However, the PST did meet on 3/15/11 to discuss restraints that occurred between 3/7/11 and 3/10/11. To facilitate the current review, although it did not capture the date originally selected, the Monitoring Team utilized the PSP addendum dated 3/15/11 for Individual #7 to examine subsequent Sections C.7.a through C.7.g of the Settlement Agreement.<br><br>Of the three individuals reviewed, zero (0%) of the individuals' teams adequately reviewed the individual's adaptive skills. The following are examples of where teams failed to do this adequately:<br>▪ Although there was evidence that the PST briefly discussed the inability of Individual #133 to utilize her problem-solving skills or replacement behaviors during extreme agitation, there was no direct discussion documented regarding her current progress in developing or utilizing these adaptive skills.<br>▪ Although the PST did identify and discuss several psychosocial variables (i.e., cancellation of outing, money, etc.) for Individual #191, team discussion regarding other potential factors (i.e., biological, medical, adaptive) was not documented. Indeed, although an SPO regarding money management was discussed, it seemed relevant and important to discuss other, more salient adaptive behaviors, including those specifically identified as replacement behaviors in the PBSP. These, however, were not discussed.<br>▪ Meeting minutes very briefly indicated that Individual #7 "… would be encouraged and supported in improving her use of replacement behaviors …" and that restrictive components of her program would be faded once she " … demonstrates psychosocial stability, i.e., no dangerous behaviors but instead demonstrating her replacement behaviors to manage stress, frustration, and disappointment." Other than these general statements, no direct or active discussion regarding the status of her multiple alternative behaviors as outlined in her PBSP (i.e., coping and calming skills, problems solving, or verbalizing anger, etc.) was evident.<br><br>Of the three individuals reviewed, one (33%) of the individuals' teams reviewed the biological, medical and psychosocial factors. The following are example of individuals who whom this was done appropriately:<br>▪ Provided evidence suggested that the PST team for Individual #7 discussed her recent evaluation by psychiatric and psychological disciplines, including her previous and current requests for inpatient evaluation. This discussion appeared to include underlying medical and psychosocial factors that were likely to influence her current status.<br><br>The following are examples of where teams failed to do this adequately: | |

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| | | ▪ Although the PST did identify and discuss several psychosocial variables (i.e., cancellation of outing, money, etc.) for Individual #191, team discussion regarding other potential factors (i.e., biological and medical) either did not occur or was not adequately documented.<br>▪ Although the PST for Individual #133 did identify and discuss several potential psychosocial variables (i.e., inability to delay gratification, being "emotionally flooded"), team discussion regarding other potential factors (i.e., biological and medical) was not specifically documented. | |
| | (b) review possibly contributing environmental conditions; | Of the three individuals sampled, only one (33%) of the individuals' teams adequately reviewed the possibly contributing environmental conditions. The following are examples of individuals for whom this was done appropriately:<br>▪ Provided documentation for Individual #7 evidenced that the PST reviewed a number of potential environmental variables that might have contributed to the behaviors that led to restraint.<br><br>The following are examples of where teams failed to do this adequately:<br>▪ Although documentation indicated that the PST reviewed the environmental factors that may have contributed to the restraint for Individual #133 (i.e., the PSP addendum dated 5/4/11 indicated that "the PST felt that environmental factors played no significant role in these incidents"), it was the Monitoring Team's judgment that this review was inadequate given that multiple environmental variables (e.g., the loss of a wallet, inability to purchase desired items, social attention from police, staff, store personnel and shoppers, etc.), that were clearly identified within the addendum, as well as variables likely given content within the SFBA and PBSP, which were likely influencing the responses that led to the restraint.<br>▪ The PST team did not adequately address potential environmental variables that might have been related to the event(s) leading to restraint for Individual #191. That is, there was no evidence in the documentation provided to indicate that the team reviewed potential contributing environmental conditions. Indeed, documented meeting minutes were vague and simply stated that: "… all other environmental factors were changed. All other methods appeared to be exhausted." This description did not identify any specific environmental variables or contingencies that would be helpful to the PST. | Noncompliance |
| | (c) review or perform structural assessments of the behavior provoking restraints; | Of the three individuals sampled, only one (33%) of the individuals' teams adequately reviewed and/or performed structural assessments of the behavior provoking restraints. The following are examples of individuals for whom this was done appropriately:<br>▪ Documentation provided indicated that the PST for Individual #133 reviewed the current SFBA, as well as current events in an attempt to integrate the | Noncompliance |

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| | | collected information to better understand the potential underlying function of the target behaviors that led to the restraint.<br><br>The following are examples of where teams failed to do this adequately:<br>▪ Evidence reflected that the PST discussed several elements of the current SFBA (dated 2/20/11) for Individual #191. However, it would have been helpful if the PST discussion compared/contrasted the current events with previously identified potential hypotheses regarding challenging behaviors, noted any consistent and/or inconsistent findings, and highlighted potential implications for future practice.<br>▪ Although the safety plan and current behavioral programming appeared to be discussed based on provided documentation for Individual #7 (PSP addendum dated 3/15/11), no direct reference to the current psychological assessment (e.g., the SFBA) was noted. It seems likely that the PST's deliberations would have benefitted from review and discussion of the current SFBA and how it related, if at all, to the current responses leading to restraint. | |
| | (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 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 | Of the three individuals reviewed, three (100%), individuals had a current PBSP. Of the three individuals in the sample who had PBSPs, the following was found:<br>▪ Three individuals (100%) specified the alternative, positive adaptive behaviors to be taught to the individual to replace the behavior that initiated the use of the restraint.<br>o Several replacement behaviors, including problem solving, verbalization of anger, and calming techniques, were identified in the PBSP for Individual #7.<br>o Similarly, several replacement behaviors, including alternative responses to aggression (e.g., walking away, counting to 10, etc.), were identified in the PBSP for Individual #133.<br>o More specifically, the replacement behavior for Individual #191 prescribed that the individual will "… be able to state 3 ways to deal with anger/frustration …" It might be more helpful if the individual were able to demonstrate three ways to deal with anger and frustration, especially in the natural environment.<br>▪ None of the PBSPs adequately defined the behavior(s) to be treated that led to the use of the restraint:<br>o On first glance, the PST meeting (dated 3/15/11) for Individual #7 appeared to reflect the review of current data and the effectiveness of the behavioral interventions. More specifically, documentation | Noncompliance |

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| | individual's ISP; | indicated that "… intervention to her behavior escalations were effective in reducing the intensity and duration." However, behavioral data was not collected on the intensity and duration of her challenging behavior. That is, according to PSP monthly reviews only frequency data was collected on target behaviors and restraint. Consequently, this statement did not appear to be based on objective data. In addition, pica was defined within the behavioral category of self-injurious behavior. Although this might appear to have face validity, this combination might limit the usefulness of the data that is collected. In addition, due to the potential severity of pica behavior, it is strongly recommended that these behaviors (i.e., self injury and pica) be defined and assessed separately. Collapsing the two responses within one category might inadvertently underestimate the occurrence of attempts or actual occurrences of pica. In addition, it would allow more accurate measurement and monitoring over time, as well as potentially more accurate assessments of underlying function.<br>o The PBSP for Individual #133 combined SIB and aggression under the sample category (Challenging Behavior #1). Collapsing these two behaviors together might increase the likelihood that subsequent assessment would inadvertently overlook underlying functions or environmental variables that might be relevant to one behavior and not the other. That is, by combining the two, the assumption appeared to have been made that they both had the same underlying function. Indeed, the SFBA collapsed them together during indirect assessments.<br>o The PBSP (dated 3/31/11) for Individual #191 defined multiple responses under the description "aggression." These responses included self-injurious behaviors, as well as property destruction. Typically, it is helpful to define, monitor and assess these behaviors separately. Consideration should be given to defining these behaviors separately as it might facilitate more accurate assessment and identification of underlying, perhaps different function(s).<br><br>The Safety Plans of the individuals in the sample were reviewed. The following represents the results:<br>▪ In three out of three of the Safety Plans reviewed (100%), the type of restraint authorized was delineated. However, as is discussed in further detail below, concerns were noted with how the restraint was implemented for Individual #191.<br>o Documentation provided indicated that a physical hold was utilized and this was consistent with the PMAB physical restraints listed in the SPCI for Individual #7. | |

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| | | o The PMAB physical restraint (i.e., hand-over-hand) utilized in the sampled restraint for Individual #133 was consistent with the identified PMAB technique listed in the SPCI.<br>o A chemical restraint was utilized for Individual #191 following self-injurious responding. However, it did not appear that the staff followed the current SPCI (dated 7/30/10) by implementing initial less restrictive (as written) PMAB physical restraints (i.e., hand-over-hand, baskethold or follow-down personal restraint). The SPCI clearly stated that "… if [Individual #191] is in restraint for 15 minutes and continues to be in restraint make a request for a chemical restraint." According to the restraint report, no physical restraints were implemented prior to the use of chemical restraint.<br>▪ Of the three individuals sampled, three (100%) individuals had the maximum duration of authorized restraint specified in their SPCI.<br>o The maximum duration of PMAB physical restraints (i.e., when the individual stops struggling or when the restraint reaches the maximum of 30 minutes) was listed in the SPCI for Individual #7. However, the duration of the documented restraint (dated 3/30/11, 8:46 am) was clearly over this duration despite several attempts to release the restraint (i.e., multiple attempts to release the restraint were unsuccessful).<br>o The maximum duration of PMAB physical restraints (i.e., when the individual stops struggling or when the restraint reaches the maximum of 30 minutes) was listed in the SPCI for Individual #133 and Individual #191.<br>▪ Of the three individuals sampled, two (66%) had the designated approved restraint situation specified in their SPCIs.<br>o Provided documentation clearly indicated the physical holding (hand-over-hand) was outlined in the SPCI for Individual #7 and Individual #133.<br>o However, as previously discussed, the way in which aggression was defined for Individual #191 appeared problematic and seemed to lead to ambiguity in staff instructions. For example, the SPCI describes and provides examples of aggressive responses directed toward others and not specifically self-injurious responses. The specific responses listed on the restraint form, which led to chemical restraint, were self-injurious behavior and property destruction. So, technically, according to the SPCI, chemical restraint is only prescribed following aggression toward others. Using the PBSP as a reference, aggression may include SIB or property destruction. Nevertheless, more specification when individually defining behaviors would be very helpful in eliminating this | |

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| | | type of ambiguity.<br>▪ Of the three individuals sampled, three (100%) had the criteria for terminating the use of the restraint specified in their SPCIs. | |
| | (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 | There was no evidence in the sampled documentation to indicate that treatment integrity was examined for any of the PBSPs of the three individuals selected. According to current verbal reports from behavioral services staff, treatment integrity data was collected, but still had not been summarized or systematically analyzed. Subsequently, treatment integrity of PBSPs had not been estimated. At the time of the review, therefore, it was not possible to ensure a high degree of treatment integrity. | Noncompliance |
| | (g) as necessary, assess and revise the PBSP. | Of three of the records reviewed, there was documentation that two (66%) of the individual's PBSPs had been assessed or revised, as necessary. The following are examples of individuals for whom this was done.<br>▪ The PST for Individual #7 appeared to discuss current progress and recommended that current behavioral programming be continued to be monitored (weekly) and implemented.<br>▪ The PST for Individual #133 discussed the current PBSP and its effectiveness and recommended no changes at that time.<br><br>The following is an example of where the team failed to do this adequately:<br>▪ The PST for Individual #191 appeared to have reviewed the PBSP by recommending that no modifications were needed at the time. However, given the presented concerns, the PST should have revised the PBSP and/or SPCI to clear up the considerable ambiguity and inconsistency in the operational definitions and procedures. In addition, more specification within the PSPA reflecting the active discussion of the PST, including the review of target and replacement behavior data, analysis and comparison of current events with previously identified potential functions, and corresponding interventions within the SFBA and PBSP would have likely assisted the PST in identifying areas in need of revision, or in highlighting interventions that had promise. One small example, noted in the PSPA (dated5/13/11), was the PST's review of the SFBA concluding that "…[Individual] does not always receive verbal redirection well, requiring staff to resort to physical redirection and at times, restraint." This should have prompted the question from the PST regarding why, in this case, physical restraint was not used prior to a more intrusive intervention (chemical restraint).<br><br>Consideration to should be given to documenting the active review of collected behavior | Noncompliance |

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| | | and skill acquisition data to ensure the PST is making data based decisions of the effectiveness of the PBSP. | |
| 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. | Generally, the Unit Incident Management Review Team reviewed the restraint on the day following the restraint, and the Incident Management Team reviewed it on the next business day. UIMRT meeting minutes had been revised to show a more thorough review of restraints. An observation of a morning meeting of a UIMRT in the Atlantic Unit indicated that the team was engaging in active discussion around restraints.<br><br>In addition, the Restraint Reduction Committee (RRC) was meeting monthly to review restraints that had been used and to look for trends and strategies for reduction in use. The RRC had been modified to include review of Personal Support Plan Addenda for restraints, which were not authorized by a Safety Plan, to determine if a PSPA meeting was held within one working day, and to discuss any further recommendations. The RRC minutes included review of the use of chemical restraints to assure that debriefing for chemical restraint and a clinical review were completed for each restraint, and recommendations were recorded. Medical restraints were reviewed, and a summary of all restraint activity and follow-up to recommendations was included. This process represented a thoughtful and thorough review of restraint use.<br><br>The Monitoring Team acknowledges the significant progress made. One area to consider is whether requiring additional investigation of identified issues would strengthen the resulting recommendations. For example, the chemical restraints administered to Individual #133 on 4/17/11 and 4/22/11 were reviewed at the 5/26/11 RCC meeting. The minutes under recommendations noted that the restraint was due to the individual's anxiety about an upcoming community placement, and current programming should continue. Given that the 4/22/11 chemical restraint followed an episode at a store, which required police intervention, this would have been an opportunity to recommend development of community-based strategies for dealing with disruptive behavior.<br><br>A sample of documentation related to 37 incidents of non-medical restraint was reviewed (Sample #C.1), including Unit Team meeting minutes, incident management review team meeting minutes, Restraint Reduction Committee minutes and PSP addenda. This documentation showed that:<br>▪ In 37 (100%) records, the UIMRT and IMT reviews occurred within three days of the restraint episode. However, it was not clear from the minutes that the UIMRT did more than review the restraint report for accuracy and refer it for correction. Observation of one UIMRT meeting revealed that there was discussion about the restraint use and the reasons for it. However, if the minutes contained referrals for action or follow-up, it was not clear how this would be | Noncompliance |

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| | | tracked in the minutes. There was usually a follow-up meeting held by the Personal Support Team and addenda added to the PSP to reflect their discussion, which sometimes included referral back to the psychologist for an amendment to the Behavior Support or Safety Plan.<br>▪ However, as noted above with regard to Section C.7, teams did not consistently and appropriately review individuals PBSPs. As a result, revisions were not always made as necessary and appropriate.<br><br>The Facility's Plan of Improvement included an action plan for this section. It involved revising the UIMRT meetings and documentation, training Unit Directors and Administrators on the revised format, and implementing that format. According to the Facility, the action plan was completed as of June 30, 2011. The format was in use in the Atlantic Unit and minutes from the May meetings were reviewed. Three individuals from Sample C.1 were reviewed, and found to have been recorded in the minutes of the next UIMRT meeting. However, the sections on restraint in the minutes were not did not contain complete information. Further, the descriptions of Root Causes were weak. For example, Individual #7 being "Upset about peer not giving her a soda" might be accurate, but the root cause might have to do with her nutritional restrictions, associating with incompatible peers, or any number of other possibilities that need to be sorted out and understood, if Individual #7 is going to have a chance at a life without restraint.<br><br>Since these processes were still relatively new, improvements in the process over the next six months will be necessary for substantial compliance to be achieved. Until then, this provision remains out of compliance. | |

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

1. Training should be provided to direct support professionals to ensure that they are prompting the use of replacement behaviors and other coping strategies, using techniques outlined in the PBSPs to prevent and address behaviors, and documenting their use adequately, when appropriate, on restraint checklists. (Section C.1)
2. The quality of the documentation of the events preceding the restraint should continue to be improved to provide an understanding of what happened to initiate the chain of events that resulted in restraint, as well as the specific actions staff took. (Sections C.1 and C.5)
3. Staff should be trained to follow the PBSPs and Safety Plans prior to the use of restraints, and to document the steps taken on the Restraint Checklist. When Restraint Monitors note lack of documentation, they should ask staff for clarification and record the information in the debriefing form. (Sections C.1 and C.3)
4. Whenever staff are unable to successfully implement a restraint, the circumstances should be reviewed to determine if the particular staff needs additional training, if the training provided needs to be modified overall, or if other factors impacted the effectiveness of the restraint. (Sections C.2 and C.3)
5. In order to ensure that individuals remain safe and are not restrained if medically contraindicated, strategies should be developed for

community-based episodes of challenging behavior to avoid police involvement and restraint procedures as much as possible. (Section C.4)

6. Desensitization plans should be individualized. Assessments should be conducted to identify individual-specific preferences, current coping skills/deficits, and likely effective supports. Once identified, these elements should be incorporated into plans and implemented across settings, including opportunities to practice coping skills in the natural setting (dental office). (Section C.4)
7. Desensitization plans should mirror the improved Skill Acquisition Plans, which are discussed in further detail with regard to Section S of the Settlement Agreement. That is, elements currently found within these plans, such as behavioral objectives, differential reinforcement, etc., are critical to the success of any skill acquisition plan and, therefore, should be the foundation of these desensitization plans as well. (Section C.4)
8. Progress on desensitization plans should be regularly documented and summarized. Such information should be summarized in Monthly Behavioral Services PSP Monthly Reviews (i.e., along with other behavioral data), or in Monthly PSP Reviews (i.e., along with other skill program data). In addition, efforts should be made to ensure that all documentation accurately and consistently reflects the implementation of these plans. (Section C.4)
9. A list of staff who have been trained as Restraint Monitors should be maintained with evidence of the training. (Section C.5)
10. The Facility should review the restraints categorized as medical restraints to ensure they meet the definition included in the Settlement Agreement. For individuals for whom restraint has been miscategorized, reviews should occur to determine if PBSPs are needed, and, if so, to develop and implement them as soon as possible. (Section C.5)
11. The Facility should ensure that restraints, such as medical/protective restraints, have documentation to support alternative schedules of monitoring and time in restraint. (Section C.5)
12. The Facility should ensure that a licensed health care professional timely monitors and documents vital signs and the 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. (Section C.5)
13. The Facility should ensure that the data and findings of the restraint audits that the Psychiatric Nurses conduct are provided to the Nursing Department for review, and development of plans of correction for any problematic areas noted. (Section C.5)
14. The quality of the Restraint Debriefing and Face-to-Face forms should be improved by ensuring staff complete forms accurately, and fill in all information, particularly explanatory comments and dates of review by the Unit Teams and the Incident Management Team. (Section C.6)
15. The names of the licensed health care professional and the psychologist should be recorded in the documentation of their consultation prior to use of chemical restraint. (Section C.6)
16. Training should continue on the new PSPA template (i.e., following more than three restraints in a rolling 30-day period) to ensure that PST are actively discussing all elements listed, including the review of behavioral and skill acquisition data, as well as to ensure that meeting minutes and/or documentation on the PSPA clearly and accurately reflect each section of the template. Most importantly, the PST should highlight the rationale as to why the PST decided to (or not to) revise the SFBA, PBSP, and/or SPCI, including the influence of current (and relevant) skill acquisition and corresponding target behavior data (i.e., reflect the PST's data-based decision making). (Section C.7)

| SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management | |
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| 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:<br>▪ **Review of Following Documents**:<br>o CCSSLC Policy and Procedure Manual Section D, including Policy #021 and related procedures D.1 through D.20, and Policy #002.2 and related procedures DD.1 through DD.18, updated through June 2011;<br>o CCSSLC Plan of Improvement, dated 6/29/11;<br>o CCSSLC Investigations During the Time Period: 1/1/11 through 5/31/11, dated 6/21/11;<br>o CCSSLC Unusual Incidents – Monthly Trending Report from 6/1/11 to 6/30/11;<br>o Abuse/Neglect/Exploitation Investigations During Time Period Between 7/11/10 and 7/11/11, dated 7/11/11;<br>o CCSSLC Abuse Neglect and Exploitation – Monthly Trending Report from 6/1/11 to 6/30/11;<br>o CCSSLC Injuries – Monthly Trending Report from 6/1/11 to 6/30/11;<br>o Individuals with Injuries for Reporting Period between 7/11/10 and 7/11/11;<br>o Letter to family members and guardians from the Qualified Mental Retardation Professional (QMRP), undated;<br>o Section D – Protection from Harm – Abuse, Neglect, and Incident Management monitoring tool, revised January 2011;<br>o CCSSLC Staff Status Tracking – by Date, dated 6/10/11;<br>o List of seven staff who failed to report abuse, dated 6/4/11;<br>o Letters to two staff involved in confirmed allegations of abuse per Document Response Request III.33;<br>o Course Delinquency List for ABU0100, Abuse and Neglect, dated 7/11/11;<br>o Individual Training Records for Facility staff assigned to investigate incidents, abuse, and neglect, dated 6/7/11;<br>o Review of Unusual Incident Report form, dated June 2011;<br>o Investigation Review and Approval Form, undated;<br>o Sample #D.1: This included a sample of 39 DFPS (approximately 17% of the 224 conducted between 1/1/11 and 5/31/11 investigations of abuse, neglect, and/or exploitation reports. This sample included the following investigation numbers: #39032751, #39217147, #38982918, #38971061, #39157428, #38971096, #39167568, #39118987, #39211868, #39060367, #38956811, #38896502, #39291647, #39309967, #39316248, #39327527, #39308472, #39225449, #39330370, #39298328, #39299147, #39327247, #39371648, #38953130, #39649147, #39655128, #39998468, #39964828, #39948628, #39943708, #39911367, #39782487, #39903227, #39665187, #39709587, #39854407, #39836367, #39813727, #39746868;<br>o Sample #D.2: This included a sample of 13 Facility investigations (approximately 22% of the 58 investigations that occurred between 1/1/11 and 6/30/11). Some of these were |

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| | investigations that DFPS also had conducted, while others were investigations the Facility completed related to serious injuries or deaths. This sample included the following investigations (using the DADS number found on the reports): #491710, #485164, #488890, #488584, #489931, #489720, #489938, #491204, #484922, #489107, #495777, #49661 and #495864;<br>o Sample #D.3: This included case #39061691 brought to the attention of the monitors by the Facility in their Plan of Improvement, that resulted in the dismissal of seven employees;<br>o Sample #D.6: is a subsample of Samples D.1 and #D.2. It included DFPS case #39948628 and #39217147; and<br>o Personal Support Plans (PSPs), including those for Individual #124, Individual #372, Individual #109, Individual #7, and Individual #336.<br>▪ **Interviews with**:<br>o Iva Benson, Facility Director;<br>o Mark Cazalas, Assistant Director of Programs;<br>o Daniel Dickson, Director for Quality Assurance;<br>o Jon Breseman, Incident Management Coordinator;<br>o Twenty staff members in various residential and day locations; and<br>o Ten individuals in various residential and day locations.<br>▪ **Observations of**:<br>o All residences;<br>o Vocational Buildings including buildings: 510, 513 and 512;<br>o Atlantic Unit Management Team Meeting, at 9 a.m. on 7/14/11; and<br>o PSP meetings for Individual #228, Individual #234, and Individual #353. |
| | **Facility Self-Assessment:** Based on a review of the Facility's POI, with regard to Section D of the Settlement Agreement, the Facility found that it achieved compliance with the majority of indicators. It assessed itself to be in substantial compliance with 16 out of 22 indicators, as compared to the Monitoring Team's finding that the Facility was in substantial compliance with 10 out of 22 indicators.<br><br>As of the Monitoring Team's last report, a monitoring tool and guidelines to assess compliance with Section D had been developed. At the time of this most recent review, those tools were being applied, and data was being generated to determine the status of some of the provisions of the section. The size of the sample had been increased from five per month to 15. However, refinement of the process was still necessary.<br>In some instances, the narrow focus of data was not adequate, and a more comprehensive review was needed to determine compliance. For example, Section D.2.a, which addresses the timeliness of reporting of incidents and allegations, the Facility cited data regarding staff's ability to describe reporting requirements. Although this is important, the Facility also needs to review and report on data related to the actual outcome of whether or not incidents and allegations were reported timely. This could be done through a tracking mechanism, and confirmed through monitoring activities. In some cases, the data was not sufficient to determine if all of the elements of specific provisions had been met. For example, with regard to Section D.3.e, which addresses the timeliness of the initiation and completion of investigations, |

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| | data was provided about the initiation of investigations, but not their completion.<br><br>The Facility made note of an incident that occurred in April and resulted in some staff terminations for failure to report abuse. This was a good example of being proactive in self-assessment.<br><br>In a few instances, the Facility declined to make a current entry for a provision, marked it noncompliant, but could explain the reason in interview. It would be helpful to the Facility as well as to the Monitoring Team if such information were included in the self-assessment.<br><br>The self-assessment contained information about the use of a supervisory review checklist for Unusual Incident Reports, and the start of the audit of injuries process to assure that injuries are reported for investigation.<br><br>One error was detected in the self-assessment. Provision D.3.a indicated that all three Facility investigators had completed the Comprehensive Investigator Training Course. In fact, the training transcript for one investigator did not include that course. It is important that investigators have the appropriate training, and when it is missing, that fact needs to be reported on the self-assessment. |
| | **Summary of Monitor's Assessment:** CCSSLC did not progress towards substantial compliance for a number of indicators. During this review, the Monitoring Team found the Facility to be in compliance with 11 out of 22 provisions of Section D, as opposed to the 13 of the 22 indicators for which compliance was found during the last monitoring review. However there was progress in a number of areas. Highlights of that progress included:<br>▪ Procedures were in place to discourage retaliation against reporters of abuse, and actions were being taken to address allegations of retaliation. Posters regarding retaliation were up and staff had been retrained<br>▪ Actions to protect individuals who were involved in unusual incidents or abusive situations were taken quickly. Staff alleged to have been abusive or neglectful were routinely put on temporary work reassignment to remove them from direct contact with individuals served.<br>▪ Staff were trained in reporting abuse, and used the information on their identification badges to prompt their actions. They also had been trained on the consequences of failure to report, which included leaving the individual at risk of harm and losing their own jobs.<br>▪ A flyer had been developed and mailed to the families or legally authorized representatives of all individuals residing at CCSSLC to inform them of their rights to report abuse, neglect, and exploitation, and the processes and protections for doing so. However, there was not sufficient evidence that individuals were being provided this information at their annual meetings.<br>▪ There was evidence of cooperation with DFPS investigations and with investigations by law enforcement and the Office of the Inspector General.<br>▪ Audit procedures had been designed to help determine whether all injuries were being reported.<br>▪ A supervisory checklist for reviewing investigator's reports was being launched.<br>▪ A protocol to track recommendations from investigation reports had been initiated. |

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| | To continue its progress toward full compliance with Section D, the Facility will need to:<br>▪ Fine-tune its investigatory processes to make them timely;<br>▪ Demonstrate that the system for documentation of supervisory reviews of investigations is working.<br>▪ Ensure that investigators are fully trained in the requisite investigatory skills, as well as skills in working with people with developmental disabilities.<br>▪ Two key processes needed additional development: the semi-annual audit of injuries, which was just beginning, and the follow-up on recommendations from investigative reports, which were not documented to conclusion. |

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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 Facility's policies and procedures:<br>▪ Included a commitment that abuse and neglect of individuals would not be tolerated; and<br>▪ Required that staff report abuse and/or neglect of individuals.<br><br>In practice, the Facility's commitment to ensure that abuse and neglect of individuals was not tolerated, and to encourage staff to report abuse and/or neglect was illustrated by the following examples:<br>▪ Posters were placed in residences, vocational locations, and offices to reiterate the Facility's zero tolerance for abuse;<br>▪ Staff identification badges included the instructions on reporting abuse;<br>▪ Staff interviewed demonstrated the value of these badges by routinely pointing to them to explain how they would report abuse; and<br>▪ When abuse or neglect was confirmed to have occurred, staff involved were appropriately terminated from employment and/or disciplined. This was evident with a recent allegation in which numerous staff, including those who had failed to report suspicions of abuse or neglect were terminated from employment. | Substantial Compliance |
| D2 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require: | | |

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| | (a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting. | According to CCSSLC Policy #021.IV.A, all staff were required to report abuse, neglect, and exploitation within one hour by phone to DFPS and to the Director or her designee. This was consistent with the requirements of the Settlement Agreement.<br><br>With regard to serious incidents, CCSSLC Policy #002.2 required staff to report unusual incidents within one hour to the Director or designee. Both Sections D.2 and DD.5 of the Facility Policy and Procedure Manual required immediate (within one hour) reporting to the Director of serious incidents. Since there was no reference to the manner of reporting in these sections, the assumption was that the reporting was to be verbal. Policy #002.2 described how the Facility was to report incidents to the DADS State Office. It appeared that the process was for the staff member who witnessed or became aware of an incident to call the Incident Management Coordinator (IMC) or designee to report the unusual incident, and the call triggered the start of the Unusual Incident Report by the IMC's office. This policy was consistent with the requirements of the Settlement Agreement. However, in the last monitoring report, it was noted that a clearer explanation was needed of what form a report about an unusual incident was to take (i.e., phone call, a written report, or whatever was expected.) At the time of the most recent review, this still required clarification.<br><br>Although in the paragraphs that follow, the Monitoring Team has provided some figures with regard to allegations and incidents, it is essential to note that reviewing pure numbers provides very little meaningful information. For each of these categories, the Facility would need to conduct analyses to determine causes, and to review carefully whether for incidents that were preventable, and adequate action had been taken to prevent their recurrence. Determining the reasons or potential reasons for increases or decreases in numbers also is essential. Although the ultimate goal is to reduce the overall numbers of preventable incidents, care needs to be taken to ensure that the result of such efforts is not the underreporting of incidents. For an incident management system to work properly, full reporting of incidents is paramount, so that they can be reviewed, and appropriate actions taken. The Facility's progress in analyzing data collected, and addressing issues identified is discussed in further detail with regard to Section D.4 of the Settlement Agreement.<br><br>According to Facility data provided in response to the document request #III.17a-e, the following numbers of serious incidents had occurred at the Facility from January 1, 2010 to December 31, 2010, and from January 1, 2011 through May 31, 2011: | Noncompliance |

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| | Abuse Allegations | Abuse Substantiated /Confirmed | Neglect Allegations | Neglect Substantiated/ Confirmed | Exploitation Allegations | Exploitation Substantiated/ Confirmed |
|---|---|---|---|---|---|---|
| 1/1/10 to 12/31/10 | 688 | 45 | 176 | 35 | 24 | 0 |
| 1/1/11 to 5/31/11 | 378 | 69 | 102 | 18 | 0 | 0 |

The percentage of A/N/E allegations that were substantiated/confirmed in the 12 months of 2010 was 9% (80/888).

The percentage of A/N/E allegations that were substantiated/confirmed in the first five months of 2011 was 18% (87/480).

According to these figures, both the number of allegations and the percentage of substantiated/confirmed allegations were increasing. The Facility should conduct further analysis to determine the potential cause(s) for this apparent increase. Causes could be positive (e.g., better reporting and/or investigations) or cause for concern (e.g., staffing issues, etc.).

According to Facility data provided in response to the document request #III.17e:

| Unusual Incidents | 1/1/10 to 12/31/10 | 1/1/11 to 5/31/11 |
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| Deaths | 5 | 5 |
| Serious injuries | 24 | 11 |
| Sexual incidents | 18 | 12 |
| Suicide threat – credible | 11 | 2 |
| Suicide threat – not credible | 46 | 8 |
| Unauthorized Departure | 14 | 5 |
| Choking | 4 | 3 |
| Other | 6 | 4 |
| **TOTAL** | **128** | **50** |

Based on interviews with 20 staff responsible for the provision of supports to individuals, 20 (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation.

Two samples of investigations were selected for review. These included:

- Sample #D.1 which included a sample of 39 DFPS investigations reports

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| | | (approximately 17% of the 224 investigations of abuse, neglect, and/or exploitation conducted between 1/1/11 and 6/30/11) This sample included the following investigation numbers: #39032751, #39217147, #38982918, #38971061, #39157428, #38971096, #39167568, #39118987, #39211868, #39060367, #38956811, #38896502, #39291647, #39309967, #39316248, #39327527, #39308472, #39225449, #39330370, #39298328, #39299147, #39327247, #39371648, #38953130, #39649147, #39655128, #39998468, #39964828, #39948628, #39943708, #39911367, #39782487, #39903227, #39665187, #39709587, #39854407, #39836367, #39813727, and #39746868.<br>▪ Sample #D.2 included a sample of 13 Facility investigations (approximately 22% of the 58 investigations that occurred between 1/1/11 and 6/31/11). Five of these were unusual incident investigations undertaken by the Facility. Eight were unusual incident investigations undertaken in concert with a corresponding DFPS investigation. The Facility only investigations were: #484922, #489107, #495777, #496610, and #495864. The Facility unusual incident investigations with corresponding DFPS reports were: #485164, #488890, #488584, #489931, #489720, #489938, #491204 and #491710.<br><br>Based on a review of the 52 investigation reports included in both Sample #D.1 and Sample #D.2:<br>▪ A total of 44 (85%) included evidence that cases of abuse, neglect, and/or exploitation or unusual incidents were reported within the timeframes required by Facility policy. Of the nine that did not, three were apparently self-reported by the alleged victims a day after the alleged event with no substantiation of the alleged complaints. Unidentified people reported four the next day. One involved a peer-to-peer sexual encounter that was reported to the Facility timely, but did not appear to involve abuse or neglect. However, the next day it was reported to DFPS. One was reported four days after the incident. The Facility cannot require a resident of the Facility to report, and cannot prevent a resident from making a false report. The Facility cannot discourage reporting of a peer-to-peer sexual encounter to DFPS, even if the Facility already knows about the incident, is investigating it, and does not believe it requires further reporting. However, if a staff member believed it needed to be reported, then it should have been reported within one hour of the occurrence. Adding back the three incidents where it was clear that the resident was late in self-reporting, a total of 47 (90%) of the cases were reported timely.<br>▪ A total of 48 (92%) included evidence that cases of abuse, neglect, and/or exploitation were reported to the appropriate party as required by Facility policy. However, it was not clear that staff, who might have reported an allegation to DFPS, also had reported it to the Facility Director, as required. Since | |

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| | | allegations to DFPS were anonymous, it was not known who the reporter was. Whether staff failed to report to the Director could only be determined if the investigation resulted in a confirmation of abuse, neglect, or exploitation, and the investigation showed that there were staff who witnessed the incident who did or did not appropriately report the allegation. In the one case that did not appear to have been reported to the Director for several hours, an individual had alleged a sexual encounter with a peer, then retracted the story, saying he made it up to get staff in trouble. However, the Director should have been informed immediately of the allegations. (Unusual Incident Report #491204.)<br><br>Since the last monitoring, the Facility had one case (DFPS case #39061691) in which seven staff were found to have failed to report suspicions of abuse/neglect. All seven were subsequently terminated. As a result of this case, all staff were retrained in reporting abuse, and reminded that when staff fail to report abuse they leave individuals at risk of harm, and the consequence for staff of failure to report abuse is termination.<br><br>The Facility had a standardized unusual incident investigation format that included the initial information collected when the incident was reported verbally. The format was clear, concise, and useful for both investigations conducted solely by the Facility and for reviews conducted in conjunction with DFPS investigations. The format met generally accepted standards and contained information necessary for adequate follow-up, as well as tracking and trending of incidents.<br><br>Based on a review of 52 investigation reports included in Sample #D.1 and Sample #D.2, 52 (100%) contained a copy of the report utilizing the required standardized format.<br><br>Although the sample evidence shows reporting to be approximately 90% in timely reporting, including reporting to the Director and to DFPS, serious concerns arose with regard to numerous staff's failure to report suspicions of abuse and neglect. The Facility Administration is commended for taking swift action to remedy the problem, once it was identified. Staff recently had been retrained on reporting responsibilities, and staff who were interviewed about reporting knew their responsibilities. It is hoped that these efforts will result in consistent and timely reporting of incidents in the future. However, the fact that numerous staff, including supervisory staff, failed to report what amounted to a pattern of allegations is extremely concerning. The issue of staff not recognizing reporting of any suspicions of abuse to be one of their primary responsibilities results in individuals not being adequately protected from harm. | |
| | (b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, | According to Section D.2 of the Facility Policy and Procedure Manual, any employee, agent or contractor must report the abuse to the Director and to DFPS by phone within the hour, act to stop the abuse, secure medical treatment, secure evidence, and comfort the victim. | Substantial Compliance |

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| | neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation. | According to Section D.3, protections for the individual include immediately placing the alleged perpetrator on Temporary Work Reassignment (TWR), if the allegation involves physical abuse that results in injury, sexual abuse, or neglect that causes physical injury or death.<br><br>Based on a review of 39 investigation reports included in Sample #D.1, 23 (59%) of alleged perpetrators were removed from direct contact with individuals immediately following the Facility being informed of the allegation. In those cases where the alleged perpetrators were not removed immediately, there appeared to be situations where the event was not significant enough to warrant removal of staff (i.e., the preliminary assessment showed the employee posed no risk), or it was not clear which staff was involved. In cases #39903227 and #39291647, the allegations appeared to have been handled by DFPS as streamlined cases, where the reporter was known to make frequent spurious allegations. The cases involved Individual #172 and Individual #246, both of whom appeared on the list of four individuals who were approved for use of the streamlined process.<br><br>Based on a review of 23 investigation cases where staff had been removed and the list of staff removed from duty and returned, a total of 23 (100%) showed that the staff that had been removed from direct contact were reinstated only after a well-supported preliminary assessment showed that the employee posed no risk to individuals or the integrity of the investigation, or the conclusion of the investigation allowed their return to direct contact duties.<br><br>Based on a review of the 39 above cases, it was documented that adequate additional action was taken to protect individuals in all cases (100%). The Facility was found to be in substantial compliance with this provision. | |
| | (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 and Procedure Manual, all staff must attend competency-based training in course ABU0100 at pre-service and annually thereafter. This was consistent with the requirements of the Settlement Agreement. In response to a document request, the Facility provided the curriculum in use to train staff on abuse, neglect, and exploitation. The document was not labeled with the ABU0100 course number, but it appeared to be the curriculum for that course.<br><br>A review of the training curricula related to abuse and neglect was reviewed for: a) new employee orientation; and b) annual refresher training. The results of this review were as follows:<br>▪ In relation to the requirement for training to be competency-based, the training included a post-test in which the employee must demonstrate a working knowledge of the policies and procedures related to abuse investigation. | Substantial Compliance |

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| | | ▪ The training provided adequate training regarding recognizing and reporting signs and symptoms of abuse, neglect, and exploitation.<br><br>Review of the Course Delinquency List for course #ABU0100, Abuse/Neglect/Exploitation, dated 7/11/11 revealed that six staff out of approximately 1000 (less than 1%) were past due to receive retraining.<br><br>Review of 40 records of staff hired between 4/1/11 and 6/1/11 showed that 39 (98%) of these staff had completed competency-based training on abuse and neglect.<br><br>Based on interviews with 20 staff:<br>▪ All 20 (100%) were able to list signs and symptoms of abuse, neglect, and/or exploitation; and<br>▪ All 20 (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation.<br><br>The Facility was found to be in Substantial Compliance with this provision. | |
| | (d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect. | According to Section D.1 of the Facility Policy and Procedure Manual, all staff must sign a statement acknowledging zero tolerance for abuse, neglect and exploitation and their obligations to report any suspicions.<br><br>A sample of 37 staff hired between 4/1/11 and 6/1/11 was selected to determine if acknowledgements had been signed. Of the 37 staff, two had not commenced employment, and the remaining 35 (100%) had signed annual acknowledgments. This performance corresponded to the Facility's audit, which found 100% compliance in a sample of 15 records.<br><br>Since the last monitoring, the Facility had one case (DFPS case #39061691) in which seven staff were found to have failed to report suspicions of abuse/neglect. All seven were subsequently terminated. As a result of this case, all staff were retrained in reporting abuse, and reminded that when staff fail to report abuse they leave individuals at risk of harm, and the consequence for staff of failure to report abuse is termination. Among the 20 staff interviewed about this issue, 100% demonstrated a clear understanding of the consequences of failure to report. The Facility deserved acknowledgement for its handling of the case of verbal and emotional abuse that was discovered, investigated, actions taken against those who did not report, and follow-up retraining conducted with staff to help prevent a recurrence.<br><br>The Facility was found to be in substantial compliance with this provision. | Substantial Compliance |

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| | (e) Mechanisms to educate and support individuals, primary correspondent (i.e., a person, identified by the IDT, who has significant and ongoing involvement with an individual who lacks the ability to provide legally adequate consent and who does not have an LAR), and LAR to identify and report unusual incidents, including allegations of abuse, neglect and exploitation. | According to Section D.19 of the Facility policy manual, QMRPs were to send a copy of the Abuse, Neglect, and Exploitation Resource Guide, and CCSSLC Preventing Abuse is Everyone's Responsibility flyer, revised 10/22/10, to families and Legally Authorized Representatives (LARs) prior to the annual PSP meeting, and to provide a copy to the individual at the meeting. The QMRP was to describe the process to the individual at the meeting.<br><br>In the last monitoring report, the findings of the Monitoring Team's review of the flyer used to educate individuals and families about their rights with regard to reporting was discussed.<br><br>Based on a review of five individuals' PSPs, including Individual #124, Individual #372, Individual #109, Individual #7, and Individual #336, there was no documentation to show that any of the individuals had been informed of the process of identifying and reporting unusual incidents, including abuse, neglect, and exploitation at the PSP meeting. Based on the Monitoring Team's attendance at three PSP meetings (for Individual #228, Individual #234, and Individual #353), information about reporting allegations of abuse was not discussed or distributed during the meeting. However, one meeting ran long, and it is possible that it was addressed at the very end of the meeting after the Monitoring Team member had left.<br><br>In interviewing a sample of 10 individuals, all 10 were able to describe what they would do if someone hurt them, or they had a problem with which they needed help. In reviewing sample #D2, it was clear that individuals were not reluctant to report abuse. There were several cases within the sample where individuals reported falsely, indicating little fear of reprisals or reluctance to seek help to report.<br><br>Since incidents of abuse, neglect, and exploitation were reported anonymously, it was difficult to find a measurement for whether or how well individuals were being assisted to report. However, in the context of the sample of investigative reports, there were several mentions of staff escorting an individual to the phone or asking if he/she wanted to make a report.<br><br>The Facility had developed materials and a mechanism for informing individuals and their LARs of the methods for reporting abuse and neglect. However, the mechanism for informing individuals included discussion and provision of written materials at the PSP meeting. Neither documentation nor on-site observations confirmed that this was happening. Discussions with the Incident Management Coordinator confirmed that Facility monitoring was not finding a record of discussion of abuse and neglect in the Personal Support Plan. The Monitoring Team's findings were consistent with the Facility that this provision was not yet in compliance with the Settlement Agreement. | Noncompliance |

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| | (f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights. | According Section D.20 of Facility policy and procedure manual, all residences and day programs were to have the "Rights Poster" on display.<br><br>A review was completed of the posting the Facility used. It included a brief and easily understood statement of: 1) individuals' rights; 2) information about how to exercise such rights; and 3) information about how to report violations of such rights.<br><br>Observations by the Monitoring Team of residences and day programs on campus showed that all nine (100%) of those reviewed had postings of individuals' rights in an area to which individuals regularly had access. The Monitoring Team's finding of substantial compliance was consistent with that of the Facility. | Substantial Compliance |
| | (g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement. | According to Facility Policy D.11, all allegations that might involve criminal activity must be reported to DFPS who would then notify the appropriate law enforcement authority.<br><br>Based on a review of 39 allegation investigations completed by DFPS (Sample #D.1), in all cases (100%) for which a referral to law enforcement was necessary/appropriate, DFPS and/or the Facility had made referrals. In 18 cases, referrals were made to both local law enforcement and to OIG, and in 16 cases DFPS or the Facility made referrals to either OIG or law enforcement. Only four cases in the sample were not reported to law enforcement or OIG. These four were cases involving allegations of verbal abuse and failure to follow instructions, which did not rise to the level of criminal activity.<br><br>Based on a review of 13 investigations completed by the Facility (Sample #D.2), referrals were made to OIG in all but three cases, involving deaths, where there was no apparent reason to suspect criminal activity.<br><br>Based on this review, referrals were being made to law enforcement and to the OIG on a regular basis. The Facility was found to be in substantial compliance with this provision. | 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, | According to Section D.6 of the Facility Policy and Procedure Manual, all forms of retaliation against individuals, their families and LARs, as well as employees who reported allegations of abuse/neglect/exploitation in good faith was prohibited. These individuals could immediately report any alleged incident of retaliation to the Facility Director or her designee. Phone numbers for other reporting alternatives also were provided in the policy.<br><br>Based on interviews with the Assistant Director for Programs, the following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be | Noncompliance |

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| | 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. | tolerated:<br>▪ When the Assistant Director for Programs received a report of retaliation, he forwarded it to the Office of the Inspector General.<br>▪ OIG would respond as to whether they would investigate.<br><br>A list of individuals who reported they had been retaliated against was requested, and there were no names provided.<br><br>Based on interviews with 10 individuals served by the Facility, 10 (100%) reported they thought they could tell staff or call to report that someone had hurt them or not taken care of them, and they would not get into trouble. In addition, individuals reported many of the cases reviewed, suggesting that they did not fear retaliation from staff.<br><br>Based on a review of investigation records (Sample #D.1 and Sample #D.2), there was one mention of potential retaliation in remarks recorded during a DFPS interview, related to Investigation #39217147. The direct support professional being interviewed indicated: "…when you snitch on a person and give their name, they retaliate against you." There were no follow up questions about what the staff member meant or whether she had experienced retaliation, nor was there any documented follow-up by the Facility after the report was read and approved. While the issue of retaliation was not the subject of the investigation, whenever that possibility is raised, it should be noted, reported, and followed up on immediately. Given the premium of needing to ensure that staff feel comfortable to report, this was a significant oversight.<br><br>The Facility was asked for a list of staff against whom disciplinary action had been taken due to their involvement in retaliatory action against another employee who in good faith had reported an allegation of abuse/neglect/exploitation. No names were provided (Document request #III.37).<br><br>The following describes actions that were taken in an attempt to prevent such retaliation in the future:<br>▪ Posters reminding staff that retaliation will not be tolerated;<br>▪ Training emphasized the Facility's position on retaliation; and<br>▪ The stated practice of referring any allegations of retaliation to the OIG.<br><br>Based on interviews with 20 staff, it was clear that retaliation was forbidden, and that any staff member was free to report retaliation to the Director and it would be followed up on by OIG.<br><br>Although a policy against retaliation was clearly in place, implementation of the policy was insufficient to ensure that follow-up occurred on any mention of retaliation. In order to | |

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| | | encourage reporting of suspicions of abuse and neglect, it is essential that any concerns about retaliation that staff raise be followed up on immediately. | |
| | (i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation. | The purpose of a semi-annual audit of injuries is to assure that serious injuries are reported for investigation, and to ensure that non-serious injuries that raise suspicions of abuse because of the nature or location of the injury (for example bruises on the inner thigh may suggest sexual abuse), or the frequency of injury are reported for investigation.<br><br>The POI contained an Action Plan to create a process to audit injuries. According to the Quality Assurance Director, a process for auditing injury reports to determine whether significant injuries were reported for investigation was started in June 2011. The Action Plan indicated that the Unified Records Coordinators would use a newly established audit tool to complete 10 audits a month of Client Injury Reports. Although auditing a sample of records to ensure that all injuries had been appropriately reported was an important step in the process, this did not fully meet the intent of the provision.<br><br>Trend Monitoring Reports of Injuries identified numbers, types and locations of reported injuries both serious and non-serious. However, that information was not tied to the audit report insofar as it was described in the Action Plan.<br><br>This Action Plan should be revised to indicate how the Facility intends to review all injuries every six months, and report for investigation those injuries that due to frequency or other criteria raise suspicions of possible abuse or neglect, if reports have not already been made.<br><br>The Monitoring Team concurred with the Facility that it was not in substantial compliance with this provision. | Noncompliance |
| D3 | Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall: | | |

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| | (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. | According to Section DD.1 of the CCSSLC Policy and Procedure Manual, all staff who engaged in Facility investigations had to attend Comprehensive Investigator Training (CIT0100) and People with MR (MEN030), prior to assignment as an investigator and prior to completing an Unusual Incident Report investigation. In addition, the Incident Management Coordinator, Campus Administrator, Campus Coordinator, and Facility Investigators had to complete Conducting Serious Investigations or Fundamentals of Investigation training (INV0100), and a class on Root Cause Analysis within six months of employment. CCSSLC Policy #002.2 at H required staff assigned to investigations to be outside the direct line of supervision of the alleged perpetrator.<br><br>The curricula for the Facility and the DFPS investigators had been reviewed and generally determined to be adequate. As indicated in previous reports for other Facilities, with regard to the DFPS training, what was not as clear was whether the training included instruction on how to complete the DFPS report, how to review and use information from past investigations, and how to determine when recommendations would be warranted and develop appropriate recommendations. Although the training covered the basics of investigations, ongoing training should cover additional topics, such as these listed.<br><br>In response to a document request, a list of ten DFPS investigators with their hire dates and courses completed, their training transcripts, and a crosswalk to the titles of courses, which had changed, were provided. The training records for these investigators were reviewed with the following results:<br>▪ Ten or the 10 (100%) DFPS investigators whose names were provided had completed the requirements for investigations training.<br>▪ Ten out of the 10 (100%) DFPS investigators whose names were provided had completed the requirements for training regarding individuals with developmental disabilities.<br>▪ A review of the Sample #D2 revealed that all (100%) investigations in the sample were completed by trained investigators.<br><br>CCSSLC staff with responsibilities for conducting Facility investigations included the Incident Management Coordinator (IMC) who oversaw the investigations at the Facility; three full-time investigators; and nine Campus Administrators and Campus Coordinators who reported to the IMC and who could be called upon to assist in investigations when needed, or to carry out investigations on the second or third shifts for a total of 13 staff.<br>▪ Twelve training records were submitted for this monitoring review for the IMC, the three full-time investigators, and eight of those others could investigate (one was missing due to being newly hired).<br>▪ The IMC had completed all but one course.<br>▪ Five of the remaining 11 Facility investigators (45%) had completed the requirements for investigations training. | Noncompliance |

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| | | ▪ Ten of the 11 Facility investigators (91%) had completed the requirements for training regarding individuals with developmental disabilities.<br><br>The IMC and one of the full-time investigators had not completed the Comprehensive Investigator Training (CIT0100). Of the three full-time investigators, 67% had completed this training. This finding was in disagreement with the status update on the Facility Plan of Implementation, which indicated that all three Facility investigators had completed the CIT0100 training.<br><br>A review of the investigators who conducted the investigations in Sample #D2 indicated that the majority of the 13 Facility investigations were completed by the Lead Investigator. In spite of the information entered in the Facility Plan of Improvement that all three Facility investigators had completed the Comprehensive Investigator Training (CIT 0100), the training transcript for the Lead Investigator did not confirm the training. A follow-up contact with the Facility's Settlement Agreement Coordinator indicated that the investigator had not completed the training.<br><br>While at any time, some investigators might lack training due to being newly hired, it will be important to continue to ensure that those investigators do not conduct investigations until their training is completed.<br><br>Since one of three investigators lacked the basic required training, the Facility is not in compliance with this provision. The Facility should reassign the investigator to other duties until the training has been completed. The IMC also should complete the training at the next opportunity and should not conduct investigations until that is done. | |
| | (b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation. | Based on Section DD.10 of the Facility Policy and Procedure Manual, Facility staff were required to cooperate with DFPS in conducting investigations of abuse and neglect. This included suspending internal investigations and interviews until DFPS had completed its investigation.<br><br>As described above with regard to Section D.2.a of the Settlement Agreement, two samples of investigation files were selected for review. These included Sample #D.1, the DFPS investigations and the subsample of corresponding Facility investigations, and Sample #D.2, which consisted of Facility investigations.<br>▪ Review of the investigation files in Sample #D.1 showed that in 39 out of 39 investigations (100%), Facility staff cooperated with DFPS investigators.<br>▪ Review of the investigation files in Sample #D.2 showed that in 13 out of 13 (100%) investigations, there was cooperation with outside entities. This was a similar finding to that reached when CCSSLC staff completed monitoring of five Facility investigations that showed cooperation with outside entities. | Substantial Compliance |

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| | (c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations. | The Memorandum of Understanding, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency."<br><br>Based on a review of the investigations completed by DFPS and the Facility, the following was found:<br>▪ Of the 39 investigation records from DFPS (Sample #D.1), 34 had been referred to law enforcement agencies. For 34 out of these (100%), there appeared to be adequate coordination to ensure that there was no interference with law enforcement's investigations.<br>▪ Of the 13 investigation records from the Facility (Sample #D.2), nine had been referred to law enforcement agencies. In all (100%) cases, there was adequate coordination to ensure that there was no interference with law enforcement's investigations.<br><br>This compared favorably with CCSSLC's own finding of cooperation with law enforcement investigations as reported in the POI. | Substantial Compliance |
| | (d) Provide for the safeguarding of evidence. | Section D.5 of the Facility Policy and Procedure Manual described the process for securing evidence, which included collecting any physical evidence, storing it in a paper bag, labeling it, and safeguarding it until the investigator took possession of it. Evidence was to be stored in the safe under the control of the Incident Management Coordinator. Documentary evidence was to be stored or copied to prevent alteration until the investigator collected it.<br><br>Section D.5 described in detail the securing of evidence in the IMC's safe, and who had access to that safe. According to the policy, an Incident Management (IM) log must be kept in a locked cabinet in the IM Administrative Assistant's office with specific information about any access to the evidence.<br><br>Based on a review of the investigations completed by DFPS (Sample #D.1) and the Facility (Sample #D.2):<br>▪ Evidence that needed to be safeguarded was properly secured and safeguarded in 100% DFPS investigations; and | Substantial Compliance |

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| | | ▪ Evidence that needed to be safeguarded was properly secured and safeguarded in 100% Facility investigations.<br><br>Most of the evidence that was necessary for these investigations was documentary or testimonial. In a few cases, pictures and diagrams were collected or developed. In an increasingly larger number of cases, both the Facility and DFPS investigations routinely requested video surveillance footage, and documented it as part of the evidence, if it was relevant.<br><br>The Facility was found to be in substantial compliance with this provision, based on the existence of relevant policy on handling evidence, and the investigations reviewed that provided evidence of proper handling of evidence. | |
| | (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. | Based on Section DD.10 and DD.11 of the CCSSLC Policy and Procedure Manual, investigations of serious incidents:<br>▪ Were to commence within 24 hours or sooner, if necessary;<br>▪ Were to be completed within 10 calendar days of the incident;<br>▪ Required a written extension request from the Facility Director or Adult Protective Services Supervisor to be completed outside of the 10-day period, and only under extraordinary circumstances; and<br>▪ Were to result in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action.<br><br>To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately.<br><br><u>DFPS Investigations</u><br>The following summarizes the results of the review of DFPS investigations:<br>▪ Twenty-seven out of 39 commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation that described the steps taken to determine the priority of investigation tasks, as well as documentation regarding the tasks that were undertaken within 24 hours of DFPS being notified of the allegation, including the initial interviews involved. Four cases commenced later than 24 hours, but these cases had not been reported timely or had unknown dates on which they occurred. Therefore, 31 of the 39 (79%) cases were commenced timely. The remaining eight cases that did not were: DFPS #38971061, #39118987, #39211868, #39309967, #39948628, #39943708, #39665187, and #39746868. These cases began more than 24 hours after the report was received, and were potentially serious issues, | Noncompliance |

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| | | including physical and verbal abuse, and neglect.<br><br>Based on the Monitoring Panel's discussion with DFPS in December 2010, DFPS developed a policy to guide better documentation of activities that occur within the first 24 hours of the investigation. Based on comments the Monitoring Team's provided, DFPS revised the policy and met with the Monitoring Panel to discuss the comments. DFPS planned to implement the revised policy, but the new policy was not in place when the cases in the sample were investigated. No summary of the activities that occurred to initiate the investigation were found in the files submitted for review. There was additional information attached to the reports including:<br>o The Intake Report, which assigned the case number, summarized the priority determination, and noted any special handling, worker safety issues, or sensitive issues;<br>o Principal Information sheet which collected basic demographic data and phone numbers; and<br>o Information about the alleged victim, based on a phone call to the Facility.<br>This information, while helpful, did not document a plan or the investigator's priorities for the investigation tasks, as contemplated in the draft policy.<br>▪ Thirty-five out of 39 (90%) were completed within 10 calendar days of the incident.<br>▪ For the four that were not completed within 10 days, all (100%) had documentation of a written extension request that had been approved by the Adult Protective Services Supervisor, and there was documentation of the extraordinary circumstances that necessitated the extension.<br>▪ Thirty-nine (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement.<br>▪ In nine of the investigations reviewed, concerns were identified or recommendations for corrective action were included. In all nine (100%), the recommendations were adequate to address the findings of the investigation.<br><br><u>Facility Investigations</u><br>The following summarizes the results of the review of Facility investigations:<br>▪ Twelve out of 13 (92%) commenced within 24 hours of notification or discovery, or sooner, if necessary. This was determined by reviewing information in the Unusual Incident Report to determine when the first interview was done, or when some other significant investigatory activity was undertaken. In one case, #495864, involving the death of an individual, possibly from renal failure, the | |

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| | | only name on the witness list was that of the deceased individual, and there was no further reference to having conducted an interview. Integrated progress notes were collected, but it was not evident, when that took place. The Quality Assurance Nurse reviewed the documentation, but no date was recorded.<br>▪ Thirteen out of 13 (100%) were completed within 10 calendar days of the incident, or the completion of the DFPS investigation, including sign-off by the supervisor to indicate that the investigation and report was finalized.<br>▪ All 13 (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement.<br>▪ In seven of 13 of the investigations reviewed, recommendations for corrective action were included. In three of those seven cases, (Facility case #495777, #4849222, and #495864), the QA nurse who reviewed the medical record included a list of recommendations to:<br>o Review documentation standards with nursing and medical services;<br>o Instruct direct support professionals to make sure forms are dated and filed correctly; and<br>o All residents with gastrostomy/jejunostomy (G/J) tubes should be kept in an upright position for at least one hour post feeding.<br>These recommendations suggested that the nurse found some issues with care that were not included in the summary of the cases.<br><br>A finding of noncompliance has been made. For the DFPS investigations, the new policy that would require improved documentation of the initiation of investigations had not been implemented in time for the files to reflect the changes. In the Facility investigations, there was a disconnect between recommendations related to death investigations and the findings included in the reports. The medical findings are important in death reviews, and should be included in the report and summarized in the conclusion. Then, the medical recommendations would be connected to the findings, and result in a complete report. | |
| | (f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) | Based on a review of CCSSLC Policy #002.2 and the related procedure at DD.11 of the CCSSLC Policy and Procedure Manual, the policy required that:<br>▪ The contents of the investigation report be sufficient to provide a clear basis for its conclusion;<br>▪ The report utilize a standardized format that set forth explicitly and separately:<br>o Each serious incident or allegations of wrongdoing;<br>o The name(s) of all witnesses;<br>o The name(s) of all alleged victims and perpetrators;<br>o The names of all persons interviewed during the investigation;<br>o For each person interviewed, an accurate summary of topics discussed, a | Noncompliance |

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| | 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. | recording of the witness interview or a summary of questions posed, and a summary of material statements made;<br>o All documents reviewed during the investigation;<br>o All sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency;<br>o The investigator's findings; and<br>o The investigator's reasons for his/her conclusions.<br><br>The Facility investigations were reported on an Unusual Incident Investigation form, revised 11/5/10 and 6/7/11. The form had at least 21 sections, designed to be filled out electronically as the investigation progressed. The form included such additional information as the dates and times of notifications of interested parties, the staffing level assigned to the individual, the time nursing intervention was provided, and results of Personal Support Team and Review Authority Team Meeting (RATM) deliberations. The official files were organized according to a checklist, in binders, with separators between documents delineated on the checklist.<br><br>To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately.<br><br><u>DFPS Investigations</u><br>The following summarizes the results of the review of DFPS investigations:<br>▪ In 38 out of 39 investigations reviewed (97%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. In case #39998468 pages were missing from the submitted report copy, and it was not possible to make a determination.<br>▪ The report utilized a standardized format that set forth explicitly and separately:<br>o In 39 (100%), each serious incident or allegations of wrongdoing;<br>o In 39 (100%), the name(s) of all witnesses;<br>o In 39 (100%), the name(s) of all alleged victims and perpetrators;<br>o In 39 (100%), the names of all persons interviewed during the investigation;<br>o In 39 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made;<br>o In 39 (100%), all documents reviewed during the investigation;<br>o In 29 (74%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and | |

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| | | perpetrator(s) known to the investigating agency. DFPS had assured the Monitoring Team at the last monitoring visit that records of prior incidents were routinely checked electronically and that a way would be found to include reference to those checks in the reports. It appeared that sometime in May or June 2011, investigators began to include references to prior cases at the conclusion of their reports. Examples of cases that did not include evidence of review of previous investigations included cases #39327527, #39308472, #39371648, and #38953130.<br>o In 39 (100%), the investigator's findings; and<br>o In 39 (100%), the investigator's reasons for his/her conclusions.<br><br><u>Facility Investigations</u><br>The following summarizes the results of the review of Facility investigations:<br>▪ In 10 out of 13 investigations reviewed (77%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion. The following provides information regarding the concerns identified:<br>o In case #495777 involving the death of an individual, there were three recommendations from the Quality Assurance Nurse regarding documentation standards for medical and nursing service, need for direct case staff to sign and date forms, and the need to keep individuals with G/J tubes in an upright position for one hour after feeding. These topics were not covered in the investigation. Clearly there were issues related to these topics for the nurse to make the recommendations. The specific findings should have been included in the report, not just recommendations at the conclusion.<br>o In case #484922, the nurse recommended a review of documentation standards with nursing and medical services and instruction for staff to make sure forms were dated and filed, yet there was no mention in the summary and conclusions of how these issues might have been related to the recommendations.<br>o In case #495864, the cause of death was not clear due to the final autopsy report being unavailable. In this case, as in the two above, the nurse made the same recommendations without a clear tie to the investigation results.<br>These cases illustrated the need to involve the nurse in the investigation process, potentially as an expert or consultative witness, and to capture the identified issues in the summary and conclusions of the report. The Facility should consider holding death investigations open until the medical examiner's report has been read, and used in the determination of what occurred and what actions need to be taken as a result. This would assist in providing an adequate basis for the investigation's conclusions. | |

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| | | ▪ The report utilized a standardized format that set forth explicitly and separately:<br>o In 13 (100%), each serious incident or allegations of wrongdoing;<br>o In 13 (100%), the name(s) of all witnesses;<br>o In 13 (100%), the name(s) of all alleged victims and perpetrators;<br>o In 13 (100%), the names of all persons interviewed during the investigation;<br>o In 13 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made;<br>o In 13 (100%), all documents reviewed during the investigation;<br>o In 13 (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency;<br>o In 13 (100%)), the investigator's findings; and<br>o In 12 (92%), the investigator's reasons for his/her conclusions. Unusual Incident Report #49577 involved the death of an individual. The investigator wrote that: "there does not appear to be any lack of care or neglect regarding her death." However, the nurse added a recommendation that all residents with G/J tubes should be kept in an upright position for at least one hour post feeding. This suggested that the nurse found an issue with the individual's feeding that was not reflected in the investigator's conclusion. There needed to be a connection drawn between that recommendation and the investigator's conclusion.<br><br>A finding of noncompliance has been made. With regard to the DFPS investigations, the issue identified was related to reports not including a description of the results of a review conducted of previous cases involving the alleged perpetrator and/or victim. While there had been progress and it was clear that a new process had been adopted to include the required information, it had not been in place long enough to demonstrate compliance. With regard to the Facility's investigations, the role of the nurse in death reviews should include input into the investigation and resulting findings to provide an adequate basis for the investigations' conclusions and recommendations. | |
| | (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 | Based on review of CCSSLC Policy #002.2 and the associated procedure DD.11, it did not require staff supervising the investigations to review each report and other relevant documentation to ensure that: 1) the investigation was complete; and 2) the report was accurate, complete and coherent. The policy did not require that any further inquiries or deficiencies be addressed promptly. However, the reporting formats for the Facility unusual incidents investigation reports provided for a signature and comments by the supervisor. | Noncompliance |

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| | and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly. | To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (Sample #D.2) were reviewed. The results of these reviews are discussed in detail below, and the findings related to the DFPS investigations and the Facility investigations are discussed separately.<br><br><u>DFPS Investigations</u><br>The following summarizes the results of the review of DFPS investigations:<br>▪ In 38 of 39 investigation files reviewed (97%), the supervisor had signed the report indicating he/she had conducted a review of the investigation report. There were no notes or checklists in the file to indicate how the review was conducted. The case in which no supervisor's signature was found was case #39309967, for which a page was missing from the report.<br><br><u>Facility Investigations</u><br>The following summarizes the results of the review of Facility investigations:<br>▪ In 10 out of 13 investigation files reviewed (77%), there was evidence that the supervisor had conducted a review of the investigation report.<br><br>The Facility POI indicated that a checklist was adopted in May to review investigation reports. Using checklists to guide and document review of investigations was a positive step, although none were included with any of the reports reviewed.<br><br>While significant progress had been made to ensure that investigation reports were reviewed, the process changes had been recent and were not reflected in all reports in the sample. The Facility was not in substantial compliance with this provision. | |
| | (h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident. | The findings from the Monitoring Team's review of the Facility's investigation of Unusual Incident Reports are discussed in (f) above. | 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 | According to CCSSLC Policy #002.2 and procedure #DD.13, disciplinary or programmatic action necessary to correct the situation and/or prevent recurrence was to be taken promptly and thoroughly. In addition, the Facility was to have a system for tracking and documenting such actions and the corresponding outcomes.<br><br>Facility Policy D.14, entitled Participating In and Completing Review Authority Team (RAT), revised on 5/22/11, designated the Review Authority Team to review all final DFPS reports and make recommendations to the Director for approval. The responsibilities of the Team included follow-up tracking of all recommendations made by | Noncompliance |

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| | corresponding outcomes. | the Team. The policy provided a format for making recommendations, and prescribed a method for tracking the recommendations in the Incident Management Team minutes, and recording them in the investigative report.<br><br>In order to determine compliance with this provision of the Settlement Agreement, a subsample of the investigations included in Sample #D.1 and Sample #D.2, were selected for review. This subsample, Sample #D.6, included the following DFPS Investigations: #39948628 and #39217147. They were selected because the investigations were before and after the change in the RAT process. Facility Investigation #488584 was also selected. The following summarizes the results of this review:<br>▪ DFPS Investigation #39217147 involved a staff member who provided Cheetos to an individual with dietary prohibitions against eating such snacks. The concerns included that staff might not have had time to become informed about dietary considerations during a transition to that living unit, and that there was a conflict between the physical and nutritional management plan (PNMP), which required a pureed diet, and the BSP, which indicated a chopped diet. Both concerns were acknowledged in the Facility's Unusual Incident Report, and reported to the Review Authority Team for resolution. The RAT should have addressed the concerns and reported the results back to the IMT, and they should have been entered in the investigative report, but they were not.<br>▪ DFPS Investigation #39948628 involved an individual who fell from his wheelchair after a staff member transferred him without assistance, and did not fasten his wheelchair belt properly. The investigator recommended staff complete additional in-service training on lift/transfer procedures. The Facility Unusual Incident Report agreed with the DFPS investigator, and noted that the Review Authority Team recommendations were pending. It will be important to follow the procedure and enter the resolution in the investigation file in the future.<br>▪ Facility investigation #488584 involved possible sexual contact between peers, which occurred when one individual left his residence. He was on routine supervision in his home, but on one-to-one level of supervision (LOS) when out of the home. He was supposed to tell staff when he was leaving, but did not. The investigator's concern was with the expectation that the individual could be relied on to tell staff when he left, given that his BSP indicated that one of his challenging behaviors was uncooperativeness. The recommendation was for the individual's team to review and address the issue. The report indicated that the Review Authority Team would address the concerns. According to the Summary/Conclusion/and Recommendations section of the report, the team had met, concluded the LOS should be one-to-one at all times. However, this LOS did not carry over to his new residence when he was transferred. His new PST still needed to meet to resolve the LOS issue, and it was not clear how that would be | |

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| | | tracked to resolution.<br><br>It was not clear that the process for tracking recommendations to resolution was in place, and/or fully operation to ensure that the outcomes were achieved. The Facility was not in compliance with this provision. | |
| | (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. | Section DD.5.2 provided a checklist for investigation files maintained by CCSSLC, which was implemented on 12/5/10. Files of the Facility's investigations and the DFPS investigations were maintained in an office next to the IMC's office, and were readily available to permit investigators and other appropriate personnel to easily access every investigation involving a particular individual. The files examined were arranged according to the checklist, which facilitated navigation to documents of particular interest.<br><br>The Facility investigations were entered electronically into the Facility's computer system, allowing access to investigators without resorting to the paper file.<br><br>DFPS files were maintained electronically to allow access to their authorized personnel. It appeared that their official reports were transmitted to CCSSLC in hard copy, where they were filed. | Substantial Compliance |
| D4 | Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall have a system to allow the tracking and trending of unusual incidents and investigation results. Trends shall be tracked by the categories of: type of incident; staff alleged to have caused the incident; individuals directly involved; location of incident; date and time of incident; cause(s) of incident; and outcome of investigation. | The CCSSLC Quality Assurance office tracked and trended unusual incidents and allegations of abuse, neglect and exploitation by:<br>▪ Type of incident;<br>▪ Individuals directly involved;<br>▪ Location of incident;<br>▪ Date and time of incident;<br>▪ Cause(s) of incident; and<br>▪ Outcome of investigation.<br><br>While the Facility did not yet trend staff alleged to have caused incidents over time, the names of staff involved in allegations were reported by month with the number of allegations recorded.<br><br>The Facility provided tracking reports for incidents and allegations with analysis in monthly and quarterly trend reports to its QA/QI Council. Trend reports were available to Unit teams, by unit and by residence.<br><br>According to the Plan of Improvement, the Facility began presenting trend analyses reports to the QA/QI Council in June 2011 for development of corrective action plans. This was an important step toward using data to make changes in people's lives. However, the Facility was not yet in substantial compliance with this provision. | Noncompliance |

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| D5 | Before permitting a staff person (whether full-time or part-time, temporary or permanent) or a person who volunteers on more than five occasions within one calendar year to work directly with any individual, each Facility shall investigate, or require the investigation of, the staff person's or volunteer's criminal history and factors such as a history of perpetrated abuse, neglect or exploitation. Facility staff shall directly supervise volunteers for whom an investigation has not been completed when they are working directly with individuals living at the Facility. The Facility shall ensure that nothing from that investigation indicates that the staff person or volunteer would pose a risk of harm to individuals at the Facility. | By statute and by policy, all State Supported Living Centers were authorized and required to conduct the following checks on an applicant considered for employment: criminal background check through the Texas Department of Public Safety (for Texas offenses) and a Federal Bureau of Investigation (FBI) fingerprint check (for offenses outside of Texas); Employee Misconduct Registry check; Nurse Aide Registry Check; Client Abuse and Neglect Reporting System; and Drug Testing. Current employees who applied for a position at a different State Supported Living Center, and former employees who re-applied for a position also had to undergo these background checks.<br><br>In concert with the State Office, the Facility Director had implemented a procedure to track the investigation of the backgrounds of Facility employees and volunteers. Documentation was provided to verify that each employee and volunteer was screened for any criminal history. This was confirmed in a sample of 20 staff. The information obtained about volunteers was discussed and confirmed with the Facility Director, and confirmed in a sample of the three most recent volunteers.<br><br>Background checks were conducted on new employees prior to orientation. Portions of these background checks were completed annually for all employees. Current employees were subject to annual fingerprint checks during the month of November 2010. Once the fingerprints were entered into the system, the Facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry.<br><br>In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. Examination of the self-reporting information documented that one person was terminated upon background check information showing a failure to self-report an arrest.<br><br>In an interview with the Facility Director, her decisions regarding the employment of a sample of applicants with any criminal history were discussed on a case-by-case basis. In each instance, her decisions were based on the facts and were mindful of her responsibility to safeguard the individuals and staff of the Facility.<br><br>This Facility is in substantial compliance with this provision. | Substantial Compliance |

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

1. The Facility should conduct further analysis to determine the potential cause(s) for this apparent increase. Causes could be positive (e.g., better reporting and/or investigations) or cause for concern (e.g., staffing issues, etc.). (Section D.2.a)

2. The Facility should ensure that acknowledgments of responsibility to report abuse are signed during the first week after hiring. (Section D.2.d)
3. QMRPs should discuss and provide the abuse, neglect, and exploitation handouts to individuals at PSP meetings. The provision of this information to the individual should be documented in the PSP. (Section D.2.e)
4. The Facility should maintain a strong training program on retaliation and remind staff, for example, at staff meetings, in newsletters, etc., that retaliation will not be tolerated. In addition, when the reports of investigations are reviewed, the Facility should follow up on any references to possible retaliation or expressed fears of retaliation. For example if staff have participated in an investigation, it might be necessary to offer a change of assignment to relieve strained relationships with other staff. The culture amongst staff of protecting one another as opposed to individuals served can be very strong. Facility Administration 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. (Section D.2.h)
5. The Facility's Action Plan with regard to Section D.2.i should be revised to indicate how the Facility intends to review all injuries every six months, and report for investigation those injuries that due to frequency or other criteria raise suspicions of possible abuse or neglect, if reports have not already been made. (Section D.2.i)
6. All Facility staff with investigation responsibility should complete required training. If any are conducting investigations without the basic training, they should be reassigned until the training is complete. (Section D.3.b)
7. The Facility's process for death investigations should be revised to include the medical findings and recommendations in the investigative report. This would tie the nurse's recommendations in the report to the findings. (Section D.3.f)
8. The Facility should consider holding death investigations open until the medical examiner's report has been read, and used in the determination of what occurred and what actions need to be taken as a result. This would assist in providing an adequate basis for the investigation's conclusions. (Section D.3.f)
9. The Facility should implement its new process to conduct the supervisory review of investigations. (Section D.3.g)
10. In addition to reviewing documents, as appropriate, the Facility should physically confirm that changes expected as a result of the implementation of recommendations resulting from investigation reports have occurred. This might require a change to the Incident Investigation report to add a column under section #21 to show the date the recommendation was completed. This should be possible given the recent changes to the Review Authority Team and their charge to follow-up on investigator's recommendation. It will be important to include evidence of the follow-up, such as what has changed in the individual's life as a result. (Section D.3.i)
11. The Facility should finalize its tracking and trending system. (Section D.4)
12. The Facility should expand its efforts to conduct critical analysis of the trend data collected to determine if any actions should be taken, or action plans developed to address any underlying causes of trends identified. (Section D.4)

The following are offered as additional suggestions to the State and Facility:

1. A clearer explanation should be provided in Facility policy and staff training of what form a report about an unusual incident is to take (i.e., phone call, a written report, or whatever was expected.) (Section D.2.a)
2. Consideration should be given to articulating a policy/procedure related to the use of video surveillance tapes in investigations to establish a standard of use. (Section D.3.d)

| SECTION E: Quality Assurance | |
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| 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:<br>▪ **Review of Following Documents**:<br>o CCSSLC Plan of Improvement, dated 6/29/11;<br>o Quality Enhancement Plan FY 2010, undated;<br>o Settlement Agreement Compliance Reports by Home, 6/1/10 through 5/31/11;<br>o Chart Audit Data Tool for January, March, April, and May 2011;<br>o State Center Satisfaction Survey, Family/Legally Authorized Representatives (LARs), January through June 2011;<br>o CCSSLC Quarterly Trending Report from 3/1/11 through 5/31/11 for Injuries, Restraints, Unusual Incidents, and Abuse/Neglect/Exploitation;<br>o Quality Assurance/Quality Improvement (QA/QI) Council minutes;<br>o Quality Assurance/Quality Improvement agenda and meeting materials for 7/13/11; and<br>o Centers for Medicare and Medicaid Services (CMS) Reports on Incident Investigations as provided in response to Document Request I.20.<br>▪ **Interviews with**:<br>o Daniel Dickson, Director for Quality Assurance (QA), on 7/12/11; and<br>o Program Auditors, on 7/12/11.<br>▪ **Observations of:**<br>o Daily Unit Meeting in Atlantic, on 7/14/11; and<br>o QA/QI Meeting, on 7/13/11. |
| | **Facility Self-Assessment:** CCSSLC 's Plan of Improvement had a format that was easy to follow, and contained brief descriptions of the evidence used to self-assess compliance with each element of the Settlement Agreement. The POI was arranged according to the Settlement Agreement sections with an action plan for each section and corresponding reports on progress. As noted in other sections of this report addressing the Facility's self-assessment, many of the sections of the POI, such as the one for Section E, included important narrative information regarding the activities the Facility was undertaking to move toward compliance. As the Facility moved forward in developing its self-assessment processes, in addition to the important narrative information included in the POI, data, including the results of the analyses of the data, to substantiate its findings of either substantial compliance or noncompliance had begun to be added to POI Comments/Status column. Expansion of the use of such data and analyses continued to be necessary for the Facility to complete a thorough self-assessment. This data would potentially come from a variety of sources, including, for example, the results of monitoring activities, and outcome data being collected and analyzed by various departments. Such data should be quantitative as well as qualitative in nature.<br><br>Based on a review of the POI with regard to Section E on Quality Assurance, the Facility found that it remained out of compliance with all five indicators. This was consistent with the Monitoring Team's findings. |

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| | **Summary of Monitor's Assessment:** CCSSLC had adopted policies and procedures to guide the development of its quality assurance program. A Quality Enhancement Plan was in place. The plan set out the audit tools to be used for each section of the Settlement Agreement with corresponding expectations for the samples to be drawn, the persons responsible for auditing, reporting, and analyzing the resulting data, and creating corrective action plans.<br><br>Monitoring tools to measure quality had been adopted based on the tools used by the Settlement Agreement Monitoring Teams, and adapted for use in the Facility. Guidelines for the use of the tools had been written, and Program Auditors were using the tools in the field. Raw data and summary reports were available for some of the reviews as was inter-rater reliability data. However, more work was needed with regard to inter-rater reliability, as well as the accuracy of the monitoring. Some sections of the POI were beginning to use summarized data from the monitoring tools as evidence of the Facility's compliance status.<br><br>CCSSLC continued to report trend data and analyses on a quarterly schedule for some key issues, such as restraints, abuse allegations, incidents, and injuries, and risks had been added. 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 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.<br><br>The Quality Assurance/Quality Improvement Council had been organized to develop, revise, and implement quality assurance procedures. The Performance Implementation Team (PIT) had been reorganized to focus on quality improvements in the units and in service delivery disciplines.<br><br>The next steps will include completing the Corrective Action Plan process, using the data system to report on information generated by the monitoring activities, and developing a set of key criteria to measure progress on service outcomes. |

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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. | 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, 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. | Noncompliance |

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| | | Throughout this report, there are references made to data that should be incorporated into such a system. For example, data needs to be incorporated into the system regarding at-risk individuals; medical, psychiatric, and nursing issues; infection control; physical and nutritional supports; and outcomes related to transition to the most integrated setting. This is not an all-inclusive list, but is meant to provide the Facility with ideas about the type of indicators or outcome measures that should be included in such a system.<br><br>At the time of the review, the Facility did not have a complete system such as this in place. However it did have certain critical elements, including:<br>▪ Monthly, quarterly, and annual Trend Reports that showed unusual incidents; allegations, investigations, and results of investigations of abuse, neglect and exploitation, as well as injuries, and restraints.<br>▪ These reports were displayed by type, individuals involved, location, home, hour, shift, day of week, and staff involved.<br>▪ CCSSLC POI Submissions report tracked data on areas of service, including: integrated protections and services, pharmacy services, physical nutritional management, psychological services, and others. It was not clear how this data was generated, but if done correctly, it could form the basis of the key indicators data that is needed to assess performance in areas of care.<br><br>Two issues, discussed with the Director for Quality Assurance at the last monitoring review, were how to display data involving staff members and how to develop data related to areas of care. The following summarizes the content of these discussions with updates on progress:<br>▪ The first issue involved how to track data involving staff members without displaying their names in reports, such as the Monthly and Quarterly Trend Reports for Abuse/Neglect/Exploitation, Unusual Incidents, Injuries, Restraints and Risks. The discussion during the previous onsite review involved whether employee numbers could be used to identify staff, but this remained unresolved.<br>▪ "Areas of care" referred to in the Settlement Agreement are programmatic and clinical areas, such as residential, vocational, medical, psychiatric, nursing, psychology, habilitation therapies, etc. The question was how to collect key indicators of performance in these areas. As mentioned above, the Facility had produced a list of some basic key indicators that they thought might serve as a starting point. The Facility had an Action Plan as part of its POI to address this issue.<br>o Step 1 was to develop a Policy and Procedure, and process to measure trends across all areas of care as identified in the POI. This was reported to be in process.<br>o Step 2 was to review the monthly POI Submission Report and the | |

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| | | Quarterly Trend Reports to develop quality indicators (or key indicators) to measure many areas of care, which would be reviewed during the QA/QI Council to develop corrective action plans. This was reported as completed. However, it was not clear what evidence supported the completion. There were no notes of a presentation to the QA/QI Council recorded in the minutes from April through June, and no documentation of a list of quality indicators.<br>o Step 3 language was vague and should be revised. It needed to specify that the quality indicators developed in Step 2 would be used as the basis for a tracking system that drew upon existing data sources to determine where systemic issues affecting services existed, and where multiple issues were affecting individuals, so that the QA/QI Council could set priorities, and require corrective actions to address them.<br>o Steps 4 and 5 could then follow. They required the development of the reporting system procedures, and eventually, corrective actions.<br><br>As noted in a previous report, monitoring tools had originally been adopted based on the tools used by the Settlement Agreement Monitoring Teams. Most of these tools, including Restraints, Protection from Harm, and Integrated Supports, had been modified to reflect Facility-specific needs, and to crosswalk them with ICF-MR requirements to avoid having separate and redundant monitoring procedures. The tools had guidelines to help to assure consistency of monitoring.<br><br>Most of the monitoring tools had been in use for six months or longer. Four Program Auditors and the two quality assurance nurses, who reported to the Director of Quality Assurance, were conducting audits. The four Program Auditors divided the POI sections according to their experiences, so that each Program Auditor had a specific set of tools and responsibilities. Each month a specific sample was drawn and the monitoring tools were applied and recorded. The discipline head was supplied with the sample and asked to apply the monitoring tools to the same sample.<br><br>Upon interview the Program Auditors (excluding the nurses who were not present for the interview) could identify where some tools were beginning to work, and where some of the issues were still unresolved. As examples they pointed to the Section F tools as having good State Office instructions and rising inter-rater reliability. They indicated that the tools for Sections C and D worked, but there were some issues with double negatives that needed to be worked out. It was noted that the discipline head was not yet completing the tool for Section D, and that since the tool was being used for Facility investigations (not DFPS investigations), it needed some adjustments. One big problem was dealing with terminology in the tools such as "sufficient trials," "strengths" versus "skills," and "adequate array of skills and programs." These and other difficulties will | |

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| | | need to be addressed in future revisions to the tools to promote inter-rater reliability and accuracy. Asked how long they spend on reviews, their replies were anywhere from two hours on a Section C (Restraint) audit to six to eight hours on a Section O (Physical and Nutritional Management) audit. Asked if they thought the audits were making a difference, most replied that progress was noted in some sections more than others, but that they could see the beginnings of a sharper focus on the individual and that they thought the audit process was encouraging people to change in that direction.<br><br>From the Monitoring Team's perspective, work still needed to be done to refine these tools and their implementation, including improving the guidelines or instructions associated with each tool, ensuring inter-rater reliability and accuracy of monitoring, ensuring that quality was measured as opposed to the mere presence or absence of items, as well as identifying the priorities for the tools' implementation so as to not overwhelm the system with data that could not be used effectively. The Facility was producing overall scores of compliance based on the implementation of the monitoring tools. The tools are not weighted, and were not designed to produce overall scores. In the various sections of this report, the Monitoring Team has provided comments, as appropriate, with regard to the monitoring tools and the Facility's implementation of them.<br><br>The Active Treatment Monitoring – Coaching Guide was discussed in the Monitoring Team's last report as a useful and productive tool to aid in supervising and mentoring staff. This continues to be the opinion of the Monitoring Team, and details are available in the previous report.<br><br>As indicated in the Facility's POI, the Facility was not in substantial compliance on this subsection. However, there was definite progress in the auditing of performance and the development of additional trend reports. For progress to continue the Facility should reformulate its Action Plan for this section as described above, and continue to work on auditing programs and addressing any resulting identified issues. | |
| 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 | Although the Settlement Agreement did not anticipate full compliance with this provision until 6/26/12, some data already were being analyzed regularly into Trend Reports. For example, data on personal, chemical, and medical/protective restraints was being trended and analyzed, as was data on abuse/neglect/exploitation and unusual incidents. Trended data on risk assessments were also available. The previous Monitoring Report provided a more complete description of this process with examples.<br><br>CCSSLC had reorganized the former Program Improvement Team (PIT) under Facility Procedure #E.5 into a Quality Assurance/Quality Improvement Council. Its stated role was to develop, or revise and implement quality assurance procedures "…that detect | Noncompliance |

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| | action step; the person(s) responsible; and the time frame in which each action step must occur. | problems in a timely manner in provision of adequate protections, services and supports and to ensure that appropriate corrective steps are implemented…" The QA/QI Council became the central point for analysis of data and the setting of priorities, including making assignments for corrective action plans.<br><br>Under Procedure #E.3, the former PIT had been reorganized into unit PITs to review data from monthly trend reports, and data reports that the Active Treatment Coordinator, the Psychologist, and the RN Case Manager provided. The Unit Directors oversaw these committees. Procedure #E.3 specified what each of the data reports would contain. For example the Active Treatment Coordinator was to provide among other data, the percent of individuals who participated in community inclusion activities and the number of individuals enrolled in vocational programs. Procedure #E.3 called for reporters to compile their reports, share them with the PIT, and the PIT then would make recommendations for follow-up at the next QA/QI Council meeting.<br><br>With data being trended and analyzed as part of the PIT process, and with the identification of some indicators of performance outlined in Procedure #E.3, the elements were in place to progress toward substantial compliance with this provision.<br><br>To the degree that PIT actions require Facility-wide discussion and decision-making, those actions were to be shared with the QA/QI Council for prioritization and inclusion in plans of correction managed.<br><br>It was not clear at the time of the site visit how the unit PITs were progressing or whether they had encountered obstacles to performance. No minutes of meetings were found in the documents supplied, and no evidence was provided that Procedure #E.3 had been either implemented or abandoned.<br><br>The Performance Evaluation Team (PET) process was revised in April 2011 to create seven teams. Each team represented a group of related POI sections (e.g., Sections C and K; or Sections D, E, U, and V). The Quality Assurance Department was charged with sending out a sample of individuals monthly to be reviewed by the teams. The teams would complete the monitoring tools for their sample, and bring copies to the monthly team meeting for review and discussion. The results were to be reported to the QA/QI Council for review and determination of any corrective action plans that might be needed to facilitate compliance with the Settlement Agreement. This process should help to coordinate activities around compliance and help with inter-rater reliability on monitoring forms.<br><br>Members of the Monitoring Team attended a meeting of the QA/QI Council on 7/13/11. Council participants discussed the need for PSTs to review the current risk ratings of | |

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| | | individuals, revise them, and revise Risk Action Plans, where necessary, with a deadline for completion of 9/30/11. A Corrective Action Plan was set up to track compliance. The Council also reviewed a monitoring tool and the results of its application, and made suggestions about clarifications that were needed.<br><br>The Facility remained out of compliance with this requirement. However, there was progress. Key to continued progress in this area will be the ongoing development of the Unit PITs, the PETS, and the use of the results of their analyses to identify and address problematic trends, and Facility and/or statewide identification of key indicators. | |
| 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. The POI indicated that on 6/17/11 the QA department finalized the Corrective Action Plan procedure, and it would now go to the QA/QI Council for authorization.<br><br>The Monitoring Team noted a variety of action plans referenced or attached to different documents. For example, the QA/QI Council minutes for 6/1/11, under Section I, At Risk Individuals, included a corrective action plan to evaluate the day referral process, and to further develop the process for referral to the Behavior Support Committee. A work group was designated, a due date set, and an entry made to track progress.<br><br>The Action Plans associated with the POI set out specific tasks that needed to be accomplished to bring each section of the Settlement Agreement into substantial compliance. The QA/QI procedures in E.5.2 set out a process for monthly reporting to the QA/QI Council by department heads on each action plan for which they were responsible. The PIT had a similar procedure for follow-up. It will be important to find ways to make action plans work to support, but not duplicate the same actions in multiple places. It also is important to note that not every issue requiring corrective action requires an action plan. The Monitoring Panel has discussed this with the State Office. For example, the QA/QI Council might decide that the Facility Director needs to send a memorandum to staff to correct a particular issue. The memo could be sent, and a copy attached to the next set of QA/QI Council minutes with a notation that the corrective action was completed. Likewise, for individual issues, such as modifications needing to be made to an individual's Behavior Support Plan, documentation in the form of a PSPA would be sufficient to document the occurrence of the necessary change. Judgment should be used in deciding which issues require the development and implementation of full corrective action plans, and which issues are more appropriately addressed using another format. This will reduce unnecessary paperwork, while at the same time ensuring that issues that do need formal corrective action plans have them.<br><br>Although the Monitoring Team identified a number of corrective action plans, as the | Noncompliance |

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| | | Facility recognized, there continued to be a number of areas in which data either had not been analyzed adequately to identify the need for corrective action, or a problem had been identified requiring formal attention, but a corrective action plan had not been developed. For example, much of the monitoring data the Facility had collected had not yet been formally analyzed and appropriate corrective action plans developed. | |
| 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, this procedure was under development by the QA/QI Council. 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. CCSSLC should revise its monitoring tools to meet the needs of the Facility. As is detailed above with regard to Section E.1 of the SA, this should include, but not be limited to: revisions to indicators as appropriate, the enhancement of instructions and/or guidelines, availability of training and technical assistance from subject-matter experts on substantive issues, ensuring inter-rater reliability and accuracy of monitoring, ensuring that quality was measured as opposed to the mere presence or absence of items, as well as identifying the priorities for the tools' implementation so as to not overwhelm the system with data that could not be used effectively. If the tools will be scored overall, consideration should be given to weighting the factors that go into producing an overall score. (Section E.1)
2. 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. (Section E.1)
3. The POI Action Plan should be revised to clarify that the quality indicators developed to address "areas of care" would be used as the basis for a tracking system that drew upon existing data sources to determine where systemic issues affecting services existed, and where multiple issues were affecting individuals, so that the QA/QI Council could set priorities, and require corrective actions to address them. (Section E.1)
4. The Facility should resolve its issue over how to display data related to staff. (Section E.1)
5. As problematic trends and/or individual issues are identified, the Facility should develop, implement and monitor corrective action plans. (Sections E.2, E.3, E.4, and E.5)
6. The progress of Unit PIT meetings and PET meetings should be monitored, and the modifications made to the procedures as needed. (Section E.2)
7. As the Facility moves forward in developing its self-assessment processes, in addition to the important narrative information included in the POI, the Facility should include data, including the results of the analyses of the data, to substantiate its findings of either substantial compliance or noncompliance. This data would potentially come from a variety of sources, including, for example, the results of monitoring

activities, and outcome data being collected and analyzed by various departments. Such data should be quantitative as well as qualitative in nature. This data should be a core component of what the Quality Assurance/Quality Improvement Council reviews, and the analysis of this data should form the basis for the actions that the Council implements, monitors, and revises, as appropriate, to effectuate positive changes in the lives of individuals the Facility supports. This provision of data is important in all sections of the POI including the Quality Assurance Section. (Facility Self-Assessment).

| **SECTION F: Integrated Protections, Services, Treatments, and Supports** | |
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| 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:<br>▪ **Review of Following Documents**:<br>o Presentation Book for Section F, including:<br>▪ Policies related to PSP process;<br>▪ QA/QI Council Minutes, dated 5/4/11;<br>▪ Personal Support Plan Meeting/Documentation Monitoring Checklist, dated 9/1/10;<br>▪ Training roster and handouts for session on Personal Focus Assessment Procedures and Personal Support Plan Instructions Procedures, Pages 8 through 14, dated 4/28/11;<br>▪ Training roster and curricula for Q Facilitator training, dated 4/21/11;<br>▪ Training roster;<br>▪ Training roster and handouts for PSP Facilitation Tool training, dated 5/12/11;<br>▪ Sample Personal Support Team (PST) Signature Sheets, various dates;<br>▪ Settlement Agreement Compliance Report: Section F – Integrated Protections, Services, Treatments and Supports, for 3/1/11 through 5/31/11;<br>▪ Current Referrals for Community Placement reports, dated 1/31/11, 2/28/11, 3/29/11, 4/30/11, and 5/31/11;<br>▪ Sample PSPs for Individual #126, Individual #338, Individual #356, Individual #99, Individual #191, Individual #167, Individual #153, Individual #151, Individual #142, Individual #277, Individual #321, Individual #363, Individual #282, Individual #336, Individual #72, Individual #109, and Individual #83; and<br>▪ Sample completed PSP Facilitation Tools for Individual #161, Individual #24, Individual #326, and Individual #383;<br>o Q Construction: Facilitating for Success – Workbook, dated 4/7/11;<br>o Q Construction: Facilitating for Success Lesson Plan and Content, dated 4/7/11;<br>o Q Construction: Facilitating for Success – Qualified Mental Retardation Professional (QMRP) Facilitation Skills Performance Tool, with instructions, dated 6/7/11;<br>o Completed Facilitation Skills Performance Tools for six QMRPs;<br>o CCSSLC QMRP Listing with current assignments;<br>o PSP Attendance for Meetings Held: 1/1/11 through 6/30/11, for QMRPs, Direct Contact Professionals, Unit Director, Home Supervisor/Residential Coordinator, Nursing, Home Manager/Home Team Leader, Psychiatrist, Physician/Nurse Practitioner, Psychologist/Behavior Analyst, Habilitation Program Technician, Active Treatment Staff, Audiologist, Communication Therapist (Speech), Dietician/Nutritionist, Education/Training, Occupational Therapist, Physical Therapist, Vocational Services, Dental, Pharmacist, QA Staff, Human Rights Officer (HRO)/Ombudsman, and Community Integration Specialist;<br>o CCSSLC PSP Attendance: Compliance by Unit for All Meeting Types, from 1/1/11 through |

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| | 6/30/11;<br>o Overall Facility Attendance Compliance for All Meeting Types, from 1/1/11 through 6/30/11;<br>o CCSSLC PSP Required Attendance Compliance, from 1/1/11 through 6/30/11;<br>o Sample Vocational Assessments for Individual #7, Individual #114, Individual #109, Individual #72, Individual #88, and Individual #118;<br>o Assessment Filing Number – Number of Times Filed Later than 10 Days, dated 7/14/11, with note stating: "Assessment filing database results are based on insufficient data entry. Consequently, the summary data report is inaccurate";<br>o CCSSLC Integrated Protections, Services, Treatments and Supports policies, including:<br>▪ F.1 - Preadmission – Initial Personal Plan Meeting, implemented 1/30/11;<br>▪ F.2 – Annual Personal Support Plan Meeting, implemented 1/30/11;<br>▪ F.3 – Living Options Discussions, implemented 1/30/11;<br>▪ F.4 – Rights/Consent/Guardianship, implemented 1/30/11;<br>▪ F.5 – Action Plans, implemented 1/30/11;<br>▪ F.6 – Personal Support Plan Monitoring, implemented 1/30/11;<br>▪ F.7 – Preparation for Annual PSP Meeting, implemented 1/30/11;<br>▪ F.8 – Scheduling PSP Addendums, implemented 1/30/11;<br>▪ F.9 – Staff Training on PSP Process, implemented 1/30/11;<br>▪ F.10 – Quality Assurance for PSP Process, implemented 1/30/11;<br>▪ F.11 – Completing Daily Schedules, implemented 12/5/10;<br>▪ F.12 – Completing Individual Profile Sheets, implemented 12/5/10;<br>▪ F.13 – Life Discovery Meeting (Preparation for PDP Meeting) and Completion of Comprehensive Functional Assessments, implemented 12/5/10;<br>▪ F.14 – Ensuring Timely Completion of LON [Level of Need] Documentation by PST, implemented 12/5/10;<br>▪ F.15 – Purchasing Furniture for Individual Personal Use, implementation 12/5/10;<br>▪ F.16 – Personal Support Planning, implemented 1/30/11;<br>▪ F.17 – PST: Program Implementation monitoring and Documentation of Program Effectiveness and Staff Competency, implemented 3/7/11;<br>▪ F.18 – Personal Support Planning: Developing Integrated Personal Support Plans, implemented 5/2/11; and<br>▪ F.19 – Personal Support Planning: Completing Personal Focus Assessments, implemented 5/2/11;<br>o Sample of CCSSLC PSP Meeting and Documentation Monitoring: Level of Compliance – Assessment, from 3/1/11 through 5/31/11;<br>o CCSSLC PSP Meeting and Documentation Monitoring: Level of Compliance – Monthly Trend Comparison, Monthly Trend Comparison by Home, Compliance by QMRP, and Monthly Comparison, from 3/1/11 through 5/31/11;<br>o ICF/Regulatory Chart Review blank audit form, revised 8/5/10;<br>o Chart Audit Data Tool, June 2011; |

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| | ○ Last 10 monitoring tools completed by the QMRP Coordinator – one provided, dated 3/1/11;<br>○ Last 10 monitoring tools completed by the Quality Assurance Department Staff, various dates;<br>○ List of individuals with most recent PSP date, previous date, and date of implementation; and<br>○ Personal Support Plans, Sign-in Sheets, Assessments, Personal Support Plan Addenda, (PSPAs), Personal Focus Assessments (PFAs), skill acquisition and teaching programs, and any monthly and/or quarterly reviews for the following individuals: Individual #154, Individual #282, Individual #160, Individual #363, Individual #331, Individual #299, Individual #277, Individual #114, Individual #175, Individual #281, Individual #124, Individual #372, Individual #109, Individual #7, and Individual #336.<br>▪ **Interviews with**:<br>○ Daniel Dickson, Director of Quality Assurance;<br>○ Rachel Martinez, QMRP Coordinator;<br>○ Bruce Boswell, Programs Director; and<br>○ Meetings with two teams related to risk ratings and related action plan development, for Individual #275, and Individual #247.<br>▪ **Observations of**:<br>○ PSP meetings for Individual #234, Individual #228, and Individual #353. |
| | **Facility Self-Assessment:** Based on a review of the Facility's POI with regard to Section F of the Settlement Agreement, the Facility found that it remained out of compliance on all but one of the subsections, Section F.2.f. This section required the Facility to complete PSPs within 30 days of an individual's admission, and annually thereafter, as well as to implement the PSP within 30 days of the PSP meeting. The Facility provided data indicating that of the 274 PSPs tracked, 267 (97%) were completed within the 30-day timeframe. Since January 1, 2011, when the Facility began tracking the filing date of PSPs, 127 plans had been completed. Of that 127, 115 (91%) were filed and ready for implementation.<br><br>Although the Monitoring Team's findings were consistent with the Facility's findings for the remaining provisions of Section F, the Facility's justification for its findings often was inadequate or did not provide sufficient detail. It was positive that the Facility was using data from its internal auditing to substantiate its findings, but further refinement of the data was needed. For example:<br>▪ For many of the provision, the Facility's self-assessment stated: "The facility reviewed PSPs that were held from January 1, 2011 to March 31, 2011 and found that all 81 (100%) PSPs required additional training of the PST members in understanding and documenting all components of the State Office policy # 004, dated 07/30/2010 as well as the At Risk Policy #006.2 dated 02/18/2011." This broad statement was not sufficient to assist the Facility in identifying specific areas in which corrective action was needed.<br>▪ A more helpful piece of data was included for Section F.2.d, which stated: "QA Department conducted a sample of the records to ensure monthly assessment of progress by the assigned QMRP. Data indicated 42% compliance." This data would have been enhanced with a notation defining if this represented timeliness or quality of the monthly reviews. |

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| | ▪ Data was provided regarding attendance at PSP meetings, but it was difficult to interpret the meaning of the data. For example, for one month, the POI indicated: "06/05/2011: Sixteen (16) annual PSPs were held in May 2011 using the PFA to determine who should attend the PSP. Of the 16 PSPs held 6 had attendees from Habilitation Services and Physician for 37% along with the other PST members."<br>▪ In some cases, the validity of the data was questionable. For example, with regard to Section F.2.a.5, part of which addresses community participation, the Facility found close to 100% compliance. This was inconsistent with the Monitoring Team's findings of 50% compliance. Although the sample sizes were different, the reason for the discrepancy was unclear.<br><br>The Facility's progress in developing a quality assurance process for Section F is discussed in further detail below with regard to Section F.2.g. |
| | **Summary of Monitor's Assessment:** CCSSLC, as a whole and with the leadership of the Facility Director, had recognized the importance of integrating protections, supports, and services. One of the ways in which this was evidenced was through a Performance Evaluation Team (PET) that brought together discipline leaders and other staff charged with the responsibility to meet monthly, conduct self assessments, and draft corrective action plans for presentation to the QA/QI Council. At the time of the review, the PET for Sections F, S, and T had just begun to meet.<br><br>Since the last review, QMRPs had undergone additional training on meeting facilitation, and consultants for the State had begun to train teams on the philosophical and historical context of individual planning, as well as on some of the logistics of the development of sound plans. Both the QMRP Coordinator and the State consultants had begun to provide technical assistance to teams at CCSSLC during annual planning meetings. Based on the meetings observed while the Monitoring Team was onsite, these efforts had begun to show positive changes with regard to facilitation skills, more productive meetings, and a more person centered focus. As would be expected, significant changes had not yet occurred in the PSP documents themselves.<br><br>Some areas that required attention included:<br>▪ As noted in many sections of this report, comprehensive, thorough, and adequate assessments were missing in many areas, including but not limited to nursing, speech and communication, psychiatry, skill acquisition and day/vocational, and physical and nutritional supports. Adequate assessments are the foundation for good individualized planning;<br>▪ Attendance of the full array of staff necessary to provide input into the interdisciplinary process was not consistently seen;<br>▪ Action plans largely addressed skill acquisition plans, but not other supports, services, treatments, or strategies. Focused effort was needed to improve the scope of action plans, as well as to ensure they were measurable; and<br>▪ The State and the Facility will need to ensure that person-centered concepts are incorporated with the need to develop comprehensive, integrated plans. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility, should figure out ways to |

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| | have adequate, technical team discussions, while focusing on the individual and his/her preferences, strengths, etc.<br><br>The Facility continued to develop its quality assurance system related to the PSP process. The QA Department continued to monitor PSP meetings, as well as PSP documents and implementation. Data had begun to be analyzed, and two areas had been selected in which to develop and implement corrective action plans. The system needed continued refinement, including modification of review tools and the related instructions, training of auditors on their use, establishment of inter-rater reliability as well as the accuracy of monitoring results, development and presentation of reports of the data collected that would be relevant to the various audiences (i.e., the QMRP Coordinator, and the QA/QI Council), analysis of data, and development and implementation of corrective action plans, as appropriate. |

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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: | DADS Policy #004: Personal Support Plan Process was issued on 7/30/10. The DADS policy and associated procedures outlined the basics of PSP planning, including the focus on the individual, the role of the QMRP, the use of the Personal Focus Assessment, and required the team to identify the necessary assessments at the PFA meeting. The policy addressed PSP monitoring, staff training, and quality assurance.<br><br>CCSSLC had issued a series of related policies, specifically Policies F.1 through F.19, many of which appeared to be replications of the subsections of DADS Policy #004 (i.e., Policies F.1 through F.10). These Facility policies did not provide further guidance or procedures to tailor the State policy for implementation at the Facility. For example, the DADS policy required competency-based training of staff, but did not define the methodology for assessing competency. No Facility policy was presented that identified the criteria for measuring staff competency. Likewise, the DADS policy required quality assurance monitoring to be completed, but provided few specifics. There was no Facility policy or procedure further defining the monitoring process that would be completed at CCSSLC. These provide just a few examples of areas in which it would be appropriate for the Facility to develop facility-specific policies and procedures to assist in ensuring full and consistent implementation of the State policy.<br><br>However, some of the additional policies that the Facility had developed addressed specific components of the PSP, such as daily schedules, the role of the QMRP, and monitoring of implementation of PSPs. These were positive additions, and are discussed in more detail in the sections that follow.<br><br>In order to review this section of the Settlement Agreement, a sample of PSPs was requested, along with related assessments, sign-in sheets, PSPAs, skill acquisition programs, and monthly and/or quarterly reviews. A sample was requested of the most | |

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| | | recently developed PSPs, as well as some additional plans that had been developed since the last review. This included plans for individuals who lived in a variety of residences on campus. Therefore, a variety of QMRPs and PSTs had been responsible for the development of the plans. The Facility also provided some additional plans as part of its Presentation Book. Because the Facility recognized that it was out of compliance most of the requirements of this section, a limited sample of plans was reviewed in detail. This sample included plans for: Individual #154, Individual #282, Individual #160, Individual #363, Individual #331, Individual #299, Individual #277, Individual #114, Individual #175, Individual #281, Individual #124, Individual #372, Individual #109, Individual #7, and Individual #336. | |
| 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. | Progress had been made and/or sustained with regard to the facilitation of PSPs by one person from the team who ensures that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports. Positive developments included:<br>▪ DADS Policy #004 at II.C.1.b continued to indicate that the QMRP would plan and facilitate the PSP meeting. The Facility's Policy F.16: Personal Support Planning, implemented 1/30/11, further defined the role of the QMRP, including activities before, during, and after the PSP meeting.<br>▪ The QMRP Coordinator confirmed that QMRPs facilitated the teams, including team meetings. Reviews of PSPs also suggested that the QMRP was the team leader and responsible for ensuring team participation.<br>▪ With regard to staffing, in addition to the QMRP Coordinator, two supervisory positions had been added (i.e., two Lead QMRPs). They were expected to assume their new responsibilities in the middle of July. This should assist in providing QMRPs with needed oversight and training. A total of 15 QMRP positions resulted in a QMRP being assigned to each residence. At the time of the review, two of these positions were vacant, but the positions had been posted, and two QMRPs were in training.<br>▪ Three QMRPs became certified trainers for the Q Construction Facilitating for Success training that a workgroup coordinated by State Office developed. In April 2011, the certified trainers provided training to the other QMRPs at CCSSLC. At the end of the training sessions, the QMRPs took a written test. The competency-based component of the training is discussed in further detail below.<br>▪ In addition, State Office had hired consultants to provide training and technical assistance to QMRPs and teams on the PSP process. They had provided classroom training to CCSSLC teams, which is discussed in further detail with regard to Section F.2.e, and had begun to sit in on team meetings and provide technical assistance. | Noncompliance |

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| | | ▪ During the week of the review, the Monitoring Team observed a number of team meetings, and met with two teams related to the risk rating and action plan development process. Progress definitely had begun to occur with regard to the facilitation of meetings. It should be noted that most of the meetings the Monitoring Team observed were facilitated by the QMRP Coordinator, which made it difficult for the Monitoring Team to assess QMRPs' progress in this area overall. However, based on these limited observations and review of PSPs, some of the areas in which progress had begun included:<br>o At annual PSP meetings, an agenda was clearly set forth, along with ground rules.<br>o Efforts were made to include the individual, and focus the discussion on him/her.<br>o Paper hung on the walls or white boards were used to track key components of the PSP process, such as the agenda, the individuals' preferences, and action plans that needed to be developed.<br>o More efforts were made than in the past to elicit information from all team members. However, not all team members participated to the extent they should have. For one meeting, the direct support professional did not join participants at the table (i.e., Individual #228).<br>o During the onsite observations, the QMRP Coordinator elicited a number of the individuals' preferences. Some of these were then incorporated into action plans (e.g., water assessment for Individual #234 to address preference for water). However, this was not consistently seen in the PSPs reviewed.<br>o During the onsite observations, discussions about individuals' optimal living vision showed improvement, with discussion being linked back to individuals' preferences. However, in reviewing PSPs, this was not consistently found to have occurred.<br>o During onsite observations, more integration was seen of various disciplines in problem solving (e.g., for Individual #234, OT/PT involvement in discussion about work, and for Individual #353, several members of the team engaged in discussions about smoking).<br><br>Areas in which improvements should be made in order to achieve compliance, included:<br>▪ The Q Construction: Facilitating for Success training included a competency-based component. At the time of the review, the QMRP Coordinator, with the three certified trainers, had conducted competency checks of approximately six QMRPs. This process had assisted in identifying areas in which all of the QMRPs reviewed needed to improve their meeting facilitation skills. The QMRP Coordinator had begun to work with QMRPs individually, including sitting in to assist, and or model facilitation of meetings. In addition to this ongoing technical | |

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| | | assistance, the QMRP Coordinator should continue with her plan to complete a full cycle of review of all QMRPs competency in this area.<br>▪ Based on review of PSPs as well as during observations of three meetings held the week of the on-site review, facilitation of team meetings was improving, but for none of the plans reviewed or meetings observed was it resulting in the adequate assessment of individuals, and the development, monitoring, and revision of adequate treatments, supports, and services. This is a key requirement to achieve compliance with this component of the Settlement Agreement. Missed opportunities continued to be noted with regard to:<br>o Although all plans reviewed had preferences listed, the depth of the preferences was often limited to items, food, or activities. QMRPs should continue to challenge teams to define what it is the individual prefers about such items, foods, or activities to allow teams to offer the individual new experiences based on this information, and to expand the discussion to include preferences related to work, relationships, past experiences, etc.<br>o As is discussed below, PSPs did not consistently show adequate incorporation of preferences into action plans.<br>o During onsite observations, as well as in PSPs reviewed, a significant lack of adequate integration of supports, and services was noted. QMRPs should continue to challenge team members to offer their expertise in problem-solving or developing action plans, even when the action plan does not fall squarely within their domain (e.g., psychologists should assist with addressing mealtime issues, such as fast eating pace, as well as toileting issues, and dental refusals; nursing staff, habilitation therapies staff, and dental staff should discuss strategies related to physical and nutritional management supports to ensure adequate coordination; speech/communication staff should provide expertise, including, for example, replacement behaviors for PBSPs, integration of communication devices throughout an individual's programing, choice-making, etc.);<br>o Although some minimal improvements were seen, QMRPs should seek data from various team members to assist in decision-making, and justify the teams' conclusions. For example, in meetings observed and PSPs reviewed, data was not cited consistently, such as test/lab results, or data from PBSPs and skill acquisition programs. In addition, historical information or causation was not always investigated fully enough by teams (e.g., causes for falls or fractures, history of issues related to previous failed community placements, etc.). This is essential information to inform planning for future training, treatment, supports, and services. | |

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| | | o Little discussion occurred or was documented regarding prevention, particularly with regard to health risks/issues. Much of team's focus on these areas appeared to be reactive, once an issue occurred (e.g., constipation, weight, skin integrity, infections, etc.).<br>o Teams discussion of action plans was limited. Problems were noted with regard to the scope and number of action plans discussed, as well as detail with which teams discussed action plans. More specifically, sufficient action plans were not discussed/developed to ensure the integration in PSPs of all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual, as required by Section F.2.a.3 of the Settlement Agreement.<br>o Likewise, teams generally did not discuss measurable, functional objectives during team meetings, and, as a result, they often were not included in PSPs.<br>o Teams continued to struggle with articulating meaningful outcomes for individuals. Often the outcome was expressed as a process (e.g., Individual #353 will attend smoking education 50% of the time), rather than as a change in the individual's life (e.g., Individual #353 will smoke two fewer cigarettes a day as a result of attending classes).<br>o With more cross-disciplinary discussion and participation by the individual, it was sometimes difficult for the QMRP to control the length of the meeting. One way to address that would be to establish estimated time boundaries for each topic at the outset.<br><br>The QMRP Coordinator, who, during the QA/QI Committee meeting that members of the Monitoring Team attended, was asked to identify the priorities for the next six month, correctly identified areas in which additional work was needed. Some of these areas included improving assessments available to teams, improving the action plans in PSPs, modification of the facilitation tool, and completion of the facilitation competency checklists for all QMRPs, with follow-up technical assistance and training as needed.<br><br>Progress had been made. However, based on observations as well as review of PSPs, while some meetings were much improved, the meetings were not consistently resulting in the adequate assessment of individuals, and the development, monitoring and revision of adequate treatments, supports, and services. As a result, the Facility remained out of compliance with this provision of the Settlement Agreement. | |
| F1b | Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's | DADS Policy #004 described the Personal Support Team as including the individual, the Legally Authorized Representative (LAR), if any, the QMRP, direct support professionals, and persons identified in the Personal Focus Meeting as appropriate, as well as professionals dictated by the individual's strengths, needs, and preferences. | Noncompliance |

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| | 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. | Some progress had been made with regard to tracking attendance at PSP meetings. Specifically, a database had been set up, and was being populated with information related to team members' attendance at meetings. However, this process was at the beginning stages of implementation, and it was unclear if the data was reliable. It was unclear how a determination was made regarding whether a team member's attendance was required or not. Based on the documentation provided, compliance was shown to be between 90% and 100% for various team members/disciplines. The data appeared to be based on 172 meetings. However, physician attendance was noted to be "required" at only 40, and full attendance had been noted for 36, and partial attendance at four. The Dietician's attendance was noted to be "required" at only three meetings, and full attendance was noted for each. Given the at-risk discussions being held at meetings, these team members' attendance would have been important for many individuals the Facility supports. The criteria for determining when a team member's attendance at a PSP meeting is required should be defined, and incorporated into the attendance database to ensure its reliability.<br><br>Based on the sample of 15 PSPs the Monitoring Team reviewed, for two (13%) (Individual #277, and Individual #114), it appeared that a duly constituted team was in attendance. Often, the individual presented issues requiring the attendance of specific team members, but these team members were not in attendance. Examples of concerns related to team composition have been provided in previous reports, and issues were similar during this review.<br><br>Although some progress had been made in developing a database to track attendance, the Facility remained out of compliance with this provision. | |
| 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. | Reportedly, the timeliness of submission of assessments for PSPs had improved. However, accurate data was not available to confirm this, and little improvement was noted with regard to the quality of the assessments or the completeness of the assessments used in developing PSPs.<br><br>With regard to timeliness, a database was being used to track submission of assessments prior to annual PSP meetings. For assessments not submitted, staff reported that an email would be sent to the discipline coordinator, with a copy to the Facility Director and the Assistant Director of Programs. These procedures reportedly had resulted in increased compliance with timely submission of assessments. The Facility was asked for aggregate data to illustrate the level of compliance with timeliness. The document submitted indicated that: "Assessment filing database results are based on insufficient data entry. Consequently, the summary data report is inaccurate." Once this database is more accurate, it will provide important information to assist in identifying areas of | Noncompliance |

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| | | concern and correcting them.<br><br>In none of 15 (0%) PSP files reviewed, adequate assessments were present. Often the narrative sections of individuals' PSPs identified issues of concerns for which assessments were not found. This was often the case with regard to individuals' medical needs, and sometimes, their psychiatric needs, for which updated assessments did not appear to be available to the team at the time of the PSP meeting. In other instances, assessments clearly did not provide the team with the information it needed to develop adequate plans for the individual. As the Facility had identified, assessments did not consistently and concisely list individuals' strengths, needs, and preferences. Examples of concerns related to assessments have been included in previous reports, and were similar for this review.<br><br>The PSPs reviewed included a Personal Focus Assessment that gathered information on the individual's preferences. Many of the PFAs identified the assessments that the team decided during the third quarter review should be completed for the annual PSP meeting. Generally, no justification was provided regarding whether or not a particular assessment was needed. This made it difficult to determine if teams had made appropriate decisions. The Facility should consider defining in policy a key set of assessments that should be conducted regularly, and the expected timeframes for reevaluation. Teams should be required to provide a justification for veering from this schedule. Optional assessments also should be defined with criteria/guidelines to assist teams in determining if such assessments would be beneficial to the individual.<br><br>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 vocational, 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.<br><br>One assessment that would prove useful for some individuals would be an annual review of incidents, and abuse, neglect, and exploitation allegations. This type of assessment was not found in any of the PSPs reviewed. However, for some individuals, it would be beneficial on an annual basis for teams to review aggregate individual data related to incidents, allegations, and restraints. This would ensure that the team considered the need to address whatever themes might be revealed, as an addition to reviewing new allegations or incidents as they arise. The intent of such a review would be to ensure that | |

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| | | all of the protections, supports, and services necessary to reduce to the extent possible such incidents were in place and appropriately incorporated into the PSP.<br><br>Overall, assessments were either not present or inadequate to guide teams properly in developing adequate PSPs. This is an area that will require the concerted efforts of all team members to resolve. | |
| 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. | As indicated in previous reports, although the new PSP process had been specifically designed to be more interactive and staff were trained not to read their assessments at the meetings, teams continue to need to incorporate thoroughly the results of assessments in the PSPs. The following summarizes concerns related to the incorporation of assessments into PSPs:<br>▪ In none of the 15 plans (0%) were all recommendations resulting from assessments addressed in the PSPs either by incorporation, or evidence that the team had considered the recommendation and justified not incorporating it.<br>▪ At times, recommendations were discussed in the narrative section of the report, and the team appeared to agree that the recommendation needed to be implemented, but a corresponding action plan was not developed to implement the recommendation (e.g., for Individual #154, the need for involvement of speech therapy staff, training for staff on use of communication device, use of device, implementation of BSP, implementation of PNMP, etc.; for Individual #277, essential recommendations included in the Educational and Training Assessment to address issues that led to criminal charges resulting in his placement at CCSSLC).<br>▪ 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 were: 1) based on observations and review of documentation in PSPs, 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 Settlement Agreement.<br><br>The State and the Facility should ensure that person-centered concepts are incorporated | Noncompliance |

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| | | with the need to develop comprehensive, integrated plans. Person-centered planning is not a reason for not having plans that are adequate. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility, should figure out ways to have adequate, technical team discussions and incorporate such discussions into comprehensive PSPs, while focusing on the individual and his/her preferences, strengths, etc. | |
| F1e | Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999). | 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 |
| **F2** | **Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below: | | |
| F2a | Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that: | | |
| | 1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation; | DADS Policy #004 at II.D.4 indicated that Action Plans should be based on prioritized preferences, strengths, and needs. The policy further indicated that the "PST will clearly document these priorities; document their rationale for the prioritization, and how the service will support the individual." As noted previously, the Facility had reiterated the DADS policy in its Facility policies. CCSSLC Policy F.5: Action Plans, implemented 1/30/11, addressed this component of the DADS policy.<br><br>As noted in the last report, teams were making efforts to identify individuals' preferences. The 15 PSPs reviewed generally included more information regarding the individual's preferences. However, the following concerns were noted with regard to the identification and incorporation of preferences and strengths into PSPs:<br>▪ Although all 15 of the PSPs reviewed included a listing of individuals' preferences, only one individuals' team (6%) had effectively incorporated his preferences into related action plans (i.e., Individual #363). | Noncompliance |

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| | | ▪ As noted above with regard to Section F.1.a, most of the preferences identified for individuals related to items, food, or activities. It will be important for teams to define what it is the individual prefers about such items, foods, or activities to be able to offer the individual new experiences based on this information. It also will be essential to expand the discussion to include preferences related to environments, work, relationships, past or future experiences, routines, interactions with others, etc.<br>▪ Little, if any, information about individuals' specific strengths was discussed in PSP documents. Strengths were not regularly built upon to address other need areas.<br><br>Clear prioritization of the individual's specific needs (e.g., one daily living skill as opposed to another, or which specific medical supports took priority over other needs or preferences, etc.), or careful delineation of barriers to addressing needs was generally not found. More specifically, in none of the 15 PSPs reviewed (0%) were priorities clearly defined, or barriers identified and addressed. The only plan for which the team had documented efforts to prioritize skill acquisition goals and provide rationale for the decisions was for Individual #282. The team only did this for skill acquisition goals, though, not for the individual's other need areas.<br><br>In reviewing objectives related to individuals' involvement in the community, some improvement was noted. However, many individuals' PSPs still included inadequate general community participation objectives (i.e., participating in a community activity once a month), and a limited number of skill building objectives were found to assist individuals in accessing and utilizing community offerings. Six of the 15 PSPs (40%) reviewed included specific skill acquisition action plans for implementation in the community. Examples of concerns have been provided in other reports, and were similar to the concerns identified for this review.<br><br>As is discussed below with regard to Section S.3.b, the Facility was making efforts to include objectives that encouraged community participation. Based on information that the Facility provided, at the time of the review, approximately 68 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. Although the Facility had made progress, it will continue to be a challenge to address barriers such as transportation, 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, | This continued to be an area in which substantial effort was needed in order for CCSSLC to comply with the Settlement Agreement. The action plans section of the PSP was where measurable goals/objectives, the treatments or strategies to be employed, and the | Noncompliance |

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| | 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; | 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 the individual's needs were to be detailed. Facility staff recognized that action plans were not adequate, and identified this as a priority for the next six months. The Monitoring Team agrees with this assessment. The following summarizes the concerns related to action plans:<br>▪ As noted in the last monitoring report, PSPs generally included some individualized and measurable goals/objectives, treatments or strategies, and supports. At CCSSLC, these generally related to skill acquisition plans, and in some cases, PBSPs. Eleven of the 15 plans (73%) included measurable objectives related to skill acquisition plans.<br>▪ However, none of the 15 plans reviewed (0%) included a full complement of measurable goals or objectives to address the array of supports and services the individual required. This negatively impacted the intensity of individuals' active treatment, the supports they were provided, and the teams' ability to measure progress, or lack thereof. More specifically, when such supports were identified in the action plans they often were not measurable (e.g., Individual #154's and Individual #282's had objectives that read: "Nutrition: follow and monitor"; one example for Individual #282's was an objective that read: "PNMP: will be reviewed"; some of Individual #160's action plans repeated healthcare plans, but just stated the actions with no way of measuring whether or not they were having the desired impact; or Individual #114 had objectives such as "will improve his knowledge of SMT charges," and "will improve his self-medication skills"). Most of the time, they simply were not included in action plans (e.g., Individual #154 had no objectives for implementation of BSP, PNMP, nursing care plans, etc.; Individual #282 had no objectives for implementation of PNMP or nursing care plans; or Individual #277 had major issues with behavior, but no objectives were included related to his PBSP, the STOP program, or staffing supports to keep him or others safe).<br>▪ In reviewing the action plans that had been developed to address individuals' risk areas, measurable objectives generally were not included. This is discussed in further detail with regard to Section I of the Settlement Agreement.<br>▪ Individualized, measurable goals and objectives were not defined in individuals' PSPs to support the implementation of essential plans, such as nursing plans, psychiatric treatment plans, and physical and nutritional support plans. For example, in order to provide health care supports to individuals served, direct support professionals as well as nursing staff need to provide supports to an individual. Supports such as ensuring that an individual is offered fluid throughout the day, or is repositioned every two hours should be specified in measurable ways in individuals' PSPs. In addition, PSPs should include measurable, observable objectives to determine the efficacy of these plans. In | |

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| | | other words, objectives should be designed to allow the team to determine if the individual is doing better or worse, or remaining stable. As is discussed elsewhere in this report, deficits in plans that specific disciplines had developed prevented the team from fully identifying the full array of the measurable objectives necessary for the team to provide needed supports and services, and measure the outcomes of those supports. For example, PNMPs did not include measurable objectives, and nursing assessments often did not include individualized objectives. Even when plans, such as PBSPs, included objectives, teams did not incorporate them into the overall PSP.<br>▪ In the section below that addresses Section T.1.b.1, there is extensive discussion regarding the Facility's status with regard to identifying obstacles to individuals moving to the most integrated setting, and plans to overcome such barriers. In summary, the Facility was at the very initial stages of complying with this component of the Settlement Agreement.<br><br>The Facility remained out of compliance with this provision. | |
| | 3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual; | Numerous examples are provided throughout this report regarding how plans, supports and services were not integrated through the PSPs. PSPs appeared to integrate some, but not all protections, services and supports that individuals required, as this provision of the Settlement Agreement clearly requires.<br><br>None of the 15 plans reviewed (0%) integrated all of the protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. For example, the health services portion of the plan, similar to the PBSP and PNMP, frequently still were separate plans that were not integrated in any measurable way into the PSP, through, for example, measurable objectives, and did not show an integration of various disciplines and team members. Examples of issues related to the lack of integration were found between nursing and physical and nutritional supports to incorporate PNMPs with medication administration, and dental and psychology to develop and implement desensitization plans. There was little evidence that PBSPs were integrated with other supports, such as communication supports, or health related supports (e.g., weight reduction, medication administration, etc.). All of these are examples of coordination and integration that should be occurring as part of the individual planning process. Numerous examples of these concerns have been provided in previous reports. | Noncompliance |
| | 4. Identifies the methods for implementation, time frames for completion, and the staff responsible; | Generally, for the action items identified by teams, timeframes and staff responsible were identified. However, as is discussed in further detail in the section of this report that addresses Section S of the Settlement Agreement, methods for implementation were not always adequate. | Noncompliance |

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| | | In addition, staff responsible often did not include direct support professionals, when they should have been identified. For example, although health management plans were infrequently mentioned in PSP action plans, when they were, the staff responsible were listed as medical staff. Direct support professional often play a key role in implementing portions of health management plans, and notifying medical personnel of medical issues. Likewise, direct support professionals play a key role in the implementation of PBSPs and PNMPs, but PSP action plans generally listed the clinical staff as responsible. The role of direct support professionals in plan implementation should be set forth in the action plans. | |
| | 5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and | Although all of the plans included some practical and functional interventions, none of the 15 plans reviewed effectively addressed the individual's full array of needs for services and supports. As identified in other sections of this report, the interventions, strategies and supports offered to individuals at CCSSLC did not consistently and effectively address individuals' needs, and many were not practical and functional at the Facility and/or in community settings. Again, such issues are discussed elsewhere in this report with regard to plans to address conditions that placed individuals' at-risk, psychiatric treatment plans, nursing care plans, PNMPs, OT/PT treatment plans, and PBSPs.<br><br>In addition, due to some of the characteristics of the Facility at the time of the review, providing training in areas that would be functional in the community, as well as at the Facility was difficult. For example, some of the goals and objectives developed for individuals appeared to be constrained by some of the physical plant and administrative structures in place. Food was generally delivered from a central kitchen, so cooking was not a part of daily life in the residential settings on campus. Likewise, because pedestrian safety skills on campus were different than those in the community due to strict speed limits and minimal traffic at CCSSLC, skills that individuals were learning or practicing daily on campus were not practical or functional in the community. The different set of rules on campus coupled with individuals' limited exposure to the community could become a disadvantage for individuals who decide to transition to the community. | 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 identified a person(s) responsible. As is discussed above with regard to Section F.2.a.2, the overarching concern was that many goals and objectives were not specified in individuals' PSPs, or other treatment plans that should have been integrated into the PSP (e.g., risk action plans, health management plans, PNMPs, psychiatric treatment plans, etc.). As a result, appropriate data was not being collected to assist teams in decision-making. Even when plans included objectives, such as PBSPs, individuals' PSPs did not consistently identify | Noncompliance |

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| | person(s) responsible for the data collection, and the person(s) responsible for the data review. | the data to be collected, the frequency, and/or the persons responsible for such data collection.<br><br>None of the 15 PSPs reviewed appeared to be driven by a review of data, and the presence or lack of progress on measurable objectives and outcomes. In fact, very little, if any data, was included in any of the PSPs reviewed. Data that should have been included, but was not, would relate to test/laboratory results, skill acquisition goal data, data related to the implementation of other plans (e.g., PNMPs, PBSPs, nursing care plans, weights, numbers of seizures, etc.), and information related to past events, such as causes of fractures or falls, details regarding individuals' successes or failures, etc. | |
| 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 in the previous reports, and based on the current review of PSPs, this was an area that required substantial improvement. As is discussed in other sections of this report, the Monitoring Team found a lack of coordinated supports in a number of areas, including between dental/medical and behavior/psychology; nursing and habilitation therapies; nursing and medical; speech/communication and psychology; and between the disciplines responsible for the provision of physical and nutritional supports to individuals served. Review of the PSPs generally showed a multidisciplinary as opposed to interdisciplinary approach. | 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 Individual Notebooks.<br><br>Improvements were seen in the manner in which plans were written to facilitate direct support professionals' understanding. However, some included a significant amount of clinical jargon (i.e., Individual #282, and Individual #299).<br><br>Another issue related to comprehensibility of the 15 PSPs reviewed was the lack of delineation of responsibility for the implementation of the plans. As a direct support professional, it would be difficult to read the PSPs as written and determine what his/her responsibilities were for the individual during the course of the 24-hour day. This in large part was due to the fact that the PSPs continued to lack integration, and many separate plans continued to exist that were not integrated into the one document. Although it will be necessary for the separate plans to continue to exist (e.g., PBSPs, PNMPs, health care plans, etc.), the goals and objectives of these plans, and the delineation of who is responsible for what with regard to the plans should be incorporated into the overall PSP. This is necessary to provide one document that clearly identifies all of the protections, supports, and services that need to be provided to the | Noncompliance |

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| | | individual, and clearly identifies the responsibilities of various team members. | |
| F2d | Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that, at least monthly, and more often as needed, the responsible interdisciplinary team member(s) for each program or support included in the ISP assess the progress and efficacy of the related interventions. If there is a lack of expected progress, the responsible IDT member(s) shall take action as needed. If a significant change in the individual's status has occurred, the interdisciplinary team shall meet to determine if the ISP needs to be modified, and shall modify the ISP, as appropriate. | Based on interviews with Facility staff, monthly reviews were not being completed consistently. This was confirmed through document review. Based on the sample reviewed, none had monthly reviews each month for the previous six months.<br><br>Even for those individuals for whom monthly reviews had been conducted, this was not consistently a full review of each program or support. The QMRP Coordinator identified this as an area in which changes needed to be made. She recognized that a new monthly review format would need to be developed to accommodate the more extensive review that the Settlement Agreement required. PST members also would need to be trained on the new format and process.<br><br>For the one individual (i.e., Individual #281) that the monthly reports indicated changes needed to be made, no documentation was found to show that the team had met to discuss needed changes. Moreover, examples are provided in various sections of this report of individual experiencing changes in status and their teams not taking appropriate action to modify their plans and/or treatment. Numerous examples of this are provided with regard to nursing care. In addition, as noted below with regard to Section O.3, there were times when a team member(s) identified a need for a change, but individuals' PSPs were not consistently modified to reflect such changes. | Noncompliance |
| 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 | As reported in previous reports, training on PSPs had been standardized across the SSLCs. Supporting Visions: Personal Support Planning was the standard training curriculum for personal supports planning. As indicated above, since the last review, additional training sessions and resources had been initiated. These included:<br>▪ Three QMRPs at CCSSLC had become certified trainers for the Q Construction: Facilitating for Success training, and had provided training to the QMRP Coordinator and the other QMRPs. This training included a written test that each participant completed at the end of the classroom training. It also included a competency checklist. At the time of the review, the QMRP Coordinator had completed checklists on six QMRPs. Based on interview with the QMRP Coordinator and review of the completed forms, all six QMRPs had areas in which work was needed. The tool generally provided a good format for reviewing a number of planning and facilitation skills, and it appeared the QMRP Coordinator had critically reviewed the skills that the QMRPs demonstrated. As the checklist is implemented, changes likely will need to be made to further define certain competencies, and to ensure reliability across reviewers. However, its implementation already was providing some valuable information to assist QMRPs in refining their skills.<br>▪ CCSSLC also developed a Facilitation Tool to assist QMRPs in organizing | Noncompliance |

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| | implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised. | assessment information, documenting team deliberations, and ensuring that teams discussed the need for the development of action plans, as well as their priority level. On 5/12/11, training had been provided to a number of QMRPs. Although this appeared to be a helpful tool, it was too early to assess the results of its use.<br>▪ The State had hired consultants to provide training, and work hands-on with teams on the PSP process. The consultants had provided some basic training to CCSSLC PSTs. It included an overview of the philosophical and historical context of individual planning, a discussion about differences in ICF/MR and Settlement Agreement requirements related to individual planning, and some of the logistics of planning. The specific planning topics included preferences, strengths, and needs; and the cycle of planning, including assessment, planning, implementation, re-evaluation, and more planning. The consultants also provided some training to staff responsible for writing skill acquisition plans. In addition, they had begun to sit in on PSP meetings, and provide technical assistance to QMRPs and teams. While onsite, the Monitoring Team discussed with the consultants their plans for additional training, and ongoing technical assistance to teams.<br><br>As noted previously, based on a limited number of observations of PSP meetings while onsite, improvements had begun to be seen with regard to the team process. As would be expected, the results of this training were not yet reflected in the PSP documents that the Monitoring Team reviewed.<br><br>Areas in which additional work was needed to reach compliance with the Settlement Agreement included:<br>▪ As indicated in previous reports, QMRPs should be required to demonstrate competency in meeting facilitation and the development of an appropriate PSP document. Such competency measures should be clearly defined and include criteria for achieving competence. As noted above, work was underway to address the facilitation component of competency-based training. As the QMRP Coordinator recognized, this would be an ongoing process until each QMRP demonstrated competency in this area. The QMRP Coordinator also was waiting for guidance on one of the sections of the tool, so this section had not been completed for any of the QMRPs. Competency measures had not been developed or implemented with regard to the PSP document.<br>▪ Competency measures for other team members also should be identified and used to evaluate whether additional training is needed.<br>▪ As recommended in the previous report, there should be additional training on how to the develop integrated action plans, including how to draw together the information gathered in assessments, analyze that information, incorporate the | |

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| | | individual's preferences, set priorities, provide clear directions to those working with the individual, and develop measurable objectives to track progress or lack thereof. It will be important to provide teams with the tools necessary to focus on individual's interests, priorities and vision for his/her living arrangements, while reconciling these with the individuals' medical and safety needs.<br>▪ As is discussed in further detail with regard to Section S of the Settlement Agreement, additional training on the development of skill acquisition programs continued to be an area of need.<br>▪ As discussed onsite with the State consultants as well as the QMRP Coordinator, technical assistance will be a key component of enhancing and refining the skills of QMRPs, as well as other PST members. As noted above, the consultants as well as the QMRP Coordinator had begun to sit in on team meetings and provide technical assistance in real time. These efforts should continue. | |
| 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 January 1, 2011, three individuals had been admitted to the Facility. PSPs had been completed within 30 days for two of them (67%). The PSP for Individual #78 was not completed within 30 days.<br><br>Based on the list of individuals the Facility provided with their most recent and previous PSP dates, 264 out of 274 plans (96%) were completed within one year. They were late on average by five days, ranging between one and 15 days late. While it is possible that extensions were granted for some of the seven plans that was not evident on the provided list.<br><br>Beginning in January 2011, the Facility tracked the dates that PSPs were completed and filed. Since January 1, 2011, 124 plans were tracked and 12 PSPs were not completed and filed within 30 days of the PSP meeting.<br><br>As is noted in other sections of this report, PSTs did not consistently meet to make changes to PSPs for individuals who experienced changes in status, or whose circumstances should have resulted in modifications being made (e.g., multiple restraints, requiring modifications to PBSPs). | Noncompliance |
| 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 | Progress had been made and/or sustained with regard to the implementation of a quality assurance processes that identify and remediate problems to ensure that PSPs are developed consistent with this section of the Settlement Agreement. Positive developments included:<br>▪ DADS Policy #004.V continued to address quality assurance processes to ensure PSPs were developed and implemented consistent with the provisions of the Settlement Agreement. | Noncompliance |

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| | the ISPs are developed and implemented consistent with the provisions of this section. | ▪ CCSSLC was conducting a number of reviews/audits of PSPs, including audits using:<br>o The Personal Support Plan Meeting/Documentation Monitoring Checklist;<br>o The Settlement Agreement Cross Referenced with ICF/MR Standards Section F: Integrated Protections, Services, Treatments and Supports audit tool; and<br>o ICF/Regulatory Chart Review checklist.<br>Due to other priorities, the QMRP Coordinator had only conducted one review in the recent past. However, a number of audits that the Program Monitor had completed were submitted for review. As discussed in previous reports, these appeared to be thorough and critical, and generally provided justification for both negative and positive findings.<br>▪ CCSSLC's Quality Assurance Department had begun to aggregate and analyze the data resulting from the reviews. In addition to reports that showed responses for individual indicators, graphs or reports could be generated to show the data across various factors or program components (e.g., homes, QMRPs, etc.).<br>▪ A few areas in which problems had been identified were targeted for the development and implementation of corrective action plans. Two action plans were to be developed. The first related to PSP objectives, and the second addressed monthly reviews and analysis of data related to PSP objectives.<br><br>Areas in which improvements should continue to be made in order to achieve compliance, included:<br>▪ The Facility's policy F.10 was entitled Quality Assurance for PSP Process, and had an implementation date of 1/30/11. It reiterated the State policy requirements for monitoring. However, the Facility's policy did not define in further detail how monitoring would be completed at CCSSLC.<br>▪ For the various monitoring/audit tools, inter-rater reliability needed to be established with the QA and programmatic staff (i.e., QMRP Coordinator) responsible for conducting audits. The Facility had recognized this need based on the varied results of the auditing that had been completed thus far.<br>▪ The QA Director recognized the need to add or revise the guidelines/instructions for the audit tools. This will be essential to improve the accuracy of the monitoring results (validity), as well as the congruence between various auditors (reliability). Instructions also need to clearly direct auditors to review the quality of the PSPs, assessments, objectives, etc., and not just their presence or absences. For example, the review tool entitled Settlement Agreement Cross Referenced with ICF-MR Standards Section F: Integrated Protections Services, Treatments and Supports contained guidelines, which should be helpful in | |

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| | | ensuring that different auditors are reviewing the same information. The Monitoring Team did not review the guidelines in detail. However, an overall comment would be that the guidelines did not always provide enough information to ensure that the quality of various components of the PSP process was being effectively evaluated. For example, indicator F.2.3 addressed integration of services. The guideline correctly referenced that all services and supports the individual needed should be included in the PSP, and gave an example of the need for a PNMP to be "addressed in the PSP." This did not provide sufficient guidance to ensure the integration of services and supports. For example, with a PNMP, an auditor would need to look to ensure components of the PNMP were integrated into other relevant plans, such as nursing care plans and medication administration records, and that clear objectives for the measurement of the efficacy of the PNMP had been incorporated into the PSP. Similarly, in providing guidance about the indicators related to assessments, the quality of the assessments was not addressed. As the Facility gains experience with implementing the review tools, changes should be made to these guidelines, as necessary.<br>▪ Many of the data reports provided an "overall score." As discussed with the QA Director, caution should be applied in providing an overall score, because the individual indicators have not been weighted.<br>▪ The QA Director recognized that the extensive data being collected through the auditing process should be distilled down to a format that would be usable to the QMRP Coordinator, as well as the QA/QI Council. At the time of the review, the QA Department had plans to develop a report(s) that offered summarized data.<br>▪ As noted above, the Facility was at the beginning stages of utilizing the data collected to identify areas in need of remediation, and to develop action plans to address them. The Monitoring Team looks forward to reviewing action plans and their implementation during upcoming reviews.<br><br>In its POI the Facility recognized that it remained out of compliance with this provision, which was consistent with the Monitoring Team's findings. As discussed above, the QA Director articulated next steps for moving the Facility towards compliance. | |

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

1. As appropriate, the Facility should develop facility-specific policies and procedures to assist in ensuring full and consistent implementation of the State policy on the Personal Support Plan process. (Section F.1)
2. The QMRP Coordinator should complete competency checks for all QMRPs, and, as necessary and appropriate, provide QMRPs with additional technical assistance or training on group facilitation, particularly as is relates to the interdisciplinary team process. (Section F.1.a)
3. The criteria for determining when a team member's attendance at a PSP meeting is required should be defined, and incorporated into the attendance database to ensure its reliability. (Section F.1.b)

4. 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. (Section F.1.c)
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. (Section F.1.c)
6. The Facility should consider defining in policy a key set of assessments that should be conducted regularly, and the expected timeframes for reevaluation. Teams should be required to provide a justification for veering from this schedule. Optional assessments also should be defined with criteria/guidelines to assist teams in determining if such assessments would be beneficial to the individual. (Section F.1.c)
7. The State and the Facility should ensure that person-centered concepts are integrated with the need to develop comprehensive, integrated plans. Many individuals require plans with multiple supports. The State, working in conjunction with the Facility, should figure out ways to have adequate, technical team discussions and incorporate such discussions into comprehensive PSPs, while focusing on the individual and his/her preferences, strengths, etc. (Section F.1.d, F.2.a.1, F.2.a.2, and F.2.a.3)
8. PSPs should integrate the recommendations from assessments, not just reference them, and make the health care, therapeutic, and behavior support plans a part of the PSP, rather than stand-alone documents. (Sections F.1.d, F.2.a.2, and F.2.a.3)
9. Team members should be provided ongoing training and technical assistance on the interdisciplinary process, including the integration of information and development of strategies to address individuals' preferences, strengths, and needs, and to identify and overcome barriers. (Section F.2.a.1)
10. The Facility should 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. Individuals' PSPs should identify these clearly, if they are barriers to providing the individual with adequate supports and services. (Section F.2.a.1)
11. PSTs should complete additional training and/or be provided technical assistance on how to the develop integrated action plans, including how to draw together the information gathered in assessments, analyze that information, incorporate the individual's preferences, set priorities, provide clear directions to those working with the individual, and develop measurable objectives to track progress or lack thereof. It will be important to provide teams with the tools necessary to focus on individual's interests, priorities and vision for his/her living arrangements, while reconciling these with the individuals' medical and safety needs. (Sections F.2.a.2, F.2.a.3, F.2.a.4, F.2.a.5, F.2.a.6, and F.2.e)
12. The Facility should be creative in ensuring that skills that are functional in community settings, but are not regularly taught or practiced at the Facility, such as cooking, cleaning, and realistic community safety skills, become a regular part of training programs for individuals served. (Section F.2.a.5)
13. QMRPs should be required to demonstrate competence in both meeting facilitation, and the development of an appropriate PSP document. Such competency measures should be clearly defined and include criteria for achieving competence. Competency measures for other team members also should be identified and used to evaluate whether additional training is needed. (Section F.2.e)
14. 
15. As is discussed in further detail with regard to Section S of the Settlement Agreement, additional competency-based training on the development of skill acquisition programs should be provided. (Section F.2.e)
16. The Facility's QA processes with regard to PSPs should be refined by modifying review tools and the related instructions as appropriate, training auditors on their use, establishing inter-rater reliability, ensuring the accuracy of monitoring results, developing and presenting reports of the data collected that are relevant to the various audiences (i.e., the QMRP Coordinator, and the QA/QI Council), analyzing data, and developing and implementing corrective action plans, as appropriate. (Section F.2.g)

| **SECTION G: Integrated Clinical Services** | |
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| 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:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o CCSSLC Policy F. 18: Developing Integrated Personal Support Plans, draft/revision 4/26/11, approval 4/26/11, implementation 5/2/11;<br>o CCSSLC Policy F. 19: Completing Personal Focus Assessments, draft/revision 4/26/11, approval 4/26/11, implementation 5/2/11;<br>o CCSSLC Policy W.5: Residential Services: Participating in Unit Incident Management Team Meeting, draft/revision 4/27/11, approval 4/28/11, implemented 4/28/11;<br>o CCSSLC Policy E.4: Quality Assurance: Participating in Performance Evaluation Team (PET) Monthly Meeting, draft/revision 3/1/11, approval 6/16/10, implementation 4/1/11;<br>o CCSSLC Policy G.5: Integrated Clinical Services: Diagnostics, Appointments, and Consults Tracking, draft/revision 3/11/11, approval 2/16/11, implementation 3/7/11;<br>o Diagnostics log book, Diagnostics Tracking log, and Appointment and Consult Tracking log;<br>o CCSSLC Policy: Medical Care LL.3.1: Responding to Acute Medical Problems, implemented 1/17/11, revised 2/14/11;<br>o Email dated 4/29/11 concerning recommendations for discipline specific assessments;<br>o CCSSLC Policy: Nursing Care M.28: Medical Emergency Response, draft/revision 6/17/11, approval 1/3/11, implementation 6/17/11;<br>o Emergency medical drills FY 2011;<br>o Mock code drill meeting minutes, dated 5/6/11, 5/31/11, and 6/8/11;<br>o Consultation reports for the following individuals: Individual #30, dermatology on 1/3/11; Individual #26, mammogram on 10/28/10; Individual #242, cardiology on 5/7/10, and echocardiogram on 5/17/11; Individual #187, endocrine on 3/4/11, and nephrology on 5/17/11; Individual #291, ophthalmology on 1/13/11, ophthalmology on 1/11/10, and DEXA on 4/19/11; Individual #4, neurology on 12/18/10; Individual #211, GI on 4/25/11; Individual #329, orthopedics on 1/19/11, and DEXA on 1/21/11; Individual #174, cardiology on 3/21/11; Individual #205, ophthalmology on 5/4/11, and DEXA on 4/29/11; Individual #239, ophthalmology on 1/14/11, Individual #72, ophthalmology on 4/18/11; and<br>o Presentation Book for Section G.<br>▪ **Interviews with**:<br>o Sandra Rodrigues, MD; and<br>o Althea Pat Stewart, Medical Compliance Registered Nurse (RN).<br>▪ **Observations of:**<br>Morning medical meetings, on 7/12/11, 7/13/11, and 7/14/11. |
| | **Facility Self-Assessment:** In its self-assessment, the Facility provided a narrative description of steps taken to comply with Section G of the Settlement Agreement. This included reports that: |

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| | ▪ Several policies were implemented to provide structure and guidance to several departments in ensuring integrated clinical services. Several of these policies were interdisciplinary. The medical policy concerning acute illness and injury included detailed guidance for the direct support professionals, nursing staff, and Primary Care Practitioners (PCPs), in order to provide efficient, effective care in an integrated manner.<br>▪ The Medical and Dental Departments revised the timelines of the annual assessments to ensure they were completed prior to the annual PSP.<br>▪ Several tools were developed, including PCP checklists, and tracking of tests and consultant reports to ensure quality of care.<br>▪ The medical quality assurance (QA) internal reviews and external reviews encompassed such aspects as the quality of the integrated progress notes that the PCPs write, as well as communication with the Emergency Room (ER) and hospital when individuals are transferred. Quality of the annual assessment was reviewed, including preventive care. The Facility cited some of the results of these audits in its Plan of Implementation. However, the data appeared to be an overall compliance score. It was unclear how these overall scores were reached, because the monitoring tools did not appear to have been designed to provide an overall score. Regardless, it would be more helpful from a self-assessment perspective to review and report on the scores and/or analysis of individual indicators, in order to allow the Facility to identify areas of strength, as well as areas needing improvement.<br>▪ The external peer reviewer recommendations were incorporated into the annual assessments and the PCPs reviewed them.<br><br>The Facility determined it was noncompliant in both areas of Section G. This was consistent with the Monitoring Team's findings. |
| | **Summary of Monitor's Assessment:** A number of interdisciplinary policies were created to improve integration of services and quality of care. In preparation for the annual PSP, the Medical and Dental Departments revised the schedule of due dates of the annual exam, and the pharmacy aligned the quarterly drug regimen review (QDRR) in order for updated information to be available to the PST at the time of the annual review.<br><br>Improved attendance at the PSP meetings was also noted, especially for the Dental Department, which tracked attendance at the PSPs. Attendance at these meetings, as well as at the Performance Evaluation Team meetings allowed for interdisciplinary communication and a team approach to care and improvement in services.<br><br>Policies such as the acute medical problem policy and tracking of diagnostic tests and consults provided detailed guidance to direct support professionals, as well as the Nursing, Medical, and Dental Departments in ensuring timely, efficient, and effective health care integrating the roles of several departments. All of the policies were implemented within a few weeks to months of the Monitoring Team's visit and would require time to ensure compliance. |

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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 part of quality PSP development, annual assessments were to be completed 10 days prior to the PSP. This included all departments. Guidance was provided in an email, dated 4/29/11, from Facility Administration. Each of the disciplines was to include the following three components: community placement recommendations, discipline-specific recommendations, and skill acquisition training recommendations. If this new timeline were followed, the PST would have updated information for review. The e-mail indicated that each of the department's recommendations would be reviewed in an integrated discussion. As part of the integration process, both the annual medical assessment and the annual dental summary began to include a section for these areas in their final documents. Additionally, the PCP and dentist's attendance was encouraged at the annual PSP meeting.<br><br>There were several policies that were implemented in the six months prior to the Monitoring Team's visit that focused on integration of clinical services. These included:<br>▪ The policy Medical Care LL3.1: Responding to Acute Medical Problems, implemented 1/17/11, was a clinical pathway outlining the responsibilities of the direct support professionals, the nursing staff, and the PCP for an acute illness or injury. The policy included a table outlining common acute problems, and the expected steps concerning RN assessment and PCP notification. This policy required the cooperation of three different departments, Medical, Nursing, and residential staff.<br>▪ The Dental Department also had a policy that was pending approval, which reflected similar guidance, entitled: "Dental Services Q.22: Management of Acute Illnesses and injury." It applied to all CCSSLC staff.<br>▪ In tracking acute health care needs, the Dental Department had an additional policy: "Dental Services Q.23: 24-hour nursing log," which was pending approval, and applied to all CCSSLC staff. It outlined the steps for ensuring that all acute care needs were entered into the nursing log, which would include dental care needs.<br>▪ The policy "Integrated Clinical Services G.5: Diagnostics, Appointments, and Consults tracking," implementation 3/7/11, provided guidance to all the different clinical and clerical staff that assisted in tracking and ensuring PCP orders were completed for lab tests, other diagnostic tests and procedures, and consultant appointments. This system was designed to ensure timely completion of the orders and follow through until the PCP reviewed the lab result or consultant reports. There were both Diagnostics logs and Appointment and Consult Tracking logs created to ensure sedation had consent (form sent and form received), sedation was ordered, and tracking of the results/report for review by the PCP. This policy outlined the expectations of several departments | Noncompliance |

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| | | in this process: medical, nursing, QMRP, and Unit Coordinator. For closure, it is recommended that the column indicating PCP was notified be clarified to read: "PCP reviewed and initialed." The current log stated: "MD informed of report/result," but did not provide evidence that the PCP actually processed and signed it.<br>▪ The policy "Quality Assurance E.4: Participating in Performance Evaluation Team (PET) Monthly Meeting," draft/revision 3/1/11, approval 6/16/10, implementation 4/1/11, applied in part to medical and dental staff, and assisted in a team approach to improve performance and quality care. There were sub-teams who were tasked with working together to achieve compliance with various and interrelated sections of the Settlement Agreement. For example, the lead staff for Sections G, H, I, L, M, O, P, and R were one sub-team. They were expected to involve staff throughout the organization as appropriate, as they developed integrated approaches to the provision of supports and treatment. At the time of the review, this process was just beginning.<br>▪ The policy "Developing Integrated Personal Support Plans F.18: Personal Support Planning," draft/revision 4/26/11, approval 4/26/11, implementation 5/2/11, and "Completing Personal Focus Assessments F.19: Personal Support Plan," draft/revision 4/26/11, approval 4/26/11, implementation 5/2/11, provided further guidance regarding the PSP process and each department's role in this process.<br>▪ As part of the systems improvement for integrated and timely care, a policy was revised: "Residential Services W.5: Participating in Unit Incident Management Team Meeting, draft/revision 4/27/11, approval 4/28/11, implemented 4/28/11. This described the communication and organization of information on a daily basis related to incidents. Although it directly involved the Unit Directors, QMRPs, Psychologists, RN case managers, and Residential Coordinators, it also affected medicine and dentistry. The daily report template of the Unit Incident Management Review Team meeting addressed a wide range of concerns, including health concerns/significant medical issues, aspiration triggers, admission to the Infirmary, admission to the hospital, scheduled on-campus medical and dental appointments, scheduled off-campus medical and dental appointments, medical appointment refusals, and dental appointment refusals. Priority medical and dental concerns were reviewed and documented at the daily unit meetings.<br>▪ "Nursing Care M.28: Medical Emergency Response, draft/revision 6/17/11, approval 1/3/11, implementation 6/17/11, focused on training all of the professional and paraprofessional staff on emergency measures. Based on documentation submitted for recent months, interdisciplinary emergency mock drills were conducted. Training in cardiopulmonary resuscitation (CPR) was tracked at the Mock Code Drill meetings on 5/6/11, 5/31/11, and 6/8/11. | |

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| | | These new policies and procedures had been newly introduced at the time of the Monitoring Team's visit, and there was little evidence of implementation or results from these new processes. These will be reviewed at the Monitoring Team's next visit. It appeared that there were many policies addressing integration of care, but it was not clear these were part of a cohesive master plan for achieving integration. These policies appeared to be independent of one another and it was not clear how they interfaced or potentiated the ultimate goal of integration. Each was presented as an "island," rather than an essential part of a whole. Providing an organizational flow chart/ladder of how these different policies, if implemented correctly, would assist in refining the integration of care process would be instructive to the Facility to ensure there are no gaps in the process and important information is tracked until closure.<br><br>Since the last review, there had been an increase in the collaboration between Nursing and the Physical and Nutritional Management Team (PNMT), especially with the addition of a dedicated nurse assigned to the PNMT. However, the increase in collaboration had not resulted in positive outcomes especially for the Individuals designated to be at high risk for health indicators. Consistent with the last three reviews, nurses were still not understanding the importance of checking the Physical and Nutritional Management Plans (PMNPs) prior to administering medications, or ensuring individuals were in the correct positions after administering medications and throughout the day.<br><br>In addition, there was a decrease in collaboration between the Nursing and Pharmacy Departments regarding medication variances as noted in the Pharmacy and Therapeutics Committee meeting minutes. However, the forward movement made by the members of the Mock Drill Committee since the last review resulted in a number of positive interventions being implemented. | |
| G2 | Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing supports and services. | The Facility submitted 18 consultations for review. They are listed in the above under documents reviewed. Of these, all had initials and dates from PCPs, indicating review. There was no direct information on the consult report to indicate agreement or not from the PCP. Integrated progress notes (IPNs) were then reviewed. Of the 18 consultations, six had IPN entries discussing the consultant report, with agreement in these cases. This was a compliance rate of six out of 18 (33%). As noted with regard to Section L.3, on a monthly basis, the medical QA system tracked this information, and results were discussed with the PCP. | Noncompliance |

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

1. For the Diagnostics Tracking log and Appointment and Consult Tracking log, the column indicating the MD was informed of the report/result should be replaced by the date the PCP reviewed and signed it. (Section G.1)
2. Providing an organizational flow chart/ladder of how the different policies will assist in refining the integration of care process would ensure there are no gaps in the process and all of the important information is tracked to closure. (Sections G.1, G.2, and H.7)
3. As the Facility's self-assessment process is further developed, the Facility should identify data and objective documentation sources that can be used to substantiate compliance with the provisions in Section G of the Settlement Agreement. The "Texas Settlement Agreement Monitoring Instrument" for Section G should be modified, as appropriate, and the Facility should utilize it to self-assess its own processes. Objective data and information gained from this process should be incorporated into the Facility's POI to substantiate the Facility's findings of substantial compliance or noncompliance. (Facility Self-Assessment)

| SECTION H: Minimum Common Elements of Clinical Care | |
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| 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:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o Copy of any in-service training for PCPs on International Classification of Diseases (ICD) and Diagnostic and Statistical Manual (DSM) diagnostic criteria in last six months;<br>o Settlement Agreement Section H: Minimum Common Elements of Clinical Care QA tool;<br>o CCSSLC Action Plans for H.1 through H.7;<br>o Quarterly medical review form;<br>o Calendar June 2011: Quarterlies;<br>o Copy of Active Problem List, implemented 6/1/11;<br>o Policies: DADS SSLC: Medical Care policy #009.1, dated 2/16/11; Developing Integrated Personal Support Plans F.18: Personal Support Planning, draft 4/26/11, approval 4/26/11, implementation 5/2/11; Completing Personal Focus Assessments F.19: Personal Support Planning, draft 4/26/11, approval 4/26/11, implementation 5/2/11; Residential Services W.5: Participating in Unit Incident Management Team Meeting, revision 4/27/11, approval 4/28/11, implemented 4/28/11; Quality Assurance E.4: Participating in Performance Evaluation Team (PET) Monthly Meeting, revision 3/1/11, approval 6/16/10, implementation 4/1/11; Integrated Clinical Services G.5: Diagnostics, Appointments, and Consults Tracking, revision 3/11/11, approval 2/16/11, implementation 3/7/11; and Medical Care LL.3.1: Responding to Acute Medical Problems, implemented 1/17/11, revised 2/14/11;<br>o Email, dated 4/29/11, concerning recommendations in three areas to be addressed in each discipline-specific assessment;<br>o Request to post/training roster, dated 4/28/11: Timely assessment, completion, addition of living options recommendations;<br>o Request to post/training roster, dated 5/11/11: Responsibilities of PCP (Acute problems, active problem list, PCP orders, hospitalization/ER visit, consults, response to pharmacy concerns); and<br>o Presentation Book for Section H.<br>▪ **Interviews with**:<br>o Sandra Rodrigues, MD;<br>o Althea Pat Stewart, Medical Compliance RN; and<br>o Enrique Venegas, DDS. |
| | **Facility Self-Assessment:** The Facility determined that it was not in compliance with Section H. According to the narrative included in the Facility's POI, a number of steps were taken to improve assessments and timing of assessments. The Medical Department created a quarterly medical summary form as part of the assessment process, and this was just beginning to be implemented. Based on the May 2009 Health Care Guidelines, 27 policies for integrated clinical services were created in 11/10. The At Risk policy provided direction to many departments and interdisciplinary groups in ensuring health status monitoring, and |

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| | creation of risk plans based on quality assessments.<br><br>The Facility's POI repeated portions of the narrative related to the development of policies, and the implementation of the quarterly medical summary several times. However, this often was not adequate to describe the Facility's status with regard to specific provision of Section H. For example, Section H.5 requires the Facility to put a system in place to effectively monitor the health status of individuals. The Facility's narrative discussed changes made with regard to the At-Risk process, the Active Problem List, and quarterly reviews. However, the Facility provided no information about how these activities were designed to create a system to monitor the health status of individuals on a systemic level. In addition, no data was provided to measure the effectiveness of the new initiatives. |
| | **Summary of Monitor's Assessment:** A number of initiatives were beginning, such as the development of the quarterly medical summary. This document required the PCP to conduct a quarterly review of medical care to ensure that recent events and lab were reviewed periodically and health assured. It was in the early stages of implementation. QDRRs were completed on a quarterly basis. The annual dental assessment was more comprehensive in scope. Both the medical and dental assessments had begun to include components of levels of risk for various health categories, as well as recommendations concerning community placement. Consult and lab reports were being tracked to closure. A number of tools were developed to assist the PCP to comply with the tasks and documentation required for an integrated approach to health care.<br><br>The morning medical meeting was a routine part of the PCPs and Nursing Department's schedule. This was a forum for asking and researching critical clinical concerns. Quality integrated care should be evident through the morning medical meeting group reviewing the various campus daily logs, asking critical questions about ongoing acute illness, as well as making recommendations for preventive steps in care, and documenting follow up to closure in an interdisciplinary setting. The potential of this meeting had not been accomplished, but the group was progressing toward the goal of ensuring timely integration of care.<br><br>Clinical indicators were not identified. The Facility was expecting completion of clinical pathways in the near future, which would provide assistance with regard to many of the provisions within Section H, including the development and implementation of clinical indicators.<br><br>The Facility remained out of compliance with this section. However, progress continued to be made. |

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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 | DADS Policy #005: Minimum and Integrated Clinical Services provided the administrative structure and oversight needed to obtain compliance with Section H of the Settlement Agreement. This policy provided precise guidance concerning such areas as periodicity and timeliness of clinical assessments and evaluations. It provided expectations across a wide range of disciplines such as quarterly reviews by nurses, | Noncompliance |

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| | basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs. | annual dental examinations, regular review of drugs, annual physical exams, and periodic assessment of risk status. Changes in status had assessment expectations within 24 hours for non-urgent change, within one hour for urgent change, and immediately for emergent change.<br><br>At the time of the Monitoring Team's review, the Facility had not had sufficient time to review and comment on DADS Policy #005, and/or incorporate all of the requirements into their local policies. For example, the DADS policy required identification of health status changes by any staff involved in the care of the individual, as well as timely response from the Nursing and Medical Departments. Many of the policies the Facility already had drafted were based on the Health Care Guidelines. In order to be consistent with State Office policy, the timeliness of response will need to be added to several of these policies, especially ones focusing on acute care illness and injury.<br><br>A quarterly medical summary form was developed for guiding the PCPs in completing the essential areas of review for each of their assigned individuals. This form was to be implemented effective 6/1/11. The "quarterly medical review" used a Subjective, Objective, Assessment, and Plan (SOAP) note format. Included for completion were "S - active/significant chronic medical problems, O - labs/diagnostic tests/consults in last three months, A – summary, and P – plan." After completion, it was to be placed in the IPN section of the individual's medical record. According to the lead physician, the goal was for sufficient detail to be documented on these forms so the three quarterly summaries could be used as an efficient reference tool in completing the annual medical assessment. However, the process was just beginning, and no examples of completed quarterly medical summaries were submitted or identified upon review of the medical records. As the form is initiated, it is recommended that the focus be completion of the form in order to provide a complete assessment, review, and update for that quarter. At some point as the system matures, additional detail needed for the annual medical assessment could be included.<br><br>Additionally, as the quarterly medical summary form was new, there was a quarterly summary schedule developed to assist in the PCPs with compliance. As part of this schedule, the June 2011 schedule for quarterlies was submitted, identifying the individuals' names assigned to the weekdays during that month, suggesting a due date or reminder date for completion. There were 55 names listed. There was no PCP name attached, so it was unclear if this was for the entire Medical Department or one PCP. Extrapolating the 55 individuals per month over a quarter would result in 165 individuals being seen in that quarter. The census exceeded 165 individuals. It also did not indicate if that was the due date for the quarterly summary, or whether it was a date ahead of the due date designed to provide a window of time for completion. There was in-service training for the PCPs, which was completed on 5/31/11. The Action Plans for | |

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| | | this section indicated the quarterly summary schedule had been completed on 5/31/11.<br><br>One of the need areas that the non-Facility physician reviewers identified was documentation for those individuals who had a nicotine habit, and an indication of whether or not counseling to stop smoking had been provided. This had subsequently been added to the active problem list. The additions to the active problem list included whether there was a history of smoking, if the individual was a current smoker, if the individual was advised to quit, and whether there was a history of alcohol or substance abuse. Considering individuals might also chew tobacco, it was not clear what entry, if any, the PCP was expected to complete for individuals who fell into this category.<br><br>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 experienced acute illness; individuals who might benefit from communication systems; and individuals being considered for enteral nutrition. | |
| H2 | Commencing within six months of the Effective Date hereof and with full implementation within one year, diagnoses shall clinically fit the corresponding assessments or evaluations and shall be consistent with the current version of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems. | During the prior six months, staff were not provided an in-service training on ICD and DSM diagnostic criteria. An Active Problem List was part of the annual medical assessment. The State's CARE DG-1 system included coding for the diagnoses. With the recent change in the ICD codes to the new ICD-10 codes, guidance needed to be provided to the medical coding clerk(s). It would be beneficial to spend a few minutes at regular intervals in providing in-service training to all the PCPs concerning these new codes. The more complete the code, the more accurate the CARE DG-1, as well as other documents that document diagnoses. It is recommended that one body system/organ system be reviewed monthly at the morning medical meeting so that the PCPs can begin to comprehend the changes in the ICD-10 coding system.<br><br>As is illustrated with regard to Section J of the Settlement Agreement, the assessment processes used to determine diagnoses were not always consistent with DSM criteria or generally accepted standards of practice. The psychiatric diagnoses utilized at the CCSSLC were consistent with the nomenclature 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. | Noncompliance |
| H3 | Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions | The Facility was awaiting the release of clinical pathways from the State Office. However, CCSSLC developed Facility policies for 27 integrated clinical areas. These policies had been implemented at the Facility level. A number of PCP checklists were created to assist the PCPs in providing quality care and quality documentation. A policy entitled: "Medical | Noncompliance |

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| | shall be timely and clinically appropriate based upon assessments and diagnoses. | Care" was implemented on 2/16/11, and provided broad guidelines concerning quarterly reviews, preventive, acute, and chronic care, diagnostic and consult report tracking, active problem lists, integrated progress notes, transfer of individuals to the ER, and monitoring of acute illness until closure.<br><br>The morning medical meeting was a routine part of the PCPs and Nursing Department's schedule. This was a forum for asking and researching critical clinical concerns. Quality integrated care should be evident through the morning medical meeting group reviewing the various campus daily logs, asking critical questions about ongoing acute illness, as well as making recommendations for preventive steps in care, and documenting follow up to closure in an interdisciplinary setting. The potential of this meeting had not been accomplished, but the group was progressing toward the goal of ensuring timely integration of care.<br><br>As discussed in detail with regard to Section F of the Settlement Agreement, assessments were missing from many of the PSPs reviewed, the Personal Focus Assessment process did not consistently identify all of the assessments that should have been conducted based on the individuals' needs, and treatments and interventions identified in assessments were not consistently incorporated into individuals PSPs.<br><br>DADS new Policy #006 - At Risk Individuals addressed change of status, risk guidelines, as well as ongoing and quarterly risk review. This allowed another mechanism to ensure areas of health concern were not overlooked, but were addressed methodically. However, as discussed in detail with regard to Section I, CCSSLC was not developing adequate treatments to address the areas of risk that teams identified for individuals through this process. | |
| 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. | The determination of clinical indicators awaited the State Office's completion of clinical guidelines.<br><br>As is illustrated in various sections of this report, clinical indicators often were not identified for individuals. For example, when psychiatric medications were prescribed, the target symptoms were generally not 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. Many physical and nutritional management plans also did not identify the functional outcomes to be measured. As is discussed with regard to Section I, teams were not identifying the clinical indicators related to individuals' risks to determine the efficacy of treatments. | Noncompliance |
| H5 | Commencing within six months of the Effective Date hereof and with | DADS Draft Policy #005 also set the standards and expectations the Medical Director needed to use in creating a health status monitoring system. The expectation | Noncompliance |

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| | full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals. | appropriately, but ambitiously set the standard as monthly monitoring on a wide variety of domains of health care, including staffing, timeliness, equipment and resources, quality of care, morbidity, clinical indicators, etc.<br><br>The monitoring tool provided in the Presentation Book for Section H was entitled: "Settlement Agreement Section H: Minimum Common Elements of Clinical Care." However, the completion of this document was difficult and subjective, as there were no concise instructions to guide the reviewer in completing the form. There would be the potential for great variability in completing the form, and the inter-rater reliability would indicate the need for increased specificity in defining measurable criteria.<br><br>Additionally, the creation of the clinical guidelines will prompt clinical indicators, and the finalization of these clinical guidelines is essential to allow the Medical Department to proceed to the next step. | |
| H6 | Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators. | This section is dependent on valid clinical indicators to reflect improvement in health, and each area of health risk. Once clinical indicators are chosen, the measurement of these indicators would provide guidance as to efficacy of treatment, and need to continue treatment or change treatment. | 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. | The Facility had begun to develop and implement policies that were interdisciplinary in scope, and provided guidance for integration. These policies were discussed in Section G.1, and include the following: Developing Integrated Personal Support Plans F.18: Personal Support Planning, implemented 5/2/11; Completing Personal Focus Assessments F.19: Personal Support Planning, implemented 5/2/11; Residential Services W.5: Participating in Unit Incident Management Team Meeting, implemented 4/28/11; Quality Assurance E.4: Participating in Performance Evaluation Team Monthly Meeting, implemented 4/1/11; Integrated Clinical Services G.5: Diagnostics, Appointments and Consults Tracking, implemented 3/7/11; and Medical Care LL.3.1: Responding to Acute Medical Problems, revised 2/14/11. Additionally, guidance was provided for recommendations in each discipline's annual assessments concerning three areas that were required to be addressed: community placement, discipline-specific recommendations, and skill acquisition training.<br><br>Each of these policies was interdisciplinary in scope, and provided structural guidance in integrating clinical services, as well as bringing quality information to the PST for dialogue and decision in determining risk categorizations and action plans and completing the annual PSP. However, as noted with regard to Section G.1, these policies appeared to be independent of one another and it was not clear how they interfaced or | Noncompliance |

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| | | potentiated the ultimate goal of integration. Each was presented as an "island," rather than an essential part of a whole. Providing an organizational flow chart/ladder of how these different policies, if implemented correctly, would assist in refining the integration of care process would be instructive to the Facility to ensure there are no gaps in the process and important information is tracked until closure. | |

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

1. Initially the focus of the quarterly medical summary form should reflect an assessment, review, and update for that quarter. As the PCPs become familiar with the form and its required contents, additional information should be added to meet the needs of the annual review. (Section H.1)
2. Clinical guidelines/pathways should be finalized and implemented. They should provide a timeframe and critical clinical steps in the work-up and treatment of common diagnoses and illnesses. Clinical indicators should be built into the pathway as a measurement tool, which can then be readily used for quality care measurement. (Sections H.1, H.3, H.4, H.5, and H.6)
3. Monthly in-service training sessions should be held during one body system/organ system is reviewed in reference to the ICD-10 coding system. As PCPs provide a more complete diagnosis using the nomenclature and terms of the ICD-10, then the DG-1 will be as accurate as possible. (Section H.2)
4. The Medical Department should focus on quality improvement initiatives using data that is known to be complete and accurate, while waiting for the clinical guidelines/pathways to be finalized. (Section H.5)
5. Providing an organizational flow chart/ladder of how the different policies will assist in refining the integration of care process would ensure there are no gaps in the process and all of the important information is tracked to closure. (Sections G.1, G.2, and H.7)
6. CCSSLC should identify the monitoring tools, and/or data streams that will be utilized to self-assess whether or not the Facility is in compliance with Section H of the Settlement Agreement. The narrative descriptions of the Facility's status should continue to be included, but data also should be included as another objective measure of progress. (Facility Self-Assessment)

| SECTION I: At-Risk Individuals | |
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| 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:<br>▪ **Review of Following Documents**:<br>▪ DADS SSLC "Risk Guidelines" laminated record;<br>o CCSSLC Presentation Book for Section I;<br>o CCSSLC POI;<br>o CCSSLC At Risk Individuals policy;<br>o CCSSLC At Risk Lists of Individuals;<br>o The following documents: Integrated Risk Tracking Forms, Action Plans for Risk Assessments, PSPs and PSP Addendums, Physical and Nutritional Management Plans, OT/PT/SLP assessments, Comprehensive Nursing Assessments, and Health Management Plans for the following 26 individuals: Individual #58, Individual #43, Individual #247, Individual #48, Individual #218, Individual #24, Individual #92, Individual #7, Individual #222, Individual #163, Individual #183, Individual #270, Individual #153, Individual #379, Individual #159, Individual #117, Individual #21, Individual #284, Individual #303, Individual #378, Individual #86, Individual #136, Individual #293, Individual #210, Individual #326, and Individual #312;<br>o For Individual #247, PSP, dated 3/11/11; and Integrated Risk Rating form, dated 3/11/11;<br>o For Individual #275, PSP, dated 4/13/11; Integrated Risk Rating form, dated 4/13/11; BSP, implementation date 5/14/11; Safety plan for crisis intervention, reviewed by HRC on 6/15/11 date, and BSC on 6/7/11;<br>o Medical records, including Integrated Risk Rating form, risk plans, one year of IPNs, most recent annual medical assessment and physical exam, CARE DG-1 form, most recent nursing assessment, most recent PSP and subsequent quarterlies, last one year of laboratory results, x-rays, other diagnostic tests, consult reports for the last year, the most recent health management plan, most recent BSP, hospital admission history and physical summaries and discharge summaries for the past year, ER visits for the past year, resuscitation status, and out-of-hospital DNR forms, active problem list/inactive problem list, physician orders for past one year, and operation/procedure reports for the past year, for the following: Individual #48, Individual #58, Individual #179, Individual #183, Individual #160, Individual #24, Individual #348, and Individual #175;<br>o DADS SSLC Policy #006.2: At-Risk Individuals, approved 12/29/10, implemented 2/18/11;<br>o CCSSLC Policy Medical Care LL 18.2: The prevention and management of aspiration pneumonia, revision 1/13/11, approval 1/13/11, implementation 1/17/11;<br>o PowerPoint presentation entitled "Aspiration Prevention," dated 3/7/11;<br>o SSLC Aspiration Triggers Data Sheet, dated 12/10;<br>o Prevention and management of aspiration competency questionnaire (nursing), revised 3/4/11;<br>o Prevention and management of aspiration competency questionnaire (non-nursing), |

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| | revised 3/4/11;<br>o Person-specific PSP (program implementation and staff competency) monitoring tool, revised 4/20/11;<br>o Person-specific monitoring in dining room (form);<br>o Competency-based monitoring for staff (form);<br>o Monthly person-specific mealtime PSP monitoring database, 3/11 schedule;<br>o CCSSLC Active Treatment Monitoring: level of compliance – monthly comparison by Units, dated 6/11/11;<br>o CCSSLC Active Treatment Monitoring level of compliance – monthly comparison by residence, dated 6/11/11;<br>o Monthly monitoring assignment list for July 2011;<br>o CCSSLC initial risk assessments and ratings tracking – regular diners, updated 2/26/11;<br>o CCSSLC initial risk assessments and ratings tracking – enteral nutrition, updated 2/26/11;<br>o CCSSLC policy: At risk individuals I.1: At risk procedure – PST, draft 6/28/11, approval 6/28/11, implemented 7/1/11;<br>o CCSSLC policy: At risk individuals I.2: Positioning for the prevention of aspiration pneumonia coaching and monitoring guide – residential services, draft 6/17/11, approval 6/20/11, implemented 6/22/11;<br>o CCSSLC policy: At risk individuals I 3: Positioning for the prevention of aspiration pneumonia coaching and monitoring guide – PST and others, draft 6/17/11, approval 6/20/11, implemented 6/22/11;<br>o QA/QI Council minutes, dated 7/8/11; and<br>o Presentation Book for Section I.<br>▪ **Interviews with**:<br>o Colleen M. Gonzales, BSHS, Chief Nurse Executive; and<br>o Meeting with PST members for integrated risk rating analysis for Individual #247, on 7/12/11, and Individual #275, on7/13/11.<br>▪ **Observations of**:<br>o PSP Meeting for Individual #332, on 7/12/11;<br>o PSP Meeting for Individual #234, on 7/12/11;<br>o PSP Meeting for Individual #228, on 7/13/11; and<br>o PSP Meeting for Individual #353, on 7/14/11. |
| | **Facility Self-Assessment:** The Facility determined that it was not in compliance with any of the provisions of Section I. This was consistent with the Monitoring Team's findings. However, the Facility determined that progress had been made. According to the Facility:<br>▪ By 4/1/11, the first phase of the implementation of the At-Risk Individuals policy, which involved completion of the risk screening tools, had been completed for 276 individuals through the PST process.<br>▪ On 4/20/11, the Facility completed a review of the PSPs that were created in the first quarter of the calendar year, and determined that the PSTs needed additional training to comply with the two State Office policies (#004 PSP policy, and #006 At Risk policy). On 5/1/11, a mentoring program |

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| | was begun to work with the PSTs.<br>▪ On 5/2/11, the Facility determined that for the PSPs completed in the first quarter of 2011 that identified aspiration risk, all had an action plan completed, but that no other risk areas had had action plans developed. The QA/QI Council developed a corrective action plan to correct this deficit. The State Office Discipline Coordinator and State Office Consultants then began to train the habilitation, nursing, and PNMT staff regarding risk action plans development. A Performance Evaluation Team then reviewed a sampling of risk action plans with a habilitation therapy consultant, and determined that the corrective action plan needed revisions.<br><br>It was positive that the Facility had used data from its internal audits to identify issues related to the at-risk process, and to develop action plans to address these issues. As the Facility's self-assessment processes evolve, additional data should be analyzed, addressed, and included in the POI to substantiate compliance or noncompliance with the Settlement Agreement. Such data could come from a variety of sources, including audits, as well as other data sources, such as databases or outcome indicators. |
| | **Summary of Monitor's Assessment:** The Facility had concentrated on implementing the integrated risk rating form. A specific focus had been placed on aspiration pneumonia, particularly with regard to the development of action plans. However, the action plans for individuals designated as being at high risk due to aspiration pneumonia were found to be generic and clinically inadequate. No Integrated Risk Action Plans had been developed for individuals who were designated as high or medium risk for other health indicators other than aspiration.<br><br>The State Office Discipline Coordinator and consultants had assisted in mentoring the PSTs to develop quality ratings with adequate rationale to justify the rating. Based on the Monitoring Team's observations of PSPs during the onsite review, the PSTs had made some progress regarding the At-Risk process. However, there had been no improvements found affecting the clinical outcomes for individuals designated to be at risk.<br><br>The Facility was just beginning to implement the next step, specifically the development of risk action plans for all medium and high-risk ratings. The Facility continued to be out of compliance with Section I, but progress was being made. |

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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 | In February 2011, CCSSLC had implemented the revised State policy addressing the At-Risk Individuals. This policy included Risk Guidelines, which consisted of specific criteria to assist the teams during individuals' PSP meetings to determine the appropriate risk levels for each risk indicator. CCSSLC's POI indicated that in April 2011, the Facility had completed 276 individuals' Integrated Risk Rating forms and that the Facility's review of the PSPs that were held from January 1, 2011 to March 31, 2011 found that all the PSPs conducted (81) indicated a need for additional training of the PST members regarding | Noncompliance |

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| | whose health or well-being is at risk. | the understanding of and documentation requirements for the PSP and At-Risk Policy processes. In response to this finding, the Assistant Director of Programs and QMRP Mentors began attending PSPs in May 2011 to provide training and mentoring to PSTs.<br><br>In addition, CCSSLC's POI indicated that the Facility's review of all individuals' Integrated Risk Rating forms that PSTs completed (276) from 1/3/11 to 3/31/11 found that the 88 individuals that were designated as being at risk for aspiration had action plans developed as part of the Aspiration Pneumonia Enteral Nutrition Evaluation (APEN). However, the Integrated Risk Ratings List-by Home, which the Facility provided during the review, dated 6/27/11, indicated that only 21 individuals were rated at high risk for aspiration. Of these 21 individuals, the Monitoring Team found that five (Individual #48, Individual #105, Individual #64, Individual #136, and Individual #312) had not been referred to the PMNT, and thus did not have PMNT Action Plans or Integrated Risk Action Plans developed (PMNT Action Plans are discussed in further detail with regard to Section O.2). In addition, the action plans contained in the APENs reviewed were found to be generic and clinically inadequate.<br><br>The Facility's POI indicated that there had been no Integrated Risk Action Plans developed for individuals who were designated as being at high risk for other health indicators other than aspiration, which was consistent with the findings of the Monitoring Team. The Facility reported that in June 2011, the State Office Discipline Coordinator and State Office Consultants provided training to the Facility's habilitation staff, PNMT Committee, and Nursing Department leadership regarding the development of risk action plans. At the time of the review, revisions were being made and implemented to the Facility's Corrective Action Plan addressing at-risk individuals. Based on the Monitoring Team's observations of four PSPs during the onsite review, the PSTs had made some progress regarding the At-Risk process. However, there had been no improvements found affecting the clinical outcomes for individuals designated to be at risk.<br><br>To assess the Facility's risk screening process, members of the Monitoring Team observed four individuals' PSP or PSP addendum meetings (Individual #332, Individual #228, Individual #353, and Individual #234) while on site. Specifically, the observations of the PSPs indicated that:<br>▪ All appropriate disciplines were present at two (50%) of the PSPs. The individuals' PSPs/PSP addendum meetings that did not include all appropriate disciplines included: Individual #332 (Physician), and Individual #234 (Physician).<br>▪ The staff present at the PSPs/PSP addendum meetings were the actual staff that worked with the individual, and not substitute staff sitting in for other staff | |

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| | | members for three (75%) of the PSPs. The individual's PST that did not include the actual staff that worked with the individual, and had substitute staff sitting in the PSP included: Individual #332 (Nursing).<br>▪ The individual was present at four (100%) of the PSPs/PSP addendum meetings.<br>▪ The PST used the Risk Level Guidelines when determining risk levels at three (75%) of the PSPs/PSP addendum meetings. The individual's PSTs that did not use the Risk Level Guidelines when determining risk levels was the meeting for Individual #332.<br>▪ The PST consistently used supporting clinical data when determining risks levels for two of the PSPs observed (50%). The individuals' PSTs that did not use supporting clinical data when determining risk levels included: Individual #332 (the PST did not refer to any clinical data when assessing risks), and Individual #234 (clinical data was not presented regarding blood pressures, and no Braden Score was presented to support risk level for skin integrity). The Monitoring Team did note that there was some overall improvement for this indicator with the exception of one Individual's PST (Individual #332). However, specific supporting clinical data should be consistently used when determining risks levels.<br>▪ The risk levels the PSTs designated were appropriate for each category for two individuals (50%). The individuals' PSTs that did not appropriately designate risk levels due to the lack of and inconsistent clinical data presented during the PSPs included: Individual #332, and Individual #234. Due to the significant lack of clinical data used by the PSTs to determine risk levels and the lack of use of the Risk Guidelines, the Monitoring Team could not validate many of the risk levels that these PSTs assigned.<br>▪ There was adequate and appropriate clinical discussion among appropriate team members in decisions regarding risk levels in three (75%) of the PSPs/PSP addendum meetings observed. The individual's PSP where adequate clinical discussions for making decisions regarding risk levels did not occur included Individual #332, due to the significant lack of clinical data the PST presented when determining the risk levels for each of the clinical indicators. Although the Monitoring Team noted improvement for this indicator with the exception of one Individual's PST (Individual #332), the PSTs should continue to expand the depth and scope of the clinical discussions related to the risk indicators and risk levels. Future compliance scores will reflect the adequacy of these clinical discussions.<br>▪ Team disagreements regarding risk levels were noted in two of the PSPs, and they were appropriately resolved for Individual #234, and Individual #353 (100%). No team disagreements were noted in the other two PSPs. In the event this situation should occur, the Monitoring Team would evaluate the process of resolution based on the use of specific clinical data, the use of the Risk | |

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| | | Guidelines, appropriate clinical judgment, and the use of a person-centered focus.<br>▪ The PSP facilitator kept the team focused for three (75%) of the PSPs/PSP addendum meetings observed. The individual's PSPs/PSP addendum meeting where the facilitator did not keep the team focused was for Individual #332. Although the Monitoring Team noted improvement for this indicator, the PSPs observed were exceptionally lengthy and required more structure to keep discussions focused and productive.<br><br>In addition, other positive observations from the Monitoring Team included:<br>▪ The PST for Individual #353 used a wall chart to track the team's information, ideas, and recommendations about the individual;<br>▪ The PST for Individual #353 captured specific information regarding the individual's reactions and behaviors to determine the individuals likes and preferences;<br>▪ The PST for Individual #353 actively engaged the direct support professional during the PSP;<br>▪ The PSTs for Individual #353 and Individual #288 had good discussions regarding specific community needs and preferences;<br>▪ Some of the PST members for Individual #332 were aware that the individual had accurate memories of past family members and friends; and<br>▪ Although a number of the PST members for Individual #234 had newly begun to work with the Individual, the PSP included good discussions regarding some of the risk levels and the associated clinical data.<br><br>Problematic areas that needing focus or improvement included:<br>▪ The PSTs should consistently use the Risk Level Guidelines and specific clinical data when determining risk levels;<br>▪ Some PST members for Individual #332 were not aware of significant medical issues;<br>▪ PSTs were uncertain whether or not to rate risk levels based on if supports were in place, or to rate the risk as if the supports were not already implemented;<br>▪ Some rating of risks was based on "institutional" standards, rather than how a community practitioner would rate the risk level (i.e., a lower standard was used, for example, with regard to dental health for Individual #332);<br>▪ Some PSP meetings lacked structure and focus, allowing PSTs to digress to unrelated issues, and were extremely lengthy resulting in team members and individuals leaving the PSPs;<br>▪ Physicians were not consistently present at the PSPs;<br>▪ The PSTs' discussions regarding Action Plans for risks did not include | |

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| | | measurable, functional, outcomes and interventions, and the interventions mentioned during the PSPs were not in alignment with the level of risk designated by the teams; and<br>▪ Although the Integrated Risk Rating form submitted after the review for Individual #332 included specific clinical information for each heath category, most of this information was not presented or discussed during the PSP.<br><br>To further assess the risk rating and follow-up process, during the onsite visit, the Monitoring Team met with the PSTs for two individuals to review the completed integrated risk rating forms and the action plans. The following provides a summary of the reviews related to Individual #247, and Individual #275:<br>▪ On 7/12/11, the Monitoring Team met with the PST for Individual #247, to learn of the team's approach in completing the "Integrated Risk Rating Form." He was considered high risk for aspiration, respiratory compromise, osteoporosis, and seizures. Osteoporosis was discussed. When the record was reviewed, no DEXA scan had been completed in the recent past. He had several fractures in the past, but the location/type of fracture, and date, were not recorded in the rationale section of the Integrated Risk Rating form. The team did not appear to have sufficient information with which to determine the risk level, and subsequently, would not be able to determine what needed to be assessed, as the tests already completed were not reviewed. This individual had a diagnosis of GERD, which might have been contributing to his recurrent aspiration pneumonias. However, medically, there was little information available as to the work up to determine severity. He had a fundoplication in the remote past, and it was not known if a determination had been made as to whether or not it remained intact or was unwrapped. There were other surgical options to consider. The PNMT followed this individual's care, but their plan had not been integrated into the PSP, and remained separate. Additionally, while making rounds in the Infirmary, the Monitoring Team noticed that Individual #247 appeared to be lying with the head of the bed less than 30 degrees, and he was lying in a custom made contoured support overlay to his mattress. Presumably, the position maximized his pulse oximetry readings, but it appeared to place him at risk for reflux and aspiration. Overall, there was little assessment of the reason for his recurrent aspiration pneumonia or ways to prevent a recurrence. The team did not have the background information necessary to determine what further assessment needed to be completed.<br>▪ On 7/13/11, the Monitoring Team also met with the PST for Individual #275 to review the team's completion of the risk rating form. Most areas were considered low risk, expect polypharmacy, challenging behavior, and falls. She intentionally had been losing weight, having lost about 50 pounds in 17 months, | |

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| | | with a continued focus on weight loss. She remained above her ideal body weight range, but was approaching that range. She had been on Topamax, but that had been discontinued in May 2011. This was a medication that might have a weight loss side effect. She had a history prior to moving to CCSSLC of anorexia, and, reportedly, the provider agency was concerned about the weight loss and her use of food as a control. There might also have been some bulimia in the recent past. Although the CCSSLC PST was creating a supportive environment and encouraging her in her weight loss and exercise program, there appeared to be a need to understand her vulnerability in this area, and a recognition that an area of success could have the potential to become a risk. The team needed to address the long-range plan for her weight loss and her focus on weight loss to ensure it remained a healthy aspect of her life. The team might need to focus on other aspects of her life in which she could have control or more control, so that weight loss and food did not become the only outlet of control in her life. Her weight loss needed to be tracked carefully, but the team had not included this as part of her risk plan. Additionally, there was the diagnosis of diabetes mellitus, which might have been a concern in the past, but there appeared to be no evidence of this currently, according to the serial Hemoglobin A1C tests and blood glucose levels. The PCP needed to thoroughly review her medical history to determine the accuracy of the diagnosis, and if diabetes mellitus was not one of her current diagnoses (or even past diagnoses), this should be removed and clearly documented by the PCP. The PST, meanwhile, continued to incorporate that diagnosis into her PSP, and the PCP needed to provide guidance in this area.<br><br>Discussion with the PSTs concerning the risk ratings for these two individuals revealed the need for an additional high-risk category, one that was stable, yet would likely be high risk chronically. This would be in contrast to the high-risk category already in the system, one needing considerable PST time and review, and considered to be active, because optimal treatment and risk reduction had not yet occurred.<br><br>Additionally, the risk guideline category for infection needed further options to provide guidance for this broad subject. Currently, the description of high risk for infection requires two or more Multiple drug resistant organism (MDRO) infections, or an open wound. It would be helpful to expand this to any hospitalization for an infection (e.g., sepsis, UTI, diverticular abscess, empyema, meningitis, etc.), because infections requiring hospitalization indicate the need for intense review for risk reduction, not only those with MDRO or a surgical wound.<br><br>An additional eight medical records of individuals were reviewed to determine the use of the Integrated Risk Rating Form. These individuals included: Individual #48, Individual | |

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| | | #58, Individual #179, Individual #183, Individual #160, Individual #24, Individual #348, and Individual #175. The following summarizes the results of this review:<br>▪ There were only two records for which the attendance roster was included for the PSP meeting. Both appeared to be poorly attended.<br>▪ Based on the documentation provided it was difficult to determine, but it appeared that for the two meetings for which rosters were provided, neither individual was present or neither signed the roster.<br>▪ Of the eight records reviewed, six teams (75%) utilized the definitions in the Risk Guidelines developed by the State Office.<br>▪ Of the eight records reviewed, six teams (75%) documented supporting clinical data in providing a rationale for the risk level.<br>▪ Out of the eight records reviewed, three integrated risk-rating tools (38%) were adequate in justifying the risk categorization.<br><br>From the Monitoring Team's observations, the Facility should provide additional training for the PSTs regarding the At-Risk process and the development and implementation of the associated Action Plans. This is essential to ensure that CCSSLC identifies timely and adequately significant clinical issues and implements appropriate Action Plans that reflect the needed clinical intensity in alignment with the designated risk levels. | |
| 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. | Based on a review of records for 23 individuals determined to be at risk (Individual #58, Individual #43, Individual #247, Individual #48, Individual #218, Individual #24, Individual #92, Individual #7, Individual #222, Individual #163, Individual #183, Individual #270, Individual #153, Individual #379, Individual #159, Individual #117, Individual #21, Individual #284, Individual #303, Individual #378, Individual #86, Individual #136, and Individual #312), there was documentation that the PST started the assessment process as soon as possible, but within five working days of the individuals being identified as at risk for none of these (0%) individuals.<br><br><u>Nursing Assessments</u><br>Based on a review of 23 individuals' records for which assessments were to be completed to address the individuals' at risk conditions, none (0%) included an adequate nursing assessment to assist the team in developing an appropriate plan. Records that did not contain documentation of this requirement included: Individual #58, Individual #43, Individual #247, Individual #48, Individual #218, Individual #24, Individual #92, Individual #7, Individual #222, Individual #163, Individual #183, Individual #270, Individual #153, Individual #379, Individual #159, Individual #117, Individual #21, Individual #284, Individual #303, Individual #378, Individual #86, Individual #136, and Individual #312. From a review of the documentation, nursing staff were using the last quarterly or annual Comprehensive Nursing Assessment to meet this requirement, even if it had been completed months prior to the meeting determining risk levels. A review of | Noncompliance |

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| | | the Comprehensive Nursing Assessments for the above 23 Individuals found that they were not adequate assessments in that none of the assessments specifically addressed the high risk health indicators, and were not updated regarding health issues related to the high risk health indicators. The assessment form itself did not lend to the presentation of a focused assessment addressing health risk indicators. The following provides some examples of assessments that did not adequately address the health indicator designated as placing the individual at high risk:<br>▪ The Integrated Risk Rating form, dated 5/24/11, indicated that Individual #58 was designated as being at high risk for aspiration. The Comprehensive Nursing Assessment, dated 4/30/11, noted only that the individual "was high risk for aspiration," and had no other assessment or information for this health risk indicator included in the assessment.<br>▪ The Integrated Risk Rating form, dated 6/10/11, indicated that Individual #284 was designated as being at high risk for aspiration, respiratory compromise, and osteoporosis. The Comprehensive Nursing Assessment, dated 10/30/10, seven months prior to the meeting at which health risk indicators were rated, did not address any of the high-risk indicators.<br>▪ The Integrated Risk Rating form, dated 3/1/11, indicated that Individual #153 was designated as being at high risk for constipation. The Comprehensive Nursing Assessment, dated 3/01/11, only mentioned that a bowel management plan was in place, but was "minimally effective." No assessment or other information was included in the assessment addressing this high-risk health indicator.<br><br>Based on interviews with Chief Nurse Executive during the review, nursing was unclear regarding the nursing assessment requirements related to the At-Risk process. Based on an interview with the State Coordinator for Specialized Services, State Office Nurse Practitioner Consultant, and Nursing Discipline Coordinator, there was no indication that the current Comprehensive Nursing Assessment form had been reviewed to determine if it would appropriately meet the requirements of an adequate assessment tool for addressing risk areas. It also did not appear that the need for the information contained in the Comprehensive Nursing Assessments to be updated in response to the identification of health risks had been identified specifically as a necessary component of the process. The Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals.<br><br><u>Physical and Nutritional Management, and/or OT/PT/SLP Assessment</u><br>Based on a review of five individual's records for whom assessments had been completed to address the individuals' at risk conditions, none (0%) included an adequate PNMT assessment or OT/PT/SLP assessment to assist the team in developing an appropriate plan. Records that did not contain documentation of this requirement included: | |

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| | | Individual #48, Individual #312, Individual #293, Individual #210 and Individual #326. The following provides examples of assessments that were not comprehensive:<br>▪ Integrated Risk Ratings-by Home, dated 7/5/11, identified Individual #48 as being at high risk for aspiration, dental, diabetes, GI problems and weight. Individual #48 had not been referred and/or assessed by the PNMT.<br>▪ Individual #312's was rated at high risk for aspiration and weight. Individual #312 had not been referred and/or assessed by the PNMT.<br>▪ Individual #293 was admitted to the hospital on 1/3/11 with a discharge diagnosis of pneumonia and admitted to the Infirmary upon her discharge from the hospital. Her Integrated Risk Rating Form, dated 2/18/11, did not document her diagnosis of pneumonia. She had not received an OT/PT/SLP update to assess her change in status.<br>▪ Individual #210 was discharged from the hospital on 3/21/11 with a discharge diagnosis of pneumonia. Her Integrated Risk Rating Form, dated 1/20/11, had not been updated post hospitalization. Individual #210 had not received an OT/PT/SLP update to address her change in status.<br>▪ Individual #326 was discharged from the hospital on 6/3/11 with a discharge diagnosis of pneumonia. Her Integrated Risk Rating Form, dated 3/25/11, had not been updated to reflect her change in status. An OT/PT/SLP update had not been completed to assess her change in status.<br><br><u>Medical Assessments</u><br>Based on a review of eight records for individuals determined to be at risk (Individual #48, Individual #58, Individual #160, Individual #24, Individual #179, Individual #183, Individual #348, and Individual #175.), there was documentation that the PST started the assessment process as soon as possible, but within five working days of the individual being identified as at risk for none of the individuals (0%). The Facility Director stated the teams had not gotten to the risk planning stage, but had concentrated on risk identification. The following provides an example of concerns related to timely medical assessments:<br>▪ For Individual #48, there was a lack of recent assessment information, as well as no next steps identified. Risk ratings should lead to complete assessments of specific risks in preparation for action plans. For instance, he was given a low risk for seizures, and the rationale was that he had no history of seizures in the last three years. However, he had a cluster of 26 seizures in 4/10. He last saw the neurologist in 9/10, and had a "no show" appointment in 4/11 (the reason was not documented). The risk guideline would place him at moderate risk. There was no information concerning following up on the "no show" to determine the cause, or to reschedule him in a timely manner (in either 5/11 or 6/11). The rating form indicated the Medical and Nursing Departments were not providing needed updated information. The team cannot determine risk | |

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| | | levels or complete proper assessments, unless there is accurate and complete information.<br><br>Based on a review of two individuals' medical records who had experienced changes in status (Individual #160, Individual #175), there was documentation that the IDT started the assessment process as soon as possible, but within five working days of the individuals' changes in an at risk condition for none of individuals (0%). As an example:<br>▪ Individual #175 had a DEXA scan with a score of -3.5 on 6/1/11, but the team did not convene to address this concern, because it changed his osteoporosis risk from medium to high risk.<br><br>Based on a review of eight individual records for which assessments had been completed to address the individuals' at risk conditions, one (13%) included an adequate medical assessment to assist the team in developing an appropriate plan. Records that did not contain documentation of this requirement included: Individual #48, Individual #58, Individual #179, Individual #183, Individual #160, Individual #24, and Individual #175. The following provides examples of assessments that was not comprehensive:<br>▪ Individual #58 had a history of GERD, and pneumonia on 1/24/11. He had a G-tube. There was no further work-up to determine the severity of the GERD as a potential contributor to severe aspiration and pneumonia. A recent bout of C difficile in 2/11 was not mentioned. The risk of challenging behavior was left blank, which did not allow the PST to review of all potential risks in developing an adequate plan.<br>▪ Individual #48 was high risk for obesity. He was also on two medications for hypertension, but there was no mention of this in the risk rating form, either under cardiac disease or circulatory system. He continued to gain weight, suggesting the need for a team meeting involving the dietician, as well as direct support staff to determine if he is obtaining food outside of the prescribed diet. However, there was no mention of obtaining serial weights to guide the team, a list of blood pressures to determine adequacy of treatment, or review of side effects for his supra-therapeutic doses of Dilantin (which was needed to suppress his seizures) to assist the team in determining if he was on the optimal medication for his seizure disorder. | |
| 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 | Based on a review of 26 records for individuals determined to be at risk (Individual #58, Individual #43, Individual #247, Individual #48, Individual #218, Individual #24, Individual #92, Individual #7, Individual #222, Individual #163, Individual #183, Individual #270, Individual #153, Individual #379, Individual #159, Individual #117, Individual #21, Individual #284, Individual #303, Individual #378, Individual #86, Individual #136, Individual #293, Individual #210, Individual #326, and Individual | Noncompliance |

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| | 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. | #312), there was documentation that the Facility:<br>▪ Established and implemented a plan within fourteen days of the plan's finalization, for each individual, as appropriate, in none of the (0%) cases.<br>▪ Implemented a plan that met the needs identified by the PST assessment in none of these cases (0%).<br>▪ Included preventative interventions in the plan to minimize the condition of risk in none of the cases (0%).<br>▪ When the risk to the individual warranted, took immediate action in none of the cases (0%).<br>▪ Integrated the plans into the PSPs in none of the cases (0%).<br>▪ None (0%) of the plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs.<br>▪ For none of the plans (0%) were appropriate, functional, and measurable objectives incorporated into the PSP to allow the team to measure the efficacy of the plan.<br>▪ Plans included the clinical indicators to be monitored and the frequency of monitoring for none of the individuals (0%). None of the 26 individuals had Risk Action Plans developed.<br><br>The Facility was in the beginning stages of developing risk plans for each individual. However, as mentioned above, update and complete information needed to be available to the teams in attempting to create risk plans. Further, the PCP should be able to define the extent of evaluation and treatment that occurred up to the time of the PST. Results and dates of tests should be available to the team, with interpretation by the PCP or nurse. Considerable time needs to be spent preparing information used in the rationale section of the "integrated risk rating form." Results of important diagnostic tests should be included in the rationale that would guide the team in finalizing the risk plans. | |

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

1. In prioritizing involvement in the PSP/at risk process, PCPs should be expected to attend the at-risk discussion to ensure teams arrive at clinically appropriate conclusions.
2. The PCP should provide background information concerning the diagnostic tests already completed, the dates of completion, with a brief entry concerning results. The PSTs cannot arrive at correct risk ratings without sufficient information, nor can further assessments be recommended if it is not known what assessments have already been completed. (Section I.1)
3. The State Office should consider the need for an additional high-risk category, a "stable high risk" category for those chronic conditions meeting the criteria of high risk. However, teams should focus on the "active" high-risk categories needing further discussion and intervention. Separating the two would allow teams to prioritize their attention, yet not lose track of the other high-risk categories. (Section I.1)
4. The State Office should consider expanding the "infection" category to provide additional options to provide guidance to the PSTs. Currently, the description of high risk for infection requires two or more Multiple drug resistant organism (MDRO) infections, or an open wound. It would

be helpful to expand this to any hospitalization for an infection (e.g., sepsis, UTI, diverticular abscess, empyema, meningitis, etc.), because infections requiring hospitalization indicate the need for intense review for risk reduction, not only those with MDRO or a surgical wound. (Section I.1)

5. As detailed in the Monitoring Team's Austin report, the risk guidelines should be reviewed to determine if further subcategories are needed to address the diverse topic of challenging behavior. (Section I.1)
6. Additional training on the at-risk process should be provided to the PSTs. This is necessary to ensure that the at-risk process adequately identifies the critical issues, and that appropriate and clinically sound action plans are developed to address the risks identified. (Sections I.1, I.2, and I.3)
7. To standardize the team process, one nurse and one behavior analyst should be trained on implementation of the new risk rating process, risk action plan development, and plan implementation process. These staff could then act as mentors for the risk process implementation, and attend as many of the PST meetings as possible to ensure basic aspects of the new policy and procedure are followed. (Sections I.1, I.2, and I.3)
8. When the team convenes about an individual, the departments responsible for background information concerning a risk category should be sufficiently knowledgeable about that category to explain the risk to the remainder of the team. (Section I.1)
9. Each PST member should obtain all relevant information ahead of the meeting, especially information on which the team will base a risk rating. (Section I.1)
10. There should be evidence to confirm the team's rationale for each category of risk reviewed. (Section I.1)
11. When there is a change in health status, the PST should reconvene to rate the categories of risk, and incorporate any changes in health into the risk categories and into a risk action plan. Particularly, when an individual is hospitalized and subsequently discharged home, the PST should meet promptly address any changes in health and functional status. (Sections I.1, I.2, and I.3)
12. The PCPs should ensure complete and timely assessments are ordered, and results incorporated into the individual's treatment and care. The risk action plan requires critical clinical thinking on how to prevent recurrences such as ER visits or hospitalizations to improve the quality of life by improving the health of the individual. (Sections I.2 and I.3)
13. The Facility, in conjunction with the State, should define specifically the assessment process regarding at-risk individuals for all disciplines. (Section I.2)
14. Given that PSTs, at times, do not realize when more assessment is indicated, and department heads should review PST findings relevant to their department to ensure appropriate guidance is provided to the teams in determining needed assessments. (Section I.1, and I.2)
15. As individuals' risks are identified, and risk action plans are developed, teams should ensure that measurable objectives or indicators are established to allow the team to measure whether or not the individual is better or worse, and if his/her risk level is reduced. If a plan is not working, the team needs to reevaluate it, and potentially revise it. (Section I.3)
16. The Facility should monitor the PSPs to ensure the risk ratings and action plans are integrated into individuals' PSPs. (Sections I.1, I.2, and I.3)
17. As the Facility's self-assessment processes evolve, additional data should be analyzed, addressed, and included in the POI to substantiate compliance or noncompliance with the Settlement Agreement. Such data could come from a variety of sources, including audits, as well as other data sources, such as databases or outcome indicators. (Facility Self-Assessment)

| SECTION J: Psychiatric Care and Services | |
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| 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:<br>▪ **Review of Following Documents**:<br>o Policies Related to the Use of Pre-Treatment Sedation Medication;<br>o Spreadsheet of individuals who have received pre-treatment sedation medication in the last six months for medical or dental procedures, name and dosage of medication, including date of administration, and indication as to whether a Desensitization Plan was in effect;<br>o Job descriptions of Psychiatrists;<br>o List of individuals whose psychiatric diagnoses have been revised, along with the Psychiatrists' rationale for the new diagnosis;<br>o List of individuals prescribed intra-class polypharmacy;<br>o Schedule and dates of all Psychiatric Treatment Reviews for the last six months;<br>o List of all meetings and rounds that are typically attended by the Psychiatrist, including other professional disciplines that usually attend those meetings;<br>o Blank copies of the Professional Service Log for Psychiatrists, the Psychiatric Evaluation Form, the CCSSLC Quarterly Psychiatric Review Form, and the CCSSLC Monthly Psychiatric Review Form;<br>o List of support services for Psychiatry Department;<br>o Minutes of Polypharmacy Meetings Review for the last six months;<br>o Response to requests for documentation pertaining to complaints about the psychiatric and medical care at CCSSLC, indicating "No complaints";<br>o The newly developed Risk versus Risk Analysis "coaching tool" developed by Psychiatry team;<br>o Lists of individuals with tardive dyskinesia, and individuals being monitored for tardive dyskinesia;<br>o List of all individuals prescribed psychotropic medication, including diagnosis, name of medication, and dosage;<br>o List of all individuals prescribed anticonvulsant medication as a psychotropic medication;<br>o The completed Reiss Screen for the following individuals: Individual #139, Individual #79, Individual #342, Individual #24, Individual #319, Individual #113, Individual #293, Individual #245, Individual #101, Individual #366, Individual #64, Individual #239, Individual #173, Individual #302, Individual #132, Individual #190, Individual #280, Individual #56, Individual #214, Individual #329, Individual #200, Individual #91, Individual #310, Individual #87, Individual #293, and Individual #132;<br>o The Reiss Scoring Sheets for the five individuals whose elevated scores resulted in a Comprehensive Psychiatric Evaluation (CPE), as well as a copy of the CPE, including the following: Individual #48, Individual #44, Individual #235, Individual #208, and Individual #193;<br>o Spreadsheet of Reiss Screen Examinations, with due date and Delinquency Report for all |

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| | CCSSLC individuals as of 7/11/11;<br>o List of individuals receiving anticholinergic medication;<br>o List of individuals prescribed benzodiazepines;<br>o The following from the active record: Face Sheet, Social History, Rights Assessment, Consents for Psychotropic Medication, Consents for Pre-Treatment Sedation Medication, Human Rights Committee (HRC) Referral Form and Addendums related to Psychotropic Medication, Behavioral Support section, Hospital section, Psychiatry section, Side Effect section, Pharmacy section, and the Neurology Consultation section for:<br>▪ The following individuals who were recently admitted to the Facility: Individual #96, Individual #78, Individual #71, Individual #169, and Individual #341;<br>▪ The following individuals who the Facility selected for the pre-review document request: Individual #185, Individual #154, Individual #109, Individual #363, Individual #372, Individual #312, Individual #105, and Individual #168; and<br>▪ The following individuals who were selected based on the acuity of their psychiatric presentation: Individual #313, Individual #275, Individual #140, Individual #26, Individual #336, Individual #158, Individual #238, Individual #177, and Individual #7;<br>o The master spreadsheet for completion of the Monitoring of Side Effects Scale (MOSES) and the Dyskinesia Identification System: Condensed User Scale (DISCUS) for the months of December 2010 through May 2011;<br>o List of individuals receiving Reglan as of 7/11/11;<br>o The master spreadsheet of Neurology Consultations that have been reviewed by the Psychiatrist and the psychiatric team, dated 7/11/11;<br>o Ten examples of the psychotropic medication side effect monographs that are provided to guardians as part of the consent process;<br>o Curriculum Vitae (CV) and Contracts for the locum tenens Psychiatrist, Dr. Jason Kirkpatrick; and the Consulting psychiatrist, Dr. Michael Hernandez;<br>o Ten Comprehensive Psychiatric Evaluations prepared by Drs. Hernandez and Kirkpatrick (five for each Psychiatrist);<br>o The MOSES and DISCUS Side Effect Rating Scores for the last year for the following individuals receiving Reglan, and who were not also receiving a psychotropic medication: Individual #266, Individual #137, Individual #15, Individual #124, Individual #130, Individual #205, Individual #222, Individual #127, and Individual #245;<br>o List of individuals with Behavioral Desensitization Plans for Medical and Dental Appointments, and examples of five recently completed Plans from Psychology;<br>o Schedule and Summary Sheets for the Psychiatric Clinics on Kingfish Living Unit on 7/12/11, and the Psychiatric Clinic on the Dolphin Living Unit on 7/13/11; and<br>o CCSSLC Presentation Book for Section. J, Psychiatric Services, which contained the following sections: a) Compliance Review; b) Plan of Improvement; c) Monitoring Tools; d) Evidence J.1 through J.15; and e) Recommendations 1 through 3 and Recommendations 7 through 10. |

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| | ▪ **Interviews with**:<br>o Glynn Bogard, Psychiatric Assistant, Michelle P. Lora-Arteaga, R.N., Brinda Fuller, R.N., Psychiatric Nurse, and Joseph Ward, Psychiatric Assistant, on 7/11/11 and 7/14/11;<br>o Michael Hernandez, M.D., Consulting Psychiatrist, on 7/12/11 and 7/13/11;<br>o Robert Cramer, Psy.D., Clinical Psychologist, and Erin Willis, Psychology Assistant, on 7/11/11;<br>o Mina Nguyen, Clinical Pharmacist, on 7/11/11, and with Dr. Rodriguez, on 7/13/11;<br>o Sandra Rodriguez, M.D., on 7/13/11; and<br>o Enrique Venegas, D.D.S., and Kathy Roach, Dental Hygienist, on 7/11/11.<br>▪ **Observations of**:<br>o Tour of the Dental Office, on 7/11/11;<br>o Psychiatric Clinics on Kingfish I and II Living Units, on 7/12/11;<br>o Psychiatric Consultations performed by Dr. Hernandez regarding Individual #20 and Individual #323, on 7/13/11;<br>o Behavioral Support Committee Meeting, on 7/14/11;<br>o Psychiatric Clinics on Dolphin Living Unit, on 7/13/11;<br>o Human Rights Committee Meeting, on 7/13/11;<br>o Risk Assessment/Risk Management Meeting with the Personal Support Team regarding Individual #247, on 7/12/11;<br>o Risk Assessment/Risk Management Meeting with the PST regarding Individual #275, on 7/13/11;<br>o Observations of the following individuals: Individual #140, Individual #243, Individual #172, Individual #20, Individual #109, Individual #323, Individual #105, Individual #92, Individual #231, Individual #302, Individual #177, Individual #193, Individual #267, Individual #339, Individual #47, Individual #69, Individual #53, Individual #275, Individual #213, Individual #166, Individual #132, Individual #13, Individual #278, Individual #372, Individual #87, Individual #221, Individual #376, Individual #215, Individual #274, Individual #3, Individual #141, Individual #315, Individual #356, Individual #256, Individual #329, Individual #102, Individual #289, Individual #371, Individual #214, Individual #202, Individual #331, Individual #242, Individual #312, Individual #182, Individual #38, Individual #103, Individual #269, Individual #175, Individual #31, Individual #209, Individual #211, Individual #19, Individual #131, Individual #282, Individual #223, Individual #273, Individual #58, Individual #111, Individual #285, Individual #142, Individual #378, Individual #177, Individual #71, Individual #281, Individual #154, Individual #342, Individual #236, Individual #331, Individual #16, Individual #52, Individual #90, Individual #166, Individual #69, Individual #308, Individual #268, Individual #44, Individual #184, Individual #60, Individual #246, Individual #10, Individual #42, Individual #338, Individual #144, Individual #208, Individual #311, Individual #72, Individual #46, Individual #294, Individual #18, Individual #343, Individual #132, Individual #298, Individual #167, Individual #300, Individual #233, Individual #26, Individual #332, Individual #225, and Individual #224. |

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| | **Facility Self-Assessment:** The Presentation Book that the Psychiatry Department prepared indicated that they had paid close attention to the prior monitoring report and related recommendations. The specific actions that had been implemented in response to those recommendations were contained in the summary of progress that had been made since the last monitoring review that was presented, at the opening meeting on 7/11/11. In this summary, the Psychiatry Department indicated that progress had been made in a number of areas, including: 1) completion of a plan of action related to polypharmacy for Section J.11, with trending graphs showing improvement; 2) the plan of action nearing completion for Section J.15 related to communication between neurologists and psychiatrists; 3) CCSSLC Psychiatric Services Policy J.1 revised to specify review parameters regarding DISCUS/MOSES assessments; and 4) all REISS assessments completed, as well as all individuals requiring psychiatric services having been reviewed for pre-sedation needs.<br><br>In addition to the review of the Presentation Book and the Plan of Improvement, a member of the Monitoring Team met with the Psychiatric Assistants and the Psychiatric Nurses on 7/14/11. During this meeting, the materials were sequentially discussed, in order to provide the Monitoring Team with a more thorough understanding of the Facility's Self-Assessment process and related POI.<br><br>The template that the CCSSLC had developed for their Internal Compliance Review of individual records was detailed, and covered the subject matter discussed in the provisions of the Psychiatry section of the Settlement Agreement. The inspection of these internal reviews indicated that they were generally consistent with the findings of the current analysis of the random sample. The internal reviews indicated an awareness of the lack of sufficient psychiatric consultation time to fully address the clinical needs of the individuals CCSSLC supported.<br><br>The Facility's overall self-assessment of its compliance with the specific provisions of Section J of the Settlement Agreement related to Psychiatric Services was similar to that of the Monitoring Team. However, CCSSLC did not substantiate its findings with data from its monitoring/auditing processes. This is an essential component of an adequate self-assessment. Although the Facility provided important narrative information about actions taken to come into compliance, no objective data was provided to show whether or not these steps were resulting in compliance with specific provisions of the Settlement Agreement. The Facility should use data it collects from its internal audits, as well as other data streams to identify areas of strength, as well as areas in need of improvement.<br><br>The prior report commented on a tendency for the internal CCSSLC reviews to focus on the presence or absence of the factors discussed in the Settlement Agreement, rather than assessing the quality of those clinical interventions. The current review of the Facility Self-Assessment and the POI indicated that the Facility had made progress in this area. This was especially apparent in the meeting with the Psychiatry Staff on 7/14/11, during which each individual provision was reviewed and the basis for the Psychiatric Team's assessment was discussed. |
| | **Summary of Monitor's Assessment:** During the visits to the residences and program sites, the Monitoring Team observed approximately 65 percent of the 140 individuals who were receiving psychotropic |

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| | medication. These observations did not identify any individuals who appeared to be grossly over-medicated, drooling, or displaying overt side effects. However, their involvement in active programming was variable. The Psychiatric Clinics for 36 percent of the individuals who were prescribed psychotropic medication also were observed. The Psychiatric Reviews included extensive input from Psychology and Nursing staff. There did not appear to be any pressure to finish the meetings quickly, and there was ample time for discussion.<br><br>During the last year, the Facility also hired a locum tenens Psychiatrist, who was on site at CCSSLC for approximately six weeks, during which time he focused on completion of the individual comprehensive psychiatric evaluations. He was scheduled to return again in the near future for another two months. Staff members noted that, in addition to record reviews, he interviewed a number of clinicians and direct support professionals, coupled with direct observation of the individuals. The Consulting Psychiatrist also had been completing CPEs for individuals who had been newly admitted, so that they were performed in a timely manner. The recent CPEs that the Consulting Psychiatrist and the locum tenens Psychiatrist had completed complied with both the format and content specified in the Settlement Agreement. At the time of this review, the Psychiatry Department reported that new CPEs, which followed this outline, had been completed for 50 of the 140 individuals who were receiving psychotropic medication.<br><br>Polypharmacy continued to be an issue, and was being reviewed regularly in the Polypharmacy Committee Meetings.<br><br>This Monitoring Report outlines potential changes to the consent process for medications, in terms of being able to provide guardians with more comprehensive information on side effects. The Psychiatric Team had also refined the information that was used to formulate the Risk versus Benefit Analysis.<br><br>At the time of the prior review, the Facility was in the process of developing a new system to document the communication between the Consulting Neurologist and the Psychiatrist regarding individuals to whom they both provided services. The solution to this problem was to create a system that ensured that the Neurologist reviewed and commented on the most recent Psychiatric Consultation Notes. Each new Neurology Consultation also was discussed and commented on in the next Psychiatry Clinic and documented in the corresponding notes. The current status of this process is discussed with regard to Section J.15.<br><br>The Psychiatry Department, working in conjunction with the Psychology Department, also had made significant progress in relation to the screening of individuals who did not receive psychotropic medication to ascertain if they had any signs of undetected mental illness. Those individuals who were identified as being in need of a mental health evaluation were then referred for a formal CPE.<br><br>At the time of the prior review, an initiative that involved Psychiatry, Psychology, Medicine, and the Pharmacy, had been established to ensure that the development of Pre-Treatment Sedation Medication Plans for medical and dental appointments were well thought out, with input from all of the above disciplines. This process had not been fully implemented and is commented on below. The responsibility |

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| | for the development of the Desensitization Plans for medical and dental appointments continued to reside with the Psychology Department.<br><br>An area that continued to require additional attention was the documentation to empirically demonstrate that the prescribed psychotropic medications were effective. This was especially relevant for those individuals who were receiving multiple psychotropic medications, as it becomes much more difficult to substantiate the efficacy of individual medications, as the number of medications prescribed for a specific individual increases. The determination of the degree to which a specific medication has been helpful is also an integral factor in the risk-benefit analysis, as one cannot fully complete this analysis without having concrete data on both the efficacy of the medication, as well as the perceived and potential side effects of the medication.<br><br>Another factor that will continue to need attention is the identification of the linkage between the psychiatric diagnosis and the identified target behaviors of the prescribed psychotropic medications. The dual classification of behaviors as being both targets of the psychotropic medication, and as being present on a learned basis or as a response to environmental factors, also continued to be problematic.<br><br>Thus, overall, it appeared that the Psychiatry Department had carefully reviewed the monitoring report and had implemented strategies to address a number of the recommendations.<br><br>Although the Psychiatry Department at CCSSLC had definitely made progress in meeting some of the provisions of the Settlement Agreement since the last review, a fundamental issue remained. The Facility relied on only 12 hours per week of psychiatric consultation time to manage the psychotropic medication for 140 individuals, some of whom had very complex psychiatric presentations. However, from a positive perspective, the Psychiatry Department had been able to accomplish a great deal through the diligent work of the two Psychiatric Assistants and the two Psychiatric Nurses at CCSSLC. The infrastructure that they had created, and the ancillary services that they had provided, had made it possible to maximally utilize the limited amount of psychiatry time that was available. |

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| J1 | Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals. | At the time of the review, Dr. Michael Hernandez, who was Board Certified in Adult Psychiatry by the American Board of Psychiatry and Neurology, was CCSSLC's Consulting Psychiatrist. During the interviews, which took place on 7/12/11 and 7/13/11, he indicated that, in addition to his consultation at CCSSLC, he also had provided psychiatric services to individuals with intellectual/developmental disabilities (ID/DD) through his private practice, as well as his work for a community provider of residential services. In addition, he had evaluated and treated outpatients with ID/DD through a local community mental health clinic.<br><br>Dr. Hernandez estimated that he had engaged in providing psychiatric services to | Substantial Compliance |

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| | | individuals with ID/DD for over five years. He had been a psychiatric consultant to CCSSLC for approximately four years. Thus, in addition to being Board Certified in Adult Psychiatry, he also had substantial clinical experience in working with this population and their unique needs.<br><br>During the time period following the last review, the Facility had contracted with Dr. Jason Kirkpatrick through a locum tenens physicians' agency. He was on site for approximately six weeks following the last monitoring review, and was scheduled to return for another two months in the near future. During Dr. Kirkpatrick's tenure at CCSSLC, Dr. Hernandez continued to provide the direct psychiatric services to the individuals receiving psychotropic medication, while Dr. Kirkpatrick focused on completion of the CPEs for individuals receiving psychotropic medication. During the July 2011 review, the Psychiatric Team indicated that Dr. Kirkpatrick's time would again be allocated to completion of the CPEs for individuals receiving psychotropic medication.<br><br>The review of Dr. Kirkpatrick's CV indicated that he was Board Eligible in Psychiatry, having completed a residency at the Institute of Living in Hartford, Connecticut. However, he was not Board Certified in Adult Psychiatry by the American Board of Psychiatry and Neurology. The CV did not specifically indicate if he had any substantial experience working with individuals with intellectual deficits, and he was not available for interview. However the review of the CPEs that he had completed indicated a reasonable degree of clinical familiarity with this population, as evidenced by the differential diagnoses that he considered and the bio-psycho-social formulations that he developed for the individuals that he reviewed. | |
| 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 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 consultations outside of the Psychiatric Clinics.<br><br>Two Psychiatric Nurses and two Psychiatric Assistants supported the Consulting Psychiatrist. The Clinical Nurses and Psychologists on the residential units also worked with the staff of the Psychiatry Department to schedule the Psychiatric Clinics and the Consulting Psychiatrist's direct observations of individuals.<br><br>The goal of the Psychiatry Department at CCSSLC was to have every individual who was prescribed psychotropic medication reviewed by the Psychiatrist on a monthly basis, and directly observed by the Psychiatrist during the quarterly reviews. A sample of 22 | Noncompliance |

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| | | individuals' records (16 percent) who were receiving psychotropic medication was selected for purposes of this review, and the following documents/sections of those records were requested: Face Sheet, Social History, Rights Assessment, Consents for Psychotropic Medication, Consents for Pre-Treatment Sedation Medication, HRC Referral Form and Addendums related to Psychotropic Medication, Behavioral Support section, Hospital section, Psychiatry section, Side Effect section, Pharmacy section, and the Neurology Consultation section. The rationale for the selection of the individuals in the sample was described above in the section entitled, "Review of Following Documents." The review of these records indicated that the goal of conducting both a Monthly and Quarterly Review in the Psychiatric Clinic was documented for the following 18 individuals (82%): Individual #154, Individual #109, Individual #372, Individual #168, Individual #7, Individual #96, Individual #313, Individual #336, Individual #275, Individual #26, Individual #140, Individual #177, Individual #238, Individual #158, Individual #341, Individual #71, Individual #78, and Individual #169.<br><br>The deficiencies in this documentation that were identified in the remaining records were as follows: Individual #105's most recent documentation was dated 4/6/11, Individual #312's most recent documentation was dated 3/16/11, Individual #363's most recent Psychiatric Quarterly was dated 2/15/11, and for Individual #185, no psychiatric Notes were present in the record submitted for review.<br><br>The corresponding goal to have every individual observed by the Psychiatrist at least quarterly was attained for 16 of the individuals in the sample (73%). Those individuals for whom this documentation could not be identified were: Individual #109, Individual #372, Individual #312, Individual #105, Individual #168, and Individual #185. Documentation to indicate that the Consulting Psychiatrist observed these individuals at an alternate time could not be located.<br><br>The review of this sample also indicated that there was a current CPE within the last 18 months for all but the following four individuals: Individual #105, Individual #238, Individual #158, and Individual #7. Thus, a current CPE was located for 18 of the 22 records reviewed (82%). The CPE corresponded to the information and content requirements of the Settlement Agreement for the following seven individuals (32%): Individual #169, Individual #312, Individual #177, Individual #78, Individual #341, Individual #154, and Individual #109.<br><br>The report from the previous monitoring reviews commented on "a lack of the identification of the specific symptoms which supports the *DSM-IV-TR* Axis I and Axis II diagnoses." The Psychiatry team had responded to this observation and the related recommendations by implementing a significant change to the documentation that appeared in many of the Quarterly and Monthly Psychiatric Consultation Notes. That | |

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| | | change involved the identification of symptoms that the individual manifested that were related to the specific identified psychiatric diagnosis. This documentation appeared contiguous to each diagnosis. This process had been fully implemented following the prior review. The current review found that this documentation could be identified in the records of the following 17 individuals (77%): Individual #105, Individual #363, Individual #154, Individual #109, Individual #372, Individual #168, Individual #7, Individual #312, Individual #313, Individual #336, Individual #275, Individual #26, Individual #140, Individual #177, Individual #238, Individual #158, and Individual #341.<br><br>The five records that did not contain this information were those of Individual #78, Individual #71, Individual #169, Individual #185, and Individual #96. However, this appeared to be due either to missing documentation and/or the individual having been recently admitted to the CCSSLC.<br><br>The addition of the listing of the symptoms that relate to the psychiatric diagnosis was an important addition to the clinical documentation. However, the symptoms listed per individual were variable, and were not sufficient in and of themselves to fulfill the criteria for the corresponding diagnosis. Thus, a related but separate issue was whether the records, as a whole, contained sufficient information to support all of the individuals' psychiatric diagnoses. Accordingly, the records also were assessed with regard to whether there was adequate documentation in the records as a whole (including the Psychiatric Clinic Notes, the CPE, and the Psychology section) to conclude that the psychiatric diagnosis of record was justified. This composite documentation was adequate to justify the psychiatric diagnosis for the following six individuals (27%): Individual #154, Individual #105, Individual #177, Individual #341, Individual #313, and Individual #336.<br><br>This documentation was not extensive enough to fully substantiate the related psychiatric diagnosis in terms of all of the symptoms that would be required to fulfill the complete diagnostic criteria set forth in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*, published by the American Psychiatric Association, or the *Diagnostic Manual of Intellectual Disability (DM-ID)*, published by the National Association of Dual Diagnosis (NADD), or the quality standards inherent in the Settlement Agreement for the following individuals: Individual #158, Individual #78, Individual #275, Individual #71, Individual #26, Individual #7, Individual #140, Individual #363, Individual #109, Individual #372, Individual #312, Individual #168, Individual #238, Individual #169, Individual #96, and Individual #185.<br><br>There were four individuals who were judged to have a completed CPE that corresponded to the specifications of the Settlement Agreement (as discussed above), and yet the record did not contain sufficient information to support the working | |

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| | | psychiatric diagnoses identified in the psychiatric clinic notes. The rationale for this determination related to the observation that the CPE for Individual #78 and Individual #169 contained a reasonable discussion of the primary psychiatric diagnosis and the differential diagnosis, based on the available records and initial assessment. However these individuals had only been admitted to CCSSLC very recently, and thus there had not been enough direct observation to confirm the validity of these diagnoses, which were primarily derived from prior observations from the community. The CPEs for Individual #312 and Individual # 109 also contained an adequate discussion of the primary psychiatric diagnosis and the differential diagnosis. However the psychiatric clinic notes listed as many as five Axis I psychiatric diagnoses for these individuals, which were not justified in either the CPE or the remaining sections of the record. This was judged to primarily represent the use of multiple Axis I working psychiatric diagnoses, rather than a deficit in the CPE. The utilization of multiple Axis I psychiatric diagnoses (in the range of three to five) occurred in the records of a number of individuals. The Psychiatry Department might find it instructive to select a subsample of these individuals, and determine the degree to which all of the psychiatric diagnoses can be clinically justified.<br><br>A related issue, which was also identified in the prior reviews, concerned the lack of documentation that would explain how the identified target behaviors (usually aggression, agitation, and/or self-injury) were derived from the psychiatric diagnosis. The review of the relevant records indicated that this linkage in the psychiatric diagnostic process had not yet been addressed. The importance of this issue derives from the observation that the identified "targets" of the psychotropic medication were usually aggression, self-injury, and/or agitation, and not the identified symptoms of the psychiatric disorder. Thus the identification of the linkage between the psychiatric disorder and the identified target behaviors should have been identified to substantiate that the medication was being prescribed to treat a psychiatric disorder and not to suppress an inappropriate/maladaptive behavior that might be present on a behavioral basis.<br><br>A corollary issue is the identification of behaviors that are designated as "targets" of the psychotropic medication, as also being described in the Functional Analysis and Behavioral Support Plans as being present on a learned and/or environmental basis. Discussions with members of the Psychiatry Department indicated that collaboration with the Psychology Department had continued around this issue. However, the review of the records contained in the sample indicated that this dual classification of behaviors as both targets of the psychotropic medication, and as being present on a behavioral basis, still remained problematic. Specifically, this dual classification of behaviors was found in the records of 15 individuals (68%). Those individual records that contained this dual classification were: Individual #105, Individual #158, Individual #7, Individual #109, Individual #372, Individual #312, Individual #26, Individual #140, Individual | |

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| | | #363, Individual #313, Individual #336, Individual #275, Individual #168, Individual #177, and Individual #238. This issue also will be further discussed below with regard to Section J.13 of the Settlement Agreement. | |
| 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 punishment, or for the convenience of the staff. During the review, it was possible to directly observe approximately 64 percent of the 140 individuals who were prescribed psychotropic medication. The identifying information for these individuals is listed above in the section entitled, "Observations of." These observations did not identify any individuals who appeared to be grossly over-medicated with psychotropic medication, as might have been expected, if these medications were used for the convenience of the staff.<br><br>All of the individuals included in the sample who received psychotropic medication had a treatment program and one or more psychiatric diagnoses. However, as discussed above with regard to Section J.2, the documentation was not extensive enough to fully substantiate the related psychiatric diagnosis in terms of all of the symptoms that would be required to fulfill the complete diagnostic criteria. In addition, the dual classification of behaviors as being present on a learned basis and/or secondary to environmental factors, as well as being identified as targets of psychotropic medication, created the impression that psychotropic medications were being utilized to suppress behaviors that would more appropriately have been addressed with non-pharmacological approaches. | 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. | A new initiative that related to this provision of the Settlement Agreement was being developed at the time of the prior review. It involved the establishment of an inter-disciplinary process to ensure the appropriateness and safety of medications that were prescribed for sedation prior to medical and dental appointments. This process included direct input from the Psychiatrist, the Psychiatric Nurse, the Unit Nurse, the Primary Care Practitioner (PCP), the Psychologist, and the Clinical Pharm.D. These reviews were scheduled to occur at the beginning of the Psychiatric Clinics, because all of the disciplines identified above routinely participated, with the exception of the Clinical Pharm.D. The scheduling of the reviews at the beginning of these meetings allowed the Pharm. D. to participate in an efficient manner. The Psychiatry Team also had devised a method to include the review of the documentation in the Psychiatric Quarterly Reviews. This documentation was identified for 20 of the 22 records reviewed (91%). The individuals for whom this could not be identified were those of Individual #312 and Individual #105.<br><br>The system described above was designed to ensure a multidisciplinary discussion of the most appropriate medication to use for an individual for pre-treatment sedation. This provision also discusses the monitoring of the individual after the administration of the | Noncompliance |

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| | | medication for both the efficacy of the medication, as well as the occurrence of any adverse side effects related to the medication. This issue will be investigated in subsequent monitoring reviews.<br><br>Concerns related to the current Desensitization Plans are discussed with regard to Sections C.4 and S of the Settlement Agreement. The purpose of the Desensitization Plans is to provide the individual with the necessary skills to successfully participate in dental or medical procedures without receiving sedative medication prior to the appointment, or to reduce the need for such sedation to the extent possible. Accordingly, the Facility should specifically track information that identifies those individuals for whom the implementation of a behavioral Desensitization Plan has resulted in their no longer requiring pharmacological pre-treatment sedation for dental and medical procedures, or their being a reduction in the use of pre-treatment sedation. | |
| J5 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement. | The prior reviews 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 70 individuals for each Psychiatrist. Many of the individuals who reside at the CCSSLC present with complex psychiatric disorders. The current utilization rates of multiple psychotropic agents for numerous individuals would suggest that this is a reasonable estimate.<br><br>The Facility was relying on one part-time Consulting Psychiatrist to provide the day-to-day psychiatric care to all of the 140 individuals who were receiving psychotropic medication. His allotment of time was 12 hours per week (three four-hour blocks per week). This equated to slightly more than 25 percent of one full-time equivalent Psychiatrist. As noted above with regard to Section J.1, the Consulting Psychiatrist was board certified.<br><br>An additional locum tenens Psychiatrist had been on site on a full-time basis for six weeks following the last review. His time was devoted to completing the CPEs for the individuals who were prescribed psychotropic medication. The Facility confirmed that he was scheduled to return for another two months in the near future, and would again focus on completing the individual CPEs. As noted above with regard to Section J.1, the locum tenens Psychiatrist was board eligible.<br><br>The Psychiatry Department had been able to accomplish a great deal through the diligent work of the two Psychiatric Assistants and the two Psychiatric Nurses at CCSSLC. The infrastructure that they had created, and the ancillary services that they had provided, had made it possible to maximally utilize the limited amount of psychiatry time that was available. However, psychiatrist staffing remained inadequate to meet the psychiatric | Noncompliance |

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| | | needs of the individuals CCSSLC supported.<br><br>During the interview on 7/13/11 with the Facility's Acting Medical Director, she described the efforts that CCSSLC had undertaken to recruit additional psychiatrists, which included an increase in salary, networking with local physicians, and advertising in national publications. Thus, the Facility's administration had been making an active, sustained effort to address this deficiency, but had not yet been successful. | |
| 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. | One Psychiatrist, who worked on a contractual basis, provided psychiatry services at the CCSSLC. The primary contact that the Psychiatrist had with the individuals and their teams took place in the context of the Monthly and Quarterly Psychiatric Clinics. As discussed with regard to Section J.2 of the Settlement Agreement, evidence that the Psychiatrist observed the individual at the quarterly meeting was documented for 16 individuals (73%) from the sample of 22 individual records reviewed. The Psychiatric Nurses, Psychiatric Assistants, and the residential nursing staff, working in conjunction with the members of the Psychology Staff, contributed to the execution of the schedule of Psychiatric Clinic reviews. As noted with regard to Section J.2, evidence that the monthly and quarterly reviews of psychotropic medication took place as scheduled was documented for 18 individuals (82%) from the sample of 22 individual records reviewed. Current Psychiatric Assessments also were identified for 18 individuals (82%) from the sample of the 22 individual records reviewed. Deficiencies related to both the documentation of the Psychiatry Clinics and the CPEs are described in more detail with regard to Sections J.2 and J.13.<br><br>Specific missing documentation that was directly related to this provision of the Settlement Agreement included the information that would link the monitored behavior, such as aggression, agitation, and/or self-injurious behavior (SIB), to the psychiatric diagnosis of record, as well as empirical data that would substantiate that the psychotropic medication had been effective. The latter point is important, in that this information is necessary to justify that the benefits of the medication(s) outweigh the risks that they present, based on their side effect profile(s). | Noncompliance |
| 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 | The Department of Psychiatry at the CCSSLC implemented their first series of the Reiss Screen for Maladaptive Behavior in August of 2009. This process involved the screening of all of the individuals who were not receiving psychotropic medication. The overall administrative responsibility for the implementation of the Reiss Screen resided with the Psychiatry Department. However, the actual interviews with direct support professionals that formed the basis of the screening evaluations were implemented by each individual's Psychologist. The completed protocols were then processed through the appropriate computer software program, and the individuals who were identified as requiring a CPE were referred to the Consulting Psychiatrist for a consultation. | Substantial Compliance |

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| | 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 third round of implementation of the Reiss Screen was begun in 2011. During the Monitoring Team's onsite review, a spreadsheet was requested that included the names of the individuals who were administered the Reiss Screen and the dates of administration. This spreadsheet indicated that the Reiss Screen had been administered to 133 individuals during 2011.<br><br>At the time of the onsite review, the census at the CCSSLC was 272, of which 140 were receiving psychotropic medication and, thus, would have undergone a CPE as part of that process. The combined total of 273 did not correspond to the total Facility census of 272, due to deaths and recent admissions that had occurred at the Facility. The spreadsheet suggested that the Reiss Screen was completed for all of the individuals who were not receiving psychotropic medication. In order to assess the accuracy of the data contained in the spreadsheet, a random sample of 20 percent of the individuals who had been evaluated with the Reiss Screening instrument was identified, and a copy of the Reiss Screening instrument and the computer scoring sheet was requested. This request produced a random sample of 26 individuals who were identified as having been administered the Reiss Screen for Maladaptive Behavior Version 1.1, as well as the dates of administration, and the 26-item scores. None of the individuals selected in the random sample had an elevated score that would have prompted further clinical evaluation. Accordingly, a request was made for documentation concerning all individuals whose scores on the 2011 Reiss Screening assessments were above the clinical cut-off score that would require further clinical evaluation. The specific information requested for these individuals included: the date and results of the Reiss Screening, the date the CPE was completed, and a copy of the actual CPE. A summary of the Reiss-related documentation for these individuals was as follows:<br><br>INDIVIDUAL — REISS ADMININSTRATION DATE — REISS SCREENING SCORE — DATE CPE COMPLETED<br>Individual #48 — 5/18/11 — 11 — 7/5/11<br>Individual #44 — 5/18/11 — 12 — 7/5/11<br>Individual #235 — 5/18/11 — 21 — 7/6/11<br>Individual #208 — 5/18/11 — 9 — 7/6/11<br>Individual #193 — 5/18/11 — 19 — 7/5/11<br><br>These findings indicated that the Facility had developed an effective mechanism for ensuring that individuals who were not receiving psychotropic medication were evaluated with the Reiss Screen and further, that those individuals who were identified as requiring follow-up psychiatric assessment were evaluated by the Psychiatrist in a timely manner. The CPEs that were performed on the individuals who had scores on the | |

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| | | Reiss Screening Instrument that precipitated further clinical assessment were requested and reviewed. The review of these CPEs indicated that they did conform to the format specified in the Settlement Agreement.<br><br>This provision of the Settlement Agreement also indicated that the Reiss Screening Instruments should be administered to individuals who were newly admitted to the Facility, who were not prescribed psychotropic medication. All of the individuals who had been admitted to CCSSLC since the prior review were receiving psychotropic medication at the time of their admission and, thus, had undergone a CPE as part of their assimilation into the ongoing psychiatric clinic process. | |
| 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 evident at the 7/12/11 and 7/13/11 Psychiatric Clinics. The Psychologist who was assigned to the individual being reviewed led the presentation and discussed the behavioral data for the month. When making decisions regarding the use of psychotropic medication, it was clear that the Psychiatrist relied on this information.<br><br>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. However, there were deficiencies in the integration of the psychiatric and psychological perspectives on the individual.<br><br>In the records reviewed, the symptoms that were described as being "targets" of psychotropic medication also were described frequently in the Functional Analysis as being present on an operant basis, as a response to a demand situation, representing an escape behavior, or being related to environmental, stressful events. As discussed with regard to Section J.2, this occurred for 68 percent of the individuals in the sample. 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. Thus, the available documentation indicated that the psychiatric 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/or "self-injurious behavior," rather than the symptoms of an identified psychiatric disorder.<br><br>The integration of psychiatric services with psychological services at CCSSLC could be improved by the integration of 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. For those | Noncompliance |

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| | | individuals for whom both biological and psychological processes are thought to determine the identified behavior, this should be clarified with adequate justification provided to show the connections between each. | |
| J9 | Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition, and whether the individual will best be served primarily through behavioral, pharmacology, or other interventions, in combination or alone. If it is concluded that the individual is best served through use of psychotropic medication, the ISP must also specify non-pharmacological treatment, interventions, or supports to address signs and symptoms in order to minimize the need for psychotropic medication to the degree possible. | This provision describes a collaborative process through which "the Interdisciplinary Team, including the Psychiatrist" shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric condition.<br><br>There was no documentation in the records reviewed that this collaborative process was occurring at the CCSSLC. The Psychiatric Clinics were attended by multiple disciplines, including the PCPs, nursing staff, direct support professionals, Psychology staff, and QMRPs. The composition of the disciplines that attended the Psychiatric Clinics qualified as an Interdisciplinary Team (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 the Psychologist presented. The discussion also included the subjective impressions of other team members, as well as nursing staff's description of any medication side effects. 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 have adversely affected the frequency of the monitored behaviors. The Psychiatrist clearly took this information into account when making decisions.<br><br>Based on the Monitoring Team's review of PSPs in relation to Section F, the Psychiatrist did not attend individuals' PSP meetings. Even when the individual had significant psychiatric issues, the Psychiatrist was not in attendance<br><br>There was no evidence in the 22 records reviewed that there was an inter-disciplinary 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. The lack of this integration was likely affected by the Facility's reliance on 12 hours of psychiatric consultation time to manage the psychotropic medication of 140 individuals, many of whom presented with complex psychiatric presentations. To a certain extent, this allocation of time limited the focus of the Psychiatrist and the Interdisciplinary Team to the most pressing clinical considerations related to psychotropic medications.<br><br>The discussion above with regard to Section J.8 of the Settlement Agreement concerning the lack of integration of psychiatric and psychological services was also relevant to this provision, as is the discussion below with regard to Section J.13. | Noncompliance |

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| 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 examines the importance of carefully assessing the benefits of the utilization of specific psychotropic agents against the risks posed by the side effects of those medications. The primary documentation of this process appeared in the Human Rights section of the individuals' record. This documentation consisted of only limited terminology related to the extent that the benefits of the medication outweighed the risks, and then included 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. These observations applied to all of the records reviewed, and represented inherent deficiencies in the risk versus benefit analysis assessment process and not isolated examples of incomplete documentation.<br><br>The Human Rights review of the psychotropic medication also addressed an individual's entire regimen of psychotropic medication, rather than discussing each individual medication separately. The rationale for this policy appeared to be the perception that the prescribed psychotropic medications constituted a Medication Treatment Plan. This policy obfuscated the risk inherent in the utilization of each medication. It also impeded the ability to assess a specific medication's efficacy, which is a factor that is central to the risk versus benefit analysis. In addition, as the number of medications increase, the possibility of pharmacological interactions between the different agents increases exponentially.<br><br>The Psychiatry Department recently had developed a tool that would provide a more thorough and balanced examination of the risk versus benefits considerations in the use of psychotropic medication. This instrument was only at the initial stages of implementation and, therefore, its impact will be assessed in future reviews.<br><br>During the onsite review, a member of the Monitoring Team had discussions with the Psychiatric Team and the Pharm. D. regarding reference sources, such as Micromedix (which the Facility currently has access to) that are able to provide medication-specific side effect data. This data provides the actual percentages with which adverse effects have been experienced in the general population. The utilization of actual percentages, coupled with an indication of which potential side effects are in the serious, life-threatening category, as opposed to those that are of minor physical consequence, would enhance the clarity of these factors which are an integral component of the risk versus benefit analysis. | Noncompliance |
| 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 | 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 (most recent meeting held on 6/29/11). The documentation from the minutes identified the | Noncompliance |

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| | 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. | Psychiatric Assistant as the primary facilitator, and the following individuals who would typically attend this meeting as follows: Psychiatrist, Psychiatric Assistant, Clinical Psychologist, Clinical Pharmacist, Psychiatric RN, QMRP Coordinator, M.D., and PCP.<br><br>A Psychiatric Assistant prepared the minutes of the meeting. 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 the use of such medications is clinically justified and that medications that are not clinically justified are eliminated." The clinical justification for 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 and with regard to Section J.13 of the Settlement Agreement.<br><br>In response to a recommendation made in prior monitoring reports, the Psychiatry Department had begun to incorporate longitudinal data into the content of the monthly minutes of the Polypharmacy Committee Meetings. This data was presented in both tabular and graphic formats. The statistical data indicated that as of the 6/29/11 Meeting, 137 individuals were receiving psychotropic medication. This figure did not correspond to the number of 140 individuals receiving psychotropic medication at the time of the Monitoring Team's onsite review, because the information regarding recent admissions had not yet been incorporated into the database. The distribution with regard to the number of individuals who were prescribed multiple psychotropic medications was as follows:<br><br>NUMBER OF PSYCHOTROPIC MEDICATIONS — NUMBER AND PERCENTAGE OF INDIVIDUALS<br>One or Two — 59 (41.5%)<br>Three — 40 (29.1%)<br>Four — 26 (18.9%)<br>Five — 7 (5%)<br>Six — 4 (2.9%)<br>Seven — 1 (less than 0.5%)<br><br>These frequencies were not significantly different from those reported in the prior monitoring report. A comparison of the current polypharmacy statistics with the October 2010, data indicated that the greatest progress had been realized in the category of intra-class polypharmacy, which declined from 25 percent (N=37 of 147 individuals receiving psychotropic medication) in October 2010, to 18.2 percent (N=25 of 137 total | |

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| | | individuals receiving psychotropic medication).<br><br>The tables and graphs of the polypharmacy statistics contained monthly data points between October 2010 and June 2011. The number of individuals (expressed both as an absolute number and as a percentage of the total number of individuals receiving psychotropic medication) did not vary significantly throughout this time frame for the number of individuals prescribed one, two, and three psychotropic medications. The percentage of individuals receiving four psychotropic medications had actually increased by five percent, from 13.6 percent (N=20) in October 2010 to 18.9 percent (N=26) in June 2011. The percentage of individuals receiving five psychotropic medications has decreased from 9.5 percent (N=14) in October 2010, to five percent (N=7) of June 2011. The total number receiving six psychotropic medications has consistently been in the range of three to four throughout this time period. The corresponding frequency for those prescribed seven psychotropic medications has also been in a similar range between three (October 2010) and one (June 2011).<br><br>As indicated above, this provision of the Settlement Agreement focuses not only on the quantitative-numerical aspects of polypharmacy, but also addresses qualitative-clinical factors, chief of which is the "clinical justification" of those polypharmacy medication regimens that are considered to be necessary to maintain the individuals' psychiatric stability. The minutes of the Polypharmacy Meetings indicated that there were detailed clinical discussions of individuals whose pharmacological regimens met the criteria for polypharmacy. The aspects of these discussions, which relate to the "clinical justification" for the continued use of polypharmacy, frequently were subjective in nature. For example, Individual #363 was receiving Zyprexa 20 milligrams (mg) twice a day (BID), in addition to Ativan 1 mg three times a day (TID), and Tenex 1 mg BID. The observation that the Zyprexa dose was higher than the usually accepted Federal Drug Administration (FDA) approved range of 20 mg per day was discussed during the 6/29/11 meeting. The justification for its continued use at this dosage was that this dose was "within limits of normal clinical practice per psychiatrist; also of note, patient appears to benefit from this medication." The observation that an individual "appears to benefit" from a medication does not meet the criteria for "clinical justification." This is not an isolated example, but rather was indicative of the degree of subjective evidence put forth in several of the individual discussions as justification that a particular psychotropic medication was necessary for an individual's continued stability.<br><br>In order for the Facility to achieve compliance with this provision of the Settlement Agreement, clinical justification of the use of multiple medications for the individuals who reside at the CCSSLC will need to be more empirically based, as described below with regard to Section J.13 of the Settlement Agreement. | |

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| | | The Facility should consider establishing a separate database to initially track the polypharmacy related to individuals who have been newly admitted, as the number of psychotropic medications they had been prescribed would negatively skew the Facility's statistics regarding polypharmacy. | |
| J12 | Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly. | The policy at the CCSSLC was to administer the MOSES on a quarterly basis for all individuals receiving psychotropic medication. A Psychiatric Nurse administered these evaluations for individuals who were receiving psychotropic medication. To assess for compliance, a sample of 22 of the individuals who were receiving psychotropic medication (16%) was selected. A review of the medical records for those individuals contained documentation that a MOSES evaluation had been performed on a quarterly basis over the last year, and was current for the following 19 individuals (86%): Individual #154, Individual #313, Individual #336, Individual #275, Individual #26, Individual #140, Individual #312, Individual #109, Individual #105, Individual #168, Individual #177, Individual #238, Individual #158, Individual #78, Individual #71, Individual #96, Individual #7, Individual #341, and Individual #169. Those individuals whose records did not comply with this Provision were Individual #363, Individual #185, and Individual #372.<br><br>The Facility also had developed a policy related to the timely review of the MOSES documentation by the Psychiatric Nurse. This policy addressed the importance of having both the MOSES and the DISCUS reviewed by the prescribing physician within seven calendar days of its completion. The review of the sample of records described above indicated that the prescribing physician had reviewed the MOSES in a timely manner for the following seven individuals (32%): Individual #154, Individual #238, Individual #78, Individual #71, Individual #341, Individual #109, and Individual #169. For the remaining individuals, problems included the lack of signatures at all, or reviews that had occurred outside of the seven-day policy requirement.<br><br>A Psychiatric Nurse also performed the Dyskinesia Identification System: Condensed User Scale on a quarterly basis for all of the individuals who receive antipsychotic medication. Review of the random sample indicated that documentation of current and quarterly evaluations for the last year could be identified for the following individuals: Individual #313, Individual #336, Individual #275, Individual #26, Individual #140, Individual #312, Individual #105, Individual #168, Individual #177, Individual #238, Individual #158, Individual #78, Individual #71, Individual #96, Individual #7, Individual #341, and Individual #169. The record of Individual #154 did not contain documentation of a DISCUS. However, this individual was not receiving an antipsychotic agent and, thus, a DISCUS was not required, resulting in a compliance rate of seventeen out of 21 individuals (81%). Those individuals whose records did not contain documentation that the DISCUS had been completed on a quarterly basis and the related | Noncompliance |

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| | | deficiencies were as follows: Individual #363, Individual #185, Individual #372, and Individual #109.<br><br>As noted above, the Facility had also recently developed a policy related to the timely review of the DISCUS by the prescribing physician. The individuals in the sample whose records indicated that the DISCUS had been reviewed in a timely manner were those of the following eight individuals (38%): Individual #177, Individual #238, Individual #78, Individual #71, Individual #341, Individual #169, Individual #109, and Individual #363. The remaining either did not have signatures, or the review was completed outside of the timeframe that Facility policy required.<br><br>The MOSES also was performed at CCSSLC for those individuals who received Reglan. The rationale for this was that although Reglan is used to treat severe Gastroesophageal Reflux Disease (GERD), it also has dopamine-blocking properties that are similar to those of some of the antipsychotic agents and can, thus, also produce extrapyramidal motor side effects. The Clinical Nurses on the residential units performed the MOSES 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 MOSES for the last year was requested for every second remaining individual (50%). This process identified the following nine individuals: Individual #266, Individual #137, Individual #15, Individual #124, Individual #130, Individual #205, Individual #272, Individual #127, and Individual #245. The documentation that was provided by CCSSLC in response to this request indicated that the MOSES had been completed quarterly, and was current for eight of the nine individuals (89%). Those individuals were: Individual #266, Individual #137, Individual #15, Individual #124, Individual #130, Individual #205, Individual #127, and Individual #245. The only individual whose record did not contain documentation of a quarterly review was Individual #222, for whom there was a gap between 12/8/10 and 5/29/11.<br><br>The records also were reviewed for evidence that the prescribing physician had completed a timely review and signed the form. The MOSES had been reviewed in a timely manner for the following four individuals (44%): Individual #137, Individual #124, Individual #127, and Individual #245. The remaining individuals' MOSES had been signed, but they showed a review outside of the allotted timeframe.<br><br>The same sample also was reviewed for the completion of the DISCUS evaluation. This review indicated that the DISCUS had been completed quarterly and was current for the following eight individuals (89%): Individual #266, Individual #137, Individual #15, Individual #124, Individual #130, Individual #205, and Individual #127. The only deficiency was for Individual #222 (gap between 12/8/10 and 5/29/11). The records of | |

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| | | these individuals also were reviewed with regard to the prescribing physician's timely review/signature. The records of the following four individuals (44%) indicated a timely review: Individual #137, Individual #15, Individual #124, and Individual #245. The remaining had been reviewed/signed outside of the timeframe that Facility policy required.<br><br>The psychiatric nurses had developed a system that should have ensured that the side effect monitoring for each individual occurred at the specified intervals. Thus the Psychiatry Department might want to investigate the degree to which the deficiencies in the documentation of the MOSES and DISCUS were due to problems with the filing of the forms in the individuals' records, as opposed to actual failures in completing the examinations. | |
| J13 | Commencing within six months of the Effective Date hereof and with full implementation in 18 months, for every individual receiving psychotropic medication as part of an ISP, the IDT, including the psychiatrist, shall ensure that the treatment plan for the psychotropic medication identifies a clinically justifiable diagnosis or a specific behavioral-pharmacological hypothesis; the expected timeline for the therapeutic effects of the medication to occur; the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatment's efficacy, by whom, when, and how this monitoring will occur, and shall provide ongoing monitoring of the psychiatric treatment identified in the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly. | This provision of the Settlement Agreement addresses three significant inter-related factors that are central to the appropriate use of psychotropic medication for individuals with ID/DD. These factors include: 1) The 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 three factors, a sample of 22 individuals who were receiving psychotropic medication (16%) was chosen based on the selection criteria described in the "Review of Following Documents" section, which appears at the beginning of this section of the report.<br><br>At the time of the initial reviews, a significant finding was the inability to locate documentation in the records that would describe the presence of the symptoms necessary to support the psychiatric diagnosis of record. The Psychiatry Department responded to the recommendations related to this finding by developing a system that identified the symptoms related to a psychiatric diagnosis next to that diagnosis in both the monthly and quarterly Psychiatric Clinic Notes. This system had been fully operational for a number of months prior to the current review. The number of symptoms listed varied between individual diagnoses. However, overall, this represented a positive response to the previously identified deficiencies in this regard. The current review found that adequate symptomatic support for the psychiatric diagnoses could be identified in six of the 22 records reviewed (27%). This finding is discussed in greater detail above with regard to Section J.2. However, this incremental improvement does not fully reflect the significance of this positive change. The observation that there is now a mechanism for identifying the symptoms in both the Quarterly Psychiatric Notes and the CPE indicates that, over time, the Facility should be able to expand this documentation to a degree that will meet the requirements of the Settlement Agreement. | Noncompliance |

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| | | A related issue in the prior reviews was the lack of documentation linking the monitored target behavior to 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, and agitation. Based on the current review, 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. This could be effectively addressed through active collaboration with the Psychology Department, and would benefit from further integration of the Psychology and Psychiatric Treatment Plans.<br><br>As noted above, with regard to Sections J.2 and J.8, these behaviors (aggression, SIB, and agitation) also were often identified in the Functional Analysis and Behavioral Support Plan as being present on a learned-behavioral basis, representing a response to demand situations, and/or were used by the individual to escape or avoid a situation. During the discussions with members of the Psychiatry Department, they indicated that there had been initial collaboration with the Psychology Department concerning this issue. 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 sample in the prior review.<br><br>The current review found adequate differentiation between behaviors that were identified as targets of psychotropic medication and those that were thought to be present on a learned/environmental basis in the records of 15 individuals (68%) in the sample. The specific information regarding the individuals whose records contained this dual classification of behaviors is provided with regard to Section J.2.<br><br>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 had both biological and behavioral determinants, 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 might 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.<br><br>As noted above, another important aspect of this provision relates to the effectiveness of the psychotropic medication. The behavioral data that was present in the sample from | |

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| | | the prior monitoring review 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 significant contribution to this deficiency was the lack of any baseline data that could be compared to the contemporary data to determine efficacy. This problem was carried over into the current review. With the exception of one individual (Individual #154), there was insufficient information to indicate that the existing psychotropic medication had been of therapeutic benefit.<br><br>The Psychiatry Department had added a column to the listing of the psychotropic medications in the Monthly and Quarterly Psychiatric Clinic notes, which identified the expected time frame for the therapeutic effects of the medication to be realized. However, the utility of this information was hampered by the lack of adequate behavioral data that would allow one to determine if these timelines had been met. In addition, this information was not commented on in the narrative discussions of the Medication Treatment Plans, nor did it appear to affect clinical decisions related to the continuation of the medication. The members of the Psychiatry Team, working in collaboration with the Psychology Department, should be able to construct data collection and reporting systems that make this type of historical 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 could also provide this information, but can be cumbersome to maintain. This issue was discussed with members of both the Psychiatry and Psychology Departments during the most recent onsite review. One mechanism for beginning to initiate this process would be to identify those individuals for whom the PST believes there has been unequivocal evidence that a particular medication has been effective and then devise a way to illustrate this positive response. This exercise could produce a template that could then be used throughout the population of individuals receiving psychotropic medication. | |
| 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 | The individual's LAR or the Facility Director signed the informed consents for the use of psychotropic medication at the CCSSLC. In the sample reviewed, the LAR signed the consent documentation for seven individuals (32%). The Facility Director signed the informed consent forms for 13 individuals (59%) who did not have a LAR. The guardianship status could not be identified in the available documentation for two individuals who recently had been admitted to CCSSLC (Individual #78 and Individual #71). Signed consents for psychotropic medication also could not be identified for these individuals. | Noncompliance |

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| | procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks. | This review indicated that signed consent documentation was consistently being obtained for the individuals who resided at the CCSSLC, other than the exceptions noted above. However, the Risk versus Benefits section in the records, as discussed with regard to Section J.10, were so minimal and formulaic in nature that it is doubtful the information presented to the LAR or Facility Director would have been sufficient to provide a truly informed decision.<br><br>The integrity of the risk versus benefit determination process is inherently linked to the informed consent process. The implementation of the changes in the sections of the record related to the risk versus benefit consideration in the use of psychotropic medication, as discussed above with regard to Section J.10, 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. | |
| 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 prior monitoring reports identified deficiencies in the communication of relevant clinical information between the Psychiatrist and the Neurologist, related to individuals who were followed by both disciplines. In response to these observations, the Psychiatry Department developed a system that was intended to enhance the communication between the two disciplines. This system, which was facilitated by the Psychiatric Nurses, would ensure that any recent Neurological Consultations would be reviewed and documented during the next Quarterly Psychiatric Clinic for that individual. Furthermore, the Neurologist also would be made aware of the individual's psychotropic medication, as well as recent changes in those medications, prior to the next scheduled Neurological Consultation. This process had been fully implemented in the months prior to the current review and, thus, was assessed by reviewing the completion rate for this documentation in the sample of 22 individuals described above.<br><br>In order to assess the efficacy of this process, the Neurology section of the records for the 22 individuals were requested. Review of this documentation indicated that the Consulting Neurologist had seen the following individuals in consultation within the last 18 months: Individual #158, Individual #109, Individual #372, Individual #313, Individual #26, Individual #140, Individual #154, and Individual #363.<br><br>The most recent Neurology Notes for four of these eight individuals (50%) contained reference to the psychotropic medications and the related psychiatric treatment, including the following individuals: Individual #313, Individual #363, Individual #372, and Individual #158. The psychiatric treatment was not alluded to in the records of Individual #26, Individual #140, Individual #363, and Individual #154.<br><br>Reference to the most recent Neurology Consult was located in the Psychiatric Clinic | Noncompliance |

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| | | Notes for the following five of the eight individuals (63%): Individual #313, Individual #154, Individual #109, Individual #372 and Individual #158. A specific reference to the most recent Neurological Note was not present in the Psychiatric Clinic documentation for Individual #26, Individual #140, and Individual #109.<br><br>The system that the Psychiatry Team had developed to ensure that the written communication occurs between the Consulting Psychiatrist and the Neurologist was simple, and should prove to be clinically effective when fully implemented. As noted above, this system had only been fully implemented within the last several months. The utility of this process will be further assessed in subsequent monitoring reviews. This system in and of itself might not prove to be sufficient to address the requirement of this provision, which requires that the neurologist and psychiatrist "coordinate" the use of medication. However, it does form the basis for the necessary communication in light of the fact that the current staffing deficiencies do not allow for direct communication between the psychiatrist and neurologist through joint neurology and psychiatry clinical rounds. | |

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

1. Additional psychiatry staffing to complete a contemporary CPE for each individual that receives psychotropic medication in a manner that complies with the format specified in the Settlement Agreement should be provided. (Sections J.2, J.3, J.6, J.8, J.9, and J.13)
2. Information should be included in the CPEs that describes the symptoms that support the psychiatric diagnosis, identifies the linkage between the psychiatric diagnosis and behavioral targets of the psychotropic medications, and documents the efficacy of the psychotropic medications. (Sections J.2, J.3, J.6, J.8, J.9, and J.13)
3. The Facility should conduct an in-depth review of five individuals who have four or more operational Axis I psychiatric diagnoses to ascertain to what degree they meet the criteria set forth in accepted sources, such as the *DSM-IV-TR*, or the *DM-ID*, which is published by the National Association for Dual Diagnosis. Based on what is learned from this process, individuals with similar lists of psychiatric diagnoses should be reviewed. (Sections J.2, and J.6)
4. The Psychiatry and Psychology Departments should investigate and address the dual classification of individual behaviors as both targets of the psychotropic medication and as being described in the Functional Analysis and Positive Behavior Support Plan as being present on a learned basis or as a response to environmental factors. 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. (Sections J.2, J.3, J.8, J.9, and J.13)
5. With regard to the integration of psychiatric and psychological data-collection system:
    a. The noticeable progress that the Psychiatry Department has made in identifying the symptoms related to an individual's psychiatric diagnosis should be included in the data-collection systems that are maintained in the individual residences and incorporated into the behavioral data that the Psychology Department maintains.
    b. The Psychiatry and Psychology Departments should collaborate to develop a method to substantiate the link between the symptoms of an individual's psychiatric disorder and the identified target behaviors of the prescribed psychotropic medication, such as aggression, SIB, and agitation. (Sections J.2, J.3, J.6, J.8, J.9, and J.13)
6. Procedures and individualized programs should be developed and implemented that will decrease the reliance on psychotropic medication for

pre-treatment sedation of individuals for medical and dental procedures. (Section J.4)

7. Psychiatry staffing should be increased to the two full-time equivalent positions currently allotted to CCSSLC. (Sections J.5)
8. The Treatment Plans for the use of psychotropic medications should be integrated 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. (Sections J.2, J.8, J.9, J.10, and J.13)
9. The Risk versus Benefit Analysis/Human Rights approval process should be revised with a view toward assessing the risks and benefits presented by each prescribed medication and in a manner that more fully articulates the probability of the potential benefits of the medications, as well as any potential risks. (Sections J.9, J.10, and J.14)
10. With regard to the monitoring and reduction of polypharmacy with psychotropic medication:
    a. Improvements in the systems for identifying and monitoring the symptoms of psychiatric diagnoses should be made;
    b. The link should be established between the psychiatric diagnosis and the identified target behaviors of the psychotropic medication; and
    c. There should be an empirical demonstration that the prescribed medications have been clinically effective. (Sections J.3, J.9, J.11, and J.13)
11. With regard to the completion of side effect monitoring:
    a. The Facility should implement its newly developed policy requiring the prescribing physician to review and sign the MOSES and DISCUS side effect rating instruments in a timely manner.
    b. The factors that contribute to the deficiencies in the completion rates of the MOSES and DISCUS side effect ratings should be investigated and addressed. (Section J.12)
12. With regard to the efficacy of medications:
    a. 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.
    b. An exercise that the Facility should consider to facilitate this process would be to gather the data available that can be utilized to substantiate the efficacy of the prescribed psychotropic medications for a small number of individuals for whom they believe the prescribing medications have definitely been effective, and pilot a data collection system with them. Once a system is tested and revised as appropriate, it could be used Facility-wide. (Sections J.3, J.8, J.9, J.10, and J.13)
13. The newly developed process to facilitate communication between the Consulting Psychiatrist and Neurologist and develop strategies to track the efficacy of this process should be implemented fully. The factors that have impeded the full implementation of this process should be investigated and corrected. (Section J.15)
14. The internal review processes should be further refined to include quality parameters in addition to completion rates where appropriate. (Facility Self-Assessment)
15. In addition to the important narrative information that describes the efforts undertaken to achieve compliance, data collected as part of the Facility's internal auditing and review process should be analyzed and summarized in the POI. (Facility Self-Assessment)

The following are offered as additional suggestions to the State and Facility:

1. The Facility might want to consider developing a parallel polypharmacy tracking system for newly admitted individuals, as their polypharmacy regimens of psychotropic medications negatively skew the Facility's statistical progress in reducing polypharmacy. Information related to the medications regimens of individuals admitted to the Facility, in conjunction with the successful reductions of these medications over time also might provide the State Office with important information about the quality of psychiatric and/or behavioral supports in community settings.

| SECTION K: Psychological Care and Services | |
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| 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:<br>▪ **Review of the Following Documents**:<br>o Presentation Book and Opening Visit Presentation Notes, Section K, completed by Dr. Cam Cramer, Clinical Psychologist;<br>o Copies of Master of Science Diploma, Texas State Board of Examiners License, and Board Certified Behavior Analyst (BCBA) Certificate for Judy Sutton;<br>o Copies of Resume, and BCBA Certificate for Christine Soilz;<br>o Board Analyst Certification Board (BACB) Fieldwork and Practicum Experience Supervision Forms for Dr. Cramer, dated February to April 2011;<br>o BACB Fieldwork and Practicum Experience Supervision Forms for Everett Bush, dated 7/7/11;<br>o BACB Fieldwork and Practicum Experience Supervision Forms for Samantha Mendoza, dated 7/7/11;<br>o Emails documenting off-site case review and consultation of Robin Palmer Blue, BCBA;<br>o CCSSLC Psychological and Behavioral Services Policies, including the following documents that were revised on 7/1/10, approved on 7/9/10, and implemented on 8/9/10): 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;<br>o Summary of Behavioral Services Position Credentials, updated 6/7/11;<br>o Summary of Coursework Completed (and enrolled) of Behavioral Services staff;<br>o Invoice for payment of online courses for the University of North Texas, dated 7/1/11;<br>o Summary of budgeted positions (total, filled, and unfilled) within behavioral services;<br>o Behavior Support Committee (BSC) meeting minutes, dated 1/4/11 through 5/31/11;<br>o Supplemental External Peer Review (SEPR) meeting minutes, dated 2/16/11, 3/16/11, 4/20/11, and 5/25/11;<br>o SEPR emails, dated 2/7/11, 3/24/11, 4/12/11, and 4/19/11;<br>o Behavioral Sciences Database Spreadsheet: Psychological Exams – Due Dates and Delinquency Report, dated 7/15/11;<br>o Behavioral Sciences Database Spreadsheet: Individuals with Desensitization Plans, dated 7/15/11;<br>o Behavioral Sciences Database Spreadsheet: Individuals with Structural Functional Behavior Analyses (SFBAs), dated 7/15/11;<br>o Behavioral Sciences Database Spreadsheet: Individuals with Positive Behavior Support Plans (PBSPs), dated 7/15/11;<br>o Behavioral Sciences Database Spreadsheet: Individuals with Safety Plans for Crisis Intervention (SPCIs), dated 7/15/11;<br>o Sample for Section K.4: Positive Behavior Support Plans, Safety Plans for Crisis |

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| | Intervention as appropriate, and PSP Monthly Behavioral Services Reviews, for the last three months, as available, for: Individual #186, Individual #58, Individual #200, Individual #275, Individual #9, Individual #174, Individual #114, Individual #268, Individual #335, Individual #109, Individual #16, Individual #7, Individual #312, and Individual #105;<br>o CCSSLC Behavior Support Committee (BSC) Review and Approval Cover Sheet for Psychological Evaluation/Update, Structural and Functional Behavior Assessment, Positive Behavior Support Plan, Safety Plan for Crisis Intervention, Desensitization Plans, Referrals (counseling, psychiatric, at-risk, supplemental external peer review), Progress Review, and Counseling Review, revised 5/20/11;<br>o Sample for Section K.6: Psychological Evaluations and Inventory for Client and Agency Planning (ICAP), as available, for: Individual #379, Individual #186, Individual #58, Individual #200, Individual #275, Individual #9, Individual #114, Individual #268, Individual #109, Individual #16, Individual #155, Individual #71, Individual #161, Individual #372, Individual #105, and Individual #363;<br>o CCSSLC Structural and Functional Behavior Assessment revised template, dated 6/1/11;<br>o CCSSLC Psychological Evaluation/Update, revised template, dated 6/1/11;<br>o CCSSLC – Counseling Treatment Plans, as provided, for: Individual #140, Individual #357, #325, Individual #246, Individual #94, Individual #7, Individual #289, Individual #300, Individual #275, and Individual #26;<br>o CCSSLC List of Individuals currently receiving counseling;<br>o Counseling Progress Notes, as provided, for: Individual #318, Individual #7, Individual #275, Individual #140, Individual #246, Individual #6, Individual #357, Individual #94, and Individual #325;<br>o CCSSLC Positive Behavior Support Plan template, dated 6/1/11;<br>o CCSSLC Safety Plan for Crisis Intervention template, dated 6/1/11;<br>o List of tools for assessment for psychological and behavioral services;<br>o Sample for Section K.5: Structural and Functional Behavioral Assessment for: Individual #275, Individual #9, Individual #363, Individual #105, Individual #48, Individual #96, Individual #141, and Individual #140;<br>o Sample for Section K.9: Positive Behavior Support Plans for: Individual #275, Individual #268, Individual #7, Individual #9, Individual #335, Individual #109, Individual #16, Individual #200, Individual #58, and Individual #186;<br>o Competency Check for Behavior Support Plan, provided examples from April to June 2011;<br>o CCSSLC Psychological and Behavioral Services – Meeting Minutes from Competency Based Training Workgroup meetings, dated 2/11/11, 2/18/11, and 2/22/11;<br>o Summary data of Competency Check PBSP/BSE/SFBA Report, dated 6/7/11; and<br>o CCSSLC Review and Approval Cover Sheets, revision date of 5/20/11, for: Behavioral Support Committee, Structural and Functional Behavior Assessment, Positive Behavior Support Plan, Safety Plan for Crisis Intervention, Desensitization Plan, Referrals, Progress Review, and Counseling Review. |

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| | ▪ **Interviews and Meetings with**:<br>o Iva Benson, Facility Director; Mark Cazalas, Assistant Director of Programs; and Bruce Weinheimer, State Office Coordinator, on 7/11/11;<br>o Dr. Robert Cramer, Clinical Psychologist; Bruce Weinheimer, State Office Coordinator; and Erin Lewis, on 7/11/11;<br>o Bruce Boswell, Active Treatment Director and Interim Acting Chief of Behavioral Services; Bruce Weinheimer, State Office Coordinator; and Judy Sutton, incoming Director of Behavioral Services, on 7/12/11;<br>o Dr. Robert Cramer, Clinical Psychologist; Erin Lewis; and Bruce Boswell, Active Treatment Director and Interim Acting Chief of Behavioral Services, on 7/12/11;<br>o Meeting with PST to discuss at-risk issues for Individual #247, on 7/12/11;<br>o Bruce Boswell, Active Treatment Director and Interim Acting Chief of Behavioral Services; Rachel Rodriquez, QMRP Coordinator; and Jim Sibley, Ric Savage, and Sally Schultz, State Consultants, on 7/12/11;<br>o Daniel Dickson, Quality Assurance Director; Araceli Metehuala, Program Compliance Monitor; and Karen Ryder, Program Compliance Monitor, on 7/13/11;<br>o Meeting with PST to discuss at-risk issues and process for Individual #275, on 7/13/11;<br>o Bruce Weinheimer, and Judy Sutton, incoming Director of Behavioral Services, on 7/13/11;<br>o Kimberly Benedict, Program Coordinator; Sandra Martinez, Socially Responsible Behavior (SRB) and Adult Life Skills (ALS) Supervisor; Pat Zygorski, The Harbor class room teacher; Savana Kirk; and Judy Sutton, incoming Director of Behavioral Services, on 7/14/11;<br>o Robyn Palmer Blue, M.A., BCBA; and Judy Sutton, M.A., BCBA, incoming Director of Behavioral Services, on 7/14/11;<br>o Dr. Robert Cramer, Clinical Psychologist; and Judy Sutton M.A. BCBA, incoming Director of Behavioral Services, on 7/14/11;<br>o Bruce Boswell, Active Treatment Director and Interim Acting Chief of Behavioral Services; and Judy Sutton, M.A. BCBA, incoming Director of Behavioral Services, on 7/14/11; and<br>o Jim Sibley, Ric Savage, and Sally Schultz, State Consultants, on 7/14/11.<br>▪ **Observations Conducted**:<br>o Observation and discussion with staff members at the Behavioral Support Committee Meeting, on 7/12/11;<br>o Observation and discussion with staff members at the Skill Acquisition Review Committee meeting, on 7/13/11;<br>o Observation of Personal Support Team members at the Personal Support Plan Meeting for Individual #353, on 7/14/11;<br>o Observation of PBSP training conducted Psychological Assistant, on 7/14/11;<br>o Observation of treatment integrity checks of skill program implementation for Individuals at Apartment 517 and Apartment 522B, on 7/14/11;<br>o Onsite direct observation, including interaction with direct support professionals, and other professionals including residence coordinators, psychologists, psychology assistants, home team leaders and assistants, active treatment supervisors, active |

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| | treatment specialists, community integration specialists, vocational coordinators, rehabilitation therapy technicians, and/or QMRPs were conducted throughout the morning, day, and/or evening hours at the following residential and day programming, and habilitation sites:<br>▪ Apartment 516 (Sanddollar), on 7/11/11;<br>▪ Apartment 522A (Kingfish 1), on 7/11/11;<br>▪ Apartment 522D (Kingfish 4), on 7/11/11;<br>▪ Apartment 522 C (Kingfish 3), on 7/11/11;<br>▪ Apartment 524A (Ribbonfish 1), on 7/12/11 and 7/13/11;<br>▪ Miracle Field, on 7/12/11;<br>▪ Ribbonfish 2, on 7/13/11;<br>▪ Apartment 524D (Ribbonfish 4), on 7/13/11;<br>▪ Apartment 514 (Dolphin), on 7/13/11;<br>▪ Apartment 522B (Kingfish 2), on 7/13/11;<br>▪ Apartment 517 and 522B, on 7/14/11;<br>▪ Angel Day Program, on 7/15/11;<br>▪ The Harbor Program for Individuals with Autism, on 7/15/11; and<br>▪ The Outer Reef Day and Vocational Program, on 7/15/11. |
| | **Facility Self-Assessment:** As previously noted, the Facility developed a Plan of Improvement with regard to Section K of the Settlement Agreement. This POI contained outcomes, action steps, required evidence, facility target dates, completion status, judgment on current noncompliance or substantial compliance, and additional comments. According to the current POI, CCSSLC indicated that it was in noncompliance with all provisions within Psychological Care and Services (Sections K.1 to K.13). This finding was consistent with the Monitoring Team's review.<br><br>As previously reported, the Facility also developed a self-assessment tool based on the Monitoring Teams' Section K rubric. Current verbal reports, as well as documentation provided indicated that QA staff and behavioral services staff members had been completing ongoing regular reviews. This included the completion of 12 Section K monitoring tools between March and May 2011. Scores on these reviews, as reported in the QA/QI summary sheets, ranged from 36% to 95%. However, it was unclear how overall compliance scores were being calculated, because the indicators on the tools had not been weighted, and the tools were not designed to provide an overall score. Verbal reports with staff completing these tools indicated that this process was still in its development phase. The auditors continued to meet (i.e., multiple conciliation meetings had been held), and were continually revising the tool and process to ensure more accurate measurement (i.e., less subjectivity), as well as more valid quality indicators. |
| | **Summary of Monitor's Assessment:** In general, progress was noted in the area of psychological care and services. Observations across all the staff members within behavioral services reflected sincere desire and effort to improve the quality of psychological supports to all residents at CCSSLC and meet the requirements of the Settlement Agreement. |

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| | A majority of behavioral services staff continued to improve in their development of professional competencies, as they progressed through the necessary coursework toward the BCBA certification. In addition, some of the more advanced students had started to obtain the necessary supervision. The recent hiring of a BCBA as the Director of Behavioral Services, as well as contracting with a second BCBA should support the continued improvement of behavioral services.<br><br>Progress in the area of peer review was also noted as the internal peer review process had been revised to expand its oversight of additional behavioral services (e.g., counseling services, monthly reviews, etc.) and an additional external peer review process had been initiated.<br><br>Substantial concerns remained regarding the nature of data collection, data reliability, data display, and the utilization of data in PST decision-making.<br><br>Progress was observed in the area of psychological assessments. Behavioral services staff continued to complete comprehensive SFBAs, and a process to conduct standardized tests of intelligence was initiated. Although improved, concerns remained regarding the adequacy of SFBAs and counseling treatment plans.<br><br>Limited progress was observed in the area of PBSPs, since the previous review. Although a comprehensive process was in place to ensure the quality and timeliness of PBSPs, the quality of the plans remained inadequate. It continues to be anticipated that, as professional competencies in ABA develop through coursework and supervised training, the quality of the PBSPs will continue to improve over time.<br><br>Concerns continued to be noted with regard to the limited progress in monitoring and ensuring adequate competency-based training to direct support professionals, as well as treatment integrity of behavioral programming. |

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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 | Many of the Behavioral Services staff had made progress in obtaining necessary educational competencies, and supervision needed to demonstrate competency within Applied Behavior Analysis (ABA).<br><br>At the previous Monitoring Team visit, it was evident that a policy had been developed and implemented to facilitate the recruitment and/or training of BCBA-level professionals. This policy, entitled "Psychological and Behavioral Services Positive Behavior Support Staffing," appeared effective as a BCBA consultant had been retained to provide case consultation, review behavioral programming, and supervise Behavioral Services staff undergoing the certification process (although supervision had not yet been started). No changes within this policy were reported. According to current verbal reports, this BCBA consultant continued to actively participate in the Behavior Support Committee, and the Skill Acquisition Plan Review Committee, and complete additional | Noncompliance |

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| | individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint. | case review and consultation. More information regarding peer review is discussed below with regard to Section K.3.of the Settlement Agreement. In addition, since the Monitoring Team's last visit, a second BCBA consultant had been hired to complete necessary supervision.<br><br>With regard to the educational competencies of the Behavioral Services staff, progress continued for many as they worked to complete requisite graduate coursework necessary for application to take the BCBA exam. At the Monitoring Team's previous visit, five staff members had completed coursework during the fall of 2010. Currently, provided documentation indicated that seven staff completed coursework in the spring of 2011. In addition, it appeared that 12 of 15 psychologists were enrolled in a course this summer. Consequently, it appeared that 13 out of 15 (87%) of psychologists were currently enrolled, and/or had completed at least one or more graduate course necessary for certification. This was a significant improvement compared with the previous estimate of five (33%) of the 15 eligible psychologists who had completed one or more courses at the last review.<br><br>It was unclear why the two remaining psychologists had not taken advantage of the multiple opportunities to complete necessary graduate coursework. Indeed, verbal reports continued to suggest that staff found the tuition support, as well as the availability of educational leave (i.e., up to four hours a week) as a beneficial and necessary part of their professional development. It remained unclear how CCSSLC would respond to current employees who were not enrolled in coursework and, subsequently, not in compliance with the current policy. At the time of the most recent review, it appeared that many of the barriers initially identified with completing coursework (e.g., the cost, time, etc.) had been removed.<br><br>At the time of the previous onsite review, no supervision necessary to support the application for BCBA certification had occurred. However, at the time of the current review, it appeared that at least three of the 13 eligible (23%) behavioral services staff recently had started to receive the pre-requisite clinical supervision necessary for certification. Both of the two contracted BCBA consultants were providing this supervision. Staff and supervisors should ensure the adequate completion of supervision hours, according to the Behavior Analytic Certification Board (BACB), as well as the completion of supervisory signature forms.<br><br>This provision item continues to be rated as being in noncompliance because the professionals in the Behavioral Services Department were not yet demonstrably competent in applied behavior analysis 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 | |

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| | | with regard to Section K.9 of the Settlement Agreement. | |
| K2 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility. | At the Monitoring Team's previous visit, it was established that the previous Chief Psychologist and Director of Behavioral Services had moved into the Clinical Psychologist position and, as a result, an Interim Director of Behavioral Services had been identified. At that time, this interim position was described as temporary solution as CCSSLC searched for and hired a replacement for the position of Chief Psychologist and Director of Behavioral Services. Consequently, in the Monitoring Team's previous report, this item of the Settlement Agreement was not rated.<br><br>During the most recent Monitoring visit, a new Director of Behavioral Services was hired. Because this change was unanticipated and occurred during the Monitoring Team's review in July, it did not allow sufficient time to establish whether or not the new Director of Behavioral Services had established and maintained a consistent set of psychological practices throughout the Facility, as the Settlement Agreement requires. As a result, the Monitoring Team has not rated the Facility's compliance with this provision. At the time of the next review, it is likely that the newly appointed Director of Behavioral Services will have been in place for a sufficient period of time to allow the Monitoring Team to estimate whether or not she has maintained a consistent level of psychological care throughout the Facility. | Not Rated |
| 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. | Since the Monitoring Team's last visit, progress had been noted in the area of peer review within Psychological and Behavioral Services.<br><br>At the previous visit, peer review of behavioral programming had been established through critical review of positive behavior support plans during the Behavior Support Committee meetings. At that time, it was estimated that the BSC met for 61% of the projected 31 potential scheduled meetings during the previous six-month time period (i.e., 6/1/10 through 12/28/10). Current data indicated that the BSC met for 100% of the projected 22 potential scheduled meetings over the course of a five-month period. Indeed, the Committee actually met on three additional occasions. This reflected an improvement since the last review.<br><br>CCSSLC policy recommended that the BSC have a diverse membership. In an effort to examine the diversity of membership, BSC meeting minutes were reviewed during the same period as listed above. As found during the Monitoring Team's last review, behavior services staff, including psychologists and psychology assistants, were most consistently in attendance. In addition, representatives from psychiatry were in attendance approximately 60% of the time. Representatives from nursing, habilitation therapies, and/or administration were typically each in attendance less than 45% of the time. The contracted BCBA's attendance remained consistent with the previously | Noncompliance |

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| | | determined estimate (at the Monitoring Team's last visit) of less than 50% of the time. Verbal reports from the Clinical Psychologist, however, indicated that the BCBA often provided input via email prior to the meeting if she could not attend the meeting. This was confirmed for two of the meetings (i.e., 2/15/11 and 3/29/11) with emails reflecting document review of upcoming cases at the BSC.<br><br>As reported in the Monitoring Team's last report, several important key players who supervise the implementation of behavioral programming (e.g., Residence Coordinators, Unit Directors, or other administrative staff) were not referenced in the current policy. It is important to involve those who have direct administrative supervisory authority of the implementation of the plans, as well as anyone who was directly involved in the plans' design and/or training at the BSC meeting. In addition, it was clear from current documentation that assessments and/or plans were not reviewed at BSC, if the authors of those products were not present. The current policy should specifically identify those staff members whose attendance is required for adequate review of assessments and/or PBSPs.<br><br>Similar to the previous onsite reviews, direct observation during a BSC meeting by a member of the Monitoring Team continued to reflect good attendance by behavioral services staff, as well as other professionals from diverse disciplines, active participation of team members, and data-based review and decision-making.<br><br>Documentation provided also indicated attendance by a community-based counselor, who was providing psychological support to CCSSLC residents. This professional's attendance at multiple meetings reflected active collaboration with psychology staff and is likely to improve counseling treatment plans, as well as ongoing monitoring of progress.<br><br>As previously reported, the BSC typically reviewed a substantial number of documents (e.g., psychological evaluations, SFBAs, PBSPs, and/or SPCIs), in addition to discussion of ongoing psychology department business (e.g., referrals, skill programming, review of delinquent reports) at each weekly meeting. As previously reported, this appeared to limit the Committee's ability to thoroughly review each presented assessment and/or plan. In response, CCSSLC decided to increase the number of weekly BSC meetings. That is, since June 2011, the BSC had begun meeting twice weekly. This also included an expansion of the scope of the BSC. It was to include the review and approval of all assessments and evaluations produced through psychological and behavioral services, as well as review of monthly progress review notes, counseling notes, and referrals for additional review. It remained to be determined if this increase facilitated more effective review without diminishing consistent attendance by key and diverse professionals. | |

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| | | As established at the Monitoring Team's previous visit, one of the identified functions of the BSC was to review the status of delinquent assessments and/or plans. Indeed, meeting minutes from the BSC reflected ongoing monitoring of delinquent documents. Data presented below appeared to confirm that this practice had facilitated the timely completion of documentation.<br><br>In addition to the peer review conducted through the BSC, a second peer review process, known as the Supplemental External Peer Review, was established since the Monitoring Team's previous visit. According to provided documentation, this group of professionals met on a monthly basis (starting in February 2011), and was charged with conducting a comprehensive, multi-disciplinary review of selected cases. Although verbal reports indicated that there was a benefit from this supplemental review, it was difficult to determine from the available meeting minutes whether or not the group consisted of professionals external to CCSSLC. Indeed, it appeared that most participants at monthly meetings were professionals from within CCSSLC.<br><br>This provision item continues to be rated as being in noncompliance because of the inadequate attendance of professionals demonstrably competent in applied behavior analysis, as evidenced by the absence of professional certification and documented attendance by the contracted BCBA, as well as by the absence of professionals external to CCSSLC currently participating in SEPR. | |
| K4 | Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target | At the Monitoring Team's previous visit, it was observed that progress had been made in the area of data collection regarding PBSPs, SPCIs, and PSP behavioral services monthly reviews. As of this most recent review, it appeared that minimal progress was made in this area. Concerns remained about the adequacy of the data collected, as well as how data was displayed.<br><br>In an attempt to examine the nature of data collection, a sample of 14 PBSPs were selected and reviewed. These are specified above in the section listing the documents reviewed. This sample reflected nine percent of the total PBSPs currently in place, and a majority of PBSPs (12 out of 14) reviewed had been revised since the last review. Of this sample, 14 (100%) PBSPs prescribed data collection for one or more target behaviors and one or more replacement behaviors. As presented below with regard to Section K.9 of the Settlement Agreement, however, there were concerns with how behaviors were operationally defined. In addition, of this sample, 13 (93%) displayed data in tabular format, graphic format, or both, within the PBSP and PSP Monthly Reviews of Behavioral Services. This data included target behaviors and replacement behaviors, as well as data on restraints and medications, as appropriate. One of the PBSPs, however, (i.e., Individual #16) did not provide any data. This lack of graphic display was surprising, given that graphs were included within the monthly PSP behavioral services reviews for | Noncompliance |

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| | behaviors do not improve or have substantially changed. | this individual. Although the data was typically available within documentation, concerns remained with how the data was displayed. That is, displayed data was often difficult to interpret (this is further discussed with regard to Section K.10 of the Settlement Agreement).<br><br>In addition, a sample of Safety Plans for Crisis Interventions was reviewed to determine how data was monitored and reviewed. Within the sample selected, which is specified in the list of documents reviewed, six individuals had SPCIs, this represented 18% of the total number of individuals with SPCIs. Of these, only two (33%) of the SPCIs contained any data on restraints. That is, data on restraint was summarized (across months) in the SPCIs for Individual #186 and Individual #275. Although data on the frequency of restraint was summarized, both of these individuals had SPCI objectives targeting the duration of restraint, which was not specifically collected and/or tracked in available tables or graphs. Although data on restraint was not provided on the SPCI for Individual #7, restraint data was provided on the PSP monthly behavioral services review. Indeed, frequency data was available on PSP Monthly behavioral services reviews for 50% of the individuals sampled (i.e., monthly documentation for Individual #186, Individual #275, and Individual #7). It was unclear, however, if any data on restraints was being formally tracked for Individual #58, because no summary data was presented on either the PBSP, SPCI, or in the PSP Monthly behavioral services reviews. Similarly, it did not appear that summary data on restraints (i.e., time out of restraints) was formally tracked or displayed for Individual #9, despite the fact that his SPCI listed an objective to "… spend a minimum of 5 minutes per hour out of protective mittens." A similar absence of restraint data was observed for Individual #16 in the PBSP, SPCI, and PSP Monthly behavioral services reviews. It is essential to monitor restraint data, because it is an indication of the frequency with which less restrictive alternatives and established behavioral supports have failed to prevent a crisis situation.<br><br>Overall, data display using graphs was inconsistent across documents. Continued progress in monitoring target and replacement behaviors appeared evident for most individuals sampled. However, several individuals lacked graphic display of replacement behaviors (e.g., Individual #275, Individual #375, and Individual #7), and, as presented above, data on frequency and duration of restraint appeared insufficient for some sampled individuals. Lastly, the quality of graphic display of data, as discussed with regard to Section K.10 of the Settlement Agreement, continued to be problematic.<br><br>Consistent with previous reviews, data reliability (i.e., inter-observer agreement of behavioral data) was not currently being assessed. This finding is similar to the findings in the Monitoring Team's previous reports. This is discussed further below with regard to Section K.10 of the Settlement Agreement. Verbal reports indicated that psychological and behavioral services staff were still working to determine the most effective and | |

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| | | efficient methods to collect inter-observer agreement. CCSSLC staff were encouraged to identify a small number of individuals, perhaps those with the most restraints or most restrictive programming, and attempt to collect inter-observer agreement data on target and replacement behaviors. This would be an initial step in examining how to most effectively and efficiently collect this necessary data, and provide insight on how to expand this process to the larger Facility.<br><br>In addition to the lack of reliability estimates of collected data, one of the more significant problems was the lack of data collected on replacement behaviors outside of formal teaching trials. The majority of displayed replacement behavior data appeared to be measured during teaching trials. Although staff should be encouraged and praised for conducting these teaching trials when individuals are receptive to learning new skills (i.e., when calm and ready to learn), taking data only during these times severely limits the team's ability to examine if these new skills will be utilized in the natural environment, and at times when they are most needed.<br><br>In an effort to establish whether or not interventions were re-evaluated and revised promptly if target behaviors did not improve or had substantially changed, the written rationales on PBSPs of the selected sample were examined to identify why the plans were revised. Almost all the PBSPs sampled provided a rationale describing the revision as coinciding with the annual PSP and not due to changes (or lack of changes) in behavioral functioning. The one exception was the rationale describing the revision of the PBSP due to new assessment information provided for Individual #312.<br><br>This provision item continues to be rated as being in noncompliance because of the lack of adequate reliability estimates on tracked behavior, as well as continued limitations with data collection as described above (i.e., replacement behaviors not tracked in natural settings, missing or incomplete data, etc.). | |
| K5 | Commencing within six months of the Effective Date hereof and with full implementation in 18 months, each Facility shall develop and implement standard psychological assessment procedures that allow for the identification of medical, psychiatric, environmental, or other reasons for target behaviors, and of other psychological needs that may require intervention. | Progress continued to be observed in the area of psychological assessment, including the completion of SFBAs. However, concerns remained about the adequacy of these reports.<br><br>As presented below with regard to Section K.6 of the Settlement Agreement, of the sampled psychological assessments, 16 (100%) were updated within the last 12 months and 15 (94%) contained results of previously completed standardized tests of intelligence and adaptive behavior. These assessments were completed, on average, approximately 12.5 years ago (range 0 to 23 years). Approximately 69% of these intelligence tests were conducted over 10 years ago. Two (13%) of the individuals had intelligence tests completed this year. As described below, evidence indicated that CCSSLC had initiated the utilization of standardized intellectual testing, when updating annual psychological assessments. Verbal reports indicated that a structured timeline | Noncompliance |

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| | | was being developed to facilitate the completion of standardized intellectual testing in the future.<br><br>As observed during previous monitoring reviews, in addition to the above psychological assessment, screening for psychopathology, emotional and behavioral issues continued to be completed either through the psychiatric clinic's completion of a psychiatric assessment, or through the utilization of the Reiss Screen for Maladaptive Behavior to screen for the need of a psychiatric assessment. The Reiss screenings continued to be utilized on an annual basis to examine individuals who were not receiving psychiatric services. The Facility's compliance with the implementation of the Reiss screening process is discussed above with regard to Section J.7 of the Settlement Agreement.<br><br>Each monitoring visit has noted continued improvement in the area of assessment as increasing progress has been made in completing SFBAs. According to documentation provided, 62 SFBAs were completed since the Monitoring Team's previous visit. Currently, according to the behavioral sciences database, dated 7/15/11, a total of 146 SFBAs had been completed to date.<br><br>Eight SFBAs completed since the Monitoring Team's last visit were selected from documentation provided. This sample represented 13% of the total number of SFBAs completed since the Monitoring Team's last visit. Based on this review, only one (13%) appeared adequate (i.e., appeared to have a majority of required elements judged as adequate). The other seven SFBAs had elements that were either missing or inadequate.<br><br>A brief summary of general findings is presented below followed by a detailed examination of a smaller sample (i.e., only two SFBAs) that appeared to accurately reflect concerns noted across the sample. CCSSLC behavioral services staff are strongly encouraged to review noted concerns and recommendations in the Monitoring Team's previous reports, because the concerns previously noted are consistent with current findings.<br><br>Overall, the progress in completing these challenging assessments was recognized. However, as reported based on the Monitoring Team's previous visit, concerns remained regarding the adequacy of these assessments. It was apparent that behavioral services staff were beginning to master the format of the assessment (i.e., including the language and necessary structure), but were still struggling with truly understanding the components of the assessment, as well as how to integrate findings and ultimately utilize the findings to inform treatment. It is anticipated that, as professional competencies in ABA develop through coursework and supervised training, the quality of the assessments will continue to improve over time. | |

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| | | In general:<br>▪ The SFBAs provided a standardized rationale for why the assessment was completed. The exception was the SFBA for Individual #105, in which no rational was provided.<br>▪ As found during the last review, none of the reviewed SFBAs indicated that they were completed or revised because the individual did not meet treatment goals or was experiencing significant changes in functioning. These conditions should have triggered review and/or changes.<br>▪ All of the SFBAs included behavioral data. However, some of the data was not interpretable (e.g., Individual #363) and, at times, replacement behaviors were not included in graphic displays (e.g., Individual #105).<br>▪ All of the assessments included sections targeting indirect (rating scales, interviews) and direct (direct observation) methods. However, many did not show an understanding that conducting direct observation was an opportunity to examine contingencies associated with target as well as more adaptive behaviors (e.g., Individual #105, Individual #96, and Individual #140). It is very possible that target behaviors might not occur during observations. When this occurs, staff might want to discuss this and identify environmental stimuli or contingencies that support more adaptive responding.<br>▪ Redundancy and the inclusion of raw data continued to increase the length and complexity of these assessments (e.g., Individual #105, and Individual #275). Behavioral services staff are encouraged to synthesize the raw data and briefly summarize the findings.<br>▪ Continued challenges in adequately identifying and describing setting events, antecedents, and/or consequences continued to be observed (e.g., Individual #363, Individual #48, individual #96, Individual #141).<br>▪ The current review also evidenced a continued disconnect between the identified function(s) of the SFBA, and the identified functionally equivalent replacement behaviors. It should be noted that many behaviors might have multiple functions. Some SFBAs appeared to only focus on one function.<br>▪ As described in earlier reports, careful consideration of the identified underlying functions of behavior should occur, perhaps evidenced by a summary of all the indirect and direct evidence in the "findings" section, and specific function-based interventions should be conspicuously described or recommended.<br>▪ At times, it was very difficult to find the functionally equivalent replacement behavior in the SFBAs (e.g., Individual #363, Individual #48, Individual #96, and Individual #141). It is evident that behavioral services staff continued to have difficulty in adequately identifying and defining replacement behaviors. As previously presented, it might be helpful to encourage behavioral services staff to place less emphasis on the terms "replacement behavior" and the behavioral objective, and more emphasis on the actual desired responses. The use of these | |

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| | | generalized terms appeared to overshadow the necessity of operationally defining specific responses with examples. Indeed, it was very challenging, at times, to identify the specific replacement behavior in documentation reviewed. This is likely because the replacement behavior was not specifically identified, labeled, or defined. This phenomenon did not happen with target behaviors.<br>▪ In addition, behavioral services staff continued to demonstrate difficulty understanding the concepts of setting events, antecedents and/or consequences.<br>▪ Reference to mentalistic or internal states (e.g., "control," "insecure," etc.) should be avoided, because they are not helpful in assisting direct support professionals identify environmental contingencies that are maintaining behavior and that can potentially be changed in an attempt to reduce problematic behavior.<br>▪ Lastly, some of the reviewed SBFAs contained a level of specificity with regard to the content provided that was unnecessary and counterproductive. Expectations should be established to clearly identify the information that is required, the level of detail that would be helpful, and encouraging summarization and integration of information, when possible.<br><br>In general, as the newly revised SFBA format, dated 12/15/10, becomes more commonly used, it is likely to improve the assessment process and lead to a stronger link between assessment and intervention. The goal is to inform treatment. In other words, the intent should be to ensure that the link between developed hypotheses (based on assessments) and interventions, including replacement behaviors, are conspicuous within the PBSP.<br><br>Previous Monitoring reports identified areas for improvement and provided multiple detailed examples. The current report will supplement previous observations and recommendations by providing fewer examples, but more detailed examinations of a few SFBAs to illustrate continued concerns. In general, current concerns were consistent with those noted in previous reports. That is, many of the same issues found in previous SFBAs also were noted during the current review. One example of a provided assessment that appeared "on the right track" was the SFBA, dated 3/21/11, for Individual #105. The following provide examples of concerns noted. It must be understood that these concerns were not specific to these individuals, but represent concerns across most of the SFBAs reviewed.<br><br>The SFBA for Individual #275 could be improved in a number of ways. First, redundancy should be avoided as much as possible and, when appropriate, unnecessary detail should be eliminated. For example, the detailed descriptions of daily events in the "Response to Behavioral Programming" section (p. 2-3) might be more helpful if the events were summarized and noted implications for assessment or intervention were provided. Redundant data displayed in table format (p. 4-5) would not be necessary, if the same information were clearly evident and easily interpreted in graphic form. In addition, | |

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| | | detailed information regarding previous intellectual and adaptive behavior testing (p. 6), likely also found in the psychological evaluation, was not necessary in the SFBA (i.e., beyond current diagnosis and/or functioning level). Specific data derived from rating scales (p. 6-8) was not necessary to include in the report, as long as it was accurately summarized (i.e., store the raw data and include only a summary of findings). Adherence to previously and currently recommended graphing conventions (as discussed with regard to Section K.10 of the Settlement Agreement) would likely improve the graphic display of target and replacement behavior and medication dosages (p. 5). Direct observation (p. 8) should be used to examine potential contingencies of target and more adaptive, replacement behaviors (i.e., consider the three-term contingency of antecedent-behavior-consequence (A-B-C) when reporting observations) and, if possible, validate findings from more indirect methods (e.g., rating scales). The repeated report of "no pattern" for any of the target behaviors for Individual #275 seemed inexplicable given the consistent function (access to staff attention) found for most target behaviors. In addition, it appeared redundant to provide definitions of target behaviors again in this subsequent section. In addition, they appeared to be incorrect (p. 8). Interviews of direct support professionals, in the absence of direct observation of target behaviors, might likely be the most useful method to collect meaningful information regarding the nature of responding. Given that, the Interview section (p. 9) was wholly inadequate. Comprehensive interviews, like those listed as assessment tools within psychological and behavioral services, should provide substantial information regarding the occurrence and non-occurrence of target behaviors. The Findings section (p. 9) did not appear to summarize data from any of the previous sections, but rather provided historical data that would be more appropriate in earlier sections. The antecedents listed under the Conclusions section and hypotheses table (p. 9-10) were not actually antecedents. Recommendations (p. 10) indicated continuing with the replacement behavior objective, yet no replacement behaviors and/or objective were described anywhere in the report. The described: 1) general teaching strategies; 2) prevention strategies to integrate into the IPP; and 3) strategies to teach new skills or strengthen current skills as replacement behaviors were identical (i.e., appeared to be "cut and pasted"), and did not appear likely to teach new skills. Information regarding antecedent- and consequence-based interventions seemed out-of-place in the SFBA and redundant (unnecessary), because it was found in the PBSP. Lastly, the lack of information specifically labeling and defining a replacement behavior(s) was problematic. The SFBA should inform the PBSP, which is about teaching new, adaptive skills. That is, the assessment should help psychologists develop hypotheses about the functioning underlying the identified target behaviors. In this case, the function across all behaviors was identified as '"attention" from staff. The strategies listed, for example, providing reassurance, informing her about the schedule, giving choices, might all be helpful, but they did not directly address the identified function. The replacement behavior(s) should be linked directly to each developed hypothesis regarding identified functions of target behavior. In this case, teaching her | |

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| | | how to get staff attention.<br><br>The SFBA for Individual #9 also needed improvement. In general, the author should refrain from referencing internal states that cannot be verified and are likely not helpful in framing an understanding of why self-injury occurs. For example, suggesting that "… [Individual #9] appears to feel insecure about his relationship to his environment", "… his need to feel secure," as well as " … enjoys feeling in control of situations" and "… provide him a way to help him feel he has some control …" These references did not necessarily help staff understand or focus on the nature of the environment, including the many external and controllable variables that were likely to maintain his SIB. Statements appeared to suggest (p. 3 and 6) that other identified responses (e.g., aggression, sleep cycle, activity level during the day, use of mittens, etc.) were being closely monitored and appeared likely to influence the occurrence of SIB. However, no data was included on these important variables and they were not referenced later within the assessment or findings as related (e.g., potential setting events) to SIB. It was unclear why the title of graph indicated "monthly comparison of behavior to medication," when no medication data was presented. In addition, it was also unclear why the same data and definitions of SIB were repeated (p. 7 and 8) throughout the document. Similar to the previously presented SFBA, a substantial amount of raw data should be removed from the document and summarized instead. That is, the specific raw data simply could be summarized (as reflected in the table on p. 10), and stored if further analysis was required. This is true for observation notes (p. 11) as well, which could be summarized. Redundant data regarding rating scales [i.e., restating results of Functional Analysis Screening Tool (FAST) and Motivation Assessment Scale (MAS)] should be removed from the interview section (p. 12) to allow discussion of other information. Direct observation data was encouraging to review and might be the most important piece of this assessment. However, assessors should remain mindful and vigilant in ensuring that their beliefs regarding underlying function not bias their objectivity when describing observed events. Appropriately, the findings section (p. 13) summarized the results of the assessments. However, it was unclear what that author meant when indicating that the MAS indicated: " … the function of self-injurious behavior at home was sensory 4 out of 4 times," when the MAS was only completed with two staff. The same confusion was noted with the FAST summary. If not already in place, duration data should be collected on the use of the mittens. This data will allow the PST to determine if this restrictive intervention was utilized less over time (i.e., as stated as a goal of the PST on page 13). The information in the conclusions section (p. 14) continued to reflect confusion regarding the differences between setting events, antecedents, and consequences. The replacement behavior section (p. 14) did not provide a specific, operational definition of the alternative response that was being trained. Instead, a somewhat vague objective was stated. Lastly, it was unclear why teaching strategies, antecedent, and consequence-based interventions, data collection information, etc. were listed within the SFBA (p. 14– | |

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| | | 17). This information should only be included within the PBSP. The inadequacy and error within the PBPs for Individual #9 will be discussed with regard to Section K.9 of the Settlement Agreement below.<br><br>Due to the ongoing issues related to the quality of the SFBAs, as well as the timeliness of adequate psychological assessments, the Facility remains out of compliance with this provision of the Settlement Agreement. | |
| 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. | As previously reported, the current CCSSLC Psychological Care and Services – Psychological Evaluations policy indicated that each individual residing at CCSSLC must have a current psychological evaluation. Since the Monitoring Team's last visit, the expectation, that a psychological assessment would be completed, updated and/or reviewed at least annually for each individual served, remained in place. This expectation also included reviewing results from the Inventory for Client and Agency Planning (ICAP) evaluation on an annual basis, with the requirement of conducting a re-evaluation using the ICAP at least once every three years or sooner if significant events appeared to impact adaptive functioning.<br><br>To determine whether or not psychological assessments were based on current, accurate, and complete clinical and behavioral data, psychological assessments and ICAP documentation from a sample of 16 individuals was examined. This sample represented 6% of the total (N=267) number of psychological evaluations currently in place. As presented below with regard to Section K.7 of the Settlement Agreement, of the sampled psychological assessments reviewed, 16 (100%) were updated within the last 12 months. In addition, 15 (94%) of the sampled individuals had an ICAP evaluation completed within the last three years. The actual ICAP evaluation was not available for the one psychological evaluation with an evaluation date beyond the three-year criterion (i.e., psychological evaluation for Individual #105). Consequently, it is unknown if a more recent ICAP was completed between the psychological evaluation completion date (1/29/11), and the ICAP due date (6/23/11). In some cases, it was unclear why ICAP evaluations would be conducted after the psychological assessment was completed, and thereby preclude any potential to inform the overall assessment (e.g., Individual #379), or why summary data from a more recently completed ICAP evaluation (completed in 2009) was not included in the recent psychological evaluation (i.e., only listed ICAP data from 2006) for Individual #58.<br><br>Of the psychological assessments reviewed, 15 (94%) contained results of previously completed standardized tests of intelligence. The exception included a psychological evaluation that did not contain any specific information about the test that was conducted (i.e., only the date and diagnosis was provided) in the psychological evaluation for Individual #268. These assessments generally included the use of the Wechsler, | Noncompliance |

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| | | Slosson, and/or Leiter tests and were completed, on average, approximately 12.5 years ago (range 0 to 23 years). Approximately 69% of these intelligence tests were conducted over 10 years ago. Two (13%) of the individuals had intelligence tests completed this year (i.e., Individual #71 and Individual #9). It appeared, then, that behavioral services staff had begun conducting intelligence assessments using standardized testing (i.e., using the Slosson). This was consistent with verbal reports indicating that psychological assessments utilizing newly purchased testing materials had been initiated. Specific policies regarding ongoing use of standardized intellectual testing should be clarified in current policy, if not already in place.<br><br>Overall, review of the sampled psychological evaluations reflected the progression of completed assessments across the templates with different revision dates. That is, many of the older assessments (dated in the first quarter of 2011) were completed using the 12/15/10 template, while more recent assessments (dated in the second quarter of 2011) utilized the more recently revised template, dated 5/15/11. According to verbal reports, only minor revisions had been made to more recent templates. However, inconsistencies across these formats were noted. For example, behavioral data was evident in either table and/or graphic format in some evaluations (e.g., Individual #379 and Individual 181), but not in others (e.g., Individual #114 and Individual #109). This was true for psychological evaluations completed using the new template as well. That is, some evaluations included the display of behavioral data (e.g., Individual #9), and others did not (e.g., Individual #71 and Individual #363). Overall, data was displayed in either tables and/or graphs in seven (44%) of the psychological evaluations sampled.<br><br>Lastly, none of the sampled evaluations utilized the most recently dated psychological evaluation/update template, dated 6/1/11. This was not surprising, because all but one evaluation was dated prior to 6/1/11 (i.e., the psychological evaluation for Individual #9, dated 6/7/11, utilized the template dated 5/15/11).<br><br>Due to the ongoing issues related to the inadequacy of psychological assessments, specifically the majority of assessment with outdated standardized intellectual assessment, the Facility remains out of compliance with this provision of the Settlement Agreement. | |
| K7 | Within eighteen months of the Effective Date hereof or one month from the individual's admittance to a Facility, whichever date is later, and thereafter as often as needed, the Facility shall complete psychological assessment(s) of | Progress was noted in the completion of psychological assessments for individuals newly admitted to CCSSLC, and continued in the provision of psychological assessments for all CCSSLC residents.<br><br>To determine whether or not psychological assessments were completed, updated or reviewed as often as needed, documentation provided on 16 sampled individuals was examined. As presented in Section K.6 of the Settlement Agreement, 16 (100%) sampled | Noncompliance |

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| | each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures. | individuals had psychological assessments updated within the last 12 months.<br><br>According to provided documentation, since the Monitoring Team's last visit, there were five new individuals admitted to CCSSLC. These included: Individual #71, Individual #78, Individual #96, Individual #169, and Individual #341. Of these individuals, three were selected (i.e., Individual #78, Individual #71, and Individual #96) in order to examine whether or not a psychological assessment was completed within one month of admittance. Of those sampled, three (100%) had psychological assessments that were completed within 30 days of admittance. Of these, standardized intellectual assessment was completed for two (67%) of the individuals within 30 days of admittance (i.e., Individual #71 and Individual #96). In addition, initial PBSPs were developed and implemented for three (100%) individuals within two months of admission, and one (33%) individual had an SFBA completed to inform the PBSP.<br><br>At the Monitoring Team's previous visit, a new system, the Behavioral Sciences Database, had been developed and was being populated with data. At the time, some information had not yet been entered into the database. This system allowed staff to track important completion, approval, and/or implementation dates of Psychological Evaluations, Structural Functional Behavioral Assessments, Positive Behavior Support Plans, Safety Plans for Crisis Intervention, and Desensitization Plans over time. In addition, this system was agile enough to allow examination of the data in multiple ways (e.g., by psychologist, unit, etc.). In the previous report, it appeared that a certain percentage of annual Psychological Evaluations (36%), PBSPs (19%), and SPCIs (38%) had lapsed. In addition, data on the recently completed SFBAs indicated that, as of 1/6/11, 159 had been completed and 57 remained to be completed. Currently, behavioral services summary data provided, dated 7/11/11, indicated that a certain percentage of annual Psychological Evaluations (6%), PBSPs (10%), and SPCIs (6%) were identified as delinquent. These numbers reflected an improvement in timely completion of yearly updates and/or revisions. In addition, according to recent data, a total of 159 and 73 dental and medical desensitization plans, respectively, had been completed. Also, data on the recently completed SFBAs indicated that, as of 7/11/11, 144 had been completed. This number was less than the number identified at the last review. It appeared that the total number of SFBAs was likely to change as decisions were made regarding the necessity of behavioral programming. Given that, summary data still indicated that at least five SFBAs were delinquent or not completed as a total of 150 individuals had a PBSP in place. In addition, documentation appeared to reflect uncertainty about the necessity of updating or revising at least 20 SFBAs that were completed over one year ago.<br><br>As a result of issues related to the timeliness of psychological assessments, including the inadequacy of current standardized intellectual testing, the Facility remained out of | |

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| | | compliance with this provision. In addition, some concerns were noted with regard to the timely completion of psychological updates and SFBAs. | |
| 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. | Progress was noted with regard to the provision of psychological services, including the way in which counseling treatment plans were developed and monitored.<br>In the previous monitoring report, some progress was noted in improving access to community-based counselors, and in including measureable objectives within counseling treatment plans. Although this appeared to be a step in the right direction, at that time, many of the identified objectives and definitions remained vague, plans appeared to include arbitrary goals, and strategies did not appear to be linked to a larger treatment plan.<br><br>At the time of the most recent review, two community-based counselors continued to provide weekly counseling supports both on and off campus. This was consistent with previously reviewed available counseling supports. However, documentation provided, including counseling treatment plans and counseling progress notes, primarily represented work from one of the two counselors. As a result, it was difficult to compare ongoing programming and monitoring (e.g., using progress notes) across the two professionals.<br><br>According to the documentation provided (i.e., listing of individuals receiving counseling services), it appeared that 15 individuals currently received counseling services. However, counseling notes provided and treatment plans indicated that three additional individuals were receiving counseling services (i.e., Individual #51, Individual #26, and Individual #300). It is unclear why the Facility did not identify these three individuals. With the exception of four plans that were not dated, all of the counseling treatment plans were recently completed in May 2011.<br><br>In an effort to examine the adequacy of current counseling treatment plans, two individuals were selected from the list of individuals currently receiving counseling services. More specifically, the counseling treatment plans were reviewed for Individual #7 and Individual #275. This sample represented 13% of the individuals identified as receiving counseling services.<br><br>The sampled counseling treatment plans (i.e., for Individual #7 and Individual #275) did appear to be improved compared to previous plans, because they included more precise and concrete treatment plan objectives. More specifically, the plans included more objective language when identifying treatment plan objectives, as well as information (e.g., objectives and definitions) from the PBSP regarding target and replacement behaviors. The addition of this information, however, added a bit of ambiguity regarding which objectives were being identified as indicators of treatment success as specifically | Noncompliance |

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| | | related to the counseling supports. If the PBSP replacement behaviors were being targeted, each replacement behavior should be more clearly defined with examples, so that each desired adaptive response(s) is conspicuously evident to ensure appropriate prompting and reinforcement as well as monitoring, in addition to providing a behaviorally stated objective, which were evident. If these PBSP target and replacements behaviors were included as indicators of counseling success, the requisite data was being collected and apparently was monitored monthly, as evidenced by the most recent PSP Monthly behavioral services reviews. However, if the identified treatment plan objectives were utilized to monitor progress of the counseling treatment plan, which was the Monitoring Team's assumption, ongoing collection and review of relevant data was not conspicuous. For example, Individual #7's treatment plan listed attendance at weekly counseling sessions, her target and replacement behaviors, and percentage of participation in daily activities. However, review of PSP behavioral services monthly reviews did not evidence ongoing monitoring of these specific indices. For Individual #7: 1) program refusals were being monitored per month, but an overall percentage was not generated and displayed to allow comparison over time; and, 2) counseling progress notes appeared to monitor some of these variables, and verbal reports indicated that this data would be integrated into future PSP behavioral services monthly reports. Similarly, progress toward meeting objectives listed on the counseling treatment plan for Individual #275 were difficult to judge given that the necessary data (i.e., five acceptable ways to communicate, and participation in 75% of daily schedule) was not specifically monitored or reviewed on the most recent PSP monthly behaviors services review, dated June 2011.<br><br>Although the counseling treatment plans were now integrating content from the PBSPs (i.e., information on identified target and replacement behaviors), they included vague definitions of replacement behaviors. As noted, behavioral objectives were listed for the replacement behaviors, but these behaviors should be operationally defined (including specific, concrete examples), and be more immediately evident to the reader. Overall, counseling treatment plans would be much improved if they identified specific replacement behaviors (i.e., objectively defined examples of appropriate and acceptable responses) that could be targeted and measured in the therapy, as well as within the natural environment. In addition, there was a difference between listing target or replacement behaviors, which were two of the five treatment plan objectives for Individual #7 for example, and demonstrating actual adaptive replacement behaviors in the natural environment. It would seem that the PSP teams might want an estimate of how well individuals exhibited (or not) learned skills in the natural environment. This distinction should be considered when identifying treatment plan objectives.<br><br>As noted in the Monitoring Team's previous reports, other critical elements central to effective interventions (i.e., description of treatment methodology, "fail criteria," | |

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| | | generalization strategies, etc.) continued to be deficient and should be included in current treatment plans. In addition, counseling supports should be identified within the PSP. At the current time, reference to these supports was not evident in the PSP, dated 5/18/11, or psychological evaluation, dated 11/16/10, for Individual #7. It should be noted that counseling services might have been initiated after these dates (i.e., it was not discernable from documentation provided when the counseling services had been started). Similarly, reference to or recommendations of counseling supports were not evident in the psychological evaluation, dated 2/24/11, for Individual #275. The importance of these supports were described in the recent PSP, but were not included within the outlined actions plans.<br><br>As noted in the Monitoring Team's last report, rubrics had been developed to standardize the referral, treatment, and monitoring of counseling services. In addition, one psychologist was going to be assigned as a liaison with community-based counselors. According to recent verbal reports, however, referrals for counseling, development of counseling treatment plans, and monthly monitoring (through PSP monthly reviews) would be generated through active collaboration between each psychologist and contracted counselor and reviewed at BSC. This change to the BSC was reflected in revisions within the format of BSP approval sheets and was evident in provided templates. Verbal reports also indicated that data from counseling progress notes would now be integrated within monthly PSP behavioral services reviews. As described below with regard to Section K.10 of the Settlement Agreement, these notes would be sampled and reviewed at BSC meetings. This process appeared likely to facilitate more effective monitoring.<br><br>The changes discussed above should be formally stated within the current policy, and because these were recent changes, will be examined during the next monitoring review.<br><br>As described in previous Monitoring reports, other types of therapeutic supports, in addition to counseling services, had been noted during on-site visits. These included sensory rooms where individuals were offered opportunities to experience different sensory stimulation across many modalities (visual, tactile, olfactory, etc.), as well as other environments (e.g., the Comfort Zone and Snoezelen Room), where individuals were encouraged to participate in other formal or informal programs and activities. As recommended in the past, if such settings were designed to assist in providing individuals with therapy or treatment, then specific outcomes should be identified for each individual, and data collected and reviewed to determine the therapy's effectiveness on an individualized basis. In response to these recommendations, a new position was created to support the identification, procurement/development, and implementation of evidenced-based assessments and treatments for individuals with autism. This position was successfully filled and, according to reports from the Director of Active Treatment, | |

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| | | the new staff member had played an integral role in the development of programming within The Harbor Program. Discussions with this staff member, as well as others familiar with the Harbor program indicated that, at the time of the recent onsite visit, programming had been in place for approximately five weeks and currently served approximately eight individuals. Verbal reports indicated that the primary assessment utilized for individuals within this program was a sensory integration inventory. It appeared that the Occupational Therapist completed this assessment, and the outcome was, in part, the basis for recommendations regarding skill programming. Although this assessment might have some value in determining preferences for individuals, staff are strongly encouraged to examine additional assessments that are likely to facilitate the identification of functional skill areas.<br><br>Due to the continued inadequacy of counseling treatment plans as well as the insufficient use of evidence-based practices within provided services (e.g., the Harbor) the Facility remains out of compliance with this provision of the Settlement Agreement. | |
| 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. | Limited progress was noted in the area of PBSPs. Significant concerns remained regarding their adequacy.<br><br>The Monitoring Team's previous report noted progress in terms of the utilization of a revised PBSP format, dated 12/15/10. At that time, the new format included highlights of medical and psychiatric issues, operational definitions of target and replacement behaviors, potential function(s) of behavior, antecedent-based (preventative) and consequence-based (reactive) strategies, teaching strategies to promote replacement behaviors and weaken undesired behaviors, data display, and an area to document signatures. However, as identified in the previous report, the new format did not include some critical components, including information on prior interventions and related outcomes, reminders to utilize reinforcement (individualized reinforcers), specification regarding data collection, or procedures/strategies to reduce the intensity of prescribed interventions. The current review continued to note concerns with the consistent use of the revised formats, as well as in the adequacy of content across all areas of the PBSPs. Previously recommended changes regarding missing components had not been addressed.<br><br>Currently, 10 PBSPs were sampled from those completed, since the Monitoring Team's last visit. This sample represented 10% of the total number of PBSPs completed since the Monitoring Team's last visit (i.e., documentation revealed that 99 PBSPs had been completed since the last visit). Based on this review, a brief summary of general findings is presented below. CCSSLC behavioral services staff are strongly encouraged to review noted concerns and recommendations in the Monitoring Team's previous reports, because the concerns previously noted are consistent with current findings. | Noncompliance |

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| | | Overall, the effort needed to complete 99 PBSPs since the last visit was noted. However, as reported after the Monitoring Team's previous visit, as well as at the conclusion of the most recent review, significant concerns remained regarding the adequacy of these plans. It continues to be anticipated that, as professional competencies in ABA develop through coursework and supervised training, the quality of the PBSPs will continue to improve over time.<br><br>The following summarizes the concerns identified in the most recent review of PBSPs:<br>▪ In general, the PBSPs adhered to a prescribed format, dated 12/15/10. However, several plans appeared to use an older format, dated 11/22/10 (e.g., Individual #200 and Individual #58), and two PBSPs did not specifically identify which format was utilized (Individual #16 and Individual #7). It appeared that when a prescribed format was not identified, critical elements were missing. For example, no data was presented in the PBSP of Individual #16, and no staff instructions (cheat sheet) was available in the PBSP of Individual #7.<br>▪ Rationales for current interventions were found for PBSPs, but they were most often vague. For example, the PBSP for Individual #268 indicated that the plan was not successful in teaching the replacement behaviors, but did not specify what (if any) changes were made in programming to address this ongoing issue. In addition, the rationale provided a hint that "… similar previous interventions (p. 3)" were successful, but did not specifically identify which strategies were most helpful.<br>▪ Authors of PBSPs continued to be challenged to identify and define acceptable functionally equivalent replacement behaviors. This process should be viewed as similar to identifying and defining the target behaviors they are intended to replace. Specific problems with regard to replacement behaviors included:<br>o In many cases, a vague behavioral objective was utilized in place of a more specific operational definition of the replacement behavior. For example, replacement behaviors continued to be vague and required more precise operational definitions (e.g., Individual #275), and needed to target the identified underlying function(s) of target behaviors they were trying to address (e.g., Individual #268).<br>o In addition, some target and replacement behaviors did not appear to be well defined, and, at times, the teaching strategies within the PBSP appeared to target a different skill. For example, the target behaviors of aggression and self-injurious behaviors were collapsed/defined together but tracked (in table and graphs) separately within the PBSP for Individual #335. In addition, the replacement behavior of "… ask for specific activities or objects …", as based on an identified function of gaining access to wants and needs, did not appear to be part of the skill | |

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| | | programming found later in the PBSP. More specifically, the prompting and practicing of coping skills was promoted as the replacement behavior within the staff instructions targeted later in the PBSP. Combining separate responses within the same definition was also noted in the PBSP for Individual #16.<br>o Lastly, for the replacement behavior to be effective, it needs to address the identified function underlying the target behavior. For example, the identified function of aggression for Individual #58 was escape. However, the replacement behavior targeted participation in sensory activities. Instead of teaching an appropriate escape response, it appeared that strategies outlined in the PBSP were attempting to reinforce compliance. It would appear that a more adaptive alternative to demonstrating aggression would be necessary.<br>▪ When direct support professionals are asked to only record data on more intense levels of behavior, the differing levels of response intensities need to be well defined to allow staff to accurately discriminate between them. For example, direct care staff were directed only to record the frequency of moderate to high intensity SIB for Individual #9. However, these differing levels of SIB were not defined.<br>▪ A consistent finding across the PBSPs was lack of objectives for target behaviors. Although most target behaviors identified within the PBSPs were better defined (i.e., more precise, more objective, etc.), measureable objectives for target behaviors were not included to establish goals for treatment (e.g., PBSPs for Individual #7, Individual #9, and Individual #268).<br>▪ In addition, when behavioral objectives were included, at times they were somewhat unrealistic (e.g., "… 30 out of 30 trials for 6 consecutive months" as found on the PBSP for Individual #335). Clear, measurable behavioral objectives should be stated for each target and replacement behavior, and used to evaluate the effectiveness of the PBSP. Continued intensive training should be provided on writing acceptable behavioral objectives. If not already completed, specific instructions should be added to the revised PBSP rubric to remind staff of the necessary components of adequate behavioral objectives.<br>▪ As presented earlier with regard to Section K.5 of the Settlement Agreement, behavioral services staff's difficulty in discriminating between setting events, antecedents, and/or consequences continued to impair not only the SFBAs that were developed, but the subsequent antecedent- and consequence-based interventions as well. An example of where this was problematic was the PBSP of Individual #9. More specifically, the Prevention of Challenging Behaviors of the PBSP (p. 2) did not adequately discuss setting events or antecedents. As a result, the prescribed strategies appeared inadequate. Information found earlier in the PBSP (p. 2) alluding to potential setting events (e.g., lack of sensory | |

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| | | stimulation, being bored, etc.) could be specifically described and integrated within antecedent-based strategies.<br>▪ Difficulty in identifying appropriate antecedent-based interventions to prevent target behaviors continued to be noted in some PBSPs. For example, no potential antecedents were mentioned in the prevention section of the PBSP for Individual #109. Instead, the prescribed procedures appeared to be reactionary. However, a behavioral contract was mentioned (i.e., "… remind him of his behavioral contract …"), and could likely be utilized in a preventative fashion, but instructions on its use were not found in the PBSP. Similar findings were evident in content under prevention of challenging behaviors in the PBSP for Individual #16.<br>▪ PBSPs also seemed, in general, inconsistent in the inclusion of information on how to reduce the restrictiveness of interventions. When found in plans, this section often only targeted the reduction of medication (e.g., Individual #7). Indeed, other restrictive interventions (e.g., mitts, increased level of supervision, etc.) were found within PBSPs, and strategies within plans to slowly fade their use should be identified and attempted through data-based decision making by the PST.<br>▪ Sampled PBSPs typically identified verbal praise and/or campus bucks as reinforcers. In addition, no mention was made of preference assessments in any of the plans reviewed. As previously noted, formal preference assessments should be completed on a regular basis, and identified reinforcers should then be integrated into formal skill programming, incidental teaching opportunities, and antecedent-based interventions. In addition, as appropriate, highly preferred reinforcers should be used for correct responding and perhaps less preferred reinforcers for good effort.<br><br>One of the PBSPs reviewed appeared to be "on the right track," and might serve as a better example compared to the others that were reviewed. For example, the PBSP for Individual #7 stood out due to its specificity regarding target and replacement behaviors, as well as linking the underlying functions to interventions. However, there were areas in which this PBSP could be improved. This included ensuring that data for all identified target and replacement behaviors was tracked (e.g., no data was presented on unfounded allegations), targets that were to be tracked should be defined (e.g., no definition for "agitated/disruptive" behavior), and that behavioral objectives were stated for each behavior (e.g., objectives for target behaviors were not included). When tracking a very serious behavior like pica, it might be helpful to ensure accurate monitoring, assessment and programming, if the behavior is defined independently from self-injurious behavior (p. 1). This would allow assessment of potential differences in function, including any subsequent differences in intervention, as well as help differentiate the response due to its life threatening potential (not to mention its significant history). In addition, the plan | |

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| | | as well as any future psychologist would likely benefit from additional historic information regarding previously tried interventions. Identified functions (e.g., "escape") should not be overlooked when highlighting potential functionally equivalent replacement behaviors (p. 1 and 2). Also, the potential treatment integrity of the plan should be enhanced by providing staff instructions (i.e., "cheat sheet"), as prescribed by the PBSP template. Lastly, the prescribed strategies should be founded on empirically-supported treatments. That is, it was noted that some of the preventative strategies were based on information from a website. It was not clear if the information provided was based on scientific research or theory. It would be good practice to start identifying the empirical support for central interventions included in PBSPs. This information might not necessarily need to be stated in the PBSP, but certainly should be accessible when plans are reviewed at BSC.<br><br>A new template/format for PBSPs, dated 6/1/11, appeared to be recently developed. However, this template did not appear to be significantly different compared to the previous format. Currently, none of the PBSPs sampled during the current review had been completed using this new template. The utilization of this new format will be assessed during the Monitoring Team's next review.<br><br>Since the Monitoring Team's last visit, the behavioral sciences database had been fully populated and, according to verbal reports and documentation provided, was being reviewed at weekly BSC meetings to identify delinquent documentation, including delinquent PBSPs. Information provided on the database, dated 7/15/11, was reviewed to examine if necessary consents and approvals were obtained for the PBSPs. According to documentation provided, 16 (11%) were currently delinquent. Closer review of the database revealed potentially out-of-date consents, BSC approval, and/or HRC approval for 18 additional PBSPs that were not identified as delinquent. More specifically, the recorded consent date, BSC approval date, and/or HRC approval date had exceeded 12 months for: Individual #184, Individual #172, Individual #168, Individual #47, Individual #30, Individual #83, Individual #174, Individual #62, Individual #318, Individual #114, Individual #326, Individual #268, Individual #153, Individual #254, Individual #88, Individual #146, Individual #226, and Individual #353. It was unclear why these PBSPs were not considered delinquent with one or more of these consents/reviews missing.<br><br>Requested documentation, including the PBSP, HRC Review of BSP form, BSC Review and Approval Form, Consent to Treatment-Therapy form, and Training Documentation on PBSPs, as provided, was reviewed (using the sample described above in the section listing documents reviewed) to ensure that consents and approvals for PBSPs were obtained prior to their implementation. Of note, a number of documents were not provided as requested. As a result, the following data might underestimate compliance | |

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| | | with appropriate consent and review of PBSPs. Of the 10 individuals sampled, eight (80%) of the individual's PBSPs had the necessary consents or approvals. More specifically, none of the required consents, approvals or signatures were available for review on the PBSP for Individual #200, dated 3/18/11, and signatures were missing on the PBSP for Individual #268, dated 5/17/11). In addition, evidence of HRC review and approval was not available for Individual #335. Training documentation was not available for three of the sampled individuals. For the remaining seven individuals, it appeared that consents, reviews and approvals were received prior to training for five (71%) of the individuals. The two exceptions appeared to be cases were training of the PBSP was initiated prior to completion of all necessary consents: 1) Documentation indicated that the PBSP for Individual #268 was trained on 7/20/10, prior to receipt of guardian consent on 8/19/10; and, 2) Documentation indicated that the PBSP for Individual #9 was trained on 3/15/11 prior to receipt of guardian on 4/11/11.<br><br>This provision item continues to be rated as being in noncompliance because of the inadequacy of behavioral programming as described above. | |
| 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. | No progress had been noted in completing inter-observer agreement (IOA) checks on behavioral data being collected. In addition, concerns remained regarding the adequacy of data collection, data display, and ongoing monitoring.<br><br>Currently, inter-observer agreement of PBSP data was not being collected. This finding was consistent with previous findings. As a result, the accuracy of collected data still could not be estimated. As presented in the Monitoring's previous reports, the availability of data that PSTs could have confidence in is essential in ensuring that teams make effective data-based decisions. Discussions with CCSSLC staff continued to center on starting with a small sample (i.e., perhaps with those individuals with the most restraints or with the most restrictive programming), and piloting an initial methodology/process for collecting IOA data, and examining its effectiveness and efficiency in collecting sufficiently reliable data. This process, obviously, also needs to be acceptable and feasible to behavioral service staff.<br><br>As noted in the previous monitoring report (i.e., Section K.10, report dated 2/25/11), the current policy required additional specification with regard to how reliability checks would be completed and scored, as well as more detail with regard to the implications for inadequate scores. It should be noted, however, that this additional specification in policy will be increasingly necessary as behavioral services staff start to conduct IOA on their data collection systems and determine what exact procedures will be acceptable.<br><br>As noted in the Monitoring Team's previous report, the presentation of data using graphic display appeared to have become typical practice. This included both behavioral | Noncompliance |

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| | | and skill data. It appeared that CCSSLC behavioral services staff were becoming more familiar with graphing data. However, as presented earlier with regard to Section K.4 of the Settlement Agreement, there were still some concerns regarding the quality of the graphs. These concerns were not new, as most were consistent with previously identified issues described following the Monitoring Team's previous visit.<br><br>Previously presented concerns that continued to be noted as problematic following the Monitoring Team's most recent visit included: 1) displaying multiple types of data (e.g., frequency, percent, milligram) on a single Y-axis; 2) dark backgrounds or colored data paths that did not copy well; 3) not labeling axes, especially multiple Y-axes; 4) compressed data range for one variable due to the very large range of a second variable (usually medication dosages); 5) the inclusion of too much data on one graph; 6) including data on graphs that had not been defined or not including data that was defined; and 7) using bars/columns in place of line graphs. Many examples were noted in the previous Monitoring report (i.e., Section K.10 of the Settlement Agreement, dated 2/25/11).<br><br>Examples of currently noted issues are briefly described below:<br>▪ Displayed data (either graphed or in tabular format) should include dimensions of behavior that are included as objectives.<br>o Individual #186, for example, had an objective on his SPCI that targeted the duration of restraints. However, data on the total or average duration of restraints was not provided in the data table. In general, data on duration of restraints was not typically noted.<br>▪ When the displayed data was more than one type of data (e.g., frequency and percentage), a second Y-axis should be used to facilitate more effective interpretation.<br>o The data graph for Individual #174 on the June PSP monthly behavioral services review was difficult to interpret due to many legends, as well as a shared y-axis across both frequency and percentage values.<br>▪ The presented data should be consistent with the behavioral descriptions or objectives.<br>o Data on the graph provided on the PBSP for Individual #58 reflected multiple replacement behaviors. However, only one replacement behavior was identified and defined within the PBSP.<br>o There was no objective, operational definition provided for the replacement behavior for individual #58 on the PSP monthly review.<br>o Although a second replacement behavior was defined for Individual #312, data did not appear to be graphed for this behavior.<br>▪ Data that is displayed should be interpretable.<br>o When reviewing the PSP monthly data for Individual #58, it was | |

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| | | challenging to determine what the data on which Skill Acquisition Objective (SAO) and Skill Acquisition Plan (SAP) were represented on the graph. It could not be determined if they were frequencies or percentages.<br>o It is often more difficult to interpret changes in responding over time using bar graphs (e.g., PBSP data for Individual #335 and monthly data for Individual #109). Consideration should be given to using line graphs.<br>o In general, many Y and X-axis across reports were not clearly labeled and, at times, incorrectly labeled (e.g., June 2011 monthly behavioral services review for Individual #9).<br>▪ The interpretation of presented data should not be inhibited by colors of bars/lines, or difficult to read due to background color of graph or number of legends presented.<br>o Interpretation of the graph provided within the PSP monthly review for Individual #186 was difficult to interpret given that the bar graph uses colors to discriminate between dependent measures listed on the legend.<br>o Interpretation of the data paths across multiple variables (i.e., nine potential data paths) was made more difficult by colored background on the June 2011 PSP Monthly Behavioral Services Review for Individual #164. A similar difficulty was noted, for example, in the PBSPs of Individual #335, Individual #312, and Individual #109.<br>▪ Data graphed should accurately represent raw data provided with tables.<br>o The data displayed with the graph on the PBSP for Individual #105 did not appear to coincide with the raw data presented with the table. In addition, it would be helpful to have more recent data included in the graph.<br>▪ Data included on graphs should be provided to assist the PSP team in interpreting the effectiveness of treatments, including medications. It was difficult, if not more inefficient, to interpret whether or not changes in medication were related to changes in behavioral functioning when the information was presented on separate graphs. If possible, information should be included on the same graph to assist with more effective interpretation.<br>o Two separate graphs are included to: 1) show target and replacement behaviors; and 2) medication changes for Individual #58 on the PSP monthly review for behavioral services. Medication (name and dose) could be included below the 1st graph where the raw target and replacement behavior data were displayed (i.e., this redundancy is not necessary). This would allow more efficient comparison of medication changes and potential correlate changes in behavioral functioning. | |

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| | | o The range of daily dosages was so extreme that changes in medications over time were imperceptible in the graphs on the June 2011 PSP Monthly Behavioral Services review for Individual #7. In general, adding medication information to graphs is helpful and often necessary in interpreting potential relationships (i.e., effectiveness) with behavioral functioning. If they are not graphed together or there are no changes in medication dosages over time, it might not be beneficial to provide the medication information.<br><br>As recommended at the previous review, consideration should be given to: 1) accurately labeling both axes; 2) using multiple graphs, when appropriate, 3) illustrating data differently (e.g., providing medication dosages in tables below graphs), when appropriate; 4) using multiple Y-axes to display different dimensions of behavior; 5) utilizing phase/condition change lines to demarcate changes in treatment or other significant changes in functioning; 6) avoiding using color to differentiate between variables as graphs will ultimately be copied; and 7) avoiding using bar/columns within graphs to represent behavioral functioning (i.e., they might be helpful in representing medication levels).<br><br>Overall, if data is more thoughtfully displayed within graphs and/or tables, a significant amount of displayed information could be removed from PBSPs and PSP Monthly Reviews to eliminate redundancy. For example, it is unnecessary to display the raw data beneath a graph (e.g., graph in PBSP for Individual #312), if the data could be reasonably and quickly estimated by viewing a conspicuous data path on a graph. In this example, medication(s) and dosages information across months could replace the behavioral raw data at the bottom of the graph. A good example of this was found in the graphs displayed in the psychological evaluation for Individual #268. However, the replacement behaviors should be graphed on a separate Y-axis to allow more effective interpretation.<br><br>Lastly, one area where improvement was noted was in the area of the format and review of the PSP behavioral services monthly progress review note. More specifically, the monthly review note template was revised to include progress related to counseling and desensitization plans. In addition, a small random sample of these notes was selected and reviewed weekly by BSC (as of May 2011). As this process was random and the Clinical Psychologists made the selection, it ensured that an accurate reflection of the current status of these reports was sampled.<br><br>This provision item continues to be rated as being in noncompliance because of the lack of IOA, and the continued limitations observed within data display that impaired effective and efficient interpretation. | |

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| 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. | Progress had continued within the area writing PBSPs so that they could be understood and implemented by direct support professionals.<br><br>At the time of the last review, CCSSLC had recently adopted the State Office PBSP template, dated 12/15/10, which was significantly shorter, more organized, and easier to read. One of the benefits of this template was the "staff instructions" section, which was the second half of the PBSP and was developed as a "cheat sheet" for the overall PBSP. According to verbal reports, this cheat sheet was designed to be a brief summary of critical components of the PBSP and, consequently, facilitate staff training and treatment integrity. At that time, however, plans had not yet been developed using the new template.<br><br>For this most recent review, 10 PBSPs were sampled from those completed since the Monitoring Team's last visit. This sample represented 10% of the total number of PBSPs completed since the Monitoring Team's last visit (i.e., documentation revealed that 99 PBSPs had been completed since the last visit). Of these sampled PBSPs, the staff instructions section had been completed for nine (90%). There were no staff instructions found in the PBSP developed for Individual #7. It was unclear why this PBSP did not include the abbreviated staff instructions. Overall, the staff instructions averaged 4.5 pages in length and ranged from three to six pages in length. In some cases, however, this "cheat sheet" was a long as the PBSP it was designed to supplement (e.g., Individual #275 and Individual #186). Overall, if this abbreviated document is going to be helpful, vigilance regarding its length must be maintained.<br><br>It should be noted that, although it is assumed that a shorter "cheat sheet" would likely increase treatment integrity, the staff instructions section needs to be accurate, and is only as useful as the original PBSP from which it is developed. For example, the staff instructions sections section did not adequately define the target behavior for Individual #16. Consequently, behavioral services staff need to ensure that the staff instructions section is an accurate reflection of a quality PBSP.<br><br>Verbal reports during the Monitoring Team's most recent visit indicated that the State Office format for PBSPs was likely to change again in the very near future. This new format will be examined at the subsequent monitoring visit in January 2012.<br><br>As reported in the previous Monitoring report, integrity checks, using the Competency Check for Behavior Support Plan, had been occurring since April 2010. This rubric was utilized to examine how knowledgeable a particular staff member was regarding a randomly selected PBSP, including the 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. | Noncompliance |

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| | | According to verbal reports, these checks had continued. At the Monitoring Team's last visit, it was reported that, although data had been collected using this new tool for some time, the data had not yet been sufficiently analyzed. According to verbal reports, this continued to be the status at the time of the most recent review. That is, no summary data from these checks was available for review, and, at the time of the onsite review, no implications had been drawn from the collected data.<br><br>This provision item continues to be rated as being in noncompliance because of the lack of a comprehensive system to monitor and ensure adequate treatment integrity. | |
| 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. | Minimal progress had been made in the area of competency-based training.<br><br>At the Monitoring Team's previous visit, it was noted that rubrics designed for the assessment of staff competency had been developed, and were regularly utilized across programs. Documentation provided for this most recent review evidenced that behavioral services staff were using this checklist with staff. More specifically, 25 completed Competency Check for Behavior Support Plan rubrics provided as examples indicated that these were used between this past April and June, and were completed on the PBSPs of 20 individuals across nine residential programs. Review of the rubrics indicated that 12 (48%) appeared incomplete or completed incorrectly. More specifically, some of the completed checklists did not indicate if the interviewed staff had been trained on the PBSP (e.g., Individual #184, dated 5/28/11; and Individual #83, dated 5/25/11), did not score all of the items (e.g., Individual 297, dated 5/10/11; Individual #155, dated 5/14/11; and Individual #202, dated 5/30/11), did not date the assessment (e.g., Individual #176), or appeared to complete the rubric incorrectly (e.g., Individual 315, dated 6/4/11).<br><br>Overall, based on documentation provided and verbal reports, these competency checks appeared to be ongoing. According to the current small sample reviewed, direct support professionals answered more items correctly than incorrectly. Unfortunately, the rubric did not produce a quantitative score, and no reliability estimates had been generated. As a result, the current review was limited. It would be helpful that, in the future, reports summarizing the data collected are generated, displaying the data over time to illustrate trends, and draw implications for subsequent practice.<br><br>It was noted that a workgroup, comprised of professionals both within and external to the Behavioral Services Division, was formed and met several times (in February 2011) to discuss how to approach competency-based training at CCSSLC. It appeared that the group initiated changes to the new staff orientation, and were considering changes to onsite training as well. The Monitoring Team strongly encourages this group to continue its work, and more specifically, to review and examine the data that had been collected | Noncompliance |

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| | | with regard to the PBSP competency-checklist. Considerable data collected had been collected, and the workgroup should consider the utility of the data collected and whether or not additional items, revision to the rubric, or other changes are necessary to support the assessment as a useful tool that will allow accurate monitoring of staff competencies, as well as an efficient process that can be regularly used to offer implications for future training.<br><br>Previous verbal reports indicated that staff trainings continued to incorporate active learning strategies (e.g., modeling, rehearsal, repeated practice, etc.). These types of strategies were highlighted in recently implemented Psychological and Behavioral Services Positive Behavior Support Plan policies. However, at the most recent onsite visit, an observation of a PBSP training session did not evidence the use of these active learning strategies. Only one brief training session, which a relatively new psychology assistant led, was observed. Although the trainer was knowledgeable about the PBSP and the individual, presented as enthusiastic, and was comprehensive (i.e., used lots of examples), the training was primarily didactic, and did not include use of data sheets, the PBSP, or the "cheat sheet" as supplemental aids during the training. In addition, onsite requests for training documentation appeared challenging for staff. That is, it appeared difficult at times for the Facility to locate specific training documentation. This appeared to suggest, for example, that it might be difficult for supervisory staff to identify who had been trained on a particular PBSP when trying to assign pulled staff.<br><br>As previously noted, the provision of adequate training in the area of PBSPs and SPCIs continued to be a serious concern, and a result, this provision item continues to be rated as being in noncompliance. | |
| 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 most recent review, based on verbal report and documentation provided, there were 14 Associate Psychologists, in addition to the Clinical Psychologist (who did not carry a caseload), and 6.5 Psychology Assistants (i.e., six full-time and one part-time position). None of these professionals currently held BCBAs. In addition, at the time of the most recent onsite visit, a new Director of Behavioral Services was hired. She did have her BCBA.<br><br>As of the most recent on-site review, CCSSLC served 273 individuals. Based on this number and the understanding that the Clinical Psychologist and Director of Behavioral Services would not carry a caseload, an approximate average psychologist-to-individual ratio was estimated at 1:20. Given the provided documentation, there appeared to be less than two psychological assistants for every Associate Psychologist employed.<br><br>However, as noted with regard to Section K.1 of the Settlement Agreement, this provision | Noncompliance |

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| | | was rated as in noncompliance because the professionals in the Psychology Department were not yet demonstrably competent in applied behavior analysis as required by the Settlement Agreement 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 identify and ameliorate, if possible, reasons why the remaining few staff members are reluctant to take graduate coursework toward their BCBA. It might be necessary to meet individually with these staff to identify remaining obstacles, and problem-solve regarding their unwillingness or inability to pursue professional competencies in ABA. (Section K.1)
2. CCSSLC should ensure that the contracted BCBA professionals have sufficient time to adequately supervise staff members enrolled in coursework according to supervision guidelines outlined by the Behavior Analyst Certification Board. This might include developing a specific schedule across the two supervising BCBAs to ensure that all staff enrolled in coursework are provided the necessary supervision. (Section K.1)
3. Behavioral services staff should ensure that they are documenting (on required BACB forms) and tracking their supervision over time. (Section K.1)
4. In order to ensure adequate critical review during BSC meetings, especially when the consulting BCBA is not available to be onsite, any supplemental feedback (e.g., emails, etc.) should be included in the meeting discussion and documented in the BSC meeting minutes. (Section K.3)
5. BSC attendees should be scheduled to attend one of the two weekly meetings to help avoid burnout of staff. If a member targets only one of the weekly meetings, it might maintain more consistent attendance, as well as more diverse attendance at weekly BSC meetings. (Section K.3)
6. The membership of the SEPR should be expanded to include competent professionals (e.g., BCBAs) from settings external to CCSSLC. This could occur via emails, phone conference, online (e.g., Skype), etc. This should include continued efforts to attract BCBA professionals from other Texas Facilities or elsewhere that would offer alternative perspectives, evaluations, and feedback on perhaps more restrictive or intrusive behavioral programming. Preferably, the membership of this committee should include professionals who are board certified in behavior analysis. This committee should continue to meet to provide alternative perspectives, evaluations, and feedback on CCSSLC's most challenging individuals, including perhaps those individuals with more restrictive or intrusive behavioral programming. (Section K.3)
7. Polices regarding internal and external peer review should be updated to reflect current practice. This should include specific items related to the agendas of BSC and SEPR, as well as identification of the professionals who need to be in attendance to ensure adequate critical peer review. (Section K.3)
8. More standardization of data collection methodology and expectations is needed. The policies should be modified to include more detail regarding what data is to be included and in what format across documents (e.g., psychological evaluations, SFBAs, PBSPs, SPCIs, etc.). (Section K.4)
9. When appropriate, data should be collected, monitored, and graphed on the frequency and duration of restraints, especially in cases where the duration of restraint is actively targeted as a goal or objective. (Section K.4)
10. Now that the behavioral services database has been fully populated, percentages of delinquent documents should be monitored (by residence, unit or professional) per month over time as a method of providing performance feedback and remaining vigilant regarding workload issues. (Section K.5)
11. With regard to SFBAs, expectations should be established to clearly identify the information that is required, the level of detail that would be helpful, and encouraging summarization and integration of information, when possible. Too much information, specifically raw and redundant

data, should be removed from these assessments. Raw data should be summarized and integrated into the reports. Psychologists should ensure that the raw data is stored appropriately and available, as necessary. (Section K.5)

12. Ongoing training should be provided to psychologists on the concepts of setting events, antecedents, and consequences, as well as how to integrate these identified elements into effective PBSPs. (Section K.5)
13. Ongoing training should be provided to psychologists to ensure adequate understanding of elements of the SFBA. That is, psychologists should understand why direct observation is critical to effective assessment and document their observations accordingly. When findings from rating scales are inconsistent, additional indirect and/or direct assessments should be completed. (Section K.5)
14. 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 might be more appropriate and/or would provide more meaningful data (i.e., scatter plot, ABC 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. (Section K.5)
15. Specific policies regarding ongoing use of standardized intellectual testing should be clarified in current policy, if not already in place. (Section K.7)
16. All recommended psychological services, including but not limited to psychological counseling, should be identified within the psychological assessment and PSP. In addition, these services should be goal-directed, include measureable outcomes, and treatments should be evidenced-based. These might best be evidenced through the use of a more expanded comprehensive treatment plan, which would need to be integrated into the PSP. Recent changes within CCSSLC practices in this area should be included in revisions to current policy and/or procedures. (Section K.8)
17. As previously recommended, data should be collected on the use of any intervention conceptualized, described or utilized as therapeutic (or therapy). 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 determinations of whether or not procedures reflect evidenced-based practice can occur. Then, psychological and behavioral services staff as well as the PST can determine whether or not the time and resources spent on these therapies are effective. (Section K.8)
18. The empirical support should be reviewed for any assessment methodologies or therapy strategies provided to individuals served by CCSSLC, whether on or off campus. In addition, PSTs, with the assistance of the new Autism Specialist, should consider whether or not other evidenced-based assessments (e.g., The Assessment of Basic Language and Learning Skills) and/or practices (e.g., functional communication training, picture exchange communication system, etc.) might be a better match to assess and address the underlying needs of those identified as requiring alternative therapies. (Section K.8)
19. Staff should ensure that a brief section on history of previous interventions as well as reducing restrictiveness (of behavioral interventions and strategies, not just medication) is included in PBSPs. It is important to provide a background on ineffective procedures, as well as specific criteria (clear objectives) of behavioral progress (or deterioration), and to include target and replacement behaviors, which would identify when team reviews or PBSPs revisions would be considered. Levels of supervision or other restrictive procedures (e.g., use of mitts) should be identified within a hierarchy, and goals should be established for the fading of restrictive practices based on performance. (Section K.9)
20. In addition, PBSPs should include reminders to utilize reinforcement, specification regarding data collection, and procedures to reduce the intensity of the intervention. (Section K.9)
21. Peer reviews of PBSPs should continue to determine if target and replacement behaviors are operationally defined, prescribed interventions address identified hypotheses, if replacement behaviors are functionally equivalent, and whether or not antecedent interventions are truly preventative in nature. In addition, they should examine whether or not the use of reinforcement is conspicuous, and if reinforcers are individualized. (Section K.9)
22. As recommended in previous reports, 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 utilized. That is, provision of reinforcer (and/or quality of reinforcer) should be dependent upon the accuracy of responding. (Section K.9)

23. In addition to previous recommendations regarding reinforcers, formal reinforcer/preference assessments should be completed with regularity and findings should be integrated within skill acquisition programs and PBSPs. (Section K.9)
24. A system should be developed for assessing and monitoring inter-observer agreement for PBSP data. It might be helpful to approach this as a pilot program and start on a small scale. More specifically, this system should be implemented and data should be collected, examined, and analyzed on a select number of individuals or with a few programs before implementing it system-wide. Staff are encouraged to review the textbook Applied Behavior Analysis (2nd edition) by Cooper, Heron, and Heward (2007) for more specific information on conducting IOA. (Sections K.4 and K.10)
25. On behavioral graphs, just as target behaviors are labeled (e.g., "aggression" "SIB", etc.), replacement behaviors should be labeled as well. This should include identifying them naturally. For example, identifying a behavior as "adaptive coping" as opposed to "replacement behavior #1." In addition, replacement behaviors should be conspicuously and operationally defined. (Section K.10)
26. Replacement behaviors should, in addition to formal teaching sessions, be monitored and tracked as they occur in the natural environment. As this additional data is collected, it should be integrated into monthly graphs. (Section K.10)
27. In an effort to facilitate more efficient and effective visual analysis of graphs, psychologists should:
    a. Accurately label both axes;
    b. Use multiple graphs or eliminate unnecessary data (especially across multiple formats of display);
    c. Illustrate data differently (e.g., providing medication dosages in tables below graphs), when appropriate;
    d. Use multiple Y-axes to display different dimensions of behavior;
    e. Utilize phase/condition change lines to demarcate changes in treatment or other significant changes in functioning;
    f. Avoid using color to differentiate between variables, as graphs will ultimately be copied; and
    g. Avoid using bar/columns within graphs. (Section K.10)
28. Treatment integrity data should be collected, summarized, and examined. The collection and review of this data is necessary to ensure confidence that programs are implemented as written, and that the system is being responsive to issues related to poor integrity. (Section K.11)
29. 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. This data was not always quickly available. (Section K.12)

The following are offered as additional suggestions to the State and Facility:

1. When appropriate, the amount of redundancy should be reduced within reports by integrating and summarizing information or avoiding the inclusion of information repeatedly throughout reports, such as data, definitions, strategies, etc. When appropriate, the amount of redundancy should be reduced across reports. That is, some data and information is not needed across different reports, for example, specific information related to intelligence tests are not necessary in SFBAs or PBSPs. (All of Section K)

| SECTION L: Medical Care | |
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| | **Steps Taken to Assess Compliance:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o Physician services staffing;<br>o Name and CV of Medical Director;<br>o Name and degrees of all primary care providers that are new to Facility since last monitoring;<br>o Number of individuals on each physician's caseload;<br>o Employees listed under Medical Department completing CPR training certification with dates of completion;<br>o Copy of any in-service training for PCPs on ICD and DSM diagnostic criteria in last six months;<br>o Copy of continuing medical education (CME) for each primary care provider, since the Monitoring Team's last visit;<br>o Copy of any clinical guidelines developed and implemented, since the Monitoring Team's last visit;<br>o Infection Control Committee minutes, dated 3/23/11;<br>o Skin Integrity Committee meeting minutes: dated 11/30/10, and 2/16/11, and graph of decubitus at CCSLC, from 9/10 to 3/11;<br>o Most recent results/report of the medical quality improvement program, including identification of trends and descriptions of improvement actions taken; record audit report and trend analysis 4/11, and Medical provider quality assurance audit by external medical peer reviewers, dated 4/18/11 to 4/19/11;<br>o Medical team morning meeting minutes and documents, including 24-hour log, Infirmary and hospitalization reports, dated 7/11/11, 7/12/11, 7/13/11, and 7/14/11;<br>o Medical team meeting minutes, dated 6/13/11 to 7/11/11;<br>o Most recent results/report of the Facility-wide medical review system, including copy of any non-Facility physician review reports or data since last monitoring visit;<br>o List of individuals who died since last compliance visit with clinical background information;<br>o Transition packet, community agency submitted documents, autopsy report for Individual #351;<br>o Corrective actions related to Mortality Reviews;<br>o Current Do Not Resuscitate (DNR) list, with reason/criteria for DNR;<br>o List of death reports that remain incomplete/outstanding;<br>o Annual medical assessments and physical examinations and prior annual assessment and examination for following individuals: Individual #48 annual medical assessment 1/27/10, 5/25/11, physical evaluation 1/17/10, 5/25/11; Individual #147 annual medical assessment 1/8/10, 5/28/11, physical evaluation 1/8/10, 6/1/11; Individual #31 annual medical assessment 1/11/10, 5/30/11, physical evaluation 1/11/10, 5/30/11; Individual #296 annual medical assessment 1/28/10, 5/25/11, physical evaluation |

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| | 1/29/10, 5/26/11; Individual #251 annual medical assessment 10/28/09, 5/17/11, physical evaluation 10/28/09, 5/17/11; Individual #174 annual medical assessment 12/21/10, 5/20/11, physical evaluation 12/21/10, 5/20/11; Individual #114 annual medical assessment 8/25/10, 5/4/11, physical evaluation 8/25/10, 5/4/11; Individual #268 annual medical assessment 7/8/10, 4/25/11, physical evaluation 7/8/10, 4/25/11; Individual #335 annual medical assessment 11/24/09, 5/18/11, physical evaluation 11/24/09, 5/18/11; Individual #109 annual medical assessment 7/27/10, 5/23/11, physical evaluation 7/29/10, 5/23/11; Individual #56 annual medical assessment 12/28/10, 5/9/11, physical evaluation 9/1/10, 5/9/11; Individual #52 annual medical assessment 1/12/09, 5/24/11, physical evaluation 1/11/10, 5/25/11; Individual #348 annual medical assessment 12/10/09, 5/18/11, physical evaluation 12/7/09, 6/6/11; Individual #13 annual medical assessment 1/28/10, 5/26/11, physical evaluation 1/29/10, 5/26/11; Individual #274 annual medical assessment 1/11/10, 5/31/11, physical evaluation 1/11/10, 6/1/11; Individual #87 annual medical assessment 7/12/10, 6/2/11, physical evaluation 7/12/10. 6/2/11; Individual #112 annual medical assessment 7/30/10, 5/20/11, physical evaluation 7/30/10, 5/23/11; Individual #193 annual medical assessment 1/25/10, 5/25/11, physical evaluation 1/26/10, 5/31/11; Individual #308 annual medical assessment 7/6/10, 6/3/11, physical evaluation 7/6/10, 6/3/11; Individual #302 annual medical assessment 1/27/10, 6/2/11, physical evaluation 1/27/10, 6/6/11;<br>o Specialty clinic schedule per month for past six months;<br>o List of all outside consultations for medical purposes for the past six months, categorized by specialty;<br>o List of individuals with vagal nerve stimulator (VNS), and date of VNS placement, if applicable, replacement date;<br>o List of individuals with fractures, date of fracture, type of fracture, bone fractured, since last Monitoring Team's visit;<br>o List of individuals with injuries requiring visit to emergency room (ER) or hospitalization, since last Monitoring Team's visit;<br>o List of individuals with pica or ingesting inedible object, date of ingestion, object ingested, whether taken to ER or hospitalized, since the last onsite review;<br>o Policies and procedures for medical screening and routine evaluations, including Health Care Guidelines (HCG)-Medical and Nursing LL.17, Prevention Overview, draft 1/4/10, approval 11/4/10, implementation 12.5.10;<br>o For those over 50, date of last colonoscopy, and list reason for colonoscopy (preventive versus evaluation of active problem), with reason if not up-to-date: colonoscopy tracking;<br>o For those women over 40, date of last mammogram and reason listed if not up-to-date: mammogram tracking;<br>o Current list of all those with osteopenia/osteoporosis with medications and dosage per person, from 1/1/10 to 6/3/11;<br>o All DEXA scan reports completed in prior two years, including DEXA scan, from 2009 to present; and list of those with osteoporosis/osteopenia, osteomalacia undated; |

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| | o For all individuals over the age of 50, a list of the last DEXA scan dates, as well as copies of the most recent DEXA scan reports for each individual;<br>o For individuals with Down syndrome, date of last thyroid test;<br>o Integrated progress prior to transfer to ER for the following: Individual #184, dated 4/29/11; Individual #177, dated 5/12/11 to 5/23/11; Individual #183, dated 4/6/11 to 4/16/11; Individual #294, dated 3/4/11 to 3/5/11; Individual #202, dated 4/30/11 to 5/3/11; Individual #380, dated 4/28/11; Individual #141, dated 4/15/11 to 4/20/11;<br>o ER Reports/information for the following: Individual #184, dated 4/29/11; Individual #131, dated 3/31/11; Individual #177, dated 5/23/11; Individual #22, dated 5/31/11; Individual #3, dated 5/13/11; Individual #294, dated 3/4/11; Individual #292, dated 5/25/11; Individual #202, dated 5/3/11; Individual #380, dated 4/28/11; Individual #141, dated 4/20/11;<br>o For those going to ER and not hospitalized, post-ER documentation at Facility for following: Individual #184, dated 4/29/11; Individual #131, dated 3/31/11; Individual #22, dated 5/31/11; Individual #3, dated 5/13/11; Individual #294, dated 3/4/11; Individual #292, dated 5/25/11; Individual #202, dated 5/3/11; Individual #380, dated 4/28/11; and Individual #141, dated 4/20/11;<br>o Recent hospitalization admission and discharge information and post–hospital CCSSLC medical record information for the following: Individual #238, dated 5/1/11; Individual #177, dated 5/24/11; Individual #49, dated 5/6/11; Individual #3, dated 5/13/11; and Individual #326, dated 5/30/11;<br>o Copy of hospital liaison nurse documentation of hospitalization for the following: Individual #177, dated 5/24/11; Individual #49, dated 5/6/11; Individual #3, dated 5/13/11; Individual #276, dated 4/30/11; Individual #175, dated 5/10/11; Individual #91, dated 4/17/11; Individual #91, dated 5/20/11; Individual #316, dated 5/23/11; Individual #37, dated 4/19/11; and Individual #380, dated 4/28/11;<br>o Length of stay for Infirmary admissions for past six months;<br>o Infectious disease epidemiology report January 1, 2011 to June 1, 2011; infections by residence - 516, 518, 524D, date range 4/1/11 to 6/7/11;<br>o Avatar pneumonia tracking forms for past six months;<br>o Individuals with pneumonia and taking food/fluid by mouth;<br>o Incident rates for pneumonia June 2010 through May 2011;<br>o Incident rates for decubitus September 2010 through May 2011;<br>o Incident rates for urinary tract infections (UTI) September 2010 through May 2011;<br>o Incidence rates for bowel obstruction;<br>o Individuals newly diagnosed with cancer;<br>o Individuals newly diagnosed with cardiovascular disease over past year;<br>o Individuals newly diagnosed with diabetes mellitus over past year;<br>o Individuals with sepsis over past year;<br>o Individuals with bowel obstruction or bowel perforation for past year;<br>o Individuals newly diagnosed with pneumonia;<br>o List of individuals who have diagnosis of constipation or are receiving anti-constipation |

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| | medication at least weekly. Constipation reports 11/1/10 through 6/3/11;<br>o All policies and procedures related to seizure management: HCG – Medical and Nursing LL.12: Seizure management Medical and Nursing, draft/revision 11/4/10, approval 11/4/10, implementation 12/5/10; and Providing HealthCare Services M.24. Seizure Management, approval 4/1/11, implementation 5/1/11;<br>o A list of all individuals being treated for seizure disorders;<br>o For past six months, documentation of seizure management for following individuals: Individual #122, Individual #340, Individual #270, Individual #25, and Individual #247;<br>o List of individuals seen by neurologist with dates seen and reason, since last monitoring visit;<br>o List of those with status epilepticus, since the last monitoring visit;<br>o List of seizure medications per individual for diagnosis of seizure disorder: Individuals diagnosed with seizure disorders, revised 5/29/11;<br>o List of those going to ER for uncontrolled/prolonged/new onset seizure, since last Monitoring Team's visit;<br>o List of individuals with refractory seizure disorder;<br>o List of individuals with refractory seizure disorder who are being evaluated for VNS placement and the stage of evaluation;<br>o Percentages of individuals on two or more antiepileptic drugs;<br>o Percentages of persons on older Antiepileptic drugs (AEDs) (Phenobarbital, Dilantin, Mysoline);<br>o For individuals with pica or ingesting inedibles, copy of most recent BSP and subsequent addendums: Individual #38, Individual #379, Individual #200, Individual #159, Individual #307, and Individual #7;<br>o DADS Policy #009.1 Medical Care, dated 2/16/11;<br>o Request to Post/Training Roster "Timely Assessment Completion, addition of living option recommendation," dated 4/28/11;<br>o Instructions for living option recommendations;<br>o Copy of Annual Medical Assessment Form;<br>o Request to Post/Training Roster "Action Plan/POI, State Office Policy 009.1," dated 5/11/11;<br>o Medical records, including most recent annual medical assessment and physical exam, CARE DG-1 form, most recent nursing assessment, most recent PSP and subsequent quarterlies, last one year of lab, x-rays, other diagnostic tests, consults for the last year, most recent health management plan, most recent BSP, hospital admission history and physical summaries and discharge summaries, ER visits in the last year, resuscitation status including out-of-hospital DNR forms, active problem list/inactive problem list, physician orders for the past year, operation/procedure reports for the past year for the following: Individual #48, Individual #58, Individual #311, Individual #179, Individual #183, Individual #160, Individual #24, Individual #23, Individual #348, Individual #175, Individual #173, and Individual #247;<br>o Presentation Book for Section L; |

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| | ○ Record Audit Report and Trend Analysis, for 2/11, 3/11, 4/11, and 5/11;<br>○ CCSSLC policy: Medical Care LL.28: Quality Assurance Program, draft/revision 1/27/11, approval 2/3/11, implementation 2/5/11;<br>○ Quality assurance questionnaire: ER visits/hospitalizations, implemented 4/15/11, revised 5/16/11;<br>○ Request to post/training roster: Medical quality assurance, dated 2/11/11: clarify and reinforce CCSSLC Medical Quality Assurance Policy LL.28 to improve understanding and promote compliance;<br>○ Request to post/training roster: New Medical External Auditor Tool, dated 5/6/11;<br>○ Procedure: medical quality assurance;<br>○ Medical provider quality assurance audit tool; and<br>○ State Office draft clinical guidelines/protocols: Enteral (tube) feeding Interdisciplinary protocol, dated 7/12/11; Gastroesophageal reflux disease (GERD) interdisciplinary protocol, dated 7/6/11, and Constipation interdisciplinary protocol, dated 7/6/11.<br>▪ **Interviews with**:<br>○ Sandra Rodrigues, Acting Medical Director;<br>○ Althea Pat Stewart, Medical Compliance RN; and<br>○ Dr. Norma Brown.<br>▪ **Observations of**:<br>○ Individual #122, Individual #334, Individual #101, Individual #70, Individual #126, Individual #161, Individual #278, Individual #303, Individual #244, Individual #286, Individual #340, Individual #342, Individual #205, Individual #366, Individual #43, Individual #151, Individual #176, Individual #104, Individual #212, Individual #57, Individual #124, Individual #189, Individual #183, Individual #160, Individual #70, Individual #335, Individual #150, Individual #24, Individual #207, Individual #64, Individual #307, Individual #16, Individual #252, Individual #28, Individual #250, Individual #25, Individual #130, Individual #328, Individual #324, Individual #222, Individual #299, Individual #50, Individual #113, Individual #146, Individual #163, Individual #181, Individual #350, Individual #301, Individual #293, Individual #127, Individual #240, Individual #68, Individual #316, Individual #290, Individual #32, Individual #245, Individual #195, Individual #77, Individual #247, and Individual #314; and<br>○ Morning medical meetings, on 7/12/11, 7/13/11, 7/14/11. |
| | **Facility Self-Assessment:** The Facility assessed itself as not being in compliance with any of the provisions in Section L. However, the Plan of Improvement provided information concerning progress that was made in each of the subsections for Section L. According to the Facility, since the Monitoring Team's last visit:<br>▪ With regard to Section L.1, since the Monitoring Team's last visit, a medical policy was developed and implemented focusing on acute medical problems, and providing guidance for early detection and early treatment intervention. A procedure for the prevention and management of aspiration pneumonia was revised and implemented. To improve integration of recent information into the annual PSP discussion, the timeline for completion of the annual medical assessments was to be at |

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| | least 10 days prior to the PSP. A tracking system and database was created to monitor completion of these assessments in a timely manner. Guidelines were provided for updating the diagnoses listed on the Form CARE DG1, the goal being removal of diagnostic errors and updating of the diagnosis list reflective of changes in health status. A tracking system was developed and implemented to document closure to tests and reports. A Quarterly Medical Summary Form was developed.<br>▪ For Section L.2, two PCPs from other SSLCs, had conducted an audit at CCSSLC and reviewed five percent of each PCP's caseload. To determine inter-rater reliability, the Medical Compliance RN conducted a Facility audit of the same sample. Results of the two audits indicated a lack of updated and signed active problem lists, no information concerning individuals' smoking habits, and a lack of quarterly medical summaries. The PCPs were provided this information for corrective action on 6/10/11.<br>▪ For Section L.3, a Medical Quality Assurance Policy was created and implemented. On 2/28/11, the first internal audit was completed to determine compliance with medical policies and procedures. On 3/5/11, data was generated from this first internal audit. A second internal audit was completed on 3/31/11. Additionally, a monitoring tool was developed that the Hospital Liaison Nurse would complete to review completion of hospital packets. A third internal audit was completed on 5/31/11, with results shared with the PCPs for corrective action on 6/10/11.<br>▪ For Section L.4, a number of policies were implemented, and the implementation was followed by quality review to determine progress in compliance with these medical staff policies.<br><br>This narrative information regarding steps taken to reach compliance was very helpful. With regard to the use of internal auditing data to substantiate compliance findings, it was positive that internal audits now were being completed monthly. However, it was unclear how the data was being used to assist in making the compliance determinations. Compliance scores were overall scores for each monitoring tool (e.g., Integrated Progress Notes, hospitalizations, annual examinations, etc.), as opposed to data being broken out to address the various components of a provision, which would have made it more useful to the Facility in identifying areas still needing improvement, as well as areas of strength. As its self-assessment processes are finalized, the Facility should discuss in the POI the analysis of the information gained through its audits as well as other data streams, the identification of areas needing attention, as well as steps planned or taken to make needed improvements. |
| | **Summary of Monitor's Assessment:** The morning medical meeting had the needed components to support the provision of quality medical care, but members need to be challenged to ask critical questions and raise clinical concerns. For those admitted to the hospital or sent to the ER, the question that should be addressed until closure is what are the steps that need to be taken to prevent a recurrence of the hospitalization or ER visit.<br><br>An improved medical database was needed, an essential step in creating a medical QI program. Many of the diagnostic categories had conflicting information and/or incomplete information.<br><br>Non-facility medical peer review had begun, with one visit completed, during which five percent of the |

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| | medical records was reviewed. The medical QI component had developed many aids for the PCPs (several lists) to improve compliance, and tracked five percent of the records of each PCP on a monthly basis.<br><br>The Monitoring Team noted high compliance rates of completing preventive tests, such as colonoscopies and mammograms.<br><br>The clinical mortality reviews needed further work to ensure that they raised important issues and corresponding recommendations.<br><br>The Medical Department's involvement in transition planning was not adequate, and there was no system to track and prevent poor clinical outcomes for those transitioning to the community.<br><br>Although the Facility was not in compliance with any of the provisions of Section L, there were substantial gains with regard to all of the provisions. |

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| L1 | Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. | 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, physician participation in team process, routine care and preventative care, medical management of acute and chronic conditions, Do Not Resuscitate (DNR) Orders, and mock codes and the emergency response system.<br><br><u>Staffing</u><br>Since the Monitoring Team's last visit, the Medical Department underwent administrative changes. The Medical Director stepped down to become a full-time PCP, and carried a caseload of 61 individuals (although 62 were listed under the unit breakdown). A second PCP had a caseload of 79. A third PCP carried a caseload of 71. The Family Nurse Practitioner (FNP) carried a caseload of 63. Caseload assignments were effective as of 6/22/11. There was an ongoing search for a new Medical Director. Assisting the Medical Department was a medical administrative assistant, a medical compliance nurse, and a medical program specialist. There was also a respiratory care practitioner. Also listed under the Medical Department were two specialty physician consultants, including an orthopedic surgeon, and a neurologist.<br><br>A list of Medical Department staff completing CPR training certification was submitted. All PCPs were up-to-date on CPR recertification, assuming a two-year certificate. All Dental Department staff also were CPR certified, except one dental hygienist. There were three other staff listed, belonging to the Psychiatry Department, including a psychiatric | Noncompliance |

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| | | nurse and two psychiatric assistants, all of whom had the comment that there was limited contact with individuals, and the certification was not needed. The Facility should review the policy to ensure that all those staff who might encounter individuals on campus either in a direct role, or by proximity, are CPR-certified. It would benefit all individuals who live at CCSSLC, as well as all staff that work there, if all staff were CPR certified and participated in mock drills. This would provide a pool of trained staff in any situation in any location on campus to make a potential code maximally effective.<br><br>A copy of recent continuing education activities was submitted for the PCPs. One PCP accumulated 25 hours of CME, as of 6/1/11. The FNP completed 31 hours of continuing education. Topics were not listed on the PCP certificate by specific topics, but were under the generic heading of "general medicine." However, on the FNP certificate, the topics were osteoarthritis, hyperlipidemia and cardiovascular disease, diabetes pharmacology, and hypertensive crisis. These topics were important and relevant to care of the individuals at CCSSLC. The other PCPs had no documentation of CME submitted. The Facility should ensure that all licensed staff meet the minimum state requirements for continuing education, but also that the topics are relevant to care of the individuals residing at CCSSLC.<br><br><u>Physician Participation In Team Process</u><br>There was a morning medical meeting each business day that reviewed hospitalizations, residents in the Infirmary, and any acute needs since the previous meeting. A member of the Monitoring Team attended three meetings during the onsite review, on 7/12/11, 7/13/11, and 7/14/11. Documents reviewed during the meetings included the 24-hour log for Ribbonfish, Kingfish, and Sanddollar/Seahorse. The Medical Program Specialist took minutes the each day, which included an attendance roster, as well as updates from the infection control nurse, the hospital liaison, the Infirmary nurse, and any updates from the 24-hour report. For the three days of observation, only one concern was identified as requiring follow-up until closure. Given the numbers of individuals that were entered on the various morning report logs, this suggested that the meeting was greatly underutilized. A number of questions should be raised at the morning medical meetings that would require follow-up and subsequent closure. Discussion of the follow-up information that is presented at subsequent meetings would provide a basis for an integrated approach to the health system. For instance, conjunctivitis was discussed, but there was no information concerning the number of individuals in the building where the individual was located, if there were others that had conjunctivitis in the recent past in that residence or other residences, and the steps taken to prevent transmission. The same question could have been raised with another individual with skin abscesses. It would have been helpful to determine if others in his residence or at his day program had skin infections over the past several weeks. For those with pneumonia or bronchospasm and wheezing requiring hospitalization, issues that might have been | |

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| | | helpful, but were not discussed, included the distribution of cases in the residences, the last time the ductwork in the residence was cleaned, if there was a concern for an allergic component to the pulmonary problem, and the pattern of antibiotic resistance. Assigning the appropriate discipline to research and bring the answer back within a specified timeframe to the morning medical meeting would have provided information and education to several disciplines, as well as prompted discussion as to next steps, if needed. The morning medical meeting is central to integration of care and quality oversight of care.<br><br>Due to the increasing emphasis on transitions, and to ensure their success, the Medical Department has expanded the annual medical assessment to include a recommendation from the PCP regarding whether or not the individual was appropriate for community living, with a listing of medical supports that would be required, as well as skill acquisition training that would be needed. This information was to be completed at the time of the annual assessment, and was entitled "Living Option Recommendation." On 4/28/11, an in-service was provided to the PCPs concerning "timely assessment, completion, addition of living option recommendation."<br><br>As part of quality care, a number of areas of routine clinical care were identified for review and tracking. These requirements were outlined in and implemented pursuant to the State policy on medical care (DADS Policy #009.1). This policy included action steps and documentation requirements concerning acute medical problems, completing and updating the active problem list, PCP orders, hospitalization/ER visit documentation and communication, consult report review and documentation, and response to pharmacy concerns. An in-service was held on 5/11/11 to review these areas of compliance and expectations. As mentioned with regard to Section L.3, these areas were a central part of the medical quality improvement program developed in the six months prior to the Monitoring Team's review.<br><br><u>Preventive Care</u><br>As part of the monitoring review process, the Monitoring Team selected the medical records of 12 individuals to determine compliance with several requirements of Section L.1, separate from the Facility reviews. Selection was focused on those individuals with one or more aspects of health care that currently placed them at high risk or potentially could result in high risk in the near future. Documents reviewed included the most recent annual assessment and physical exam; the DG-1 form; the most recent nursing assessment; the most recent PSP and subsequent quarterlies; the last year of laboratory results, x-rays, or other diagnostic tests; the last year of consults; the most recent health management plan; the most recent BSP; any hospital admission history and physical, or discharge summaries for the past year; any ER visit reports from the past year; the resuscitation status and any out-of-hospital DNR forms; active problem list/inactive | |

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| | | problem list; physician orders for the past year; and any operation/procedure reports from the past year. Each aspect reviewed is discussed as the relevant preventive or routine care topic is discussed.<br><br>For the 12 medical records reviewed, six (50%) had documentation of the most recent vision screen or eye exam. The submitted documents did not appear to mention vision screening in the others. Audiological screening was documented in eight out of 12 (67%). It could be that both auditory and visual screening occurred in all 12 individuals, but this information could not be readily identified in the submitted documents. It is suggested that the annual medical assessment include all consultation screenings. If a screening is only indicated every two or more years, providing the date of the most recent screening would indicate the individual was being following in a timely manner.<br><br>The annual influenza vaccination was documented as administered in all 12 records (100%). For varicella immunity, there was testing for immunity and/or vaccine administration in 11 out of 12 medical records (92%).<br><br>Of the twelve individuals, there were five men age 50 or greater. Of these men, four (80%) had a PSA value on the record.<br><br>One of the preventive care tests recommended is a yearly thyroid test for those with Down syndrome. A list of 13 individuals was submitted with a diagnosis of Down syndrome. Of these. 12 (92%) had thyroid testing completed within the year prior to the team visit (7/10/10 to 7/10/11).<br><br>Information was reviewed concerning completion of mammograms in the eligible population. There were 101 women over age 40 living at CCSSLC. Twenty-two of these had reasons documented for not ordering a mammogram. This left 79 individuals. Of these, one was overdue (due by 6/21/11), and it had not been ordered. There were two others overdue, but appointments had been made. There was one completed 4/22/11, but this individual was scheduled for another one on 6/24/11, and the reason was not indicated. The compliance was 76 out of 79 (96%) compliance. It was noted one individual was age 83, and unless there were other indications of need, would not need a mammogram (cut off was age 75) in the future.<br><br>Of the 12 records reviewed, there was only one female in the age range for which a mammogram was recommended. This individual was current with mammogram testing.<br><br>The Facility also tracked colonoscopies. For those over the age of 50, the date of the last colonoscopy was submitted, and the reason for the test (prevention versus evaluation of an active problem). Reasons for not pursuing the test also were submitted. There were | |

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| | | 129 individuals over the age of 50. Of these, the families refused to sign consent in seven cases. Subtracting these from the total, there were 122 individuals for which preventive colonoscopies were recommended. There were seven of these 122 pending appointments. There were 12 individuals that were overdue and no reason was given, nor was there a pending appointment. Compliance was 110 out of 122 (90%).<br><br>For the twelve records reviewed, six individuals were over the age of 50. Of these four (67%) had a colonoscopy, or a colonoscopy was ordered at the time of the review. It was noted that occult blood testing was ordered at the time of the physical exam in at least some of the records, but the results could not be found. Additionally, if they were completed, the PCP did not appear to address the results in the IPN. The Medical Department should review where the results of occult blood in stool testing are located to ensure they are easily accessible. The PCP should write an IPN for stool guaiac test results.<br><br>Information concerning osteoporosis prevention and treatment was reviewed. A list of those with osteoporosis was submitted. Fifty-four names were provided. Other documentation submitted included copies of the last DEXA scan reports for each of those over 50 years of age. Based on the DEXA scan reports, several other individuals besides the 54 listed had osteoporosis. Their T scores were lower than -2.5. There were eight individuals with T scores ranging from -3.1 to -7.0. Some on the list of 54 were mislabeled as osteoporosis prevention when the T score indicated a diagnosis of osteoporosis (for example, Individual #101 with a T score -4.7, Individual #244 with a T score -5.4, and Individual #356 with a T score -5.6). The list included medications. However, the list of medications appeared to be incomplete and in need of review. There were many without Calcium and Vitamin D listed as part of treatment and prevention. Others with a diagnosis of osteoporosis were only prescribed calcium, according to the list provided.<br><br>A separate list of all those with osteopenia/osteoporosis with medications and dosage per person was submitted. This list also appeared to be incomplete. Some individuals were listed as taking calcium, and others were not.<br><br>Based on the 12 medical records reviewed, there were six individuals identified as having a diagnosis of osteoporosis. Of these, two (33%) had adequate treatment prescribed.<br><br>Although a number of individuals had DEXA scans, and medication for osteoporosis was prescribed, the databases appeared unreliable and incomplete in attempting to determine adequacy of diagnosis and treatment. The Medical Department should review this area of medical care, and meet with the Information Technology Department (IT) to | |

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| | | create a quality database as well as a system for accurate and complete database entry. Because of the high rate of osteopenia and osteoporosis in the population residing at CCSSLC, a quarterly report should be generated of individuals with these diagnoses, the most current treatment (including medications, as well as calcium and Vitamin D), as well as the T score with the date of the DEXA scan. This would provide a ready reference in determining if all individuals with osteoporosis/osteopenia were receiving recommended medication and treatment, and whether serial DEXA scans are obtained at recommended intervals to determine efficacy of medication.<br><br><u>Routine Care</u><br>The Facility submitted the twenty most recent annual medical assessments and physical examinations, along with the prior annual assessment and examination. For the current annual medical assessments and physical examinations, eight (40%) were timely compared to the date of completion of the prior medical assessment. Additionally, there was one current annual physical evaluation completed 19 days after the annual medical assessment. It is recommended that these be completed synchronously or within a week of each other.<br><br>From the 12 medical records that were reviewed, all (100%) had a current annual medical assessment and physical examination completed. This information could not be compared to the prior annual medical assessment and examination. There was information about clinical aspects of transition to the community in two out of 12 annual medical assessments (17%). These appeared to occur in the more recent annual medical assessments, as both were dated in May 2011. Smoking history and counseling, if the individual had a smoking habit, was addressed in seven out of 12 annual medical assessments (58%).<br><br>Active and inactive problem lists were components of the annual medical assessment. These were updated for the annual assessment. Of the 12 records, eight (67%) had a form entitled "medical problem list: active or resolved," which was updated. For the other four, these forms were not submitted. This could have indicated there were no new active problems since the annual medical assessment, new diagnoses occurred but there was no update, or the form was not submitted. An occasional record had several lists of medical problems, including old lists. There was also a gap in some years. It was not clear the purpose of retaining the old lists in the record. Once these lists are incorporated into the active or inactive list in the annual medical assessment, it might provide clarity to thin them from the medical record.<br><br>The CARE-DG-1 forms were reviewed. These provided information concerning Axis I, II, and III diagnoses, the ICD codes, and the last date of diagnosis. For eight of the 12 individuals (67%), the forms appeared updated. For the remaining four individuals, | |

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| | | important diagnoses were not added to the list, such as osteoporosis, placement of a gastrostomy (G-tube), and the statement that there was "no diagnosis on Axis II." This all should have been corrected at the time of the annual medical assessment.<br><br>For the IPN format, the Facility used a SOAP note (Subjective, Objective, Assessment, Plan) for PCP visits. Of the 12 records, nine (67%) consistently used this format, and two did not use this format consistently. There was one record in which the SOAP format was intermittently used. All IPNs had date and time of entry. Additionally, all had comments about consultant reports, and all commented on abnormal lab or other abnormal test results. No record had quarterly summaries, indicating no compliance with this aspect of documentation.<br><br>A list of outside consultations over the six months prior to the Monitoring Team's visit was submitted. The following number of appointments were logged per specialty: endocrinology - six, gynecology - 17, hematology - six, nephrology - eight, neurology (off campus) - nine, oncology - four, rheumatology - three, surgery - 11, ophthalmology - 121, dermatology - 24, cardiology - 56, urology - 45, gastroenterology - 56, oral surgery - 16, podiatry - 22, pulmonary medicine - 12, orthopedic consults and shoe fittings - seven, and ENT - 19.<br><br>Additionally, there were several specialty clinics completed on campus. Neurology clinic was held on 12/18/10, 1/15/11, 2/12/11, 3/12/11, 4/2/11, and 5/7/11. For the neurology clinics, the following number of appointments were made per month: December 2010 – 22 appointments, January 2011 - 27 appointments, February 2011 - 20 appointments, March 2011 - 25 appointments, April 2011 - 15 appointments, and May 2011 – 23 appointments. Orthopedic clinic was held on 1/19/11 and 4/20/11.<br><br>These specialty clinics and appointments indicated a wide spectrum of medical specialists were available to the individuals residing at CCSSLC.<br><br>Information from seven records was submitted to review the PCP's documentation prior to transfer to an ER. All 7 (100%) were considered timely in their medical treatment. Only four out of seven (57%) included a set of vital signs in the IPN. All indicated the reason for the transfer.<br><br>Medical information from nine records was reviewed to determine medical management after an ER visit. Of these, one individual was hospitalized at the time of the review, and the hospital liaison nurse made entries in the record. The other eight records were reviewed to determine whether the PCP had made an IPN entry. Seven out of eight records (88%) had an entry from the PCP. The quality of the IPN was reviewed to determine whether a summary of the ER visit was included. Of the eight records | |

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| | | reviewed, six (75%) included a summary of the ER visit.<br><br>Infirmary admissions from the prior six months were submitted. There were 135 admissions to the Infirmary, either from the residence or returning from the hospital. Length of stay varied from less than one day to 47 days.<br><br>The seizure management of five individuals with seizure disorders was reviewed. All five had seen a neurologist within the prior year. The neurologist listed the medications and dosages, and number of seizures since the last visit in all five neurology consults. A focused physical exam was documented in three of the five (60%). Side effects were mentioned in one (20%) of the neurology consult notes. Serial MOSES assessments were completed in all five records (100%). It is recommended that the form "neurology consultation report" include a brief section for side effects for summarizing the MOSES results. This document is part of the neurology office visit and would assist in ensuring that there is documentation of the neurologist's review of side effects/toxicity, as well as the PCP who signs off on the MOSES scores.<br><br>The Facility submitted information concerning the type of seizure management practice at CCSSLC. The percentages of individuals on older anti-epileptic drugs were provided. The information raised concerns. The information that was submitted documented that 85.2% of individuals (with seizures) were on Mysoline. This is an extremely high percentage for any anti-epileptic medication. When reviewing the "List of seizure medications per individual for diagnosis of seizure disorder," a brief review of the list did not find any individual on Mysoline. It is recommended the Medical Department review this information. It also was reported that 23.5% of individuals with seizures were taking Dilantin, which might be consistent with the list of seizure medications per individual. Additionally, 0.02% of individuals were on Phenobarbital. The percentage of use for these two latter medications indicated they were prescribed a minority of time, and have been replaced by newer antiepileptic medications for many of the individuals with seizure disorders. No data was submitted to indicate whether the use of Dilantin had decreased or remained the same over the past several quarters.<br><br>The information submitted indicated that 27.9% of individuals with seizures were prescribed two anti-epileptic medications. A total of 18.3% of individuals with seizures were taking three anti-epileptic medications. An additional 0.04% of individuals were prescribed four anti-epileptic medications, and 0.02% was taking five anti-epileptic medications. There were three individuals considered to have a refractory seizure disorder. In the six months prior to the Monitoring Team's visit, two individuals had been sent to the ER for prolonged seizure activity. However, during this time period, a document submitted indicated no one had status epilepticus. This information was problematic, because there were two individuals, who subsequently died, that had status | |

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| | | epilepticus during this time period (Individual #375 with status epilepticus on 12/15/10, and Individual #380 on 4/28/11). This suggested the need to ensure the data collection is complete and accurate. At CCSSLC, there were eight individuals with vagal nerve stimulators. There were two individuals for which a vagal nerve stimulator was being considered due to a refractory seizure disorder.<br><br>There were seven incidents in which there was possible pica ingestion. Six of these incidents were by one individual. In only one incident was there confirmation that pica had occurred (x-ray confirmed battery ingestion). All were examined at CCSSLC. The one confirmed ingestion was referred to the local hospital.<br><br>For individuals with pica habit or who ingested inedibles, the most recent BSP and subsequent addendums were provided. For Individual #38, the most recent BSP was signed and dated May 2011. There was the statement that there was "improvement in her challenging behaviors since her new placement 3 months ago. We will no longer be taking data on swallowing of items as staff are able to redirect as needed." The graph indicated the last incident was September 2010. There was no information indicating the type of object historically ingested. It was not clear how new staff would learn of the type of objects historically ingested in order to ensure a safe environment, or know what to observe. BSPs submitted for five other individuals had components of pica behavior prevention, and staff response to pica behavior.<br><br>Concerns were noted in relation to the data maintained regarding pneumonia. According to the data submitted (i.e., document request IX.38), for two quarters only one pneumonia was listed. However, the timeframe for the list appeared incomplete, and did not represent six months, but only appeared to include two months of data. The Avatar tracking forms did not have any pneumonia listed. However, a separate list of pneumonias indicated several pneumonias in the prior six months. A table entitled "incident rates for pneumonia" appeared to be actual numbers of pneumonias per month. Interpreted in this way, the numbers of pneumonia per month were: December 2010 - seven, January 2011 – nine, February 2011 – nine, March 2011 – six, April 2011 – one, and May 2011 – one.<br><br>There was incomplete information provided for infections over the prior six months. A list of infection type by residence was provided, but only three residences were submitted (516, 518, and 524D). Also, the time period submitted was from 4/1/11 to 6/7/11 for these three residences. The reason for the limited information was not explained in the documentation. A separate list of infections was submitted, entitled "Edit List by time frame," and the infection onset date was from 4/4/11 to 5/12/11. It appeared to also include only selected residences. One finding was the large number of conjunctivitis reports included on this list. However, it was difficult to interpret any of | |

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| | | the infectious disease data, given the limited time period and residence selection for which data was provided. If the Facility was submitting only selected information, the rationale should be provided.<br><br>Urinary tract infections numbered from three to seven per month over the prior six months, averaging 4.8 per month.<br><br>According to one document submitted, for the prior six months, there was one decubitus ulcer listed from March 2011. However, a graph of decubiti through March 2011 indicated there were two decubiti in December 2010, and two in January 2011. As has been noted in tracking other diagnoses and conditions, the lack of consistency in the submitted documents indicated a need to review database management to determine the cause of discrepancies and provide a system that is complete and accurate.<br><br>For the 12 medical records reviewed, a number of diagnoses were reviewed to determine adequacy/completeness of treatment. Two of the 12 had hypertension. Of the two, one (50%) had no change in diet (such as reduced sodium intake). The reason for not instituting a therapeutic diet (such as escalation of behaviors) was not documented. Eleven were on bowel management medication, ranging from one to five medications. Two of the 12 had four "as needed" (prn) medications for constipation. None required hospitalization for constipation. Nine of the 12 had GERD. All nine (100) had adequate medical treatment of GERD.<br><br><u>Do Not Resuscitate Orders</u><br>A list was submitted of those individuals with DNR status, totaling 30 individuals. The reasons for these included: neurological degeneration (five individuals), osteoporosis (eight individuals), decline in respiratory function (four individuals), osteomyelitis (one individual), and family request (12 individuals). The list remained problematic. Osteomyelitis is not typically considered a terminal condition. For those listed as "family request," the Facility needs to ensure the diagnosis is terminal and meets the standards the State Office set. If the standard is not met, then the DNR would need to be rescinded, and a family meeting held to provide the information and rationale for such a change. For those with osteoporosis, there are those for whom chest compression would crack several ribs and produce a flail chest. The State Office should provide guidance in such cases. A limited code might be appropriate, including the use of intravenous (IV) medication and ambu bagging, with chest compressions being the only part of the code that is not provided. For those with respiratory or neurologic deterioration, providing an actual diagnosis would be more helpful in understanding the reason for the code. A justification should be located in the IPN concerning each of these individuals. For those with respiratory functional decline, there should be proof of this, such as measurements of lung function when possible, with findings indicating decline. Those with decline | |

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| | | might require the appropriate consultant review with agreement and documentation of decline.<br><br>Dates of DNR implementation were not provided, but for those with longstanding DNR orders, the Facility should review these to determine if a DNR is the appropriate decision, or whether the individual has stabilized and no longer meets criteria for a DNR status.<br><br>No DNRs were rescinded in the six months prior to the Monitoring Team's visit.<br><br><u>Mock Code Drills and Emergency Response Systems</u><br>Findings and recommendations related to mock code drills and emergency response systems are discussed with regard to Section M.1 of the Settlement Agreement. | |
| 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. | Two physicians from other SSLCs completed medical peer review audits on 4/18/11 and 4/19/11. From each PCP's caseload, the QA Director selected a random sample. A total of 14 record reviews were completed. A copy of each of these was submitted. The external reviewers completed a State Office form entitled: "Medical Provider Quality Assurance Audit." The Facility did not provide a final written report from the two external reviewers. It was not evident there was a written report, but findings were communicated, because some changes were evident in the subsequent documentation by PCPs. This included whether individuals had a smoking history, and if currently smoking, whether counseling had been offered. The Medical Department provided a table of findings included in a different Facility medical QA document, which reviewed the findings from the external peer review. Based on the summary the Facility developed, the following summarizes a breakdown of the major areas of compliance reviewed, and provides a brief summary of points reviewed in completing the medical provider quality assurance tool.<br>▪ Compliance with the active problem list was 52%. The external peer reviewers determined if the active problem list was in the correct location, was dated, updated as new problems arose, and as problems resolved.<br>▪ Response to acute problems compliance was 83%. The external reviewers determined if the medications ordered for acute problems included indication/diagnosis and duration of treatment. The external reviewers also determined the appropriateness of diagnostic tests and treatments that were ordered.<br>▪ PCP orders compliance was 91%. The external reviewers determined if the 180-day physician order sheet included the indication and duration for each medication, and whether the PCP responded to the pharmacy recommendations in the QDRR. The QDRR also was reviewed to determine whether the rationale for polypharmacy was listed in the QDRR.<br>▪ IPN documentation compliance was 82%. External auditors reviewed significant | Noncompliance |

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| | | lab values to determine if response was documented in the IPN. There was determination if there was evidence that the PCP reviewed all tests and consultations, whether abnormal findings had follow-up and documentation of that follow up in the IPN, as well as review of the structure of the IPN, including date, time, signature, legibility, and SOAP (subjective, objective, assessment, plan) format. IPNs that focused on acute medical problems also were reviewed to determine if pertinent findings were entered, and an assessment and preliminary diagnosis were included based on this assessment.<br>▪ Consultations compliance was 81%. The external reviewers were asked to determine if the appropriate level of consultation was ordered for medical conditions. For referrals, the auditor determined whether there was transfer of information concerning present and past medical history. Written response to consultation reports was reviewed in the IPNs, and a determination made as to whether or not a rationale was provided for any recommendations not followed.<br>▪ Hospitalizations/transfers compliance was 50%. The reviewers determined whether there was sufficient documentation when an individual was transferred to the ER or hospital. When discharged from the hospital, the auditor reviewed the record to determine the quality and timing of the PCP's readmission IPN note. The reviewers also reviewed documentation in the IPN, which summarized any hospitalization or ER visit, including next steps to be ordered.<br>▪ Annual exam and summary compliance was 80%. The external reviewers determined if the annual physical exam and summary were current and complete, included important health events of the present and past years, included adequate documentation of drug/food allergies and reactions, whether the individual smoked, and if so, whether there was documentation if the individual was advised to quit smoking. There was also determination of adequacy of preventive services, and if not, if there was a reason documented.<br><br>Training on the Medical Quality Assurance program (both internal and external audits) occurred on 2/11/11. A training roster included the Medical Department PCPs. The content of the training was provided in a document: Procedure: Medical Quality Assurance and included a copy of the auditor's schedule statewide and a copy of the Medical Provider Audit tool that was to be used. A template of the Medical Provider QA audit results and action plans also was submitted, which provided action steps for significant findings discovered during the audit as well as a timeline in completing the corrective action. A compliance report for each PCP was provided for the initial non-Facility medical peer review audit. Results were then shared with each PCP for information and corrective action.<br><br>At the time of the Monitoring Team's visit, there had been one non-Facility medical peer review visit, which completed an audit of 5% of records. The threshold for compliance is | |

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| | | considered 20% record review per year (5% per quarter). Results of the findings were shared with each PCPs as part of performance improvement, and improvement in Facility compliance. According to the State Office model, the QA Department independently was to track the findings and recommendations at intervals to determine progress in addressing issues identified. The documents submitted only included blank copies of the Medical Provider Quality Correction Plan. However, the lead physician did speak with each physician and discussed findings. From the 12 records reviewed, there did appear to be improvement in some areas.<br><br>The Facility appeared to be on track for compliance, if four quarters of reviews are similarly completed. In addition, the Facility-wide results of the external medical peer review audit should be available in a written report from the two auditing PCPs. | |
| 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. | In February 2011, an internal Facility medical quality improvement initiative started. A monthly random sample of five percent of the documentation from each PCP's caseload was reviewed. A QA tool entitled "Settlement Agreement Section L – Medical Care: Routine, Preventative and Emergency Medical Care Consistent with Generally Accepted Professional Standards of Care" was utilized until the State Office tool, which the non-facility physician reviewers used, was available. This was an extensive review completed by the Medical Compliance RN. It included the following sections: active problem list documentation (eight indicators), acute medical problems documentation (10 indicators), PCP orders (four indicators), integrated progress note documentation (seven indicators), consultations (nine indicators), hospitalizations/transfers and readmissions (13 indicators), and annual plan of care/history and physical (20 indicators). Monthly results were tabulated. Once the State Office QA tool was available, it was utilized (instead of the local QA tool) to complete monthly auditing. This allowed the Facility to begin to make a determination related to inter-rater reliability between the Medical Compliance RN and the non-facility physician reviewers. As is discussed in other sections of this report, the process for determining inter-rater reliability should be standardized throughout all SSLCs.<br><br>The compliance scoring for the internal audit was an over-all 79% and for the external audit 77%, indicating close alignment in results. The findings were shared with each PCP.<br><br>For the months of February 2011, March 2011, and April 2011, the major medical services concerns (totaling seven) overall Facility-wide comparison indicated there was sustained improvement in response to acute problems compliance, but not in the other categories. This information provided the detailed tracking and findings to guide corrective action steps. Trends, which were noted during the monthly audits, indicated that the monthly active problem list was not updated, the preventive flow sheet was not | Noncompliance |

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| | | being completed, the quarterly medical summaries were not being completed, and the DNRs were not being reviewed, updated, and signed annually. One hundred percent compliance in several of the areas of the external audit tool was considered essential for an acceptable rating to occur. Facility-wide, three essential areas remained out of compliance: the active problem list was not reviewed, revised, and dated every 12 months; the active problem list was not updated with new diagnoses and problems resolved; and the annual physical exam and summary were not current. Three areas were 100% compliant: the active problem list was completed and maintained in the active record, the annual summary included significant medical events of current and past years, and drug/food allergies/sensitivities/reactions were appropriately documented.<br><br>As part of the corrective action plan, several PCP checklists were developed to assist in enhancing PCP compliance. Some or all of these checklists were placed on pocket sized/wallet sized cards to provide ready reference. These included the following checklists: Acute illness/injury checklist, ER/hospitalization checklist (on transfer to hospital and discharge from hospital), PCP orders checklist, infection control checklist, reports/consultations checklist, annual physical evaluation checklist, quarterly medical summaries, and quarterly drug regimen review. Training for these PCP checklists was completed on 1/19/11. Due date for implementation was documented as 2/5/11.<br><br>As another step to assist in achieving compliance, two other tools were created, an "annual assessment guideline," and the "DG1 guideline." The "annual assessment guideline" was implemented on 2/7/11 to ensure the annual physical assessments were completed according to the PSP Policy. The "DG1 Guideline" was implemented on 2/11/11 to ensure new diagnoses were efficiently documented on the CARE Form DG1 and submitted to the Medical Records Department for prompt database entry. These guidelines provided detailed implementation steps.<br><br>As part of the corrective action plan, a policy, "Integrated Clinical Services: G.5 Diagnostics, Appointments, and Consults Tracking," draft/revision 11/14/10, 3/11/11, approval 2/16/11, implementation 3/7/11, provided a detailed approach in tracking each step of a PCP order. Three logs were created to assist the staff in implementing this policy, including the Diagnostic Tracking Log, Appointment and Consult Tracking Log, and a Diagnostics Log Book.<br><br>Additionally a Quality Assurance Questionnaire was created for ER visits and hospitalizations, and tracked the content of the information packet sent to the hospital. The hospital liaison nurse was to complete these questionnaires. The questionnaire was implemented 4/15/11, and revised 5/16/11. | |

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| | | These numerous procedures and logs were implemented within a few weeks prior to the Monitoring Team's visit. Copies of diagnostic tracking logs, appointment or consult tracking logs, or ER/hospital QA Questionnaires that had been completed were not submitted, and will be reviewed during the Monitoring Team's next visit. Implementation of action plans based on trends revealed through the medical QA data analysis (internal and external) also will be reviewed.<br><br>The Facility did not have a quality assurance /monitoring system in place that was sufficiently sensitive to detect worsening health and safety of the individuals recently transitioned to the community. Adverse outcomes should be reviewed for at least 90 days after individuals transition to the community, and Facility expertise should be offered in an efficient and timely manner to prevent negative outcomes. In the transition of Individual #351, there was no Facility review of the adverse outcome, especially from the Medical and Nursing Departments. Reviews often require medical documents (from hospitals, ERs, and physician offices). It is recommended that at the time of transition, the guardian or responsible party be asked to sign a consent form to release medical information up to one year from the transition. For this individual, there was no specific training of community provider staff on a diagnosis that needed close follow-through on a daily basis, and could cause significant morbidity and mortality if not promptly treated. The PCP at CCSSLC should review the transition plan to ensure that all necessary medical/health training has occurred. In this case, there were recent changes in medications causing a delay of two weeks in the transition. This was a red flag, as individuals should be medically stable before transfer. There was no information to suggest shadowing of CCSSLC staff by the accepting provider agency staff had occurred, a valuable tool in understanding the nuances of behavior and health concerns in an individual. The individual that was transitioned was hospitalized shortly after transition, and 911 also was utilized several times over a short period of time. These were red flags, which should have alerted CCSSLC that there were problems in the transition. Part of the ongoing review by the appropriate CCSSLC staff should include a review of the hospital admission and discharge summaries, and other significant reports. Red flags should be followed by rapid communication between Facility administration and agency administration to offer support in appropriate areas to ensure health and safety. Not following the guidance of the Mobile Crisis Outreach Team was a red flag in this case. A positive toxicology report that was not followed to resolution also was a red flag. The inability to obtain a copy of the Medication Administration Record (MAR) was also problematic and raised concerns. The provider agency should be able to quickly obtain a copy of the MAR and forward to CCSSLC for review. This case had many red flag warnings, but there was no system at CCSSLC to catch any of these red flags. It is recommended that CCSSLC review the transition process to improve monitoring of those in transition, and provide technical assistance in a timely manner to reduce risk of a bad outcome. Additionally, a list identifying warning signs/red flags, which can be used as a | |

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| | | screen to determine whether concerns exist related to health and safety that require urgent intervention.<br><br>Various lists of individuals were provided that had specific diagnoses or conditions. A review of the fracture list indicated one of the fractures an individual sustained was not on the list (Individual #141 on 4/21/11). As noted above with regard to Section L.1, other discrepancies were noted with regard to the databases, including, for example, with regard to seizures and osteoporosis. This suggested the database management system was not complete. Medical quality review can only occur when there is reliable and complete data available. The Facility should review the quality of the data in the medical QI database to determine how a fracture would have been missed, but also review the other medical database care lists for completeness and accuracy.<br><br>An overview of the new quality improvement processes was reflected in a new policy: Medical Care LL.28: Quality Assurance Program, draft 1/27/11, approval 2/3/11, implementation 2/5/11. There was a database available, but it was incomplete, and was not being used for quality assurance purposes. There was no evidence that a comprehensive set of clinical indicators had been developed, or that the data available was being used to identify issues requiring the development of corrective action plans. In addition to the important monitoring/auditing of records, it also will be important for the Facility to develop a set of clinical indicators and outcomes through which to identify areas of strength, as well as areas of concern.<br><br><u>Mortality Reviews</u><br>Since the Monitoring Team's last visit, seven deaths had occurred of individuals that CCSSLC supported. Of these, five had autopsies completed, although one was an external exam only. One of the autopsy reports was provided, and the others were still pending. Of these seven deaths, three (43%) had both clinical and administrative reviews completed. Only the most recent ones had pending reviews. A copy of the death certificate had not been received on the most recent four deaths.<br><br>The age range was 41 to 74. The average age was 54. Five individuals had DNR status, and two were full code status. Based on the requirement to renew DNR status yearly, one DNR was outdated. Preliminary causes of death included the following: respiratory system associated death (pneumonia) in five cases; one had status epilepticus; there were comorbid conditions of renal failure in one case and congestive heart failure in a second case; and final definitive cause required the autopsy report in these two cases. In one case the cause remained unknown and autopsy was pending.<br><br>There were no recommendations from the clinical or administrative reviews for three deaths. There was a significant clinical recommendation for one death involving | |

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| | | appropriate tracking and recording of seizures and notification of health professionals (pharmacy, PCP, etc.); and two had recommendations involving location of the minutes from ethics committee. That there was only one clinical recommendation suggested the need for critical thinking from the physician reviewing the record, as well as more in-depth discussion at the time of the clinical review committee meeting. It is recommended that the Medical Department develop a list of critical questions that should be answered in reviewing each medical record. This might improve the scope and depth of clinical recommendations.<br><br>The importance of pneumonia in those that died suggested the need for continued vigilance in early recognition, but also the need to monitor to ensure there is proper positioning, timely respiratory therapy, and efficient communication between direct support professionals, respiratory therapy, and the PCPs. As a separate observation, it was difficult to determine from the medical record the date when hospice services began for those that were enrolled in this program. | |
| L4 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall establish those policies and procedures that ensure provision of medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. | The Medical Department had not drafted or implemented any clinical guidelines since the Monitoring Team's last visit. However, policies, checklists, and other guidelines were developed in the six months prior to the Monitoring Team's visit, including:<br>▪ HCG – Medical and Nursing LL.17: Prevention Overview, draft 11/4/10, approval 11/4/10, implementation 12/5/10;<br>▪ Providing HealthCare Services M.24: Seizure Management, approval 4/1/11, implemented 5/1/11;<br>▪ HCG – Medical and Nursing LL.12: Seizure Management Medical and Nursing, revision 11/4/10, approval 11/4/10, implementation 12/5/10;<br>▪ Medical Care LL.3.1: Responding to Acute Medical Problems, draft 12/22/10, revised 2/14/11, approval 1/6/11, implementation 1/17/11; Exhibit LL.3.1.1 Acute Illness/injury assessment guideline; unit referral clinic list;<br>▪ Medical Care LL.28: Quality Assurance Program, draft 1/27/11, approval 2/3/11, implementation 2/5/11;<br>▪ PCP Expectations: Acute illness/injury checklist, ER/hospitalization checklist, PCP orders checklist, infection control checklist, reports/consultations checklist, annual physical evaluation checklist, quarterly medical summaries, quarterly drug regimen review<br>▪ CCSSLC Annual Assessment Guideline, effective 2/14/11;<br>▪ CCSSLC DG1 Completion Guideline, effective 2/7/11;<br>▪ Integrate Clinical Services G.5: Diagnostics, Appointments, and Consults Tracking, draft/revision 11/14/10//3/11/11, approval 2/16/11, implementation 3/7/11; Diagnostic Logs Book, Diagnostics Tracking Log, Appointment and Consult Tracking Log | Noncompliance |

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| | | ▪ Quality Assurance Questionnaire: ER visits/hospitalizations;<br>▪ Procedure: Medical Quality Assurance; and<br>▪ Non-Facility medical peer review medical provider audit tool; medical provider QA audit – results and action plans.<br><br>As the State Office develops and issues clinical guidelines, CCSSLC will need to be prepared to implement them, and modify its policies and procedures to be consistent with the guidelines. | |

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

1. The Facility should review the CPR policy to ensure that all those staff that might encounter individuals on campus either in a direct role, or by proximity, are CPR-certified. (Section L.1)
2. The roster for CPR certification should include the date of expiration to allow the Facility to quickly determine who is due for recertification. (Section L.1)
3. The Facility should ensure that all licensed staff meet state requirements for continuing education, and that the topics included in the educational process are relevant to care of the individuals residing at CCSSLC. (Section L.1)
4. A number of critical clinical questions should be raised at the morning medical meetings, and their follow up, and subsequent closure should be documented. Concerns needing closure should be assigned to the appropriate discipline with a timeline established for researching the answer and bringing the information back to the morning meeting. (Section L.1)
5. The annual medical assessment should include all consultation screenings with the date of the last screen for that specialty (e.g., vision, audiology), even if it occurred more than a year prior. (Section L.1)
6. The Medical Department should review where the results of occult blood in stool testing are located to ensure they are easily accessible. The PCP should write an IPN for stool guaiac test results. (Section L.1)
7. The Medical Department should meet with the IT department to create a quality database for osteoporosis/osteopenia clinical management that is accurate and complete. (Section L.1)
8. A quarterly report should be generated for individuals with osteoporosis and osteopenia, along with current treatment and the T score with date of DEXA. This report should be analyzed to determine if all individuals with osteoporosis/osteopenia are receiving recommended medication and treatment, and whether serial DEXA scans have been obtained at recommended intervals to determine efficacy of medication. (Section L.1)
9. The annual medical assessment and annual physical evaluation should be completed at the same time or within a week of the other. (Section L.1)
10. For clarity, thinning the old inactive problem lists from the medical record might improve efficiency in reviewing the medical record. The inactive problem list in the annual medical assessment should be a complete list. There would be little reason to have other partial incomplete lists in the medical record, and could be potentially dangerous if copied and sent to the hospital and interpreted as the most recent and complete list. (Section L.1)
11. The form "neurology consultation report" should include a brief section for side effects summarizing the MOSES scores. This would assist in ensuring that the neurologist reviewed the MOSES, as well as the PCP who signs off on the MOSES scores. (Section L.1)
12. The Medical Department should review the quality of the information reported in the database for anti-epileptic drugs and status epilepticus. (Section L.1)

13. The Medical Department should review and correct the discrepancies in the pneumonia data, and the decubitus ulcer data, as well as collaborate with IT in ensuring such discrepancies do not recur. (Section L.1)
14. For those individuals that have DNR orders, the Facility should ensure there is a terminal diagnosis that meets the standards the State Office set. The terminal diagnosis should generally be a precise diagnosis, and not a vague clinical phrase. For those with a functional decline in a specific organ system (e.g., respiratory, neurological, cardiac), appropriate test measurements (e.g., ejection fractions, pulmonary function, etc.) and a second opinion from the appropriate specialist might be appropriate to determine agreement that the individual is in a terminal phase of a specific diagnosis. All such second opinions and test results supporting a terminal diagnosis should be documented and easily retrieved from the medical record. (Section L.1)
15. Certain conditions, such as severe osteoporosis, require State Office guidance concerning resuscitative steps that would be appropriate. The State Office might need to consider a limited (chemical) code and use of oxygen, ambu bagging without chest percussions, for example. (Section L.1)
16. The Facility-wide external medical peer review audit results should be available in a written report from the two auditing PCPs. (Section L.2)
17. When an individual is transitioned to the community and there is an adverse outcome, the Facility should review the information available, in order to identify steps to prevent a recurrence. (Section L.3)
18. The Facility should create a list of warning signs, which would prompt an offer of technical assistance to the provider agency to reduce the risk of an adverse outcome (e.g., any call for 911, any hospitalization, or ER visit). (Section L.3)
19. Separately, the Facility should create a list of high-risk events that should prompt consideration of a delay and observation period prior to transition (e.g., recent changes in medication, certain diagnoses that require nursing care around the clock). (Section L.3)
20. At the time of transition, the Facility should obtain consent for release of information of records should a review be necessary for up to one year. (Section L.3)
21. Prior to the individual transitioning, the PCP and Nursing Department at CCSSLC should review the transition plan and related documentation to ensure all necessary medical/health training has occurred, and that it has been adequate. (Section L.3)
22. For those with behavioral problems or complex medical needs, a period of shadowing by the community agency staff should occur to ensure that community provider staff are knowledgeable about the individuals' needs, their communication styles, as well as the plans in place to support them. (Section L.3)
23. The Facility should ensure the community staff are competent in responding to individuals' medical needs and behavioral challenges. (Section L.3)
24. The Facility should ensure the community provider agency completes an internal investigation of poor outcomes (including use of 911 and hospitalizations), and provides a copy to CCSSLC. (Section L.3)
25. In addition to the important monitoring/auditing of records, it also will be important for the Facility to develop a set of clinical indicators and outcomes through which to identify areas of strength, as well as areas of concern. (Section L.3)
26. The Medical Department should develop a list of critical questions that would assist in the appropriate level of in-depth review of clinical mortality reviews. (Section L.3)
27. The Medical Department should review and improve clarity of documentation of when hospice services are started for those individuals enrolled in this program. (Section L.3)
28. As its self-assessment processes are finalized, the Facility should discuss in the POI the analysis of the information gained through its audits as well as other data streams, the identification of areas needing attention, as well as steps planned or taken to make needed improvements. (Facility Self-Assessment)

| SECTION M: Nursing Care | |
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| 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:<br>▪ **Review of Following Documents**:<br>o CCSSLC's POI;<br>o CCSSLC's Nursing Supplemental POI;<br>o CCSSLC's Nursing Staffing levels;<br>o CCSSLC's Nursing Department Presentation Book;<br>o Entrance meeting department summaries;<br>o Performance Evaluation Team Presentation meeting minutes, from July 2011;<br>o Quality Assurance/Quality Improvement Council meeting minutes, dated 5/24/11, 6/1/11, 6/15/11, 6/27/11, and 7/8/11;<br>o Resume for new Infection Control (IC) Nurse;<br>o Resume for new Nurse Educator;<br>o QA Nurse's Health Monitoring Tool Audits and reports, for January through June 2011;<br>o Completed Health Monitoring tools from the Program Compliance Nurse, from January through June 2011;<br>o CCSSLC's nursing staffing vacancies;<br>o Newly developed curriculum for training regarding Nursing Care Plans;<br>o Current Emergency Equipment and Crash Cart Checklist forms for all units;<br>o Medication Observation summary data and trends;<br>o Nurse Educator Medication Observation form for onsite observation;<br>o Medication Administration Observation forms, from January through June 2011;<br>o CCSSLC's Medication Variance data;<br>o Pharmacy Medication Area Inspections, from January through June 2011;<br>o Infection Control Committee Meeting minutes, dated 3/23/11;<br>o CCSSLC's Immunization Database;<br>o Infection Control Environmental Checklists, from April through June 2011;<br>o Hand washing audits (not dated);<br>o Pharmacy and Therapeutics Committee Meeting minutes, dated 3/24/11;<br>o CCSSLC's Nursing training rosters;<br>o The training curriculum for the Comprehensive Nursing Assessment;<br>o Medication Error Committee minutes, dated 12/20/10, 1/24/11, 2/28/11, 3/21/11, 4/18/11, and 6/20/11;<br>o Timelines for infectious Outbreaks;<br>o CCSSLC's High Risk Individuals By Type list;<br>o Medical records for the following: Individual #58, Individual #43, Individual #247, Individual #48, Individual #218, Individual #24, Individual #92, Individual #7, Individual #222, Individual #163, Individual #183, Individual #270, Individual #153, Individual #379, Individual #159, Individual #117, Individual #21, Individual #284, Individual #303, Individual #378, Individual #86, Individual #136, Individual #312, Individual #332, Individual #228, Individual #353, Individual #234, Individual #247, Individual #351, |

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| | Individual #51, Individual #203, Individual #133, Individual #206, Individual #151, Individual #70, Individual #280, Individual #2, Individual #196, Individual #110, Individual #223, Individual #200, Individual #282, Individual #131, Individual #155, Individual #9, Individual #273, Individual #89, Individual #99, Individual #38, Individual #87, Individual #285, Individual #221, Individual #209, Individual #26, Individual #367, Individual #316, and Individual #297, Individual #179, Individual #276, Individual #151, Individual #350, Individual #159, Individual #327, Individual #2, Individual #210, Individual #377, Individual #213, Individual #139, and Individual #130;<br>o CCSSLC's Infection Control computerized surveillance data list;<br>o CCSSLC's lists of individuals who were seen in the emergency room, hospital, and Infirmary;<br>o Mock Code Drills Committee minutes, dated 2/14/11, 3/23/11, 5/6/11, 5/23/11, 5/31/11, and 6/8/11;<br>o Mock Code and Automated External Defibrillator (AED) Awareness Training roster;<br>o Mock Code follow-up tracking data;<br>o CCSSLC Mock Code graph data;<br>o Emergency Equipment Checklists for each residence;<br>o January through June 2011 Mock Code Trend data;<br>o CCSSLC's Mock Medical Emergency Drills and tracking sheets from January through June 2011;<br>o Emergency Competency data from January through June 2011; and<br>o CCSSLC's Mock Code DVD.<br>▪ **Interviews with**:<br>o Colleen M. Gonzales, BSHS, Chief Nurse Executive;<br>o Rhonda Lynn Warner, RN, QA;<br>o Jennifer Urban, RN, BSN, Nursing Operational Officer (NOO);<br>o Peggy Sue Miclan, RN, Program Compliance Nurse;<br>o Della Cross, RN, Nurse Educator;<br>o Kristen Middleton, RN, Nursing Educator;<br>o Elvira Obregon, RN, Assistant Infection Control Nurse;<br>o Brinda Fuller, RN, Psychiatric Nurse;<br>o Michelle Lord-Arteaga, RN, Psychiatric Nurse;<br>o Sara Jambers, Director CTD;<br>o Daniel Dickson, QA Director;<br>o Jeneba Jones, RN, QA; and<br>o Althea Stewart, RN, Medical Compliance Nurse for Medical Services.<br>▪ **Observations of**:<br>o Medication administration at the Infirmary;<br>o PSP for Individual #332, on 7/13/11; and<br>o Use of emergency equipment at Coral Sea, and Sea Horse. |

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| | **Facility Self-Assessment:** Based on a review of the Facility's POI, with regard to Section M of the Settlement Agreement, the Facility found that it remained out of compliance with the all of the provisions of Section M, which was consistent with the findings of the Monitoring Team. The Facility's POI indicated that auditing data for reviews conducted in the months of January through April 2011 for all areas for Section M were entered into State Office database, which provided an overall level of compliance for each area audited per month. However, providing one compliance percentage to represent the numerous items included on each of the Health Monitoring tools made the data impossible to interpret. Since the items were not weighted, such as the quality of a nursing note versus the mere completion of a nursing note, combining the compliance scores for all items on a monitoring tool did not accurately reflect anything of value regarding compliance.<br><br>Based on the Facility's implementation of a number of the Health Monitoring tools over the past year, the issues related to tool instructions, data presentation, and inter-rater reliability appeared to have much more meaning to the Facility during this review than in past reviews. As noted in previous reports, in order to move into a position of achieving substantial compliance, there are a number of foundational systems that have to be built solidly first. Quality of internal auditing, not just completion or the number of audits conducted, is the determining factor in appropriately assessing compliance. In order to adequately and consistently monitor all of the areas required by the Settlement Agreement, necessary structures have to be in place, including having clear and specific instructions for each of the monitoring instruments; auditors must be clinically competent in the areas they are reviewing in order for the data generated to be an accurate reflection of the current practices; and inter-rater reliability needs to be established for each of the Health Monitoring tools to ensure that all auditors are consistently determining compliance using the same process and criteria.<br><br>At this juncture, the Facility should decrease the number of Health Monitoring audits conducted, and implement the remaining critical pieces of the monitoring system listed above. This is necessary to generate credible data going forward. Since the last review, the QA Nurse and the Program Compliance Nurse had generated a significant number of completed monitoring tools. However, since the necessary structures had not been put in place, the data generated from the tools was not reliable. Once these systems are put in place, the Facility should give thoughtful consideration to prioritizing the reimplementation of the Health Monitoring tools, based on the problematic areas that affect the health and safely of the individuals at CCSSLC. |
| | **Summary of Monitor's Assessment:** Although not in compliance with the requirements of the Settlement Agreement, the Nursing Department continued to demonstrate its solid commitment to moving forward, using its relentless enthusiasm to learn from the process and implement interventions based on that information. In spite of this positive energy, a number of areas in nursing required urgent attention, as described below.<br><br>CCSSLC's Nursing staff had essentially remained stable since the last review, and had continued not to need the services of agencies to augment the nursing staffing coverage. The Chief Nurse Executive had reallocated a full-time Nurse Manager position to the Quality Assurance Department. Also, a part-time |

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| | position was added and filled for Nursing Education, with a Clinical Nurse Specialist to assist with training regarding nursing assessments and procedures. The Facility also had recently hired a full-time RN for the Infection Control Nurse position, who at the time of the review was in orientation. Additionally, a full-time RN position was assigned as the dedicated nurse on the Physical and Nutritional Management Team. These positives staffing reallocations and additions should assist the Facility in its efforts at moving forward toward achieving compliance with the requirements of the Settlement Agreement.<br><br>The data summary generated from the Facility's training database for the Health Monitoring tools was very promising. It presented the data by percentages of compliance by item for each of the nursing monitoring tools, which gave the data meaning. This type of presentation format should allow the Nursing Department, as well as other departments to determine what specific areas are operating well and those that are problematic, as well as the ability to follow the progress of these items on a monthly basis. This type of format also lent itself to developing focused plans of correction that could address the specific problematic items.<br><br>Consistent with the past three reviews, significant problems were found regarding the quality of the nursing care and documentation regarding acute illnesses, the nursing assessments, and Health Management Plans. Although a number of Health Monitoring tools for Acute Illness/Injury, Urgent Care, and Documentation had been completed, the Facility had not implemented any systemic changes, which resulted in any measurable changes regarding the nursing documentation and clinical outcomes for individuals that experienced an acute change of status resulting in an Infirmary admission, and/or hospitalization. The Facility should address urgently and aggressively the lack of the implementation of nursing protocols to guide nursing care, as well as the lack of development of appropriate Health Management Plans, and the associated documentation.<br><br>Since the last review, the Facility had continued to implement a number of interventions to address the Facility's Medical Emergency Response systems. Some of these included: the revision of the Facility's Medical Emergency Response procedure in alignment with the DADS State Office Policy for Medical Emergency Response procedure; implementation of additional emergency scenarios other than those requiring cardiopulmonary resuscitation (CPR), along with a new Medical Emergency Response form; development and implementation of a Medical Emergency Response database to track the Emergency Drills conducted and recommendations generated; development and implementation of an Emergency Response Code form to track the sequence of events during actual medical emergencies; purchase of four additional AEDs; an order for additional training mannequins; development of an impressive Mock Code Drill video as a resource for staff; posting of posters addressing procedures for choking and medical emergencies at a various locations around the Facility; and initiation of a review of Mock Code drills and actual emergencies at the Mock Code Drills Committee meeting. In addition, onsite observations of staff on two units found that the nurses observed were able to appropriately demonstrate the use of the emergency equipment. |

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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 nursing 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 assurance efforts, assessment, availability of pertinent medical records, infection control, and mock code drills and emergency response systems. 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 Settlement Agreement. Information and recommendations addressing nursing documentation regarding restraints is included in Section C.<br><br><u>Staffing</u><br>At the time of the review, CCSSLC had a census of 272 individuals. Since the last review, CCSSLC continued to have 62.7 positions allotted for Registered Nurses (RNs), and 51.5 positions for Licensed Vocational Nurses (LVNs), with 96% of the RN positions filled and 90% of LVN positions filled, according to the Chief Nurse Executive. The CNE reported that the nursing staffing continued to remain essentially stable, even with the current vacancies. The structure of the Facility's nursing services remained the same since the previous review.<br><br>In addition, the CNE had reallocated a full-time Nurse Manager (RN) position from the Tropical unit to the Quality Assurance Department, which was filled at the time of the review. Thus, the QA Department had two QA Nurses to assist in the auditing process of the Nursing Health Monitoring Tools. Also, in April 2011, a part-time position for Nursing Education was added, and filled with a Clinical Nurse Specialist to assist with training regarding nursing assessments and procedures. The Facility also had recently hired a full-time RN for the Infection Control Nurse position, who was in orientation at the time of the review. Additionally, in February 2011, a full-time RN position was assigned and filled as the dedicated nurse on the Physical and Nutritional Management Team. These positive staffing reallocations and additions should assist the Facility in its efforts at moving toward achieving compliance with the requirements of the Settlement Agreement.<br><br>Overall, CCSSLC continued to maintain an adequate and consistent nursing staff. Since the last review, the Facility had continued not to need the services of agencies to augment the nursing staffing coverage. Also, from discussions with the CNE, there was no indication that the Facility had fallen below minimum staffing levels since the last review. As recommended previously, although the nursing staffing had remained basically stable at CCSSLC, the Facility should continue its efforts in recruiting, maintaining, and evaluating reallocations of nursing positions to meet the requirements of the Settlement Agreement. Also, as previously recommended, as CCSSLC policies are | Noncompliance |

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| | | reviewed and/or revised, the Facility should ensure that policies, procedures or protocols address the integration of these new positions.<br><br><u>Quality Assurance Efforts</u><br>Although clearly, CCSSLC was invested in moving forward in meeting the requirements of the Settlement Agreement as quickly as possible, from discussions with the QA Director, CNE, QA Nurses, review of the PET meeting minutes, and review of the raw data from QA and Nursing for the Nursing Health Monitoring tools, the initial recommendations that the Monitoring Team made need repeating. To move into a position of substantial compliance, there are a number of foundational systems that have to be built solidly first, before the additional needed systems are constructed. This Facility's ability to develop this framework will affect the determination of substantial compliance in most areas. Quality of internal auditing, not just completion or the number of audits conducted, is the determining factor in appropriately assessing compliance. In order to adequately and consistently monitor all of the areas required by the Settlement Agreement, necessary structures have to be in place including:<br>▪ Clear and specific instructions should be developed for each of the monitoring instruments. At the last review, the Facility had begun using some promising instructions for some of the Health Monitoring tools. However, it appeared that they were superseded by the State Office's version of the instructions. A review of the State's tools found that there were no instructions developed for the tools, but rather references to the Settlement Agreement and Health Care Guidelines had been added to each item on the tools. Although an extremely valuable, and useful reference, they did not constitute specific instructions by which to ensure consistency in scoring between auditors. Consequently, without specific instructions, compliance will be determined according to each auditor's judgment, which should not be the case. The Facility and the State should collaborate on developing specific instructions for the Health Monitoring tools.<br>▪ Auditors scoring the Health Monitoring tools must be clinically competent in the areas they are reviewing in order for the data generated to be an accurate reflection of the current practices.<br>▪ Inter-rater reliability needs to be established for each of the Health Monitoring tools to ensure that all auditors are consistently determining compliance using the same process and criteria. Clearly, the lack of specific instructions for the monitoring tools will negatively affect this issue. In addition, the Facility in conjunction with the State should develop and implement a procedure for establishing inter-rater reliability to ensure all disciplines are using the same process. In addition, inter-rater reliability audits that do not meet established thresholds should not be included in the overall monitoring data, because this would reflect that the auditing process was different among auditors, skewing the data and rendering it unreliable. Consequently, appropriately establishing | |

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| | | inter-rater reliability is a critical process in order for the Facility to be confident that the data generated accurately reflects the practices being measured.<br><br>The Facility's training database, which generated a data summary report of the audits conducted for each of the Nursing Health Monitoring tools, was very impressive and showed promise. The data was presented by item for the specific monitoring tool, with the associated percentage of compliance listed for the months of January through April 2011. This method of presentation gave the data meaning, in that trends could easily be identified and outcomes of corrective actions easily evaluated. This type of format also lends itself to analyses that drill down to the etiology of many of the specific problematic items, resulting in the more effective development of corrective action plans.<br><br>To make this data presentation complete, as noted in previous reports, it should include the total population being reviewed (N), and the sample of that population that was audited (n) to yield a percent sample, indicating the relevance of the compliance scores. Without this information, data cannot be accurately interpreted, analyzed, or accepted as valid reflections of the practices being measured. Once the essential structures noted above are solidly implemented, using the Facility's current format to present data would allow the Nursing Department, as well as other departments the ability to promptly determine what specific areas are operating well and those that are problematic, as well as the ability to follow the progress of these items on a monthly basis. Then, the Facility should use these data to justify their compliance ratings with regard to the various requirements of the Settlement Agreement.<br><br>As noted above, in a positive move forward, the QA Department added a full-time QA nurse position, which an RN that had been employed at the Facility and had a working knowledge of the nursing systems filled. From interviews with the QA Nurses, the existing QA Nurse had continued to conduct monitoring activities using the Nursing Health Monitoring tools, and was in the process of training the new QA Nurse. In addition, the Facility revised its policy addressing participation in Performance Evaluation Teams to include all staff responsible for conducting monitoring activities. These teams were to meet at least monthly to discuss and review progress, discuss results of inter-rater reliability, and identify barriers to compliance.<br><br>Although a review of the QA Nurses' audits for the Nursing Health Monitoring tools appeared to have generated some relevant data, the data they generated was unreliable. However, initiating the structures listed above should facilitate the accuracy of the data, and move the Facility's monitoring results more into alignment with the Monitoring Team's findings. Based on the Facility's implementation of a number of the Health Monitoring tools over the past year, the issues related to tool instructions, data presentation, and inter-rater reliability appeared to have much more meaning to the | |

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| | | Facility than in past reviews. At this juncture, the Facility should decrease the number of Health Monitoring audits conducted, and implement the remaining critical pieces of the monitoring system listed above to generate credible data going forward. In addition, the Facility should give thoughtful consideration to prioritizing the reimplementation of the Health Monitoring based on the significant problematic areas that affect the health and safely of the Individuals at CCSSLC. In addition, the QA Nurses, Program Compliance Nurse, and the Nursing Department should ensure that they are critically auditing clinical issues, and focusing on the quality of the nursing services provided, not the just completion of required documentation.<br><br><u>Assessment and Documentation of Individuals with Acute Changes in Status</u><br>Since the last review, the Facility had implemented a number of positive interventions addressing the Medical Emergency Response system, which are discussed in further detail below. Specifically, the Facility provided training for the nursing staff regarding CCSSLC Policy LL.3.1: Medical Policy on Responding to Acute Medical problems, and on CCSSLC Policy G.5: Medical Policy on Diagnostic, Appointment and Consultation tracking. In addition, in March 2011, the Facility implemented the Medical Emergency/Code sheet to document response times and actions implemented for actual emergencies. Also, additional scenarios were added to the Mock Code Drills that were based on actual events that had taken place at the Facility to expand the staff's training and skills regarding emergency responses. The Facility additionally developed and implemented a new database for tracking and trending data regarding decubitus ulcers for use by the Skin Integrity Committee. Also, as noted under Staffing in this Section, the Facility hired a part-time Nurse Educator, who was a Clinical Nurse Specialist, and was responsible for performing hands-on training with RN's in the area of Physical Assessments, and the LVN's regarding Lung Assessments.<br><br>Regarding auditing activities, the Facility's POI indicated that a number of Health Monitoring tools for Acute Illness/Injury, Urgent Care, and Documentation were completed since the last review. The Facility's POI indicated that related auditing data from January to April 2011 were entered into the State Office database which provided an overall level of compliance for each month. However, there was no way to interpret what a single, overall compliance percentage represented and thus, the percentages listed in the POI were meaningless.<br><br>From discussions with the CNE, the Facility had not implemented any system modifications that would have resulted in any measurable changes regarding the nursing documentation and clinical outcomes for individuals that experienced an acute change of status, resulting in an Infirmary admission and/or hospitalization.<br><br>A review of 13 individuals' medical records (Individual #247, Individual #179, | |

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| | | Individual #276, Individual #151, Individual #350, Individual #159, Individual #327, Individual #2, Individual #210, Individual #377, Individual #213, Individual #139, and Individual #130), who had been transferred to a community hospital, emergency room, or the Infirmary found:<br>▪ Nurses promptly and consistently performed a physical assessment on any individual displaying signs/symptoms of potential or actual acute illness in 0%.<br>▪ Licensed nursing staff timely informed the PCP of symptoms that required medical evaluation or intervention in 0% of the cases.<br>▪ Appropriate information was communicated to the PCP in 0% of the cases.<br>▪ The nurse performed appropriate and complete assessments as dictated by the symptoms in 0% of the cases.<br>▪ The nurse conducted frequent assessments of the individual's clinical condition in 0% of the cases.<br>▪ A plan of care was developed including instructions for implementation and follow-up assessments in 0% of the cases.<br>▪ The documentation indicated that acute illness/injuries were followed through to resolution in 0% of the cases.<br>▪ Upon discharge from receiving facility there was a complete nursing assessment performed in 0% of the cases.<br><br>Essentially the same significant problems regarding nursing assessments and documentation that were identified during the past three reviews were consistently identified during the current review. The overall problematic issues that were found in all 13 records included specifically:<br>▪ The chronic lack of nursing documentation rendered it impossible in all cases to accurately determine when changes in status were initially occurring;<br>▪ There was a consistent lack of recognition that the symptoms the individuals experienced were signs of changes in status and warranted nursing assessments and documentation of the findings from assessments;<br>▪ A consistent lack of complete and appropriate nursing assessments was noted in response to status changes in vital signs, and oxygen saturations;<br>▪ There was a chronic lack of follow-up from health issues noted in previous nurses' progress notes;<br>▪ The nursing notes consistently lacked specific description, size, and location of skin issues, such as injuries, or bruises;<br>▪ Consistent inadequate documentation was noted addressing the administration and follow-up effectiveness for PRN medications (as needed medications);<br>▪ There was consistent inadequate assessments and follow-up addressing indications and/or complaints of pain;<br>▪ There was a chronic lack of documentation of individuals' activities and tolerance for activities during the day, evening, and night to indicate any changes | |

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| | | in mental status;<br>▪ There was a consistent lack of mental status assessments documented during status changes;<br>▪ There was a consistent lack of documentation indicating that lung sounds were assessed and documented for significant respiratory issues;<br>▪ There was a consistent lack of assessment of bowel sounds and abdomen exams documented for individuals with constipation or receiving PRN laxatives;<br>▪ There were significant gaps in nursing documentation when nurses' notes indicated that they were monitoring the individual;<br>▪ Physician/Practitioner were consistently not timely notified of change in status, due to nurses' inadequate follow-up;<br>▪ The type of temperatures taken were not consistently documented;<br>▪ There was consistently no documentation that nursing communicated with the PNMT regarding changes in status for individuals at risk of aspiration/choking;<br>▪ There was consistent lack of communication between shifts regarding status changes and the need for regular assessments;<br>▪ There was a consistent lack of specific descriptions of the individuals' behaviors and mental status, assuming that all staff reading the progress notes were familiar with the individuals;<br>▪ There was a consistent lack of analysis of contributing problematic issues affecting changes in status documented in the nursing notes;<br>▪ There were a number of chronic inappropriate abbreviations that could not be interpreted;<br>▪ There was a consistent lack of documentation regarding the individual's status and assessment at the time of transfer to hospital or emergency room;<br>▪ There was inconsistent documentation indicating that an information packet was sent to the receiving hospital at the time the individual was transferred;<br>▪ There was inconsistent documentation that the nurse or physician notified the receiving facility of the individual's transfer;<br>▪ There was inconsistent documentation of the time, date, and/or method of transfer to the receiving facility in the progress notes;<br>▪ There was a consistent lack of a complete nursing assessment upon return to the Facility, especially addressing the same symptoms that precipitated the transfer to a community hospital;<br>▪ There was a consistent lack of regular follow-up days after the transfer occurred for symptoms related to the reason for the hospitalization;<br>▪ Heath Management Plans addressing health issues were consistently inadequate with regard to the goals and nursing interventions, and were not effectively modified after Infirmary stays and/or hospitalizations;<br>▪ Dates and times were not consistently documented for progress notes;<br>▪ A significant number of nursing progress notes and signatures were illegible; | |

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| | | and<br>▪ There was a consistent lack of systematic documentation addressing the care of healthcare equipment individuals required, such as catheters, tracheotomies, and G-tubes.<br><br>Although the State had timely responded to the need to implement competency-based training throughout the SSLCs for nurses regarding basic nursing skills, this intervention alone had not, and will not remedy the overwhelmingly inadequate nursing practice that the Monitoring Team has consistently found during all past reviews at CCSSLC. This area was clearly an example of energies being spent on implementation of an inadequate monitoring system, when the essential infrastructure was not put in place. Specifically, without the implementation of nursing protocols, the auditors were making judgments regarding compliance, as opposed to basing monitoring activities on quality standards of practice. This rendered the data inadequate and inaccurate.<br><br>The Facility Administration's seeming misunderstanding about the seriousness of these significant issues was noticeably altered when the Facility Director, nursing staff, and members of the PNMT participated in a review that two Monitoring Team members conducted of the interdisciplinary notes for Individual #247 prior to his being hospitalized (specific details are provided with regard to Section M.3). Due to the extremely concerning findings from that review, the Monitoring Team requested that a Health Management Plan be developed and implemented addressing the critical health needs of the individual prior to the end of the Monitoring Team's onsite review. Although a HMP was developed and initiated as requested, the remaining individuals at CCSSLC continued to be exposed to the inadequate nursing practices listed above. The Facility should address urgently and aggressively the lack of the implementation of nursing protocols to guide nursing care, as well as the lack of development of appropriate Health Management Plans, and the associated documentation.<br><br><u>Availability of Pertinent Medical Records</u><br>From a limited review of records while on site, it was noted that a number of documents were not in the medical records and had to be obtained from the units. Specifically, several Nursing Quarterly Assessments, Nursing Annual Assessments, and Nursing Health Management Plans were not found in the records. Of 13 records reviewed, five (38%) contained the appropriate Nursing documentation. The Facility should determine if missing Nursing documentation is a product of issues related to the timely filing of documents in the records, or nursing staff not completing the required documentation or not submitting it to be filed. Once these questions are answered, then appropriate corrective actions should be implemented addressing the identified issue(s). | |

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| | | Infection Control<br>At the time of the review, the Facility recently had hired a full-time RN to fill the position of the Infection Control Nurse. Since December 2010, this position had been vacant. However, since June 2010, the Facility continued to have the same full-time RN as the Assistant Infection Control Nurse. Since the Infection Control Nurse was only recently hired, she was in the process of going through the Facility new employee orientation, and had not yet assumed her duties. From a brief interview, she was noted to have some prior experience with infection control practices and procedures.<br><br>Since the last review, the Facility's POI indicated that in January 2011, the policy addressing scabies had been updated and implemented, as well as the Facility's Isolation Protocol policy. In March 2011, a database for Infection Control was developed, but was still in the process of being piloted to detect any needed changes.<br><br>From review of the documentation and discussions with the Assistant Infection Control Nurse, and the CNE, no formalized system had been put in place yet to ensure the reliability of the Facility's IC data. As noted during all the previous reviews, without a system in place to determine the reliability of the infection control data, the Facility could not accurately identify its trends; problematic changes in trends that require timely corrective interventions; ensure that treatments and treatment plans are clinically sound; ensure that timely and appropriate training is being provided; or initiate proactive interventions from analyses of past data trends.<br><br>From review of the Infection Control Committee meeting minutes, it appeared that only one meeting had been held since the last review. This meeting occurred in March 2011, but no representative from the Medical Department was in attendance. This was especially troubling since during the last review, the handling of the outbreak of scabies clearly indicated that there was a lack of leadership, competency, formal systems for communication, adequate decision-making, and problem solving in appropriately addressing that situation.<br><br>Although the IC Committee meeting minutes included some information about individual cases of infections, such as MRSA and Shingles, the minutes lacked any type of a comprehensive analysis regarding any trends of the Facility's basic surveillance data. Since the baseline review, no additional processes had been implemented to comprehensively analyze and address trends in the IC data, make inquires into problematic trends, initiate corrective actions addressing any problematic trends, or monitor outcomes in relation to the activities and interventions of the Infection Control Department in conjunction with the practices on the units. From review of the available IC data for infections by residence, it was clearly evident that there was an outbreak of conjunctivitis in Residence 524D during April and May of this year. Although training | |

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| | | was provided to staff as individuals became infected, no evidence was provided of interventions conducted on a system-wide basis to attempt to prevent the further spread of the infection.<br><br>From discussions with the Assistant Infection Control Nurse and review of medical records, she had been conducting a great deal of staff training when she was notified of an infectious process. However, aside from reactive interventions, there were no proactive interventions that were implemented. In addition, there was essentially no Infection Control information contained in the Pharmacy and Therapeutics Committee meeting minutes. A discussion of the use of antibiotics related to infectious illnesses/diseases should have been included in the minutes, which also should have facilitated a discussion of proactive strategies regarding contagious illnesses. However, without additional supports and direction, the Assistant Infection Control Nurse's efforts were limited.<br><br>As noted with regard to Section M.3, of 27 individuals reviewed who were identified by the Facility as having an infectious illness during the review period, 15 (56%) had Heath Management Plans addressing the infectious issue. Of the 15 Health Management Plans reviewed addressing infectious diseases, none (0%) were found to be adequate. Due to the clinical relevance and ramifications of this area, clinically sound HMPs are crucial.<br><br>Overall, there had been no forward movement in the area of Infection Control since the initial baseline review. With that being said, the recommendations from the initial baseline report and the previous two reports regarding Infection Control are still applicable and have yet to be addressed. Additional expertise in Infection Control is needed to assist the Infection Control Nurses in implementing systems to effectively operationalize the Infection Control Systems in alignment with IC standards of practice, as defined in the Health Care Guidelines and the Settlement Agreement.<br><br><u>Mock Code Drills and Emergency Response Systems</u><br>Since the last review, the Facility had continued to make some positive steps forward in its efforts toward addressing issues regarding emergency response, including the following:<br>▪ The Facility revised its Medical Emergency Response procedure in alignment with the DADS State Office Policy for Medical Emergency Response procedure, effective 2/18/11;<br>▪ Additional emergency scenarios other than those requiring CPR were implemented along with a new Medical Emergency Response form;<br>▪ A Medical Emergency Response database was developed to track the Emergency Drills conducted and recommendations generated including the need for additional staff training; | |

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| | | ▪ An Emergency Response Code form was developed and implemented to track the sequence of events during actual medical emergencies, and used to review emergency responses;<br>▪ Four additional Automated External Defibrillators were purchased, bringing the total of AEDs in the Facility to 16;<br>▪ Additional training mannequins were ordered, and Mock Code Drill videos were developed and made available in the residences as a resource for staff;<br>▪ Posters with procedures for choking and medical emergencies were placed in a variety of locations around the Facility; and<br>▪ A review was initiated of Mock Code drills and actual emergencies at the Mock Code Drills Committee meeting.<br><br>In December 2010, the Facility had implemented a committee that met monthly to discuss, and review Mock Codes and actual codes, and implement Action Plans for any problematic issues for this area. At the time of the previous review, the committee had only been recently initiated. From review of the minutes of the Mock Code Drills Committee since the last review, issues discussed included the development of a choking scenario involving an individual in a wheelchair related to an actual incident; using a trainer AED during mock drills to make the drill more realistic; consideration of having one of the CPR instructors become a Master Trainer to increase the number of CPR instructors at the Facility; and posting of signs in the Facility addressing the location of emergency equipment supplies. Although the minutes included a section for analysis of Mock Code Drills, there was limited information contained in this section, which needed to be expanded since the data regarding Emergency Medical Drills indicated the following:<br>▪ 13 drills conducted in January 2011 – three passed (23%);<br>▪ 14 drills conducted in February 2011 – four passed (29%);<br>▪ 14 drills conducted in March 2011 – 10 passed (71%);<br>▪ 13 drills conducted in April 2011 – two passed (15%);<br>▪ 15 drills conducted in May 2011 – 10 passed (67%); and<br>▪ 11 drills conducted in June 2011 – seven passed (64%).<br><br>Although the pass rate of the Mock Code Drills were increasing by the end of the review period, they were still significantly low indicating that there were significant problematic issues that were not clearly reflected in the Mock Code Drills Committee minutes. Over time, trends from the Mock Code Drills should be identified so that appropriate corrective actions can be implemented timely. In addition, this same type of analysis should be conducted for the 6333 calls (actual emergencies) and included in the minutes. The Facility's implementation of the 6333 tracking log should facilitate this process.<br><br>From a review of the Medical Emergency Drills, some of the problematic issues contained | |

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| | | in the drill documentation included:<br>▪ Staff slow to respond and unsure of what to do;<br>▪ Pocket Mask missing from crash cart;<br>▪ New staff did not know where AED or crash cart was located;<br>▪ Crash cart was very messy, making it hard to locate items;<br>▪ No DNR list was found in crash bag;<br>▪ Staff unable to complete skills without prompting;<br>▪ Licensed Vocational Nurse (LVN) did not come to the drill;<br>▪ Staff were uncooperative with conducting the drill;<br>▪ Nurse did not check the pulse or tell anyone to call 911;<br>▪ Staff did not bring the AED to the scene;<br>▪ Staff scattered when drill started and did not know CPR steps; and<br>▪ Nurse did not know the oxygen flow rates.<br><br>However, of special note, since the last review, the Facility had developed a video of emergency procedures as a resource for staff to review as needed. From review of this 20-minute video, the content and presentation was excellent in that the information was clearly explained with demonstrations provided. In addition, the quality of the production of the video was impressive, and professional.<br><br>Since December 2010, the Facility had implemented a Mock Code Class that CTD staff and a CPR instructor taught for staff who required additional training based on issues found during the Mock Drills. Since the last review, the Facility implemented a tracking system that indicated which staff was required to complete this course, when it was actually completed, the date when the follow-up drill was conducted with the staff, and if the follow-up drill was passed or failed. This was another impressive system that CCSSLC had implemented to address the need to increase the quality of the staff emergency response. As noted in the last report, as the implementation of the system progresses, policies and procedures will need to be developed/revised outlining the complete system addressing the Mock Code drills, including the required training for the Mock Code Drill class, tracking system addressing staff attendance, timeframes for required attendance, and actions addressing lack of attendance.<br><br>In addition, since the last review, the Nursing Education Department had continued to provide training and impromptu spot checks regarding nursing competency related to emergency equipment, and had been keeping related compliance data. The Facility should consider maintaining the data addressing emergency competency training in the same format as the data from other nursing monitoring tools for consistency of presentation, and to facilitate the comparison of compliance by items from month to month and across other nursing areas. | |

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| | | Observations of staff's use of emergency equipment on the Coral Seas and Sea Horse units found that the nurses observed were able to appropriately demonstrate the use of the oxygen, suction machines, and AEDs. Clearly, the training the Facility had implemented for this area had made a positive change since the Monitoring Team's initial reviews.<br><br>However, consistent with the last review, problems were found on the Emergency Cart Checklists from each unit that included a number of blanks indicating that the emergency equipment was not being checked daily, as required, and that Nursing Managers were not checking these forms daily for completion. In addition, although the check sheet for the supplies for the crash cart indicated that all equipment was present, suction tubing and a rebreather were found to be missing. Also on both units, there was no indication that any of the backup equipment, such as suction machines, was being checked. The Facility should develop and implement a system to ensure that all emergency equipment is routinely checked and documented daily, and that the Nurse Managers are providing the appropriate oversight of this process.<br><br>Since the last review, the Facility had implemented several positive interventions to address the emergency response systems. Although many of these systems were still in the newly developed stage at the time of the review, the Facility's commitment to implementing the necessary improvements to the emergency response systems were clearly evident. | |
| 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. | CCSSLC 's POI for this requirement indicated that in January 2011, the Nurse Managers received training regarding the Comprehensive Annual/Quarterly Nursing Assessments. The Department began having the Nurse Educator retrain any Case Managers that were found through the QA nurses' monitoring data to be in need additional training. This training was completed through the Educational Peer Review, and included one-on-one coaching. In addition, in February 2011, the Facility modified the Summary Section of the Comprehensive Nursing Assessment form to include specific headings including; General Health Summary, Self Administration of Medications, Surgeries, Risks, and Health Management Plans. The Facility's POI indicated that auditing data regarding Comprehensive Nursing Assessments from January to April 2011 was entered into State Office database, which provided an overall level of compliance for each month. However, there was no way to interpret what one compliance percentage represented regarding the several items that were audited on the monitoring tool. The weight or importance of each item on a monitoring tool was not equal. For example, the quality of a clinical note holds more importance than the fact that a note was merely present. However, since items holding more importance were not given more weight regarding compliance, combining the compliance scores for all items on a monitoring tool did not accurately reflect anything about the compliance for the area reviewed. Consequently, the | Noncompliance |

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| | | percentages listed in the POI were meaningless.<br><br>However, as noted above, the data summary generated from the Facility's training database was very promising. This data system and the resulting reports are discussed in detail with regard to Section M.1 of the Settlement Agreement.<br><br>In addition, as mentioned with regard to Section M.1, although a number of overall nursing audits had been completed since the past review, there had been no established procedure addressing inter-rater reliability implemented, and there were no adequate instructions developed for the monitoring tools. Consequently, the data that had been generated thus far for this requirement was not reliable and did not accurately reflect the all of the problematic issues the Monitoring Team has noted below. Once adequate instructions are developed for the monitoring tools and inter-rater reliability established, the data generated for this area using the Facility's format of reporting compliance by item should be reviewed monthly, analyzed, and plans of correction generated, and integrated into the Nursing Departments' meetings.<br><br>Also, since the last review, the Facility had all three Nurse Educators and 35 RNs attend and pass the initial phase of the State Office competency-based training regarding Physical Assessment. They will have their final competency-based check offs completed in August 2011. In addition, in August 2011, the State Office Nurse Practitioner Group were expected to monitor the Nurse Educators teaching the Physical Assessment class to ensure the training and content was adequate and appropriate. Thus far, 19 out of 105 RNs, and 38 out of 46 LVNs had completed the Lung Sounds competency-based training. With the addition of a new part-time Nurse Educator, the Facility reported that they would be able to conduct more competency-based training for lung sounds in the next six months.<br><br>Although the Facility provided training regarding the Comprehensive Nursing Assessments and made some modifications to the form, without the appropriate competency-based training regarding the documentation of a clinical analysis as would be found in the Summary Section of the Comprehensive Nursing Assessments, the quality of the assessments will not improve. In spite of a number of the Comprehensive Nursing Assessments that included more raw data addressing medication regimens and some additional information regarding the new headings that were added to the form, no appreciable difference was noted in the quality of the documentation in the Comprehensive Nursing Assessment summaries since the last review. Merely listing the health risk indicators and the problems listed in the Health Management Plans under the headings for Risks and Health Management Plans did not constitute an assessment and/or an analysis of these areas. In addition, due to the extremely poor quality, the lack of proactive interventions, inappropriate goals and objectives, and the generic nature of | |

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| | | the Facility's current Health Management Plans, including them in the Summary section of the Comprehensive Nursing Assessment did not facilitate an appropriate clinical nursing analysis. In fact, noting obvious discrepancies between the list of the health risks indicators and the list of current Health Management Plans in the summaries did not result in HMPs being implemented. (This is discussed in greater detail with regard to Section M.3.)<br><br>The Quarterly/Annual Nursing Assessments for 23 individuals who were identified by the Facility as being at risk for specific health indicators were reviewed including those for: Individual #58, Individual #43, Individual #247, and Individual #48 for aspiration; Individual #218 for cardiac; Individual #24, Individual #92, and Individual #7 for challenging behaviors; Individual #222, Individual #163, and Individual #183 for choking; Individual #270, Individual #153, and Individual #379 for constipation; Individual #159, Individual #117, and Individual #21 for fractures; Individual #284, Individual #303, and Individual #378 for osteoporosis; and Individual #86, Individual #136, and Individual #312 for weight issues.<br>▪ Of the 23 individuals' nursing quarterly assessments reviewed, 10 (43%) were timely completed. Assessments that were not timely completed, had several sections not completed, or were not included in the documentation provided: Individual #58, Individual #43, Individual #247, Individual #48, Individual #218, Individual #92, Individual #183, Individual #153, Individual #379, Individual #117, Individual #21, Individual #284, and Individual #303.<br>▪ There was an adequate analysis of the health/mental data between the previous and current quarters in none (0%) of the Nursing Summaries contained in the Comprehensive Nursing Assessments to indicate if the individual was making progress related to their health/behavior issues.<br>▪ There was an adequate assessment of the high-risk health indicators included in none (0%) of the Comprehensive Nursing Assessments.<br>▪ Nursing assessments were updated as indicated by the individual's health status in none (0%) of the Comprehensive Nursing Assessments reviewed.<br><br>As noted above, there were essentially no differences seen in the quality of the nursing summary sections in all assessments reviewed. There were a number of different formats that were found among the nursing summaries, such as pasting the Nursing Health Management Plan objectives in the Summary Section with no associated analysis of the health issues included, and listing the physician orders over the past quarter. In most cases, the summaries were largely a log of sequential dates of events, such as hospital or Infirmary admissions, or the dates an individual received a PRN medication for constipation, with no associated analysis of the data indicating if the health issue was getting better or worse. Based on the consistent problematic findings found over the past reviews regarding Nursing Assessments, it is clear that nurses lack the | |

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| | | understanding of how to analyze, summarize, and document health/mental health issues, resulting in an appropriate summary of the individuals' progress regarding their health and behavioral status. The Facility should provide competency-based training to ensure nursing assessments include adequate clinical analysis, resulting in an appropriate summary of the individuals' progress regarding their health/mental health issues.<br><br>Of the Nursing Discharge Summaries that nursing completed for five individuals including: Individual #351, Individual #51, Individual #203, Individual #133, and Individual #206:<br>▪ None (0%) adequately addressed the health/mental health issues of the individuals.<br>▪ There was adequate information contained in none (0%) of the Nursing Discharge Summaries that would guide the subsequent community staff in providing the needed nursing or medical care to the individual.<br>▪ A current nursing assessment was conducted for none (0%) of the individuals prior to transferring to the community.<br>▪ There was adequate documentation specifically identifying nursing interventions needed for all health/mental health issues in none (0%) of the cases reviewed.<br><br>In the tragic case of Individual #351, he was discharged from the Facility to the community on 2/15/11. However, the date of the Nursing Discharge Summary, which was the same form as the Comprehensive Nursing Assessment, was 12/20/10, and provided little to no information regarding the individual's health status related to his diagnoses of Diabetes Insipidus, Obesity, and Asthma. The assessment contained no information addressing the nursing interventions that were needed to care for this individual. There was essentially no information contained in the Nursing Discharge Summary that would guide the subsequent community staff in providing the needed nursing care to the individual. In addition, there was no indication that a current nursing assessment was conducted prior to the individual transferring to the community. Also, there was no indication that any HMPs were sent to the community staff regarding Individual #351 health/mental health issues, although the quality of the HMPs would have been questionable. There was no indication that teaching and information was provided to the community staff regarding the individual's medical diagnoses, specifically the Diabetes Insipidus, and what signs and symptoms they needed to be aware of and regularly monitor. Unfortunately, as noted in the autopsy report, less than two months after transitioning to the community Individual #351 died from dehydration associated with Diabetes Insipidus.<br><br>The lack of quality documentation regarding the Nursing Discharge Summaries reviewed clearly indicated that the Facility did not have an adequate and consistent procedure | |

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| | | regarding the requirements for nursing and nursing documentation for discharges. It is imperative that the Facility review and revise its current nursing discharge procedures and documentation requirements to ensure that documentation addressing transition planning and implementation is specific enough to maintain continuity of care in the community.<br><br>There continued to be a significant lack of clinical assessments for critical clinical health indicators, a lack of timely and appropriate follow-up on unresolved issues, a lack of an analysis of health/mental health issues, and a lack of critical thinking found in all the nursing assessments and nursing discharge summaries reviewed. The Facility's POI indicated that it was not in compliance with the elements of this requirement, which was consistent with the findings of the Monitoring Team. | |
| M3 | Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised. | The Facility's POI indicated that in January 2011, the Nurse Managers received training addressing the development of Health Management Plans, and that the QA nurses were informing the Nurse Educators if additional training was indicated based on their auditing data for this area. In addition, the Facility's Nurse Operations Officer developed a competency-based training curriculum for nurses to improve the quality of Health Management Plans HMPs, but had not yet implemented it.<br><br>From discussions with Nursing Department staff, review of the curriculum, and a review of the initial HMP that was developed for an individual reviewed on site, a lack of understanding continued to exist regarding what constitutes a clinically appropriate and adequate Health Management Plan. Although the Facility continued to use nursing protocol templates as Health Management Plans, this basic lack of knowledge had been a significant obstacle in CCSSLC moving forward in addressing this requirement. Consequently, there had been no measurable difference in the quality of the Health Care Plans from the previous three reviews. Competency-based training should be provided to the nursing staff regarding the criteria for and structure of adequate Health Management Plans.<br><br>The records of 23 individuals who the Facility identified as being at high risk for specific health indicators were reviewed, including: Individual #58, Individual #43, Individual #247, and Individual #48 for aspiration; Individual #218 for cardiac; Individual #24, Individual #92, and Individual #7 for challenging behaviors; Individual #222, Individual #163, and Individual #183 for choking; Individual #270, Individual #153, and Individual #379 for constipation; Individual #159, Individual #117, and Individual #21 for fractures; Individual #284, Individual #303, and Individual #378 for osteoporosis; and Individual #86, Individual #136, and Individual #312 for weight issues.<br><br>Of the 23 individuals' Health Management Plans (HMPs) reviewed: | Noncompliance |

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| | | ▪ Six (26%) were found to have a HMP addressing their high-risk health/mental health indicator. Those that did not have a related HMP included: Individual #58, Individual #43, Individual #247, Individual #48, Individual #218, Individual #24, Individual #92, Individual #7, Individual #222, Individual #163, Individual #183, Individual #153, Individual #159, Individual #117, Individual #284, Individual #303, and Individual #378.<br>▪ None (0%) of the nursing interventions contained in the six HMPs 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.<br>▪ None (0%) of the six HMPs were found to be clinically adequate.<br>▪ None (0%) of the six HMPs included proactive interventions addressing the health indicator.<br>▪ None (0%) of the six HMPs were adequately individualized.<br><br>These findings were particularly troubling, because at the last review, the Facility reported that in October 2010, Individuals' Axis Diagnoses, along with the active problem list and health indicator risks, were reviewed to identify those individuals who needed to have Nursing Care Plans (Health Management Plans) developed to address these health and behavioral issues, and they were to be implemented beginning in December 2010. The current findings of the Monitoring Team did not support that these initiatives were actually implemented, as stated in the Facility's previous POI.<br><br>As noted during the previous three reviews, CCSSLC's Nursing HMPs continued to lack:<br>▪ Clinically appropriate goals/objectives related to the etiology of the identified health/mental health problems;<br>▪ Individual-specific interventions based on the individuals' needs;<br>▪ Adequate specific directions for caring for individuals who were identified as being at high risk related to their health/mental health issues; and<br>▪ Proactive interventions directed at preventing or minimizing the specific health risks.<br><br>The Health Management Plans were essentially the identical protocol template for each individual who had the same health issues, such as constipation, seizures, falls, and pneumonia, with only minimal modifications made, if any.<br><br>In order for the Facility's HMPs to be appropriate and clinically adequate, the Health Care Protocols the Facility was using as the template for HMPs have to be individualized to meet the individuals' needs, with appropriate goals, specific nursing interventions that include proactive interventions, and identification of who will be implementing the action, how often it will be implemented, where it will be documented, and when the | |

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| | | effects of the intervention will be reviewed and by whom. Also, regardless of the HMP format or template, as required by Sections G and F of the Settlement Agreement, collaboration with other disciplines regarding care plans should occur so that an interdisciplinary team approach is used consistently, and interventions from other disciplines are integrated in all Health Management Plans. Thoughtful and serious consideration should be given to the use of an integrated Health Management Plan that would incorporate all clinical disciplines' goals and interventions regarding a health risk into one plan.<br><br>While on site, a live review of Individual #247's medical record was conducted with some members of the nursing staff as well as members of the Facility's Physical and Nutritional Management Team. The documentation indicated that the individual was at risk for aspiration, was enterally nourished by a G-tube, and had several past Infirmary and hospital admissions related to aspiration pneumonias and respiratory issues. In addition, this individual was being followed by the PNMT. The IPNs reviewed indicated that a number of changes in the individual's status, such as decreased oxygen saturations, variability in vital signs, and potential and pending issues related to skin break down, were occurring. In reviewing the documentation, specifically the interdisciplinary progress notes, a number of significant problematic issues were found regarding the recent care of this individual. Some of these problems included:<br>▪ Lack of recognition of changes in status;<br>▪ No nursing assessments conducted in response to changes in status;<br>▪ No consistent and regular documentation by nursing to establish baselines and promptly identify changes in baselines regarding physical assessments, mental status, daily activities, positioning, treatments provided, pain assessments, vital signs, oxygen saturations, functioning of G-Tube and IV, site inspections for G-Tube and IV, and bowel and urinary output;<br>▪ Significant gaps in the nursing documentation (i.e., up to eight days without an IPN for an individual with several health risks and changes in status);<br>▪ Bleeding/reddened skin not reassessed or followed up on to resolution;<br>▪ No indication that the physician was notified of changes in status;<br>▪ No indication that the PNMT was notified of changes in status;<br>▪ No IPNs indicating that Individual #247 was being followed, assessed, or monitored by the PMNT, even after two hospitalizations within weeks of each other; and<br>▪ No Nursing HMPs adequately addressing the individual's current health risks.<br><br>Due to these critical deficits found regarding the care of this individual, the Monitoring Team requested that a HMP be developed and implemented at the time of the onsite review addressing the significant health risks identified. To CCSSLC's credit, the Facility promptly scheduled a meeting with the appropriate disciplines to address this issue. | |

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| | | However, prior to this meeting, it was particularly concerning to observe the Nursing Department's dilemma and challenges in discussing how to modify the Facility's template for HMPs to remain consistent with the State Office's mandate of using the adopted care plan templates, while trying to develop a clinically sound HMP for Individual #247. Prompt discussions should occur between the Facility's Nursing Department and the State Office to evaluate whether or not the adopted templates are a barrier, rather than a functional and usable outline for the development of clinically appropriate and adequate HMPs. This discussion likely should include other SSLCs' Nursing Departments, and immediate actions should be taken based on this evaluation.<br><br>Although there were a number of problematic issues related to specifying the frequency of some of the interventions, the timeliness of notification of the PNMT, the consistency of the assessment criteria to be regularly documented, and the lack of a clinically appropriate overall goal, CCSSLC's first attempt at developing what was actually an discipline-integrated HMP for Individual #247 was very promising. It is professionally and clinically unacceptable for the Facility to continue to allow disciplines to generate inadequate HMPs for the individuals under their care. Now that the disciplines have had the experience of developing an integrated HMP, albeit under some pressure from the Monitoring Team to do so during the onsite review week, the Facility should continue to develop and implement appropriate HMPs for all Individuals at CCSSLC<br><br>An additional sample of individuals' records was requested for review to determine if individuals with infectious diseases had appropriate care plans to address their needs. Although a comprehensive list of individuals who had an infectious illness/disease was not provided, the Facility provided the HMPs for 27 individuals (Individual #151, Individual #70, Individual #280, Individual #2, Individual #58, Individual #196, Individual #110, Individual #223, Individual #136, Individual #200, Individual #282, Individual #131, Individual #155, Individual #9, Individual #273, Individual #89, Individual #99, Individual #38, Individual #274, Individual #87, Individual #285, Individual #221, Individual #209, Individual #26, Individual #367, Individual #316, and Individual #297) that had a variety of infections consisting of MRSA, Staphylococcus aureus, Influenza A, Herpes Simplex 2, scabies, and conjunctivitis, since the last review period.<br>▪ Of the 27 individuals reviewed, 15 (56%) had HMPs addressing the infectious issue. Those that did not have a related Nursing Care Plan included: Individual #151, Individual #70, Individual #280, Individual #2, Individual #223, Individual #136, Individual #200, Individual #282, Individual #131, Individual #367, Individual #316, and Individual #297.<br>▪ Of the 15 Nursing Care Plan reviewed addressing infectious diseases, none (0%) were found to be adequate. Some of the deficiencies noted included:<br>o The significant lack of individualization of the HMP template; | |

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| | | o The lack of criteria for documentation, including who was to document, how often, where the documentation was to be done, who was to review the documentation, and how often it would be reviewed;<br>o Inappropriate goals that did not address the prevention of the spread of the infectious illness, but rather indicated that the individual would remain free from the infection, when the individual already had the infection;<br>o The lack of interventions addressing teaching and education for staff, as well as the individual regarding prevention of the spread of the infection;<br>o The lack of proactive interventions; and<br>o The lack of documentation demonstrating that interventions were actually being implemented.<br><br>Unfortunately, the Facility's past poor management of the outbreak of scabies discussed during the last review did not impact Nursing and Infection Control staff to take prompt and aggressive actions to ensure that individuals who had a contagious, infectious disease had an individualized and clinically sound HMP developed and implemented. Without having a guide outlining the precautions to take, how to prevent the infection from spreading, and what education should be provided to the individuals and staff regarding these critical issues, the risk of re-infection, and transmission of the organism to other individuals, family members, and staff significantly increases. Although there had been no system implemented to ensure data reliability for Infection Control, the Facility's available data suggested that eye and upper respiratory infections had spread in certain residences. As noted in the past three reports, due to the clinical ramifications of not having adequate HMPs adequately addressing infectious and communicable diseases, it is imperative that this requirement of the Settlement Agreement be addressed.<br><br>Consistent with the findings of the previous reviews, there continued to be no system in place that ensured that individuals with infectious diseases were being provided the appropriate infection control measures, or clinically appropriate interventions to prevent the spread of infections. Nursing Administration, in conjunction with the Infection Control Nurses should develop and implement a system to ensure that the HMPs addressing infectious and communicable diseases are clinically adequate, individualized, and are being implemented consistently.<br><br>The Facility's POI indicated that it was not in compliance with this requirement of the Settlement Agreement, which was in alignment with the findings of the Monitoring Team. | |
| M4 | Within twelve months of the | CCSSLC 's POI indicated that since the last review, the Facility had begun providing | Noncompliance |

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| | Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served. | training in April 2011 regarding the new policies for Seizures, Medication Transcription, Integrated Progress Notes, Documentation, Acute Illness/Injury, and Completing and Routing Medical Dental Restraints. Although these in-service training sessions were necessary, the Monitoring Team's findings reported in sections M.1, M.2, M.3, and M.5 indicated that they had no positive impact on nursing practice, and reporting protocols as required by the Settlement Agreement.<br><br>Since the last review, there had been no modifications made to the procedures and protocols contained in the resource books that the Facility obtained after the initial review in January 2010, in order to bring them into alignment with the Facility's structure and systems. These modifications should include identification of the specific responsibilities of disciplines, clear and appropriate timeframes for initiating nursing assessments, the type of assessments that should be conducted, the frequency of these assessments, and the parameters and time frames for the reporting of symptoms to the practitioner/physician and PNMT, if indicated.<br><br>From review of the State Office's Documentation Guidelines, they did not address the Facility's critical need for specific nursing protocols that defined the criteria for nursing care and documentation requirements. From discussions with nursing, review of the State's Documentation Guidelines, the significant and consistent problematic findings regarding nursing assessments, Health Management Plans, and the nursing care and documentation for individuals with high-risk health indicators, as well as those who had experienced changes in status warranting Infirmary and hospital admissions, a persistent lack of comprehension continued to exist regarding the importance of nursing protocols and how they structure nursing practice and documentation to ensure they are in alignment with quality standards of practice. At the time of the review, the Facility did not have a plan for when these procedures and protocols would be developed/modified, and implemented.<br><br>Since CCSSLC had no appropriate nursing protocols in place, there was no structured system guiding nursing practice and documentation to ensure that:<br>▪ Appropriate nursing assessments were conducted and documented at the appropriate clinical frequency;<br>▪ Timely communication occurred with practitioners/physicians or other disciplines regarding changes in status;<br>▪ Appropriate and clinically adequate HMPs were developed to outline specific nursing interventions; and<br>▪ Audits addressing nursing practice included quality standards by which to measure the care being reviewed.<br><br>Although previous joint discussions had occurred between members of the Monitoring | |

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| | | Team and the State Office Nursing Discipline Coordinator, the State Office Consultant, and other State Office staff regarding nursing practice and documentation, no progress had been made addressing this requirement. Due to the consistent negative findings discussed in detail with regard to Sections M.1, M.2, M.3, and M.5 of the Settlement Agreement, it is critical that the Facility develop and implement nursing protocols.<br><br>The findings from this review and the previous three reviews indicated that CCSSLC was continuing to fail to adequately and timely address the health care needs of the individuals residing at the Facility. The Facility's POI indicated that it was not in compliance with this requirement, which was in alignment with the findings of the Monitoring Team. | |
| M5 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall develop and implement a system of assessing and documenting clinical indicators of risk for each individual. The IDT shall discuss plans and progress at integrated reviews as indicated by the health status of the individual. | Since the last review, in February 2011, CCSSLC had begun to implement the revised State policy addressing the At-Risk Individuals. The policy included Risk Guidelines, which contained criteria to serve as a guide to assist the teams in determining appropriate risk levels for designated health indicators. The review of risks and the assignment of the risk levels were to occur during PSP meetings. At the time of the review, the Facility reported that all the individuals at CCSSLC had been reviewed using the new At-Risk process. However, the few Action Plans that were developed for health risks related to aspiration were found to be clinically inadequate in that they were generic in nature; did not include preventative interventions to minimize the conditions of risk; did not show adequate integration between all of the appropriate disciplines, as dictated by the individual's needs; did not contain appropriate, functional, and measurable objectives; and were not incorporated into the PSP to allow the team to measure the efficacy of the plan. The Facility's POI indicated that in June 2011, the State Office Discipline Coordinator and State Office Consultants provided training to the Facility's habilitation staff, PNMT Committee, and Nursing leadership regarding the development of risk action plans.<br><br>The new At-Risk policy indicated that nursing, in conjunction with the PCP, was responsible for assessing risk for the following health indicators:<br>▪ Aspiration;<br>▪ Respiratory Compromise;<br>▪ Cardiac Disease;<br>▪ Constipation/Bowel Obstruction;<br>▪ Diabetes;<br>▪ Gastrointestinal Problems;<br>▪ Osteoporosis;<br>▪ Seizures;<br>▪ Skin Integrity;<br>▪ Infections; | Noncompliance |

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| | | ▪ Fractures;<br>▪ Fluid Imbalance;<br>▪ Hypothermia;<br>▪ Urinary Tract Infections; and<br>▪ Circulatory.<br><br>To assess the Facility's overall risk screening process, including nursing's role in the process, members of the Monitoring Team observed four individuals' PSP meetings (Individual #332, Individual #228, Individual #353, and Individual #234) while on site. Overall, the Monitoring Team noted some improvements, although not consistent, in the clinical discussions, the use of supporting clinical data when determining risk levels, and use of the new Risk Guidelines when the PSTs were discussing the individuals' risk levels. Some of the problematic areas identified by the Monitoring Team included (more specific findings are provided with regard to Section I.1 of the Settlement Agreement):<br>▪ The PSTs need to consistently use the Risk Level Guidelines and specific clinical data when determining risk levels;<br>▪ PSTs were uncertain whether or not to rate risk levels based on if supports were in place, or to rate the risk as if the supports were not already implemented;<br>▪ The PSPs lacked structure and focus, allowing PSTs to digress to unrelated issues and were extremely lengthy resulting in team members and individuals leaving the PSPs;<br>▪ Physicians were not consistently present at the PSPs; and<br>▪ The PSTs discussions regarding Action Plans for risks did not include measurable, functional, outcomes and interventions.<br><br>A review of the Comprehensive Nursing Assessments for 23 individuals (Individual #58, Individual #43, Individual #247, Individual #48, Individual #218, Individual #24, Individual #92, Individual #7, Individual #222, Individual #163, Individual #183, Individual #270, Individual #153, Individual #379, Individual #159, Individual #117, Individual #21, Individual #284, Individual #303, Individual #378, Individual #86, Individual #136, and Individual #312) found that none (0%) were adequate risk assessments, since none specifically addressed the high-risk health indicators and had not been updated regarding health issues related to the high-risk health indicators. Specific findings and examples are provided with regard to Section I.2 of the Settlement Agreement.<br><br>A review of 23 individuals records was conducted to assess nursing staff's role in the assessment of the health categories that nursing was responsible for in the Integrated Risk Rating forms (Individual #58, Individual #43, Individual #247, Individual #48, Individual #218, Individual #24, Individual #92, Individual #7, Individual #222, | |

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| | | Individual #163, Individual #183, Individual #270, Individual #153, Individual #379, Individual #159, Individual #117, Individual #21, Individual #284, Individual #303, Individual #378, Individual #86, Individual #136, and Individual #312). The review found that none (0%) consistently contained specific clinical information to enable the PSTs to adequately evaluate and designate risk levels. Some of the problematic issues included:<br>▪ Lack of data regarding the number of seizures during the past year compared to previous years, needed medications changes to stabilize the seizure disorder, and the date of the last seizure activity;<br>▪ Lack of Dexa Scan scores, date(s) obtained, and treatments for osteoporosis;<br>▪ Lack of specific dates and locations of past fractures;<br>▪ Lack of specific data indicating regular bowel medication regimens, frequency of needed bowel prn medications; and additional factors such as medications, fluid intake, positioning affecting risk of constipation;<br>▪ Lack of Braden Scores, frequency of specific skin issues, responses to treatments, and additional factors, such as immobility, nutritional status, or incontinence affecting risk related to skin integrity.<br><br>As was discussed during a previous interview with the State Coordinator for Specialized Services, State Office Nurse Practitioner Consultant, and Nursing Discipline Coordinator, the current Comprehensive Nursing Assessment form did not appropriately meet the requirements of an adequate assessment tool for addressing health risk indicators. It also did not appear that the need for the information contained in the Comprehensive Nursing Assessments to be updated in response to the identification of health risks had been identified as a necessary component of the process. The Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals.<br><br>The Facility' At-Risk system is critical in ensuring that those individuals who warrant the most clinical intensity are appropriately identified and provided the needed care. The findings in Sections M.1, M.2, and M.3 address the significant deficits regarding aggressive and timely recognition and lack of implementation of clinical interventions for individuals who were at risk due to their health/mental health issues. At the time of the review, CCSSLC's POI indicated that they were not in compliance with this requirement of the Settlement Agreement, which was consistent with the Monitoring Team's findings. | |
| M6 | Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement | Since the previous review, the Nursing Department had continued to implement interventions addressing the medication administration system, as well as some of the problematic areas found through the Facility's Medication Observations audit data. Although inter-rater reliability had not been appropriately established for the Medication | Noncompliance |

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| | 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. | Observation monitoring tool, some of the relevant findings the Facility reported from the audits conducted since the last review included:<br>▪ An overall improvement in the number of blanks on the Medication Administration Records (MARs) after weekly checks of the MARs were reinstituted in response to auditing data for February 2011, showing a significant increase in blanks when the weekly checks were decreased;<br>▪ Variability in compliance regarding proper positioning checks conducted for individuals prior to administering medications;<br>▪ Variability in nurses instructing the direct support professional on proper positioning of individuals after medications administered;<br>▪ Overall improvement noted regarding nurses' knowledge of oxygen flow rates since adding this information to the Mock Code drill sheet; and<br>▪ Improvement was noted regarding administering medications within the required timeframes on the Ribbonfish Unit, since medication times were separated for individuals who were given medication enterally and by mouth.<br><br>Even though the Facility's overall monitoring system was still in the development stage, the regular review, analysis of trends, and the use of the Medication Observation data in evaluating corrective actions related to the medication administration system was exceptionally progressive and a positive move forward. As mentioned previously, the Facility should develop and implement a procedure addressing establishing inter-rater reliability, so that all disciplines are conducting the appropriate procedure to ensure that accurate data is being generated among auditors.<br><br>As noted in the previous report, the Facility's Medication Administration Committee meeting had been merged with the Medication Error Committee. The minutes of the Medication Error Committee meetings included a good structure consisting of the action steps, evidence, responsible person, start date, target date, and completion status for all outcome recommendations generated during the meetings. In addition, the minutes included information regarding data collected from the Medication Observation audits. The information regarding the actual medication error data contained in the minutes provided a somewhat limited analysis of the medication variance data. However, the numbers of "true errors" listed in the minutes per month continued to be very low indicating probable under reporting. As noted in the Medication Error Committee meeting minutes, dated 3/21/11, the pharmacy was to begin tracking and trending medication errors. However, the Pharmacy and Therapeutics Committee meeting minutes, dated 3/24/11, indicated that there was no information regarding medication errors presented at the meeting. In addition, a summary of the results and trends of the Pharmacy Medication Area Inspections were not included in either the Medication Error Committee or Pharmacy and Therapeutic Committee meeting minutes. Also, there was | |

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| | | no indication that any problematic issues found during an inspection were followed up on and resolved. Building on these systems, the Facility should continue to expand its analysis of the medication variance data in conjunction with the Pharmacy and Therapeutics Committee. As additional reliable variance data is collected, it should be thoroughly analyzed to identify trends and plans of correction generated.<br><br>A review of the raw data from the Medication Administration Observations audits from January through June 2011, and the Medication Administration Concerns reports from Nursing Education indicated that the auditors for this area were appropriately identifying more problematic issues than were noted during past reviews. Although the comments found on the Medication Administration Observation audits reflected a greater emphasis on checking for appropriate positioning before and after medication administration than previously, the following significant issues were found while observing medication administration in the Infirmary while on site. These issues were consistently found during the previous three reviews, most of which placed the most medically compromised individuals at risk. Specifically, the nurse did not:<br>▪ Ensure individuals were in the proper positioning prior to and after medication administration;<br>▪ Utilize the PNMP when administering medications;<br>▪ Know that there were discrepancies between the instructions on the MAR and the PNMP regarding with what the medications were to be mixed prior to administration;<br>▪ Investigate why nectar consistency was not continued as ordered during a recent hospitalization for Individual #276;<br>▪ Have a stethoscope to listen to lung sounds before, during, or after administering medications, or in the event an individual started coughing;<br>▪ Recognize and inform the PNMT of problems Individual #276 had regarding holding fluids in his mouth, and the nurse's use of thickener to resolve fluid loss from drooling on thin fluids (individual had recently been hospitalized for dehydration and a urinary tract infection); and<br>▪ Receive competency-based training on the PNMPs for individuals for whom she was responsible for administering medications.<br><br>From discussions with nursing and the PNMT, for individuals that were transferred to the Infirmary, no competency-based training on individual-specific PMNP interventions had been provided to the Infirmary staff. From the consistent problematic issues observed during the review regarding medication administration, the auditing process for this area did not appropriately capture compliance regarding positioning and interventions for medication administration in alignment with the PNMPs. Consequently, there continued to be a significant lack of understanding within the | |

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| | | Nursing Department of the purpose and the critical need to consistently implement the PNMPs. The Facility should develop and implement a system to ensure that prior to any nurse providing care to individuals transferred to the Infirmary, nurses are provided competency-based training regarding the PNMPs and the use of the Individual Notebooks (I-Books). In addition, training should be provided to nurses that are designated as auditors for medication administration observations regarding how to appropriately assess compliance regarding positioning and medication administration, including following the instructions in the PNMPs and I-Books.<br><br>A review of the Facility's Medication Error Report noted the following medication variances per month:<br>▪ December 2010 10 true errors 77 documentation omissions;<br>▪ January 2011 5 true errors 304 documentation omissions;<br>▪ February 2011 9 true errors 213 documentation omissions;<br>▪ March 2011 3 true errors 132 documentation omissions;<br>▪ April 2011 6 true errors 332 documentation omissions;<br>▪ May 2011 5 true errors 162 documentation omissions; and<br>▪ June 2011 5 true errors 83 documentation omissions.<br><br>Although the minutes of the Medication Error Committee meetings included a limited analysis of the variance data, the minutes indicated that some of the following corrective actions were being implemented:<br>▪ The pharmacy was working with the WORx system to print alternative medication administrative times for oral medications on the MARs;<br>▪ Respiratory Therapy provided an in-service training at the unit (Tropical) with the lowest compliance regarding knowledge of oxygen flow rates;<br>▪ State Office consulted regarding guidelines for medication orders for administration at other than standard times;<br>▪ Unit Nursing meetings included compliance data regarding knowledge of emergency equipment and oxygen flow rates; and<br>▪ Nurse Managers' input was being obtained regarding distractions during medication administration.<br><br>The Facility should continue to develop and implement strategies to increase the reliability of the medication variance data, such as conducting regular reviews and spot checks of the MARs, and documenting these as audits. At the time of the review, the Facility was in the early stages of building and restructuring the medication administration, and variance systems. Although there continued to be significant problematic issues regarding these systems, the Facility had implemented some very promising basic systematic processes and infrastructures regarding the medication | |

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| | | administration system. Increased collaboration between the Pharmacy, Nursing, and Medical is imperative in constructing a solid process that lends to a critical review of the overall medication system.<br><br>As previously noted in the past three reports, as required by Section N.8 of the Settlement Agreement, the Facility should expand its medication error system into a medication variance system that would significantly extend the scope of the review of the medication system. CCSSLC's current medication error system was limited to the reporting of errors addressing the wrong patient, wrong time, wrong dose, wrong route, wrong drug, wrong technique, and omitted medications. A medication variance system expands the review to include not only these issues, but also issues related to the entire medication system such as pharmacy issues, physician/practitioner's issues, as well as proactively reviewing areas for potential variances. Although the Facility continued to make progress regarding this requirement of the Settlement Agreement since the last review, consistent with the findings of the past three reviews, the Facility indicated that it was not in compliance with the elements of this requirement, which comported with the Monitoring Team's findings. | |

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

1. The Facility should ensure that all newly created or reallocated positions are appropriately integrated into the Facility's policies, procedures or protocols. (Section M.1)
2. The Facility and the State should collaborate on developing specific instructions for Health Monitoring tools. (Section M.1)
3. The Facility, in conjunction with the State, should develop and implement a procedure addressing the process of establishing inter-rater reliability, so that all disciplines understand the process and execute it consistently. (Section M.1 and Facility Self-Assessment)
4. At this juncture, the Facility should decrease the number of Health Monitoring audits conducted, and implement the remaining critical pieces of the monitoring system listed above in the Facility Self-Assessment section. This is necessary to generate credible data going forward. Once these systems are put in place, the Facility should give thoughtful consideration to prioritizing the reimplementation of the Health Monitoring tools, based on the problematic areas that affect the health and safely of the individuals at CCSSLC. (Section M.1 and Facility Self-Assessment)
5. The QA Nurses, Program Compliance Nurse, and the Nursing Department should ensure that they are critically auditing clinical issues, and focusing on the quality of the nursing services provided, not the just completion of required documentation. (Section M.1)
6. The Facility should address urgently and aggressively the lack of the implementation of nursing protocols to guide nursing care, as well as the lack of development of appropriate Health Management Plans, and the associated documentation. (Section M.1)
7. The Facility should determine if missing nursing documentation from the medical records is a product of issues related to the timely filing of these documents in the records, or nursing not completing the required documentation or not submitting it to be filed. Once these questions are answered, then appropriate corrective actions should be implemented addressing the identified issue(s). (Section M.1)
8. Competency-based training should be documented for Infection Control staff. Such training should ensure that the staff are competent in conducting their duties, including audits, and that they are competent in infection control practices. (Section M.1)
9. 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. (Section M.1)

10. Once the Facility implements a monitoring system for Infection Control practices, observations of staff implementing the appropriate precautions should be completed to ensure staff understand the training material, and that individuals and staff are protected from further spread and/or complications from the infectious disease. (Section M.1)
11. A schedule addressing when individuals' records will be researched to identify possible needed immunizations should be developed to ensure individuals are appropriately prioritized and that no one is overlooked. (Section M.1)
12. 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. (Section M.1)
13. Formal systems and communication lines between the units and the Infection Control Department should be established, and memorialized in policies and procedures. (Section M.1)
14. Since the Facility has only two positions for Infection Control, a system should be developed and implemented to ensure that the functions and duties of these positions are delegated in the event these staff in these positions are unavailable. (Section M.1)
15. The Facility should develop and implement a formal system to ensure data reliability regarding surveillance tracking for infection control. (Section M.1)
16. Serious consideration should be given to securing additional expertise in Infection Control to assist the Infection Control Department in implementing systems to effectively operationalize the Infection Control Department in alignment with IC standards of practice, as defined in the Health Care Guidelines and the Settlement Agreement. (Section M.1)
17. As the implementation of the Medical Emergency Response system progresses, policies and procedures should be developed/revised outlining the complete system addressing the Mock Code drills, including the required training for the Mock Code Drill class, tracking system addressing staff attendance, timeframes for required attendance, and actions addressing lack of attendance. (Section M.1)
18. Trends from the Mock Code Drills and 6333 calls (actual emergencies) should be identified, so that appropriate corrective actions can be implemented timely, and included in the Mock Code Drills Committee minutes. (Section M.1)
19. The Facility should develop and implement a system to ensure that all emergency equipment is checked daily and documentation maintained, and that the Nurse Managers are providing the appropriate oversight of this process. (Section M.1)
20. The Facility should maintain the data addressing emergency competency training in the same format as the data from other nursing monitoring tools for consistency of presentation, and to facilitate the comparison of compliance by items from month to month and across other nursing areas. (Section M.1)
21. The Facility should provide competency-based training to ensure nursing assessments include adequate clinical analysis, resulting in an appropriate summary of the individual's progress regarding his/her health/mental health issues. (Section M.2)
22. It is imperative that the Facility review and revise its current nursing discharge procedures and documentation requirements to ensure that documentation addressing transition planning and implementation is specific enough to maintain continuity of care in the community. (Section M.2)
23. Competency-based training should be provided to the nursing staff regarding the criteria and structure of the development of adequate Health Management Plans. (Section M.3)
24. As required by Sections G and F of the Settlement Agreement, collaboration with other disciplines regarding care plans should occur so that an interdisciplinary team approach is used consistently, and interventions from other disciplines are integrated in all Health Management Plans. Thoughtful and serious consideration should be given to the use of an integrated Health Management Plan that would incorporate all clinical disciplines' goals and interventions regarding a health risk into one plan. (Section M.3)
25. Prompt discussions should occur between the Facility's Nursing Department and the State Office to evaluate whether or not what the Facility believed to be the adopted templates are a barrier, rather than a functional and usable outline for the development of clinically appropriate and adequate HMPs. This discussion likely should include other SSLCs' Nursing Departments, and immediate actions should be taken based on this evaluation. (Section M.3)
26. Nursing Administration, in conjunction with the Infection Control Nurses should develop and implement a system to ensure that the Health

Management Plans addressing infectious and communicable diseases are clinically adequate, individualized, and are being implemented consistently. (Section M.3)

27. It is critical that the Facility develops and implements adequate nursing protocols. Modifications to the available resource materials should include identification of the specific responsibilities of disciplines, clear and appropriate timeframes for initiating nursing assessments, the type of assessments that should be conducted, the frequency of these assessments, and the parameters and time frames for the reporting of symptoms to the practitioner/physician and PNMT, if indicated. (Section M.4)
28. The Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals. (Section M.5)
29. The Facility should continue to expand its analysis of the medication variance data in conjunction with the Pharmacy and Therapeutics Committee. As additional reliable variance data is collected, it should be thoroughly analyzed to identify trends and plans of correction generated. (Section M.6)
30. The Facility should develop and implement a system to ensure that prior to any nurse providing care to individuals transferred to the Infirmary, nurses are provided competency-based training regarding the PNMPs and the use of the I-Books. (Section M.6)
31. Training should be provided to nurses that are designated as auditors for medication administration observations regarding how to appropriately assess compliance regarding positioning and medication administration, including following the instructions in the PNMPs and I-Books. (Section M.6)
32. The Facility should continue to develop and implement strategies to increase the reliability of the medication variance data, such as conducting regular reviews and spot checks of the MARs, and documenting these as audits. (Section M.6)
33. There needs to be increased collaboration between the Pharmacy, Nursing, and Medical in constructing a solid process that lends to a critical review of the overall medication system. (Section M.6)
34. As required by Section N.8 of the Settlement Agreement, the Facility should expand its medication error system into a medication variance system that would significantly extend the scope of the review of the medication system. (Section M.6)

| SECTION N: Pharmacy Services and Safe Medication Practices | |
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| 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:<br>▪ **Review of Following Documents**:<br>o CCSSLC Policies, including: Pharmacy Services and Safe Medication Practices N.2: Quarterly Drug Regimen Review, draft/revision 3/24/11, approval 4/7/11, implementation 4/7/11; Prescriber Medication Order Policy N.3, developed 6/2/10, approval 4/6/11, implemented 4/6/11; Adverse Drug Reaction (ADR) Policy N.6, developed 11/12/10, approval 4/6/11, implemented 5/1/11; Drug Utilization Evaluation Policy N.7, developed 11/3/10, approval 4/6/11, implemented 4/6/11; and 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 N.9, developed 3/3/10, revised 3/1/11;<br>o CCSSLC Protocols/guidelines: "Protocol for checking the allergies/ADRs implemented 1/15/11;" QA system for new orders, implemented 3/1/11; Guidelines for completing "Chemical Restraint Clinical Review on the Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint," implemented 3/31/11;<br>o Notice of Inspection, Texas State Board of Pharmacy, Pharmacy Visit Notes, from 3/17/11 to 3/18/11;<br>o All Drug Utilization Evaluation (DUE) reports completed since last monitoring visits (including background information, data collection forms utilized, results, and any minutes reflecting action steps based on the results);<br>o Minutes of Pharmacy and Therapeutics (P&T) Committee, dated 12/14/10, 3/24/11, and 6/13/11;<br>o CCSSLC Monthly Psychiatric Services Review (PSR) Minutes, dated 12/28/10, 1/21/11, 2/18/11, 3/25/11, and 4/27/11;<br>o Medication Committee minutes, dated 12/20/10, 1/24/11, 2/28/11, 3/21/11, and 4/18/11;<br>o DUE Calendar;<br>o Quarterly Drug Regimen Reviews (QDRRs) for the following: Individual #182, dated 4/19/11; Individual #172, dated 4/11/11; Individual #58, dated 4/20/11; Individual #132, dated 5/12/11; Individual #218, dated 2/15/11; Individual #30, dated 4/28/11; Individual #286, dated 4/13/11; Individual #49, dated 11/18/10; Individual #49, dated 3/9/11; Individual #174, dated 4/11/11; Individual #246, dated 5/13/11; Individual #57, dated 1/4/11; Individual #65, dated 2/9/11; Individual #294, dated 3/3/11; Individual #294, dated 5/10/11; Individual #221, dated 2/17/11; Individual #93, dated 5/17/11; Individual #16, dated 3/31/11; Individual #239, dated 5/17/11; Individual #175, dated 11/17/10; Individual #88, dated 11/2/10; Individual #367, dated 2/17/11; Individual #113, dated 5/6/11; Individual #300, dated 3/1/11; Individual #112, dated 1/13/11; Individual #236, dated 5/17/11; Individual #193, dated 4/11/11; Individual #228, dated 2/9/11; Individual #127, dated 4/15/11; Individual #173, dated 3/7/11; Individual #209, |

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| | dated 1/26/11; Individual #209, dated 4/20/11; Individual #378, dated 4/19/11; Individual #359, dated 5/13/11; Individual #308, dated 3/29/11; Individual #69, dated 2/17/11; Individual #312, dated 2/15/11; Individual #312, dated 5/5/11; and Individual #72, dated 5/5/11;<br>o All "single patient intervention reports" in WORx system, since last monitoring visit, January to May 2011;<br>o All "notes extract" associated with "single patient intervention reports";<br>o For the past six months, any adverse drug reaction reports completed;<br>o CCSSLC Policy Pharmacy Services and Safe Medication Practices N.8: Pharmacy Medication Error Reporting, implemented 6/2/10;<br>o Medication error reports for last six months by error type, nurse, residence, shift, unit, individual, category of severity, error mode (graphs/tables);<br>o CCSSLC Medication errors in 2011;<br>o For the past six months, any case analysis and/or reports addressing medication variances and plans of correction;<br>o Medication errors 12-month summary (errors/omission), September 2010 through April 2011;<br>o Copies of last 10 medication error forms completed;<br>o Copy of any communication between Pharmacy and Nursing Departments concerning medication errors/variance, since the last compliance visit;<br>o For the past two months, reports and/or summaries of any medication administration observations conducted;<br>o CCSSLC Policy: Health Care Services: Medication Administration Guidelines M.20, approval 4/5/11, implementation 5/1/11);<br>o Schedule of when quarterly drug regimen reviews are conducted by residence/unit;<br>o Polypharmacy health status assessment forms for past six months;<br>o All documentation for each emergency chemical restraint, including restraint checklist, for the following: Individual #16, dated 1/11/11; Individual #238, dated 2/25/11; Individual #191, dated 2/27/11; Individual #133, dated 2/10/11; Individual #7, dated 3/7/11; Individual #92, dated 3/9/11; Individual #7, dated 3/10/11; Individual #92, dated 3/21/11; Individual #158, dated 3/25/11; Individual #321, dated 4/6/11 10:30 p.m.; Individual #321, dated 4/6/11 11:55 p.m.; Individual #357, dated 4/16/11; Individual #133, dated 4/17/11; Individual #348, dated 2/20/11; Individual #118, dated 4/11/11; Individual #348, dated 4/11/11; Individual #348, dated 4/12/11; Individual #133, dated 4/22/11; Individual #246, dated 1/17/11; Individual #133, dated 5/3/11; Individual #133, dated 5/16/11; and Individual #191, dated 5/12/11;<br>o Any trend analysis of chemical restraint use;<br>o Summary list of all chemical restraints in the last six months;<br>o Graph: benzodiazepine usage, July 2010 through April 2011;<br>o Request to post/training roster, dated 5/10/11, and 5/11/11: Pharmacist Review of New Medication Orders, Notification of a prescriber regarding potential unexpected or undesired outcomes with addition of a new medication in combination with existing |

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| | medication regimen including supporting documentation;<br>o QA graph of compliance with new orders, March through May 2011;<br>o Pharmacy PowerPoint: Adverse drug reaction, dated 4/11; and<br>o Presentation Book for Section N.<br>▪ **Interviews with**:<br>o Sandi Suri, R.Ph.; and<br>o Minh Nguyen, Pharm.D. |
| | **Facility Self-Assessment:** The Facility determined it was not in compliance wit Sections N.1, N.2, N.3, N.5, N.6, N.7, and N.8. It determined it was in compliance with Section N.4. According to the Plan of Improvement, a number of areas of progress were documented. The Facility indicated significant activity with regard to each of the provisions in Section N. According to the Facility, since the Monitoring Team's last visit:<br>▪ For Section N.1, a number of internal monitoring audits were completed. The allergy report list was reviewed for discrepancies. A tabulation of number of orders entered into the WORx system, and the number of patient interventions was tracked per month. A small sample of records was reviewed each month beginning in March 2011 using monthly monitoring tools to determine compliance with the pharmacy policy for new medication orders. Separately, an internal QA audit of new medication orders was completed monthly. These were ongoing monitoring systems.<br>▪ For Section N.2, the QDRR schedule was changed to coincide with the PSP dates to provide updated information for discussion. The QDRR form was revised to incorporate the requirements outlined in Sections N.2 and N.3 of the Settlement Agreement, and this new form was implemented on 4/1/11.<br>▪ For Section N.3, a new process was developed for chemical restraint review. Internally, the pharmacy tracked chemical restraints using its own data for comparison with the data developed in the new interdisciplinary process. A database was developed specifically to track psychotropic use of benzodiazepines. A restraint reduction committee was formed in 3/11, and included pharmacy participation.<br>▪ For Section N.4, the QDRR form was revised to include a more detailed checkbox corresponding to each recommendation, which allowed the PCP/psychiatrist to agree or disagree, and provide comments for each of the recommendations. The Facility believed there was compliance in this area, with 100% of PCPs responding to each pharmacy recommendation. This was not consistent with the Monitoring Team's finding of noncompliance for this section.<br>▪ For Section N.5, a policy was revised to address the acceptable timeframe from MOSES/DISCUS completion to the physician review and signature.<br>▪ For Section N.6, an ADR policy was approved on 4/6/11, followed by campus-wide training, and implementation on 6/15/11.<br>▪ For Section N.7, the P&T Committee approved the Drug Utilization Evaluation policy on 3/24/11. A quarterly DUE calendar was developed. Since the Monitoring Team's last visit, two DUE studies were completed. The Monitoring Team found the Facility to be in compliance with this provision. It was unclear why the Facility's self-assessment showed noncompliance.<br>▪ For Section N.8, it was determined that the pharmacy would receive the nursing error data, and |

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| | analyze it for trends, presenting it to the P&T Committee, as well as the monthly medication committee. This began on 3/21/11.<br><br>With regard to the use of internal auditing data to substantiate compliance findings, as noted above small samples (i.e., three records) were being reviewed monthly. In addition to needing to increase the sample size, it was unclear how the data was being used to assist in making the compliance determinations. For example, for Section N.2, related to QDRRs, the data over the months since the last review, generally showed 100% compliance ratings. No narrative was provided to describe other factors that caused the Facility to find itself out of compliance with this provision. It also appeared that compliance scores were overall scores for a provision, as opposed to data being broken out to address the various components of a provision, which would have made it more useful to the Facility in identifying areas still needing improvement, as well as areas of strength. These issues were noted throughout the self-assessment for Section N. |
| | **Summary of Monitor's Assessment:** From the information provided, the Pharmacy Department was compliant with Section N.7, which addressed the implementation of regular drug utilization evaluations. The DUE system appeared to be mature and results had pragmatic application to clinical practice.<br><br>In addition, the Pharmacy Department was implementing a quality improvement (QI) system to ensure orders were meeting the Settlement Agreement requirements. This new internal QI system indicated progress with regard to Section N.1, and had the ability to verify and document sustained improvement necessary for compliance.<br><br>The QDRR was revamped, and additional sections were included for each individual recommendation. However, based on the Monitoring Team's review, for 18% of the recommendations, the PCPs had provided no response, which both Pharmacy and Medical Departments should track. Additionally, although questions were added in the QDRR related to anticholinergics and benzodiazepines, the questions did not address the requirements of the Settlement Agreement.<br><br>Progress was made in creating a system in which there was agreement between the Pharmacy and the Psychology Departments concerning the number of stat medications given, with timely written response from the Pharmacy Department.<br><br>Medical errors/variances remained a challenge, but the Pharmacy Department had assisted with root cause analysis in two cases. Omissions of medications required continued investigation.<br><br>Overall, there was significant improvement even with regard to Sections N.1, N.2, N.3, N.5, N.6, and N.8, for which the Facility was found to be out of compliance. However, the Facility reverted to noncompliance for Section N.4, due to the number of recommendations that the PCPs had not addressed. |

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| N1 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, upon the prescription of a new medication, a pharmacist shall conduct reviews of each individual's medication regimen and, as clinically indicated, make recommendations to the prescribing health care provider about significant interactions with the individual's current medication regimen; side effects; allergies; and the need for laboratory results, additional laboratory testing regarding risks associated with the use of the medication, and dose adjustments if the prescribed dosage is not consistent with Facility policy or current drug literature. | At the time of the Monitoring Team's visit, the Acting Pharmacy Director was a Pharm D. There were two Registered Pharmacist (RPH) positions filled. Two pharmacy technicians were being recruited. A Pharmacy Director also was being recruited.<br><br>Since the last review, the Pharmacy Department had developed or revised policies and procedures relevant to this provision, and had provided additional staff training. This included:<br>▪ The Pharmacy Department developed a policy to improve medication order writing. It was entitled: Pharmacy Services and Safe Medication Practices N.3: Prescriber Medication Order Policy, approval 4/6/11, implemented 4/6/11.<br>▪ To address the WORx software screening a new order and indicating a potential negative outcome, a policy guiding the pharmacist's response was revised. It was entitled: Pharmacy Services and Safe Medication Practices N.9: 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 3/1/11.<br>▪ The Pharmacy Department provided an in-service on 5/10/11 and 5/11/11 concerning pharmacist review of new medication orders, and 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.<br>▪ When a new order was screened, allergies and ADRs of the individual were reviewed. A protocol for the pharmacists to follow was created to address this aspect of medication orders entitled: CCSSLC Protocol for Checking the Allergies/ADRs.<br>▪ The pharmacy developed a QA system to monitor the new medication order review through the WORx system. A protocol was developed for this entitled: CCSSLC: QA System for New Orders. According to the policy, implemented 3/1/11, 25 orders were reviewed each month to ensure that all the essential aspects of review in placing a new order into the system were completed (i.e., allergies, drug interactions, laboratory results, monitoring parameters, appropriate dose, dosage form, duration, frequency, route of administration, and indication.) It provided monitoring to ensure all pharmacists were following standard policies and procedures of pharmacy services. Retraining followed any deficiencies. A graph indicated the findings for 3/11 through 5/11 of this quality assurance tool. New order compliance was 81% in March 2011, 67% in April 2011, and 90% in May 2011. Implementation of this QA tool indicated the pharmacy was approaching compliance in this area. If improvement continues and is sustained, compliance will be accomplished.<br><br>The Pharmacy Department submitted copies of the patient intervention reports in the | Noncompliance |

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| | | WORx system, indicating communication had occurred between the pharmacist and the PCP for clarification or change of orders. In January 2011, there were 23 entries. In February 2011, there were 16 entries. In March 2011, there were 30 entries. In April 2011, there were 37 entries. In May 2011, there were 33 entries. The content of the entries was succinct. For eight of these patient intervention entries, the name of the medication was not given. The entries for the remaining 131 appeared complete, and provided a snapshot of the topic discussed and outcome of discussion. Compliance for documentation completeness was 131 out of 139 (94%). The system of ordering new medications appeared to be working, and there was rapid communication with the PCP, when the software program indicated there were concerns.<br><br>Although improvement was seen, based on data from recent months, compliance had not yet been achieved. | |
| 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 submitted a schedule of when the QDRRs would be completed across the campus. According to this calendar, the last annual staffing date was listed, and the QDRR calendar was coordinated to ensure there was a recent QDRR completed prior to the annual PSP completion. For each person, the quarterly date on the calendar was within a three month/90-day time period from the prior QDRR.<br><br>The Pharmacy Department revised the policy on QDRR: Pharmacy Services and Safe Medication Practices N.2: Quarterly Drug Regimen Review, revision 3/24/11, approval 4/7/11, implementation 4/7/11.<br><br>For review, the Pharmacy Department submitted 39 completed QDRRs (40 were requested, but one was copied twice in the submitted request). To determine if the reports were timely and done on a quarterly basis, the current and previous reports were compared for dates of completion. Of the most current 39 reports submitted, 17 were completed more than 90 days from the prior report. This was a compliance rate of 22 out of 39 (56%) compliance rate.<br><br>Laboratory results appeared to be reviewed in all cases. In one case, results were pending. In five reports, no lab values were recorded, simply stating: "abnormal laboratory values listed: none of significance." It would be important to provide the most recent value and date of significant labs, or specifically state which lab values were normal. For certain medications, an actual value would confirm review of the important labs monitored, such as K level when Lasix is prescribed, a lipid level when a statin is prescribed, or Vitamin D level, when an individual is prescribed Vitamin D supplement to confirm a dosage adjustment is not necessary.<br><br>For drug levels, 18 QDRR profiles identified medications for which therapeutic drug | Noncompliance |

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| | | levels would be appropriate. Of these 18 QDRRs, six did not document drug levels to confirm the level was therapeutic (for such medications as Depakote, Tegretol, or Dilantin). Also falling into this category would be TSH levels, when there was prescribed thyroid replacement). Compliance was 12 out of 18 (67%). For those medications with therapeutic blood levels, stating the most recent level would indicate whether or not optimal treatment had been achieved. | |
| 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. | This provision of the Settlement Agreement encompasses a number of requirements. Each of them is discussed below, including the Pharmacy and Medical Departments' roles in addressing the use of "Stat" medications and chemical restraints, as well as benzodiazepines, anticholinergics, polypharmacy, and monitoring the metabolic and endocrine risks associated with second generation antipsychotics.<br><br><u>"Stat" Emergency Medications/Chemical Restraint Use</u><br>The Pharmacy Department assisted in the development of a new process by which the pharmacy received the Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint forms in a timely manner. The pharmacy was required to complete a section of this form (i.e., "chemical restraint clinical review") in a timely manner, which consisted of three aspects: "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."<br><br>The pharmacy made considerable progress with this new system. Of the 24 chemical restraint forms completed since the Monitoring Team's last review, 22 were submitted for review. Of these, two could not be completed due to lack of information. Of the 20 completed forms, 18 (90%) had a statement as to whether the medication was or was not clinically justified, and 18 (90%) had a statement concerning actions/recommendations, or, specifically, if no recommendations were made. Only three (15%) reviewed the potential medication related risks that needed to be considered. This was an area needing improvement.<br><br>The Pharmacy Department developed a protocol/guideline outlining the responsibilities of completing the chemical restraint form entitled: CCSSLC Guidelines for completing "Chemical Restraint Clinical Review" on the "Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint." As part of this guideline, it was expected that the potential medication related risks would be reviewed ("check for potential drug-drug interactions, review side effects of the emergency medication, do analysis for risk/benefit of using the drug.") Those pharmacists completing this form should review this guideline to ensure expected documentation is entered on the chemical restraint form. | Noncompliance |

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| | | Of great importance, the pharmacy responded within seven days in 14 (70%) of the chemical restraint reports. The pharmacy responded within two weeks in five (25%) reports, and the pharmacy completed one report (5%) after a month following the restraint usage.<br><br>The pharmacy submitted a chemical restraint tracking graph indicating that the new system of routing the chemical restraint forms to the pharmacy was successful. In 2010, in September, there were four chemical restraints, but the pharmacy only completed two chemical restraint forms. In October 2010, there were five chemical restraints, but only one chemical restraint form was completed. In November 2010, there were two chemical restraints given, but only one form was completed by pharmacy. The new system began in January 2011. Since that time, all administered chemical restraints had a form sent and completed by the pharmacy. The new system appeared to work well. Timeliness also was noted by the generally fast turn around time between the date and time of the chemical restraint and the completion of the pharmacy section of the chemical restraint form. The new system appeared to be highly successful.<br><br><u>Benzodiazepine Use</u><br>According to the Pharmacy Department, benzodiazepine use has declined 44% since 2009. Further reduction was anticipated, as one of the foci of the QDRRs was benzodiazepines. The new QDRR form has a specific question concerning use of benzodiazepines. From the sample of 39, only seven had a benzodiazepine prescribed. However, the question on the form might not immediately answer the Settlement Agreement requirements regarding whether the benzodiazepine was clinically justified, and whether the individual demonstrated the risks of significant side effects. The question simply stated: "is benzodiazepine usage being monitored?" More precise information should be documented on the QDRR (i.e., how was it being monitored?). When the pharmacy recommends monitoring of the benzodiazepine, it also should be clarified what is being measured or observed, and what would trigger a recommendation for the prescribing practitioner to review its use.<br><br><u>Anticholinergic Monitoring</u><br>The new QDRR asked a similar question for this category: "Is anticholinergic usage being monitored?" There were six out of 39 in which this was answered "yes." The older forms did not contain this question. The QDRR format should provide more guidance as to what that question means, specifically what are the details of the pharmacy's recommendation for monitoring. Additionally, there are many medications with significant anticholinergic side effects. Developing an anticholinergic drug load effect category for each individual on medications with significant anticholinergic side effects would be helpful to the medical team in specific treatments. For example, if the individual had worsening constipation despite medication, and the pharmacy provided | |

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| | | information concerning the anticholinergic drug load, the PCP might focus on decreasing or changing medications to reduce this side effect.<br><br><u>Polypharmacy</u><br>The QDRR also reviewed polypharmacy for all classes of drugs (not just psychotropic agents). Of the 39 QDRRs, 20 individuals were identified as having polypharmacy. The drugs of concern were named. As needed, the pharmacy made recommendations to reduce the numbers of medications or dosages, as appropriate. Several of the questions on the QDRR focused on the effects of polypharmacy, such as the concern for potential interactions, and pharmacotherapy appeared appropriate, to ensure justification of use, and review of related risks. There was a specific question about the risk of central nervous system (CNS) depression and/or psychomotor impairment associated with polypharmacy. Review appeared to be appropriate.<br><br>As part of monitoring for polypharmacy, the Pharmacy Department contributed risk rating for polypharmacy to the PST for the annual PSP meeting and quarterly reviews. The "Risk Guidelines" that the State Office provided appeared to be followed. However, the completion of the integrated risk rating form generated several questions. Specific to CCSSLC, the following are examples of concerns noted:<br>▪ For Individual #118, there were two risk ratings completed, one on 2/25/11 and one on 5/10/11. The descriptions related to polypharmacy were identical for both, but the risk rating was different: medium risk for one quarter and low risk for another. The rationale for either risk category was not provided. If the "Risk Guidelines" were followed, there should have been consistency in the rating. At times, the completion of the forms varied.<br>▪ For Individual #19 (2/22/11, and 5/24/11), one form simply listed "4 AEDs [Antiepileptic Drugs]," while another listed the medications. It would be important to the PST to have the medications listed. There was a listing of psychotropic medications on one of these rating forms, but it was not present on the other. It would be beneficial for interpretation, if the pharmacy consistently listed the medications, and also noted if a medication was added or dropped. For Individual #19, it was difficult to determine if the psychotropic medications were simply not listed on one rating form, but were on the other, or whether there had been a change in regimen. As he was on four medications for seizure control, regardless of side effects, according to the "Risk Guidelines," this would have been defined as high risk for polypharmacy.<br>▪ For Individual #372, there were two risk-rating forms (2/14/11, and 5/5/11). For both, four medications for seizures were listed. In one, this was given a high-risk rating. However, it did not explain whether there were side effects for the high rating score, or if the high rating was due simply to having four medications used to treat a seizure disorder, but with no side effects. The other listed not | |

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| | | only the four medications for seizure control, but also two medications for a psychiatric diagnosis. However, despite the additional medications, the rating was listed as only medium risk, providing inconsistency between the two reports.<br>▪ For Individual #311, there were two rating forms (2/14/11, and 5/5/11). In both, three psychotropic medications were listed, which should have placed him at high risk for both rating forms. However, one was listed as high risk and one as medium risk. The high-risk rating indicated valuable information as to the actual side effect of concern, which important information for the other PST members.<br>▪ For Individual #263, the risk rating form of 3/7/11 indicated he was taking five medications for a psychiatric diagnosis, yet was only listed at medium risk. This appeared to be inconsistent with the "Risk Guidelines."<br>▪ Individual #136 was rated at high risk on a 4/21/11 rating form for taking four seizure medications. It would have been helpful to know if this was based on the use of four medications for the same diagnosis, or whether side effects were known.<br><br>In general, it would be helpful if the rationale for a high risk rating in polypharmacy clarified whether or not the rating was due to the number of medications used for a diagnosis, or whether it was also based on significant side effects. This information would be valuable to the PST members in discussing options to reduce side effects. For example, Individual #153's 3/7/11 risk rating form listed four psychotropic medications under rationale, as well as concerning side effects. A high-risk rating was assigned. This was an example of important and concise information provided to the PST.<br><br>Additionally, it is suggested the Facility place the date of the form on each page (currently only the first page identified the date), because once the pages are separated, there was no ability to determine the date of the second and third pages.<br><br>Additionally, some medication polypharmacy, such as the inhalers and oral medications for respiratory diagnoses used by Individual #137 (i.e., Budesonide, Levalbuterol, and Montelukast) and by Individual #316 (i.e., Ipratropium, Levalbuterol, and Budesonide) might not have the serious side effects concern of some of the other classes of medications used for psychiatric or seizure diagnoses. However, the "Risk Guidelines" did not address these differences. The State Office might need to review subgroups of polypharmacy to determine if all subgroups represent a similar level of risk, and revise the risk guidelines as appropriate.<br><br>Psychotropic polypharmacy is reviewed at the CCSSLC monthly psychiatric services review. Minutes were submitted for 12/28/10, 1/21/11, 2/18/11, 3/25/11, and | |

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| | | 4/27/11. Focus was on review of individual cases. Psychotropic polypharmacy is reviewed in-depth with regard to Section J.<br><br><u>New Generation Antipsychotic Endocrine and Metabolic Side Effects</u><br>Of the 39 QDRRs submitted, 21 individuals had new generation antipsychotic medication prescribed. The QDRR specifically addressed this clinical area. Of these 21 QDRRs, updated metabolic and endocrine review was not evident on four of these forms. In one, the last Hemoglobin (Hgb) A1C test and lipids were from 1/19/10. Compliance was 17 out of 21 (81%).<br><br>Overall, the Pharmacy Department had made significant progress in adapting the QDRR to the needs of the individual and the PCP, as well as providing quality information for the Settlement Agreement. However, as noted above, there remain some areas needing further improvement. | |
| N4 | Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed. | There was evidence of physician review, and signature with dates on all QDRRs. The PCP agreed with the recommendations in 16 out of 39 QDRRs. There was partial agreement with the recommendations in two QDRRs.<br><br>The updated QDRR separated each recommendation for PCP agreement or not, so that a PCP could document agreement or non-agreement with each of the recommendations. A space was provided for documenting the rationale for each recommendation for which there was not agreement. This provided a process for a logical response to each recommendation, which was clearly documented. There were 10 QDRRs in which the PCP disagreed, and a response was documented on the form in each case (100%). The remaining QDRRs had a PCP note deferring the issue to the specialist (cardiology, etc.), or there was no response regarding agreement or not, but the PCP had simply signed and dated the form. It was not clear if this represented agreement, but the PCP simply did not check the appropriate box, or if there was a lack of a decision as to agreement or not. These blank agreement responses totaled seven out of 39 (18%) of the QDRRs.<br><br>The Medical Department should ensure these are completed appropriately. The QDRR form required a decision from the PCP. The lack of response for 18% of the QDRR recommendations was problematic. | Noncompliance |
| 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 | As noted with regard to Section J.12, the policy at the CCSSLC was to administer the MOSES on a quarterly basis for all individuals receiving psychotropic medication. A Psychiatric Nurse administered these evaluations for individuals who were receiving psychotropic medication. To assess for compliance, a sample of 22 of the individuals who were receiving psychotropic medication (16%) was selected. A review of the medical records for those individuals contained documentation that a MOSES evaluation | Noncompliance |

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| | dyskinesia. | had been performed on a quarterly basis over the last year, and was current for the following 19 individuals (86%): Individual #154, Individual #313, Individual #336, Individual #275, Individual #26, Individual #140, Individual #312, Individual #109, Individual #105, Individual #168, Individual #177, Individual #238, Individual #158, Individual #78, Individual #71, Individual #96, Individual #7, Individual #341, and Individual #169. Those individuals whose records did not comply with this Provision were Individual #363, Individual #185, and Individual #372.<br><br>The Facility also had developed a policy related to the timely review of the MOSES documentation by the Psychiatric Nurse. This policy addressed the importance of having both the MOSES and the DISCUS reviewed by the prescribing physician within seven calendar days of its completion. The review of the sample of records described above indicated that the prescribing physician had reviewed the MOSES in a timely manner for the following seven individuals (32%): Individual #154, Individual #238, Individual #78, Individual #71, Individual #341, Individual #109, and Individual #169. For the remaining individuals, problems included the lack of signatures at all, or reviews that had occurred outside of the seven-day policy requirement.<br><br>A Psychiatric Nurse also performed the Dyskinesia Identification System: Condensed User Scale on a quarterly basis for all of the individuals who receive antipsychotic medication. Review of the random sample indicated that documentation of current and quarterly evaluations for the last year could be identified for the following individuals: Individual #313, Individual #336, Individual #275, Individual #26, Individual #140, Individual #312, Individual #105, Individual #168, Individual #177, Individual #238, Individual #158, Individual #78, Individual #71, Individual #96, Individual #7, Individual #341, and Individual #169. The record of Individual #154 did not contain documentation of a DISCUS. However, this individual was not receiving an antipsychotic agent and, thus, a DISCUS was not required, resulting in a compliance rate of seventeen out of 21 individuals (81%). Those individuals whose records did not contain documentation that the DISCUS had been completed on a quarterly basis and the related deficiencies were as follows: Individual #363, Individual #185, Individual #372, and Individual #109.<br><br>As noted above, the Facility had also recently developed a policy related to the timely review of the DISCUS by the prescribing physician. The individuals in the sample whose records indicated that the DISCUS had been reviewed in a timely manner were those of the following eight individuals (38%): Individual #177, Individual #238, Individual #78, Individual #71, Individual #341, Individual #169, Individual #109, and Individual #363. The remaining either did not have signatures, or the review was completed outside of the timeframe that Facility policy required. | |

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| | | The MOSES also was performed at CCSSLC for those individuals who received Reglan. The rationale for this was that although Reglan is used to treat severe Gastroesophageal Reflux Disease (GERD), it also has dopamine-blocking properties that are similar to those of some of the antipsychotic agents and can, thus, also produce extrapyramidal motor side effects. The Clinical Nurses on the residential units performed the MOSES 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 MOSES for the last year was requested for every second remaining individual (50%). This process identified the following nine individuals: Individual #266, Individual #137, Individual #15, Individual #124, Individual #130, Individual #205, Individual #272, Individual #127, and Individual #245. The documentation that was provided by CCSSLC in response to this request indicated that the MOSES had been completed quarterly, and was current for eight of the nine individuals (89%). Those individuals were: Individual #266, Individual #137, Individual #15, Individual #124, Individual #130, Individual #205, Individual #127, and Individual #245. The only individual whose record did not contain documentation of a quarterly review was Individual #222, for whom there was a gap between 12/8/10 and 5/29/11.<br><br>The records also were reviewed for evidence that the prescribing physician had completed a timely review and signed the form. The MOSES had been reviewed in a timely manner for the following four individuals (44%): Individual #137, Individual #124, Individual #127, and Individual #245. The remaining individuals' MOSES had been signed, but they showed a review outside of the allotted timeframe.<br><br>The same sample also was reviewed for the completion of the DISCUS evaluation. This review indicated that the DISCUS had been completed quarterly and was current for the following eight individuals (89%): Individual #266, Individual #137, Individual #15, Individual #124, Individual #130, Individual #205, and Individual #127. The only deficiency was for Individual #222 (gap between 12/8/10 and 5/29/11). The records of these individuals also were reviewed with regard to the prescribing physician's timely review/signature. The records of the following four individuals (44%) indicated a timely review: Individual #137, Individual #15, Individual #124, and Individual #245. The remaining had been reviewed/signed outside of the timeframe that Facility policy required.<br><br>The psychiatric nurses had developed a system that should have ensured that the side effect monitoring for each individual occurred at the specified intervals. Thus the Psychiatry Department might want to investigate the degree to which the deficiencies in the documentation of the MOSES and DISCUS were due to problems with the filing of the forms in the individuals' records, as opposed to actual failures in completing the | |

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| | | examinations. | |
| 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. | The Facility was awaiting the State Office's finalization of the adverse drug reaction policy to ensure consistency between the Facility and the State policy. CCSSLC had completed the following policy: Pharmacy Services and Safe Medication Practices N.6: Adverse Drug Reaction Policy, approval 4/6/11, implemented 5/1/11. The Pharmacy Department had provided in-service training on this policy. According to the 6/13/11 P&T Committee meeting minutes, the Pharmacy Department developed a PowerPoint presentation, and this was given to the Nursing Department for training. According to the minutes: "almost 100% RNs/LVNs have been trained." At the next monitoring visit, a list of those trained to provide proof of training of all of the RNs and LVNs would assist in determination of compliance.<br><br>Since implementation of the policy on 5/1/11, no adverse drug reaction forms were submitted. There was one reported adverse affect in the hospital setting. This information was transmitted to the pharmacy and the individual's record was updated. The form "Allergy/ADR reporting form for individuals discharged from hospital" did not require a description of the reaction. Under item #6 of this form, the allergy at the hospital was to be described, but it could be interpreted as simply identifying the drug associated with the allergy. Although this is essential information, the type of reaction (hives, wheezing, etc.) also should be identified specifically. It is recommended the type of reaction specifically be included in the report and in the pharmacy system.<br><br>At the time of the Monitoring Team's visit, the policy had only been implemented for a few weeks. As noted above, there were no adverse drug effects reported during this time. Given the size of the census, one would expect one or more ADR during a six-month time period. The Monitoring Team will review this new system at the next visit, to determine if ADRs were reported and processed according to the new policy. If there were no ADRs reported, this might mean the training was insufficient and ADRs are occurring, but not being recognized, the WORx system is assisting in reviewing all potential medications for drug allergies and interactions and reducing potential ADRs, or there might be other factors which need discussing and clarification. | Noncompliance |
| 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 | The Pharmacy Department had developed and implemented a new policy concerning drug utilization evaluations: Pharmacy Services and Safe Medication Practices N.7: Drug Utilization Evaluation Policy, Approval 4/6/11 and implemented 4/6/11.<br><br>The Pharmacy Department submitted a Drug Utilization Evaluation calendar in which each quarter of the year, a different medication was reviewed. Since the Monitoring Team's last visit, two DUEs had been completed: Olanzapine, and Reclast. | Substantial Compliance |

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| | 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. | An Olanzapine (Zyprexa) retrospective study was completed on those individuals on that medication during the period between 10/1/10 and 12/31/10. Of 29 individuals prescribed that medication during that time period, 10 records were selected for review. Findings included that 30% of the individuals were prescribed Olanzapine for non-FDA labeled use, and 40% were above the maximum manufacturer's recommended daily dose. Additionally, 40% had elevated triglycerides (three out of four of these were on medication for this). The results were presented to the P&T Committee, and deferred to the psychiatrist consultant for a response. The psychiatrist provided a written response, and documented that prescribing above the official recommended daily dose was routine in standard clinic practice. As the maximum dosage was exceeded, there should have been ongoing concern of anticholinergic side effects, but this had not happened at CCSSLC, although monitoring continued. The elevation in triglycerides continued to be monitored, although there were other factors, such as dietary selection that might have contributed to this condition. Attempts at reduction in total dosage and numbers of medications were associated with exacerbations in their conditions. Changes in medication were made by consensus agreement of the psychiatrist and treatment team. Overall, the selection of olanzapine for a DUE was appropriate and provided practical information. It also allowed the Pharmacy Department and IDT members to learn of the ramifications of side effects, the psychiatry standards and practices used, as well as the caution needed in reducing medication dosages. The Psychiatry Department's response to the Olanzapine DUE was recorded at the 6/13/11 P&T Committee meeting.<br><br>The second DUE audited IV Reclast (zoledronic acid). All individuals who had been prescribed this medication from 1/1/10 through 3/23/11 were included in the study. This totaled 19 individuals. Results were instructive. A total of 32% had low-grade fever and flu like symptoms after administration. It was pointed out that Tylenol or a non-steroidal anti-inflammatory drug is recommended prior to administration, and for 72 hours after infusion to minimize fever and discomfort. Of those in the study, 89% received less than the optimal dose of calcium, and 53% had less than optimal Vitamin D blood levels, both of which are important in the treatment of osteoporosis. It was recommended that individuals should be prescribed Vitamin D3 rather than Vitamin D2. This study might not have gone through the P&T Committee for presentation at the time of the Monitor Team's visit. However, it also was a helpful study, which could be used to guide treatment of osteoporosis in those residing at CCSSLC.<br><br>As follow up, the Pharmacy Department, in collaboration with the Medical Department, should complete a study to determine if the findings and recommendations from these studies were implemented, and to determine impact. There were several clinical indicators from which one or more could be chosen for clinical follow-up.<br><br>For tracking purposes and clarification, the calendar should include the actual calendar | |

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| | | quarter (it was not clear if it referred to the state fiscal calendar or the yearly calendar starting January 1st). Also, it would be important to document at which P&T meetings these important studies were discussed. The only submitted P&T meeting was from 12/14/10, which documented progress and that the results would be discussed at the next P&T meeting. The Olanzapine materials did not include dates of which P&T committee meeting had this as an agenda item. The studies should have a final date of completion listed on them, not simply 1st Quarter 2011. The psychiatry response was dated 5/17/11.<br><br>The Facility had completed two worthwhile DUEs, and evidence was present that the results of the appropriate practitioners had reviewed and acted upon the first review. In addition, a calendar identified additional DUEs that would be completed each quarter. As a result, the Facility was found in substantial compliance with this provision. | |
| 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. | As a part of the process in reducing medication errors, a policy was created: Health Care Services M.20 Medication Administration Guidelines, approval 4/5/11, implementation 5/1/11. The policy provided guidance for such areas as identification of the individual, safe and secure practice, expected medication administration practices, documentation, communication, state assurances, staff training, and medication route guidelines.<br><br>A number of medication administration observations also were completed. When observations were done, a Medication Pass Assessment Tool, dated 3/1/11, was completed. A sample of these was submitted, dating from 4/4/11 to 4/28/11. However, the information did not include a total number of medication administration observations completed per shift per week to determine how many nurses were observed during each month. The Medication Committee minutes of 12/20/10 documented that 28 medication passes were completed, but the timeframe was not clear.<br><br>The Medication Error Committee met several times (i.e., 12/20/10, 1/24/11, 2/28/11, 3/21/11, and 4/18/11). The minutes tracked results of medication errors per month, as well as omissions. Trends that nurse educators reported included important details. In the 2/28/11 minutes, for medication pass assessments, it was noted that 45% were out of compliance with direct support professional instructions, 90% were out of compliance for positioning, 7% did not understand the calibration of the suction machine, and 17% did not know the oxygen flow rates. The minutes indicated that emergency equipment and oxygen flow rates would continue to be part of the nursing meeting agendas until compliance was 85%. The respiratory therapist and nurse educators continued to complete spot checks on oxygen flow rates. Other areas which began to be addressed in the minutes included in-servicing for narcotic counts; following up on the administration of Reglan, Prevacid, and Synthroid, which had been out of compliance because these | Noncompliance |

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| | | medications were given too close to meals; reducing distractions during medication passes; reviewing errors originating in pharmacy; crushing and mixing medications; and action steps to assist in resolution of individuals refusing to rise early enough for medications requiring an empty stomach (PSTs were to meet and write action steps into PSPAs).<br><br>Copies of the last 10 medication error forms were submitted for review. Four of the errors were Category A (circumstances or events that had the potential to cause harm), six of the errors were Category B (an error occurred, but the medication did not reach the individual), and six errors were Category C (an error occurred that reached the individual, but did not cause individual harm). Two of the forms had no category listed, and the severity index was left blank. The type of error checked appeared to be problematic in two of the submitted documents. For Individual #317's medication error report dated 1/17/11, the pharmacy dispensed the wrong dose, but the type of error was checked as "wrong drug preparation." Similarly, for Individual #72's report dated 1/16/11, the pharmacy dispensed the wrong dose, but the type of error was checked as "wrong drug preparation." For all medication errors due to nursing, a follow up nursing supervisor note was included on the medication error report.<br><br>A list of medication errors for the prior 12 months was submitted, as well as a list of documentation omissions for the prior 12 months. Medication errors were distributed across the campus, including seven errors reported in the pharmacy. There were only categories A, B, and C errors. There were no Category D or E errors, which would have indicated that an individual had been harmed as a result of the error. Most errors were due to wrong time (25 out of 47 errors reported). The second most common cause of errors was the wrong dose (11 out of 49). From this table, there was no obvious increase or decrease in medication error rate. For omissions of medications, the numbers were much larger than in the previous medication error table. The most recent month of April 2011 had the highest number of omissions, which included 332 total. The reason for the increase (March 2011 was 114) was not provided. This might represent a system change such as an improved or different reporting system. However, the Facility should have identified the increase and attempted to determine a cause(s). As appropriate, the cause(s) should have been addressed.<br><br>The Facility had begun to break down the medication errors by various parameters (by residence, category, type, process, dormitory). A report was completed: "Medication errors – Analysis report 6/16/11," which showed this information in tables. Additionally, the Pharmacy Department conducted a root cause analysis on two medication errors. | |

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| | | The Facility did not appear to make progress in reducing the number of medication errors per month. However, there was evidence of searching to determine the cause once an error occurred. More analysis needed to occur to identify potential causes, particularly on a systemic level, and to implement adequate corrective action plans to address identified issues. Due to the large number of omissions, the Facility also needed to address this area. | |

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

1. For lab review documentation on the QDRR, it is recommended the most recent value and date of significant labs be listed, or the document state specifically which lab values were normal. An actual value would confirm that the important labs were monitored. (Section N.2)
2. On the QDRR, for those medications requiring therapeutic blood levels, stating the most recent level (with date) is recommended in order to confirm optimal treatment. (Section N.2)
3. The Face-to-face Assessment form has three questions that the pharmacy is to answer. Each question should be satisfactorily answered. Pharmacists completing this form should review the guideline "Chemical Restraint Clinical Review." Pharmacists should ensure that the potential medication-related risks are reviewed. (Section N.3)
4. It is recommended that the question for benzodiazepine on the QDRR be reviewed/revised to address the Settlement Agreement requirements that their use is clinically justified, and whether or not the individual demonstrated significant side effects/risks. (Section N.3)
5. For anticholinergics, when recommending monitoring, the pharmacy should provide guidance for action steps that the PCP should take. (Section N.3)
6. An anticholinergic drug load calculation or rating should be included in the review of anticholinergics. (Section N.3)
7. On the QDRR, when there is a comment about monitoring or need for monitoring, the pharmacy should recommend precise measurements, tools, tests, observations, etc. to guide the PCP. (Section N.3)
8. When assessing risk for polypharmacy, the rationale section should be succinct, but sufficiently detailed for the PST to understand the choice of risk category. (Section N.3)
9. When assessing risk for polypharmacy, the pharmacy should consistently list the medications, and note any recent additions or deletions. (Section N.3)
10. The pharmacy follow the risk guidelines developed by the State Office in making recommendations regarding level of risk, and if the team decides to veer from these guidelines, clear justification should be provided. (Section N.3)
11. For high-risk categorization due to polypharmacy, the rationale should indicate whether the rating was due to the number of medications prescribed for a diagnosis, or was due to significant side effects, or for another reason. (Section N.3)
12. The State Office should review subgroups of polypharmacy (by organ system) to determine if all subgroups represent a similar level of risk, and the risk guidelines should be modified, as appropriate. (Section N.3)
13. Medical Compliance/QA should implement a tracking system to ensure that for each of the QDRR recommendations, there is documentation of agreement or disagreement, and rationale for any disagreement. When there is agreement indicating a need for orders, tracking should occur to ensure the orders are written and closure is provided to the recommendation. (Section N.4)
14. With regard to the completion of side effect monitoring:
    a. The Facility should implement its newly developed policy requiring the prescribing physician to review and sign the MOSES and DISCUS side effect rating instruments in a timely manner.
    b. The factors that contribute to the deficiencies in the completion rates of the MOSES and DISCUS side effect ratings should be

investigated and addressed. (Sections J.12 and N.5)

15. The form "Allergies/ADRs reporting form for individuals discharged from hospital" should clearly request the actual type of reaction. (Section N.6)
16. A monthly and quarterly summary of the total number of medication administration observations completed per shift per week should be part of the monitoring data available. (Section N.8)
17. For pharmacy dispensing errors, there should be review to confirm the category of error. (Section N.8)
18. The Facility should focus on categorizing the reasons for the large number of medication errors determined to be "omissions," and developing and implementing action plans to address potential causes, monitoring results, and modifying action plans, as necessary to achieve the outcome of reduced variances due to omissions. (Section N.8)

The following are offered as additional suggestions to the State and Facility:

1. Forms that are utilized serially should include both the page number and date of the form on each page. (Section N.3)
2. As follow up to the DUE findings, the Pharmacy Department should complete a follow up study to determine if the findings and recommendations influenced PCP clinical practice. (Section N.7)
3. The DUE calendar should clarify whether it was referencing the fiscal or chronological calendar year. (Section N.7)
4. The DUE studies should include a final date of completion, and the P&T Committee date at which the findings were discussed. (Section N.7)

| SECTION O: Minimum Common Elements of Physical and Nutritional Management | |
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| | **Steps Taken to Assess Compliance:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o Presentation Book for Section O;<br>o Presentation for July 11, 2011 for Settlement Agreement Monitoring Team Visit for Section O, not dated;<br>o The following documents: Occupational Therapy (OT)/Physical Therapy (PT)/Speech Language Pathology (SLP) Evaluations, Aspiration Pneumonia/Enteral Nutrition (APEN) Evaluation, Nutrition Evaluation; OT/PT/SLP consultations for the last year, Personal Support Plan and PSP Addendums for the last year, including PSPA for Risk Assessment, OT/PT/SLP Consultations for past year; Physical and Nutritional Management Plan (PNMP) with pictures, PST Integrated Risk Rating Form, PST Action Plan for Risk Assessment, person-specific monitoring, competency-based training for staff, supporting documentation for PST Risk Assessment and Action Plan and PNMT Action Plan implementation, for the following six individuals: Individual #48, Individual #312, Individual #136, Individual #293, Individual #210, and Individual #326;<br>o The following documents: APEN Evaluation, Head of Bed Elevation (HOBE) Evaluation, Physical and Nutritional Management Team (PNMT) Assessment and Updates, PNMT Action Plan, PSP and PSPAs for PNMT Action Plan, PNMP with pictures, Integrated Risk Rating Form, competency-based staff training by PNMT, individual-specific monitoring by PNMT and supporting documentation for implementation of PNMT Action Plan, PNMT Discharge Plan/Summary for the following 12 individuals: Individual #160, Individual #21, Individual #247, Individual #270, Individual #179, Individual #284, Individual #131, Individual #58, Individual #151, Individual #56, Individual #139, and Individual #122;<br>o The following documents: OT/PT/SLP Evaluations, APEN Evaluation, Nutrition Evaluation, PSP and PSPAs for past year, PNMP with pictures, pleasure/therapeutic feeding program/plan, person-specific monitoring, staff competency-based training, and OT/SLP Consultations for the past year, for the following 11 individuals: Individual #151, Individual #214, Individual #190, Individual #176, Individual #189, Individual #113, Individual #315, Individual #301, Individual #278, Individual #286, and Individual #68;<br>o PNMP and dining plan for the following 40 individuals: Individual#228, Individual #202, Individual #291, Individual #67, Individual #156, Individual #99, Individual #221, Individual #3, Individual #87, Individual #136, Individual #65, Individual #198, Individual #371, Individual #56, Individual #153, Individual #329, Individual #202, Individual #363, Individual #211, Individual #282, Individual #141, Individual #280, Individual #19, Individual #229, Individual #23, Individual #28, Individual #93, Individual #278, Individual #113, Individual #50, Individual #151, Individual #212, Individual #286, Individual #315, Individual #214, Individual #175, Individual #58, Individual #91, Individual #86, and Individual #223; |

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| | o Medication Administration Record (MAR) and PNMP with pictures for the following individuals: Individual #247, Individual #43, and Individual #276;<br>o Agenda and Curriculum for Aspiration Prevention Class, including handouts;<br>o Personal Support Plan Facilitation Tool, not dated;<br>o Completed competency-based check sheets for three PNMP Coordinators (PNMPCs);<br>o PNMP Coordinator Meeting Minutes, from January 2011 to present;<br>o Current PNMT caseload, not dated;<br>o Agenda for PNMT Follow-Up Review, dated 7/12/11;<br>o Activity Schedules during Independent Monitor's Visit, dated 7/11/11 to 7/15/11;<br>o Agenda for new staff orientation and any curricula revised since last site visit, dated 3/9/11;<br>o Monthly schedule for ongoing in-service training, 1/11 through 12/11;<br>o List of budgeted positions and number filled/not filled, dated 5/31/11;<br>o Movement report listing admissions, deaths, reassignments, and community placements, 12/10 through 5/31/11;<br>o List of individuals who are "at risk" per identified health risk factors, multiple dates;<br>o List of individuals who have been diagnosed with pneumonia during past year, 6/10 through 4/11;<br>o List of individuals who have had a swallowing incident during past year, 6/10 through 5/1;<br>o List of PNMT members and curriculum vitae, dated 12/8/10;<br>o PNMT meeting notes, dated 5/31/11;<br>o Roles of PMNT members, dated 5/31/11;<br>o List of continuing education sessions for PNMT members, 12/10 through 5/11;<br>o PNMT Assessment reports, 4/11 and 5/11;<br>o Integrated Risk Rating form (blank), revised 2/8/11;<br>o List of individuals with PNM needs, dated 6/3/11;<br>o List of Individuals without PNM needs, dated 5/31/11;<br>o Tools used to monitor implementation of PNM procedures and plans, revised 12/10;<br>o POI self-assessment tools completed during past quarter, 3/11 through 5/11;<br>o PNMP check sheets and person-specific monitoring in Dining Rooms, 12/10 through 4/11;<br>o Dining Plan templates, no dates;<br>o List of individuals receiving modified diets/thickened liquids, dated 6/6/11;<br>o List of individuals identified as requiring Mealtime Assistance, dated 6/6/11;<br>o List of individuals who receive nutrition through non-oral methods, dated 6/10/11;<br>o List of individuals whose diets have been downgraded, dated 6/6/11;<br>o List of individuals with Body Mass Index (BMI) greater than or equal to 30, dated 6/7/11;<br>o List of individuals with BMI less than or equal to 20, dated 6/7/11;<br>o List of individuals who have had unplanned weight loss of greater than or equal to 10%, during past six months, dated 6/20/11;<br>o List of individuals who have experienced a choking incident during past 12 months, dated 7/20/11; |

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| | ○ List of individuals who have experienced an aspiration and/or a pneumonia incident, during past 12 months, dated 6/7/11;<br>○ List of individuals who have had a chronic respiratory infection, during past 12 months, dated 6/20/11;<br>○ List of individuals who have had a skin breakdown and/or an active pressure ulcer, during past six months, not dated;<br>○ List of individuals who have had a fall, during past 12 months, dated 6/20/11;<br>○ List of individuals who have experienced a fracture, during past 12 months, dated 6/10/11;<br>○ List of individuals who have experienced a fecal impaction, during past 12 months, not dated;<br>○ List of individuals who are considered to be "at risk" of: choking, falls, skin breakdown, fecal impaction, osteoporosis/osteopenia, aspiration, and pneumonia, dated 3/5/11;<br>○ List of individuals who are non-ambulatory or require assisted ambulation, dated 6/6/11;<br>○ List of individuals with poor oral hygiene, dated 6/20/11;<br>○ List of individuals who have chronic and/or acute pain, not dated;<br>○ List of individuals who have received a videofluoroscopy, modified barium swallow study, or other diagnostic swallowing evaluation, during past year, 10/10 through 5/11;<br>○ Meal Schedules-by home, not dated;<br>○ Schedule of all PNM-related meetings, for 7/11;<br>○ PNM curricula used to train staff, multiple dates;<br>○ Agenda and curricula for foundational in-services completed since the last on-site review, multiple dates;<br>○ Competency-based training sessions addressing PNM foundational skills during past six months, from 12/10 through 4/11;<br>○ PNMPs for multiple individuals, dated 12/10 through 5/11;<br>○ List of PMNT assessment meetings and corresponding PSPAs, from 12/10 through 5/11;<br>○ PNM assessments and updates completed in last two quarters, from 12/10 through 5/11; and<br>○ PNMT meetings, pre-assessments, and minutes since last onsite review, multiple dates.<br>▪ **Interviews with**:<br>○ Dr. Angela Roberts, Habilitation Therapy (HT) Director;<br>○ Mary Wilcox, RN, Core PNMT Member;<br>○ Janie Mendoza, PT, CWS [Certified Wound Specialist], FACCWS [Fellow of The College of Certified Wound Specialists], Core PNMT Member;<br>○ Nancy Droke, OTR, Core PNMT Member;<br>○ Noela Morales, SLP, Core PNMT Member; and<br>○ Tami Loudermilk-Flores, Alternate PNMT Member.<br>▪ **Observations of**:<br>○ Follow-up PNMT Reviews, on 7/12/11;<br>○ PNMT meeting, on 7/14/11; and<br>○ Residences and dining rooms in Coral Sea, Atlantic and Pacific. |

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| | **Facility Self-Assessment:** The CCSSLC Plan of Improvement, updated 6/29/11, provided comments/status for Sections O.1 through O.8 of the Settlement Agreement. The Facility indicated it was in noncompliance with each of the provisions. This was consistent with the Monitoring Team's findings. This document also provided a summary of some of the action plans on which the Facility was working to achieve compliance.<br><br>The Plan of Improvement provided some narrative descriptions of actions the Facility had or was taking to move towards compliance within each of the eight sections, but did not present a comprehensive assessment of compliance with each of the indicators. The POI did not include data from its self-assessment reviews, and/or the status of inter-rater reliability. As the Facility moves forward in its self-assessment process, it will be important to ensure that data is used in meaningful ways to assist in identifying areas in which improvements are needed. |
| | **Summary of Monitor's Assessment:** The Habilitation Therapies Director and Facility administration were aware of the challenges faced by the Core and Alternate PNMT members to perform their PNMT responsibilities and carry a large caseload. The Facility Administration, including the Habilitation Therapy Director, need support from the State to identify additional resources to reduce the caseloads of the OT, SLP, and Dietician to enable these professionals to fulfill their PNMT responsibilities.<br><br>Currently, CCSSLC had two dieticians providing support to 272 individuals. The addition of another dietician would be beneficial to lower the current caseloads of the two dieticians as they provide supports to individuals on the PNMT.<br><br>The Monitoring Team noted the following positive observations related to the PNMT:<br>▪ The PNMT continued to refine their work products (i.e., PNMT Pre-Assessment) and updated their policies and procedures (Physical and Nutritional Management: Roles of PNMT Members, policy O.2.1, draft revision 5/31/11;<br>▪ The PNMT members during the course of providing supports to individuals also identified systemic concerns that needed to be addressed. The PNMT is commended for this approach. This revealed that CCSSLC's PNMT understood their role as not only providing supports to individuals on their caseload, but also the importance of resolving systemic issues that impacted the health and safety for individuals campus-wide. For example, the PNMT identified infection control issues related to respiratory equipment, and developed a monitoring form for documentation of cleaning. These systemic issues should be raised with the Risk Management, as well as Quality Assurance Departments.<br>▪ The PNMT PT was the PNMT Chairperson, and was fully dedicated to the PNMT.<br>▪ The addition of nurse dedicated to the PNMT was a positive improvement.<br>▪ The PNMT Database was being developed to provide information for tracking trends and analysis of supports provided to individuals reviewed by the PNMT.<br>▪ The PNMT began using a big screen television to support better facilitation during PNMT meetings.<br><br>Areas requiring continued improvement include: the PNMT process for reviewing the Integrated Risk |

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| | Rating Form; completion of the comprehensive assessment and action plan; competency-based training and performance check-offs; individual-specific monitoring; documentation in Integrated Progress Notes; the PNMT's involvement with individuals who experience hospitalizations; as well as in developing transition plans, and discharge planning.<br><br>The HT Director is commended for initiating a review of the current process for PNMPs, and initiating positive changes to the process used to develop PNMPs. Reportedly, the purpose of PNMPs was discussed with therapists, including revisiting the intent of PNMPs, as well as engaging in a critical review of the current content of PNMPs to revise the PNMPs. The goal of this initiative was to present a document that was more user-friendly for direct support professionals. A PNMP example was developed, which provided instructions for therapists. This PNMP example and instructions were presented to OTs, PTs, and SLPs on 5/17/11. With regard to Section O.3, the Monitoring Team identified multiple examples for the inclusion of specific information into PNMPs. The HT Department should formalize this initiative through established guidelines and/or policy.<br><br>The Habilitation Therapy Director is commended for her leadership in beginning the process for the development and implementation of performance check-off objectives for competency-based training.<br><br>The purpose of an APEN Evaluation was to determine if receiving nutrition by tube was medically necessary, and, where appropriate, to implement a plan to return the individual to a less restrictive form of receiving enteral nutrition and/or a return to oral feeding. Based on a review of a sample of APEN evaluations, they did not evaluate the medical necessity of the tube, and/or determine if a less restrictive approach to receiving enteral nutrition was possible and, if appropriate, recommend the development and implementation of a plan to return an individual to oral eating. |

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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 | Due to the multiple requirements included in this provision of the Settlement Agreement, as well as the requirements of this overarching provision of the Settlement Agreement being further detailed in other components of Section O of the Settlement Agreement, the following summarizes the review of the requirements related to the PNMT, including the composition of the team, the qualifications of team members, and the operation of the team. 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 Settlement Agreement.<br><br>The PNM team consists of qualified Speech Language Pathologist, Occupational Therapist, Physical Therapist, Registered Dietician, and, as needed, ancillary members [e.g., MD, Physician's Assistant (PA), Registered Nurse].<br>Physical and Nutritional Management: PNMT Core Members, Policy O.1, draft revision | Noncompliance |

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| | with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan. The PNMP will be reviewed at the individual's annual support plan meeting, and as often as necessary, approved by the IDT, and included as part of the individual's ISP. The PNMP shall be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. The Facility shall maintain a physical and nutritional management team to address individuals' physical and nutritional management needs. The physical and nutritional management team shall consist of a registered nurse, Physical Therapist, occupational therapist, dietician, and a speech pathologist with demonstrated competence in 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. | 6/8/10, with approval on 11/8/10, and implemented on 12/8/10, identified the necessary membership of the Core PNMT and Alternate PNMT.<br><br>At the time of the review, the Facility had a Core PNMT and an Alternate PNMT. A Physical Therapist and the Registered Nurse were fully dedicated to the PNMT. The PNMT Nurse began her appointment to the PNMT on 5/1/11.<br><br>The following positive achievements strengthened the PNMT process:<br>▪ The PNMT PT was the PNMT Chairperson, and fully dedicated to the PNMT.<br>▪ A dedicated nurse was added to the PNMT.<br>▪ PNMT began using a big screen TV to support better facilitation during PNMT meetings.<br>▪ The PNMT members during the course of providing supports to individuals also identified systemic concerns that needed to be addressed. The PNMT was to be commended for this approach. It revealed that this PNMT understood their role as not only providing supports to individuals on their caseload, but also in resolving systemic issues that impacted the health and safety for individuals campus-wide. For example, the PNMT identified infection control issues related to respiratory equipment, and developed a monitoring form for documentation of cleaning. These systemic issues should be raised to Risk Management, as well as Quality Assurance.<br>▪ A PNMT Database was being developed and refined to provide information for tracking trends and analysis of supports provided to individuals on the PNMT.<br><br>Physical and Nutritional Management: Roles of PNMT Member, Policy O.2.1, draft revision dated 5/31/11, was submitted. This policy addressed the roles of the PNMT members, including the physician, occupational therapist, registered nurse, registered dietician, physical therapist, and speech pathologist. This policy defined the physician as "serves as an ancillary member of the Physical Nutritional Management Team." The PNMT would benefit from having a physician assigned to the PNMT to provide support and consultation prior to, during and after PNMT meetings.<br><br>As documented in the charts below, the Occupational Therapists, Speech Pathologists, and Registered Dieticians (RD) were responsible for individuals the PNMT supported, as well as additional caseloads of individuals residing in Coral Sea and/or Atlantic. At the time of the review, the CCSSLC census was 272 individuals. The 23 individuals that the PNMT supported (according to the Current PNMT Caseload, dated 7/15/11) resided in multiple residences on campus and the Infirmary. One individual had been admitted to the hospital during the on-site review. Of the 23, three individuals were in the Infirmary (Individual #247, Individual #43 and Individual #151), one individual (Individual #179) in the hospital, ten individuals in Coral Sea (Individual #21, Individual #284, Individual | |

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| | | #124, Individual #372, Individual #244, Individual #270, Individual #139, Individual #160, Individual #314 and Individual #122), eight individuals in Ribbonfish (Individual #131, Individual #58, Individual #56, Individual #378, Individual #86, Individual #175, Individual #223, and Individual #214), and one individual in Kingfish (Individual #311). Based on interview and document review, the following chart identifies the current caseloads and/or responsibilities of the PNMT members: | |

| Core PNMT Members | Current Caseloads and Responsibilities |
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| Physical Therapist | PNMT Chairperson and supporting 23 individuals on the PNMT |
| Registered Nurse | Supporting 23 individuals on PNMT |
| Occupational Therapist | Supporting 23 PNMT individuals and 72 individuals residing in Coral Sea |
| Speech Pathologist | Supporting PNMT individuals, and 72 individuals residing in Coral Sea, and supervising a SLP working to achieve master level certification |
| Dietician | Supporting PNMT individuals and approximately 136 individuals |

| Alternate PNMT Members | Current Caseloads and Responsibilities |
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| Occupational Therapist | Supporting PNMT individuals and 109 individuals residing in Atlantic |
| Physical Therapist | Supporting PNMT individuals and 72 individuals residing in Pacific |
| Speech Pathologist | Supporting PNMT individuals and 109 individuals residing in Atlantic |
| Dietician | Supporting PNMT individuals and approximately 136 individuals of the CCSSLC |

The Facility Administration had approved the hiring of additional therapists. The HT Director had hired additional therapists (SLP and OT), but the caseloads for therapists as well as Core and Alternate PNMT members remained high, which impacted PNMT members' ability to successfully implement the PNMT process for those individuals at highest risk. The Facility Director, Assistant Director, and HT Director were aware of the need to lower the caseloads of the PNMT members, but to accomplish this task, additional CCSSLC positions would have to be re-classified, which would need the approval of the State. The Facility Administration, including the Habilitation Therapy Director, need support from the State to identify additional resources to reduce the caseloads of the OT, SLP and Dietician to enable these professionals to fulfill their PNMT

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| | | responsibilities.<br><br>Currently, CCSSLC had two dieticians providing support to 272 individuals. The addition of another dietician would be beneficial to lower the current caseloads of the two dieticians as they provide supports to individuals on the PNMT.<br><br>Based on information provided, the Core and/or Alternate PNMT supported 23 individuals (Individual #21, Individual #43, Individual # 247, Individual #179, Individual #284, Individual #131, Individual #58, Individual #151, Individual #56, Individual #378, Individual #124, Individual #314, Individual #372, Individual #86, Individual # 175, Individual #223, Individual #214, Individual #244, Individual #311, Individual #270, Individual #139, Individual #160, and Individual #122). In the section of this report that addresses Section O.2 of the Settlement Agreement, the Monitoring Team's review of 12 of these 23 individuals (Individual #160, Individual #21, Individual #247, Individual #270, Individual #179, Individual #284, Individual #131, Individual #58, Individual #151, Individual #56, Individual #139, and Individual #122) is discussed.<br><br>The Physical Nutritional Management Core Team Training, dated March 2010, which the State Coordinator for Specialized Services presented, consisted of ten clinical instructional domains with multiple components, including:<br>▪ Physical Nutritional Management Teams;<br>▪ Nutritional Management/GI Issues;<br>▪ Clinical Assessment Technologies;<br>▪ Seating and Positioning for Dysphagia;<br>▪ Evaluation of Seating and Positioning;<br>▪ Wound Investigation Protocol;<br>▪ Communication Issues/Strategies;<br>▪ Nursing Issues in PNMP;<br>▪ Dietary Issues with PNMP; and<br>▪ Respiratory Therapy.<br><br>Per report, no state-sponsored webinars had been conducted for the CCSSLC Core and/or Alternate PNMT members since the last on-site compliance review.<br><br>Review of a training roster and certificates of completion for the Core and Alternate PNMT OT, PT, SLP, RD, and RN members for clinical instruction revealed the following:<br>▪ One Core PNMT member (i.e., OT) attended the Beckman Oral Motor Assessment and Intervention, on 1/14/11;<br>▪ Two Core PNMT members (i.e., OT, and PT) and one Alternate PNMT member (i.e., PT) attended the Wheelchair and Bed Positioning for the Geriatric Patient, on 2/18/11; | |

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| | | ▪ One Core PNMT member (i.e., OT) and two Alternate PNMT members (i.e., OT, an PT) attended a Neuro Rehabilitation Conference, on 5/7/11;<br>▪ Five Core PNMT members (i.e., RN, OT, PT, SLP, and RD) and two Alternate PNMT members (i.e., OT and RD) attended Managing Dysphagia: Essential Assessment, Diagnosis and Treatment Strategies, on 5/24/11; and<br>▪ The Core and Alternate RDs attended multiple continuing education courses.<br><br>The Monitoring Team supported the appropriateness of the continuing education courses completed by identified Core and Alternate PNMT team members, but not all Core and Alternate PNMT team members had completed continuing education courses since the last on-site review. All Core and Alternate PNMT members have a responsibility to participate in on-going continuing education opportunities to expand their knowledge and skills, and ensure they are knowledgeable about current trends within their respective fields, as well as other team members' fields of expertise.<br><br>A continuing education tracking system for PNMT members and other therapists should be implemented to consistently document attendance through training rosters and/or certificate of completion for state-sponsored webinars, off-site clinical instruction, and conferences. This tracking system should be reviewed regularly to ensure that Core and Alternate PNMT members are attending state-sponsored clinical instructions webinars and community continuing education.<br><br><u>PNMT meets regularly to address change in status, assessments, clinical data, and monitoring results.</u><br>Physical and Nutritional Management: Participating in PNMT Meetings, policy O.2, draft revision 5/31/11, with approval on 11/5/10, and implemented on 12/8/10, defined the purpose of the PNMT; Core and Alternate PNMT membership; responsibilities of the PNMT; PNMT regular meeting schedule, as well as reasons for meetings outside of the regular schedule; and four phases of the PNMT program to include referral, comprehensive assessment, treatment/training, and review; documentation; and PNMT meeting procedures.<br><br>The PNMT should re-evaluate the referral phase of this policy. The Integrated Risk Rating Form, dated 10/10, had been revised to incorporate a check box for referral (yes or no) to the PNMT. The criteria for referrals to the PNMT should be clearly defined for the PST. It did not appear that PST members understood the criteria for referral to the PNMT and/or the PNMT process. For example:<br>• Presentation Book for Section O presented the following document, Individuals Referred to PNMT as a result of Integrated Risk Rating, (dated 6/27/11), which identified four individuals (Individual #218, Individual 65, Individual 287, and Individual 363), who reportedly had been referred to the PNMT as a result of | |

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| | | Integrated Risk Rating forms. However, the PNMT had not received these referrals. Individual #218 was identified at high risk for cardiac and weight; Individual #65 was identified at high risk for seizures and urinary tract infections; Individual #287 was identified at high risk for osteoporosis; and Individual #363's Integrated Risk Rating did not identify a high risk rating.<br>▪ Individual #48, Individual #137, Individual #105, Individual #64, Individual #136, and Individual #312 were rated at high risk for aspiration, but had not been referred to the PNMT.<br>▪ Individual #327 was admitted to the hospital on 1/27/11 for fever, dehydration, and pneumonia and admitted to Infirmary on 4/13/11 for respiratory distress, fever, dehydration, and cardiac arrest. She had not been referred to the PNMT.<br>▪ Individual #293 was admitted to the Infirmary 1/11/11 for pneumonia, and a second time on 1/26/11 for respiratory distress and recurrent pneumonia. The PST rated her medium for aspiration and respiratory concerns. These ratings did not conform to the risk guideline criteria. Individual #293 was not referred to the PNMT.<br><br>PSTs need training on the Physical and Nutritional Management policies (O.2 and O.2.1). Training should detail the criteria for referral of individuals to the PNMT; indicators for immediate referral to the PNMT; information to be provided to the PNMT for individuals being referred; philosophy of the PNMT process; and explanation of the PNMT process, including the components of the comprehensive assessment, development of action plans, and integration of PNMT action plans into PSPs and related documents, such as the PNMP, Behavior Support Plan, Health Management Plan, etc.<br><br>An additional sample of individuals was drawn from the CCSSLC hospitalization, emergency room and/or Infirmary listings, and list of individuals who were rated at high risk for aspiration. This sample included the following six individuals: Individual #48, Individual #312, Individual #136, Individual #293, Individual #210, and Individual #326.<br><br>None of these six individual records reviewed (0%) documented that the PST members had followed the at-risk process outlined in the SSLC At-Risk Individuals policy, approved 12/29/10. The PSTs had not developed an action plan, met regularly to review and update the implementation of the Risk Action Plan, and/or develop measurable outcomes to determine if the action plan successfully minimized, and/or reduced high-risk indicators. Professional staff had not provided competency-based training for direct support professionals responsible for implementation of the plans, nor was monitoring documented. | |
| O2 | Commencing within six months of the Effective Date hereof and with | <u>A process is in place that identifies individuals with PNM concerns.</u><br>As noted with regard to Section I, Section O.1 and Section P, PST members had completed | Noncompliance |

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| | full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems. | a risk assessment for individuals in the sample, but did not consistently follow the risk guidelines in the assignment of risk ratings. In addition, the At Risk Process had not been implemented as defined in the DADS At-Risk Individuals policy. It is essential that teams accurately follow this process, because the At-Risk Individuals policy had made PSTs responsible for making referrals to the PNMT, and as stated above, the referral process to the PNMTs had not been sufficiently defined.<br><br><u>The PNM Team provides individuals identified as being at an increased risk level with a comprehensive assessment that focuses on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, and positioning during the course of the day, and during nutritional intake.</u><br>The PNMT continued to refine their work products (i.e., PNMT Pre-Assessment) and updated their policies and procedures (Physical and Nutritional Management: Roles of PNMT Members, policy O.2.1, draft revision 5/31/11.<br><br>The following 12 individuals had been reviewed by the PNMT: Individual #160, Individual #21, Individual #247, Individual #270, Individual #179, Individual #284, Individual #131, Individual #58, Individual #151, Individual #56, Individual #139, and Individual #122. A review a subset of six (Individual #131, Individual #122, Individual #58, Individual #160, Individual #179, and Individual #247) of these 12 individuals' PNMT evaluations, PNMT action plans, PNMPs, individual-specific competency-based training and performance check offs, individual-specific monitoring, and other evidence submitted revealed the following:<br>▪ In zero of the six records reviewed (0%), there was documentation of correct risk identification levels completed by the PNMT prior to the comprehensive assessment based upon health, physical and nutritional history, current status, and specific criteria for guiding placement of individuals in specific risk levels.<br>▪ In six of the six records reviewed (100%), there was documentation of a comprehensive assessment.<br>▪ In none of the six records reviewed (0%) did the comprehensive assessment reflect a comprehensive review/assessment of identified risk levels.<br>▪ In none of the six records reviewed (0%) was there a PNMT Action Plan that supported identified risk levels per the Integrated Risk Action Form;<br>▪ In none of the six records (0%), the PNMT evaluation included an analysis to consistently provide a rationale for the development of recommendations and measurable, functional outcomes for individuals at highest risk to minimize and/or reduce the identified health risk(s). This indicator was impacted by individuals not being identified at high risk for aspiration pneumonia, which impacted their PNMT evaluation and action plan, because they did not address their high risk for aspiration.<br>▪ In five of the six records (83%) (except for Individual #247), a PSP Addendum | |

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| | | for the PNMT meeting was present, which included the integration of the PNMT Action Plan.<br>▪ In six of the six records (100%), there was documentation of development of implementation strategies.<br>▪ In none of the six records (0%) was there documentation of competency-based training for all the individual strategies as recommended in the PNMT Action Plan.<br>▪ In none of the six records (0%) was there documentation of individual-specific PNMT monitoring completed for individuals at highest risk.<br>▪ In none of the six records (0%) was there documentation in Integrated Progress notes of progress, and/or lack of progress with the Action Plan.<br>▪ In none of the six records (0%) was there documentation of a review process to determine the efficacy of individual strategies resulting in the attainment of identified outcomes.<br><br>In the Monitoring Team's review of the six individuals that the PNMT had evaluated, the following observations were made, which did not support compliance with the PNMT assessment process:<br>**Integrated Risk Rating Form**<br>▪ As a first step in the assessment phase, the PNMT should review the Integrated Risk Rating Form completed by the PST to determine whether or not the individual's current status of risk ratings continued to be accurate. At the time of the review, this was not consistently occurring.<br>▪ There was no documentation that the PNMT had updated the Integrated Risk Rating forms. In the absence of the PNMT completing an updated Integrated Risk Rating form, inaccurate PNMT Action Plan(s) were developed, because risk factors that the PSTs had identified were not accurate, due to the fact that they were not supported by the risk guidelines or clinical data.<br>▪ When the PNMT revised an Integrated Risk Rating Form, the individual's team should be involved, and this should be documented through a PSPA. This was not standard practice at CCSSLC.<br>**Comprehensive Assessment**<br>▪ The PNMT comprehensive assessment should clearly document when and why the individual was referred to the PNMT, including the concerns and risks that the PST has identified.<br>▪ The PNMT comprehensive assessment should incorporate the findings of a HOBE assessment for those individuals at high risk of choking, aspiration, and respiratory concerns. In the records reviewed, this was not seen consistently.<br>▪ The PNMT should review the APEN evaluation to determine if strategies have been recommended to transition an individual to a less restrictive approach to enteral nutrition, and/or implementation of therapeutic/pleasure feedings | |

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| | | leading to return to oral eating. It was not clear that this was done consistently, and/or that the quality of the APEN evaluation was adequate.<br>▪ The PNMT comprehensive assessment should reflect an assessment of the identified high-risk and medium-risk indicators. Prior to the Monitoring Team's onsite visit, the PNMT was not clear if the assessment needed to incorporate medium risk indicators. This had been clarified, however, and Facility Administration had directed teams to develop action plans to address all medium risk indicators.<br>▪ PNMT Evaluations did not consistently provide an analysis of evaluation data. The PNMT evaluations should encompass a detailed analysis of clinical evaluation data, which supports the development of recommendations and measurable outcomes.<br>**PNMT Action Plan**<br>▪ Individual PNMT Action Plans were not integrated in Health Management Plans, which did not support an intensive, integrated approach to assessing, tracking and resolving identified high and medium risk health indicators.<br>▪ PNMT Action plans did not consistently identify individual-specific objective clinical data that could indicate the onset of illness to be assessed by nursing and observed by direct support professionals. The primary objective of the PNMT Action Plan should be to identify and remediate identified high and medium risk health indicators.<br>▪ PNMT Action Plans were not specific in identifying how often the PNMT would conduct a hands-on assessment an individual's current status.<br>▪ PNMT Action Plans did not provide comprehensive recommendations to address high-risk indicators, such as for individuals at risk for aspiration. The measurable objectives and outcomes listed often were not adequate to reduce individuals' risk of aspiration. For example, the PNMT should have considered and recommended measurable objectives or outcomes, including, but not limited to the completion of a HOBE assessment to determine the safe range of elevation for mealtime, alternate positioning, tooth brushing, personal care, bathing/showering; identification of individual-specific aspiration triggers to be incorporated into individuals' PNMPs so that direct support professionals would not what to look for; identification of clinical indicators to be assessed and monitored by nursing; competency-based training and performance check-offs for nursing, appropriate supervisory staff and direct support professionals; and individual-specific monitoring related to elements of the action plan for aspiration.<br>▪ PNMT Action Plan recommendations were reviewed in PNMT review meetings, but as documented in subsequent PNMT reviews, multiple recommendations had not been implemented. The PNMT Action Plan recommendations should be implemented with a sense of urgency due to the high level of health risk | |

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| | | identified with individuals supported by the PNMT. It was not acceptable that recommendations were reported from month to month without implementation and/or resolution.<br>▪ Multiple individuals on the PNMT caseload had multiple admissions to the Infirmary, emergency room and/or hospital. The PNMT Action Plans should support proactive interventions to eliminate and/or minimize Infirmary, emergency room, and/or hospital admissions. In records reviewed, a clear correlation between risk factors that placed individuals into the hospital or Infirmary and the PNMT Risk Action Plans had not been identified as individual-specific triggers, and clinical data that needed to be collected to alert staff to the onset of illness.<br>▪ The PNMT Action Plan interventions/recommendations and measurable outcomes should answer the questions who, what, where, when and why. Multiple PNMT Action Plan intervention/recommendation and measurable outcomes did not provide this necessary information. For example, a measurable outcome such as: "revise the PNMP to address respiratory compromise by 2/17/11" did not identify who would revise the PNMP, what would be revised in the PNMP, and why these revisions were recommended. This example did identify when the recommendations would be completed.<br>**PSP Addendum**<br>▪ The PSP Addendum should incorporate the PNMT Action Plan. As noted above, this generally was being done. However, efforts should be made to ensure that this is standard practice across the Facility.<br><br>A review of the records of six individuals who were hospitalized, admitted to the Infirmary, and/or identified at high risk for aspiration pneumonia (Individual #48, Individual #312, Individual #136, Individual #293, Individual #210, and Individual #326) revealed the following:<br>▪ In none of the six records (0%) was documentation found of PST and/or PNMT review/analysis of the findings of relevant discipline-specific assessment(s), including but not limited to PNMP Clinic results, PNMP, and relevant consultation(s) leading to the development of a comprehensive summary. Such a summary should have addressed:<br>o Physical health status;<br>o Nutritional health status;<br>o Oral care;<br>o Medication administration;<br>o Mealtime strategies;<br>o Proper alignment; and<br>o Positioning during the course of the day and during nutritional intake. | |

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| | | ▪ In none of the six records (0%) were measurable, functional outcomes identified.<br>▪ In none of the six records (0%) was documentation found of PNMPs developed with input from the PNMT for those individuals at highest risk.<br>▪ In none of the six records (0%) was congruency found between Strategies/Interventions/Recommendations contained in the PNMP, and the concerns identified in the comprehensive assessment.<br>▪ In none of the six records (0%) were comprehensive summary results integrated into the design of the appropriate PNM support plans, as outlined in HCG VI and VIII and Settlement Agreement O.3 through O.8.<br>▪ In none of the six records (0%) were PNMT updates provided as needed until the individual was discharged from the PNMT. | |
| 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><br>The HT Director is commended for initiating a review of the current process for PNMPs, and initiating positive changes in the development of PNMPs. Based on staff report, the purpose of PNMPs was discussed with therapists to revisit the intent of PNMPs, as well to engage in a critical review of the current content of PNMPs. The goal of this initiative was to develop a document that was more user-friendly for direct support professionals by reducing excessive written language, eliminating foundational information and providing individual-specific information. A PNMP example was developed, for a fictitious individual named Chester Drawers, which provided instructions for therapists. On 5/17/11, this PNMP example and instructions were presented to OTs, PTs and SLPs. Revised PNMPs that were reviewed had less narrative, and reinforced individual-specific strategies. However, staff compliance with PNMPs should be supported through competency-based training and performance check-offs. As is discussed in further detail below, some information that should be incorporated into PNMPs was not.<br><br>Reportedly, the HT Director did not focus on step-down policies, but initiated changes in the PNMP process through an in-service. A step-down policy should be developed to formalize the revised PNMP process.<br><br>A review was conducted of six individuals identified at high risk, including: Individual #48, Individual #312, Individual #136, Individual #293, Individual #210, and Individual #326. Two of these individuals (Individual #48 and Individual #312) did not have a PNMP even though these individuals were rated at high risk for aspiration. These individuals did not have a Risk Action Plan, which should have identified the need for a PNMP. The lack of PNMPs for these individuals was highly problematic.<br><br>PNMPs for four individuals (Individual #293, Individual #210, and Individual #326) | Noncompliance |

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| | | were reviewed. Although many of the components of an adequate PNMP were present for these individuals, there were components missing. More specifically:<br>▪ In four of four records (100%), positioning instructions for wheelchair and alternate positions instructions were included.<br>▪ In four of four records (100%), transfer instructions were included.<br>▪ In four of four records (100%), the mealtime/dining plan included oral intake strategies for mealtime and snacks, and/or addressed receiving nutrition through a feeding tube.<br>▪ In four of four records (100%), the mealtime/dining plan included food/fluid textures, and/or addressed receiving nutrition through a feeding tube.<br>▪ In one of four records (25%) (Individual #210), the time was identified that an individual needed to remain upright after eating, and/or receiving enteral nutrition.<br>▪ In four of four records (100%), the mealtime/dining plan included behavioral concerns related to intake, and/or addressed receiving nutrition through a feeding tube.<br>▪ In none of four records (0%), strategies for medication administration were included.<br>▪ In two of four records (50%) (Individual #136 and Individual #210), strategies for oral hygiene were included.<br>▪ In four of four records (100%), individual adaptive equipment was included.<br>▪ In two of four records (50%), bathing/showering positioning and related instructions were included.<br>▪ In none of six records (0%), personal care instructions for elevation during checking and changing were included.<br>▪ In two of four records (50%) (Individual #136 and Individual #210), communication strategies were included.<br><br>Health Care Services: Medication Administration Guidelines, Policy M.20, implemented 5/1/11, incorporated the following content related to implementation of PNMPs during medication administration, and staff training on PNMPs:<br>▪ "Ensure that individual is properly positioned and utilize proper assistive equipment required by the PNMP during and following medication administration to reduce risk for swallowing difficulties and aspiration."<br>▪ "Training must minimally include the PNMP content, policies, procedures, technique and equipment. Training on the PNMP will take place on an annual basis. Unit supervisory staff will ensure that direct care professionals receive training on their role in the mediation administration process and the PNMP at a minimum of annually."<br>▪ Instructions were provided for presentation of ear medication, and nasal spray and drops. | |

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| | | In addition, the policy should incorporate competency-based training and performance check-offs for nursing staff on wheelchair positioning, alternate positioning, use of adaptive equipment, and presentation techniques, at a minimum.<br><br>The development and implementation of PNMPs should incorporate the following information:<br>▪ Individuals identified at high risk for identified health risk indicators should have a PNMP to provide essential staff strategies to reduce/minimize these high risk factors. The provision of a PNMP for these individuals should be standard operating procedure.<br>▪ The PNMPs of individuals who receive enteral nutrition, have been diagnosed with aspiration pneumonia, and/or are at risk of aspiration pneumonia should include staff instructions for medication administration, oral hygiene, and personal care (i.e., checking and changing) to ensure individuals are not in a flat, supine position while receiving personal care.<br>▪ PNMP strategies should be integrated within an individual's nursing care/health management plan, with competency-based training and performance check-offs provided to nursing staff to support nurses during medication administration, as well as other procedures requiring attention to individual triggers, adaptive equipment, positioning, and presentation techniques.<br>▪ For individuals who must be elevated and not be placed in a flat supine position, current strategies in PNMPs should be reassessed to identify appropriate elevation levels. PNMPs should reflect safe elevation range strategies in every environment for those individuals who are at risk of aspiration pneumonia, have a diagnosis of GERD, and/or other related health risk indicators (i.e., respiratory concerns). The degree of elevation for wheelchairs, alternate positioning, bathing/showering, medication administration, and oral hygiene should be clearly defined in writing and with photographic instructions.<br>▪ The recommended time for an individual to remain upright after a meal for those who eat orally, and/or were enterally nourished should be an essential staff instruction included on the PNMPs.<br>▪ Attention should be given to photographic instructions for wheelchair and alternate positioning to promote optimal alignment and support within these positions.<br>▪ Medication administration instructions should include positioning instructions, use of adaptive equipment, and instructions to support prescribed diet texture and fluid consistency for medication(s).<br>▪ Positioning for the individual and staff during oral care should be clearly defined. | |

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| | | Based on the review of PNMPs, the following additional recommendations are made:<br>▪ If an individual had an ongoing issue with meal refusals as documented through prescribed meal supplements, weight loss, etc., the PNMP should define the amount of food/fluid refused, which would potentially trigger the administration of a supplement. When an individual's risk factor for weight is recognized as high, the PNMP should be modified to provide a threshold for the number of meal refusals that would trigger a PSPA to review current strategies and/or establish new strategies.<br>▪ Individual PNMPs should reflect identified high risk factors, which alert supervisory staff and direct support professionals to the importance of consistent implementation of PNMP strategies.<br><br><u>PNM plans were incorporated into individual's Personal Support Plans.</u><br>Based on documentation provided, the Habilitation Therapy Director, QA Compliance Monitor, and QMRP Coordinator "met to discuss the content of newly revised QMRP training. The Habilitation Therapy Director provided copies of Sections O, P, and R monitoring report, dated 2/25/11, with highlighted portions. These highlighted portions indicate where the monitor reported deficiencies in appropriate information being included in the PSP document. The [QMRP Coordinator] agrees that all HT evaluations, the PNMP and consult recommendations should be included in the PSP document and in the daily schedule. She stated that she would incorporate this into her QMRP training course." The Habilitation Therapy Director informed the Monitoring Team that these changes would appear in PSPs developed during May 2011 and forward.<br><br>In six records reviewed (Individual #48, Individual #312, Individual #136, Individual #293, Individual #210, and Individual #326), none of the PNMPs (0%) were incorporated and/or integrated into individuals' Personal Support Plans. Information from the PNMP should be integrated within the PSP, not simply referenced and/or listed. PNM plan strategies should be integrated into health management plans.<br><br>The PNMT did not consistently document an individual's status in Integrated Progress Notes to communicate with PST members and provide evidence of the implementation of the PNMT Action Plan. The PNMT members should document in and read the Integrated Progress Notes.<br><br>When the PNMT discharges an individual, there should be a PSPA meeting to present and discuss the PNMT Discharge Plan. This plan should continue to support the implementation of staff strategies (nursing, therapy and direct support professionals) to minimize identified health risk indicators.<br><br><u>PNMPs are developed with input from the PST, home staff, medical and nursing staff.</u> | |

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| | | In the six records reviewed (Individual #48, Individual #312, Individual #136, Individual #293, Individual #210, and Individual #326), none (0%) of the PNMPs were developed with input from the PST, with an emphasis on direct support professionals, medical/nursing staff, and behavioral staff (if appropriate).<br><br><u>PNMPs are reviewed annually at the PSP meetings, and updated as needed.</u><br>In none of six records reviewed (Individual #48, Individual #312, Individual #136, Individual #293, Individual #210, and Individual #326) (0%) were PNMPs reviewed annually at the PSP meeting, updated as needed, and integrated within the PSP. As discussed above, there was no evidence that the PNMPs were actually reviewed, discussed, and integrated into skill acquisition programs, BSPs, health management care plans, and/or daily routines at the PSP meetings. Without such review, they were not adequately integrated across disciplines, and recommendations from other assessments and/or team members were not incorporated into the plans.<br><br><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><br>In none of six records reviewed (Individual #48, Individual #312, Individual #136, Individual #293, Individual #210, and Individual #326) (0%) were PNMPs reviewed and updated as indicated by the completion of a new Integrated Risk Rating Form that identified changes, a change in the individual's status, a transition (change in setting), or as dictated by monitoring results.<br><br>Individuals supported by the PNMT who have been hospitalized should have contact with the PNMT during their hospitalization. Multiple individuals on the PNMT caseload were hospitalized. However, according to staff, the PNMT relied upon the hospital liaison nurse for updates, which was not sufficient. The PNMT should continue to follow an individual on their caseload during hospitalization. The PNMT Action Plan should provide strategies that alert the PNMT and nursing staff when an individual might be in the initial stages of illness. The goal of the PNMT should be proactive with an individual's health status and, hopefully, prevent hospitalization(s). However, the PNMT should be aggressively involved while an individual is hospitalized, and not go into action only post hospitalization. The PNMT should develop a transition plan to prepare for their return from the hospital to CCSSLC Infirmary, as well as from the Infirmary to their home. | |
| 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 | <u>Staff implements interventions and recommendations outlined in the PNMP and/or Dining Plan.</u><br>On 7/14/11, the Monitoring Team observed breakfast in the Coral Sea dining room, and did not observe any mealtime errors. The direct support professionals, supervisory staff, therapists and PNMP Coordinators were to be commended for ensuring individuals' dining plans were implemented correctly. | Noncompliance |

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| | to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties. | Although this positive observation was seen at one meal in Coral Sea, the Monitoring Team did not observe staff to consistently implement strategies in individuals' PNMP and/or dining plans. Staff were not competent in implementing PNMPs and/or dining plan strategies. Staff engaged in unsafe mealtime practices, which posed an undue risk of harm for individuals identified at risk of aspiration and/or choking.<br><br>The following provides additional details regarding the observations:<br>▪ In 12 of 25 observations (48%), staff were following dining plans that referred to positioning, use of adaptive equipment and/or presentation techniques.<br>▪ In two of 11 observations (18%), staff were following wheelchair-positioning instructions.<br>▪ In one of four observations (25%), staff was following alternate positioning instructions.<br>▪ In none of the two observations (0%) were staff completing a pivot transfer correctly.<br>▪ In one of one observation (100%), staff were completing a mechanical lift transfer correctly.<br>▪ In none of two observations (0%) were nursing staff following the PNMP, including diet texture/fluid consistency, positioning instructions, and use of appropriate adaptive equipment for medication administration.<br><br>The Person-Specific Monitoring in Dining Room form, revised 3/7/11, and Competency-Based Monitoring for Staff, revised 3/7/11, incorporated instructions for monitors for each of the 18 questions, and space to list problems identified, resolutions, and target date, name of supervisor notified, and date resolved with signature. The provision of instructions for these forms was a step in the right direction to enhance consistency in scoring. However, to support the attainment of reliable monitoring data, as stated in previous monitoring reports, monitors must be provided with competency-based training and performance check-offs. In addition, therapists must conduct validation of mealtime monitors through side-by-side monitoring.<br><br>Staff who are competent to identify non-compliance with wheelchair positioning, alternate positioning, use of prescribed adaptive equipment, and with knowledge of presentation techniques need to monitor direct support professionals' implementation of PNMPs and dining plans. Mealtime monitors must receive competency-based training and performance check-offs to verify their competencies. Until this training initiative is completed at CCSSLC, mealtime monitoring data cannot be relied upon for accuracy.<br><br>To support an interdisciplinary mealtime safety initiative, the Facility should:<br>▪ Implement competency-based training for mealtime supervisors and monitors | |

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| | | as completed for PNMP Coordinators, including a mealtime training curriculum with specific learner objectives and competencies to provide foundational knowledge and skills related to ensuring safety at mealtimes in the following areas:<br>o Mealtime position and alignment;<br>o Diet texture and fluid consistency;<br>o Presentation techniques to enhance nutritional intake and hydration;<br>o Care and use of adaptive equipment;<br>o Aspiration and choking precautions and rationale;<br>o Understanding a swallow study;<br>o Risk indicators and problem solving; and<br>o Techniques to promote optimal levels of independence and skill acquisition during mealtimes.<br>▪ Develop and implement competency-based performance check-offs for mealtime supervisors and monitors to ensure competency with mealtime learner objectives.<br>▪ Develop competency-based training and performance skills check-off for mealtime supervisors and monitors.<br>▪ Establish a validation and re-revalidation process for mealtime monitors, which involves auditing mealtime supervisors to ensure competency with mealtime indicators.<br>▪ Establish protocols for implementation of a mealtime monitoring schedule, and auditing of completed mealtime monitoring forms to formulate corrective strategies to address individual-specific and/or systemic areas of deficiencies for specific indicators. This process should be integrated into the Facility's QA/QI and Risk Management systems.<br>▪ Establish compliance benchmarks for mealtime monitoring results to celebrate success. If monitoring results fall below established benchmarks, determine what action will be necessary, such as staff re-training and/or an administrative directive to correct deficiencies that appear to be systemic.<br>▪ Ensure a heightened mealtime monitoring schedule for individuals identified at high risk, such as individuals at risk due to aspiration pneumonia, respiratory concerns, choking, weight, fluid imbalance, etc.<br><br>CCSSLC administration might want to consider developing a method to identify staffing ratios for mealtimes/snacks. For example, in another State, a Facility had used the following eight weighted descriptors, which were assigned to each individual, to determine staffing ratios:<br>▪ Dysphagia with a weight of 0.1;<br>▪ PNM - no weight;<br>▪ Enteral - no weight; | |

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| | | ▪ Independent with a weight of 0;<br>▪ Minimal assist with a weight of .25;<br>▪ Moderate assist with a weight of .50;<br>▪ Maximum assist with a weight of .75; and<br>▪ Dependent with a weight of 1.0.<br><br>Each individual was scored using each of the eight indicators. An individual score was calculated for each individual. The individual score for each individual was totaled for all individuals within the residence to produce the number of staff needed for each meal and/or snack. This information would be helpful to managers in the development of staffing schedules for mealtimes to ensure staffing ratios were sufficient to support mealtime safety. | |
| O5 | Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that all direct care staff responsible for individuals with physical or nutritional management problems have successfully completed competency-based training in how to implement the mealtime and positioning plans that they are responsible for implementing. | <u>Staff are provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff.</u><br>The Habilitation Therapy Director is commended for her leadership in beginning the process for the development and implementation of performance check-off objectives for competency-based training.<br><br>The Performance Check-off Objective Sheet was a task analysis of steps needed to appropriately complete a specific task. The following 20 competency performance check-off sheets had been developed:<br>▪ Mechanical Lifting Objectives;<br>▪ Transfer Objectives;<br>▪ Two Person Manual Transfer Objectives;<br>▪ Bed Positioning Objectives;<br>▪ Positioning and Wheelchair Positioning Objectives;<br>▪ Bath Trolley Objectives;<br>▪ Rolling Shower/Toilet Chair and Stationary Shower Chair Objectives;<br>▪ Adaptive Dining Equipment Objectives;<br>▪ Mealtime Objectives;<br>▪ Simply Thick Objectives;<br>▪ Heel Protectors/Soft Shoes Objectives;<br>▪ Hosiery/Compression Stocking Objectives;<br>▪ Elbow Pad Objectives;<br>▪ Elbow Splint Objectives;<br>▪ Palm Protector Objectives;<br>▪ Wrist/Hand Splint Objectives;<br>▪ Ankle Foot Orthotic (AFO) Objectives;<br>▪ Helmet Objectives;<br>▪ Gait Belt Objectives; and | Noncompliance |

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| | | ▪ Walking Program/Walking Individuals' Objectives.<br><br>Based on information provided, the first phase of competency-based training and performance check-offs was completed for the 12 PNMP Coordinators. Fifteen hours of foundational competency-based training was provided. At the conclusion of the training, a PNMP Coordinator had to demonstrate successfully, without prompts from the trainer, each identified "objective" of the 20 foundational skill sets. Each of the 20 skill sets identified the threshold for passing of 80 percent. For example, the Mechanical Lifting Objectives included 37 objectives to be demonstrated (37 X .20=7.4). The following criteria was provided:<br>▪ If staff passed with 37/37, no additional coaching was required;<br>▪ If staff missed one or more tasks, required additional coaching; and<br>▪ If staff missed seven or more tasks, will need to retake the course.<br>A final score was calculated and documented on the form.<br><br>The Monitoring Team supported the logical approach to providing competency-based training and performance check-offs to PNMP Coordinators, because these individuals provide coaching support to staff and perform monthly monitoring.<br><br>The second phase of this initiative was to incorporate this foundational training into New Employee Orientation. Current employees also would receive this training, and be responsible for the successful completion of these 20 competency-based performance check-off skill sets. The projected timeline for completion of this training was in the development stage.<br><br>Based on a review of documentation provided, the NEO did not provide a comprehensive foundational training curriculum for physical and nutritional supports. A New Employee Orientation Curriculum Schedule, revised 6/2/11,for physical and nutritional supports was completed in one day with the following content:<br>▪ Lifting and transferring video including written test - duration of 45 minutes;<br>▪ Review of PNMP shell - duration of 15 minutes;<br>▪ Hands on lifting/transfer and post test - duration of one hour and 50 minutes;<br>▪ Adaptive equipment - duration of 20 minutes;<br>▪ Adaptive feeding equipment/diet texture/feeding techniques - duration of 15 minutes;<br>▪ Simply Thick demonstration and test - duration of 15 minutes;<br>▪ Hands on feeding in dorm - duration of one hour;<br>▪ Speech/deaf awareness with test - duration of one hour;<br>▪ Speech department and test - duration of 45 minutes; and<br>▪ Wheelchair tour/wheelchair cleaning - duration of one hour and 15 minutes. | |

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| | | New Employee Orientation included a course entitled Prevention and Management of Aspiration Pneumonia. The learner objectives for Prevention and Management of Aspiration Pneumonia were:<br>▪ Acknowledge that aspiration can be prevented and incidents of pneumonia can be reduced.<br>▪ Recognize interventions he/she may use to prevent aspiration.<br>▪ Make a personal commitment to use interventions routinely to prevent aspiration.<br><br>A review of the PowerPoint slide show revealed this to be a comprehensive overview of aspiration pneumonia. However, the Monitoring Team has concerns about the ability of new direct support professionals to understand and retain this level of information prior to receiving competency-based foundational training in physical and nutritional supports.<br><br>The HT Department, in collaboration with Staff Development, will incorporate 15 hours of instruction for foundational competency-based training for physical and nutritional supports, which will include performance check-offs for the 20 objective skill sets discussed above. Previous NEO testing involved staff verbalization and/or completion of written test of a learned skill, which did not meet the standard of competency-based training and performance check-offs.<br><br>During the onsite review, the Monitoring Team observed multiple individuals who were not in optimal alignment and support in their seating systems, were not positioned correctly for alternate positioning, transfers that were not done correctly, failures to use the correct adaptive equipment, and problems with mealtime presentation techniques. This led the Monitoring Team to the conclusion that staff were not competent in foundational skills in physical and nutritional supports. The HT Director's focus on implementation of foundational training for PNMP Coordinators was a logical approach to ensuring these professionals who were responsible for the implementation of programs and various types of monitoring were competent to perform these tasks. The second phase will be the integration of these foundational skills through performance check-offs for new employees and current staff. This initiative will be time-consuming, but critical to ensure all staff demonstrate competency to successfully implement PNMPs, throughout the 24-hour day, which is essential for individuals' health and safety.<br><br>Occupational and Physical Therapies: Training Staff on Physical Nutritional Management Plans, Policy P.2, implemented 12/8/10, described procedures for training direct support professionals on the implementation of the PNMP. "Staff signature on the back of the training roster indicates that they have read the PNMP and that throughout the day they will ensure that all instructions are followed as prescribed." These procedures did | |

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| | | not address competency-based training and subsequent performance check-offs for direct support professionals or supervisory staff, such as HT staff, PNMP Coordinator, Psychologist, Psychologist Assistant, QMRP, RN Case Manager, Unit Coordinator, Home Team Leader, Campus Coordinator, Infirmary RN, Executive Duty Officer, and/or Unit Director. This policy was presented to staff and a written test was administered. This policy should incorporate competency-based training and performance check-offs to support staff compliance with PNMPs.<br><br><u>All foundational trainings are updated annually</u>.<br>The Request to Post/Training Rosters form, with attached training documentation, was submitted for 28 annual refresher courses titled "Lifting People - There Is No One Person Lift." Training duration ranged from 20 minutes to one hour, and occurred between 12/2/10 and 5/25/11. The Annual Lifting Class presented the following training: stand pivot transfer, two-person/T transfer, lift versus re-positioning, mechanical lift, in-service on seatbelts, bed rails, Hospital bed, clean adaptive equipment, foot rests, supervision during bathing and transfer, maintaining fluid consistency throughout the meal, and use the most upright position during oral care and when eating. No competency-based performance check-offs were submitted for this annual refresher training.<br><br>The HT Director should review the efficacy of Annual Refresher training. The content of Annual Refresher training should reflect the analysis of monitoring results, workers compensation claims, review of relevant incidents through Risk Management, etc. Annual Refresher training should include the identification and achievement of learner objectives through the provision of competency-based training and performance check-offs.<br><br><u>Staff are provided individual-specific training on the PNMP by the appropriately trained personnel.</u><br>None of the six individual's staff (0%) (Individual #48, Individual #312, Individual #136, Individual #293, Individual #210, and Individual #326) had documentation of individual-specific PNMP training being provided by appropriately trained personnel. However, as noted below, the six individual records reviewed also did not have foundational comprehensive competency-based training for PNMP strategies.<br><br>Reviews of PNMT Action Plan and supporting documentation did not provide evidence of the completion of individual-specific competency-based training and performance check-offs to support staff compliance with the PNMT Action Plan. The PNMT should provide individual-specific competency-based training and performance check-offs to ensure prescribed and updated PNMP strategies are implemented by appropriate staff, including nursing, supervisors, and direct support professionals. | |

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| | | 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.<br>In none of the six individual staff training records reviewed (0%), for staff providing assistance to individuals determined to be at an increased level of risk (Individual #48, Individual #312, Individual #136, Individual #293, Individual #210, and Individual #326), had staff successfully completed competency-based training.<br><br>Staff are trained prior to working with individuals and retrained as changes occur with the PNMP.<br>Based on a review of staff training for six individuals identified at risk of aspiration pneumonia, none of the of six individual records (for Individual #48, Individual #312, Individual #136, Individual #293, Individual #210, and Individual #326) (0%) revealed that staff had completed competency check sheets for all PNMP strategies, and/or when changes occurred to the PNMP. As stated above, staff verbalization of a change in a PNMP did not meet the standard of competency-based training. | |
| O6 | Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans. | A policy/protocol addresses the monitoring process and provides clear direction regarding its implementation and action steps to take should issues be noted.<br>Monitoring covers staff providing care in all aspects in which the person is determined to be at an increased risk (all PNM activities).<br>The following policies had been developed related to monitoring:<br>▪ Occupational and Physical Therapies: Ensuring Safe Practices During Meals, Policy P.5, which was revised and implemented on 5/26/11, acknowledged the role of the Home Dining Supervisor, Dining Room Transporter, and Dining Room Monitor. The policy delineated the steps to be followed before, during and after the meal. In addition, procedures were identified for individuals, who for a variety of reasons, might be eating elsewhere in the home and not in the dining room. This policy should incorporate competency-based training and performance-check offs for mealtime supervisors and monitors, as well as defining the validation process by mealtime content experts to ensure accurate and reliable mealtime monitoring results.<br>▪ Active Treatment Coaching and Monitoring Guide, Policy DD.8, draft revision 6/2/11 and approved on 6/5/11, was implemented for "validation of client safety by consistent implementation of Personal Support Plans as prescribed." A section of related form involved: "PNMP monitoring (bathing, assistive and supportive equipment and constant repositioning to maintain the most upright position." As stated above, this policy should integrate competency-based training and performance-check offs for monitors as well as defining the validation process by content experts for physical and nutritional management | Noncompliance |

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| | | indicators to ensure accurate and reliable mealtime monitoring results.<br>▪ At Risk Individuals: At Risk Procedure - PST, Policy I.1, draft revision 6/28/11 with approval on 6/28/11, and implemented on 7/1/11, presented the steps the PST members would follow to assign a risk level and develop a Risk Action Plan when an individual experienced a change in status based on the established risk guidelines. This policy should include defined audit procedures to ensure PST compliance with this policy.<br>▪ At Risk Individuals: Positioning for the Prevention of Aspiration Pneumonia Coaching and Monitoring Guide - Residential Services, Policy I.2, was implemented on 6/22/11, and described the observation Notes tool as: "used by Direct Support Professionals (DSP) to document communication between the oncoming and off going DSP, the results of the implementation of assigned individual's response to his/her Personal Support Plan during each assigned shift and used by the PST To review and revise the PSP if needed. The Observation Notes are used to document communication between the results of random monitoring by the unit coordinator and/or home tem leaders on all shifts of the DSP compliance with positioning and knowledge of the importance of positioning to prevent severer reflux and aspiration." During each shift the following was to be monitored by the Unit Coordinator and/or Home Team Leader:<br>o Implementation by the DSP of designated action plans and documentation of aspiration triggers, if applicable;<br>o Importance of positioning to prevent severe reflux and aspiration and documentation of results on the observation notes; and<br>o Documentation of the names of individuals and DSPs whose knowledge regarding the importance of positioning was assessed.<br>This policy should encompass the provision of defined competency-based training and performance check-off required to support accurate and reliable monitoring results, and include a validation process by content experts.<br>• At Risk Individuals: Positioning for the Prevention of Aspiration Pneumonia Coaching and Monitoring Guide - PST and Others, Policy I.3, draft revision 6/17/11 with approval on 6/20/11 and implementation on 6/22/11. Again, this policy should encompass the provision of defined competency-based training and performance check-off required to support accurate and reliable monitoring results, as well as a validation process by content experts.<br>▪ The monitoring section in DADS Policy #012.1 for Physical and Nutritional Management, effective date 3/11/11, stated: "PNMPs should be monitored as determined by need and risk level. Individuals at highest risk shall be monitored at greater frequency to reduce the impact of high risk conditions and to prevent recurrences if possible." The policy provided six steps to further define monitoring, but did not provide specific directions to implement PNMP and | |

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| | | PNMT monitoring. It will be the responsibility of the Facility to develop a step-down policy to ensure the PNMT conducts comprehensive monitoring.<br>▪ Occupational and Physical Therapies: Documenting Meal Monitoring, Policy P.4, draft/revision 3/4/11 with approval on 3/7/11, and implementation on 3/7/11. This policy defined the steps to be completed for the Person-Specific Dining Room Monitoring Tool and Mealtime Monitoring Drill. The Mealtime Monitoring Drill, labeled P.4.1, implemented 12/15/10, identified 18 questions for staff response related to mealtime. The following observations were made with regard to the policy:<br>o The policy did not clearly distinguish the difference between the implementation of the Person-Specific Dining Room Monitoring Tool and Mealtime Monitoring Tool. Assigned monitoring staff were to print the Person-Specific Monitoring in Dining Room form, but the Mealtime Monitoring Drill was not presented in the policy steps;<br>o The policy did not Identify the validation process that would be used to achieve accurate scoring and a high level of inter-rater reliability;<br>o It did not specify that individuals at highest risk would be monitored at greater frequency to minimize and/or reduce identified risk factors;<br>o Auditing process for completed monitoring forms were not specified to identify forms completed accurately, and analyze individual-specific concerns and systemic issues;<br>o No feedback loop was identified in which deficiencies would be noted and shared with appropriate supervisory staff to ameliorate deficiencies; and<br>o The policy did not establish thresholds for staff re-training.<br><br>CCSSLC did not have a policy/protocol that addressed the monitoring process for the following monitoring forms that the Facility submitted:<br>▪ Person-Specific Bathing Monitoring Tool and Competency-Based Monitoring Tool for Staff, not dated.<br>▪ CCSSLC Mealtime Monitoring and Coaching Report, P.5.2, effective date 11/4/10, provided the following instructions: one Dining Room Monitor assigned to each meal; Dining Room Monitor responsible for documenting the results of the overall observation of the meal, and submitting the results to the Unit Director for review and follow-up, and submission to administrative assistant; and if no monitor/coach was available for the meal, a home team leader or designee must be assigned. There were 19 indicators to be monitored. The monitor/coach would provide interventions to all "NO" answers. No policy/procedure was submitted for the implementation of this form.<br><br>The absence of comprehensive, established guidelines/protocols for monitoring forms | |

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| | | likely will result in the inconsistent scoring, as well as lack of follow-up for identified issues/concerns. This was reinforced upon the review of multiple completed monitoring forms for the six individual records reviewed and/or the absence of completed monitoring forms. The following are a few examples of monitoring not being completed, or forms submitted for which identified concerns/issues were not resolved:<br>▪ Individual #48 was rated at high risk for aspiration, dental, diabetes, GI problems, and weight. Individual #48 did not have a Risk Action Plan or PNMP, and as a result no person-specific PNMP monitoring tool check sheets had been completed. Person-specific mealtime monitoring was assigned to a QMRP. However, no evidence or paper work was submitted to the HT Department in the last two months. No individual-specific monitoring had been completed.<br>▪ Individual #312 was assigned a high-risk level for aspiration and weight. He did not have a Risk Action Plan or PNMP. As a result of not having a PNMP, no person-specific PNMP monitoring tools were completed. Person-specific mealtime monitoring was assigned to a Residential Coordinator, but no evidence or paperwork was submitted to the HT Department in the last two months.<br><br><u>All members of the PNM team conduct monitoring.</u><br>A review of PNMT Action Plans and supporting documentation did not provide evidence that the PNMT was conducting individual-specific monitoring to document staff compliance with the PNMT Action Plans. Facility monitoring forms were submitted, but these forms did not consistently address recommendations within the PNMT Action Plans. In addition, PNMT Action Plans did not identify necessary staff strategies, as discussed above in Section O.2, which would require monitoring by the PNMT to support wellness and/or the onset of illness.<br><br><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><br>A review of Facility reports, including those from the Quality Assurance Department, did not illustrate that a mechanism was in place to ensure timely data was provided to the PNMT for analysis leading to the identification of potential issues, and ensuring the provision of supports to individuals with the most complex physical and nutritional support needs. For example, individuals had been referred to the PNMT via the Integrated Risk Rating Form, but these referrals had not been forwarded to the PNMT. 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 should be clearly recorded, utilized for monitoring, and analyzed to determine the efficacy of the supports provided at both the individual-specific and systemic levels. This information should be integrated into the Facility's QA/QI, Incident Management and Risk Management systems. | |

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| | | Immediate intervention is provided if the person is determined to be at risk of harm.<br>Examples are provided above with regard to Section I.2 and I.3, as well as Section O.1 of individuals who were at risk, but had not been reviewed by their PST and/or referred to the PNMT. | |
| 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. | A process is in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk.<br>The Facility policy, Physical and Nutritional Management: Participating in PNMT Meetings, Policy O.2, defined the PNMT process in four stages: referral; comprehensive assessment phase, treatment/training; and review. However, the implementation of these four phases did not consistently lead to an accurate discussion, analysis and tracking/monitoring of an individual's status of identified high and medium risk indicators. The PNMT had revised the assessment phase to incorporate a pre-assessment format. Additional revisions to the PNMT process need to be initiated as discussed in Sections O.2 through O.6 above. For example, policies need to be revised to ensure that the Integrated Risk Rating form accurately addresses high and medium risk indicators; the PNMT evaluation acknowledges identified health risk indicators resulting in a comprehensive analysis leading to the development of recommendations and measurable outcomes; and PNMT Action Plans sufficiently address the tracking/monitoring of health indicators leading to the resolution and/or reduction of these health risk indicators.<br><br>For none of the six individual records reviewed, who had not been assessed by the PNMT (Individual #48, Individual #312, Individual #136, Individual #293, Individual #210, and Individual #326) (0%) had their PSTs completed a risk action plan and a comprehensive assessment leading to the development of strategies for these individuals. These individuals received enteral nutrition, had been diagnosed with aspiration pneumonia, and/or were at risk of aspiration. In addition, individual PSTs did not refer these individuals to the PNMT. The PST did not document progress of individual strategies on a monthly basis to ensure the efficacy of those strategies in minimizing and/or reducing PNM risk indicators. In none of the six records was documentation found to support if strategies were not effective, that these strategies and the PNMP were revised.<br><br>Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators.<br>The PNMT did not consistently provide specific recommendations for PNMT individual-specific monitoring, nor was consistent evidence provided to support implementation of PNMT monitoring of staff's compliance with the PNMT Action Plan recommendations and measurable outcomes.<br><br>Based on review, in none of the six individual records (Individual #48, Individual #312, | Noncompliance |

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| | | Individual #136, Individual #293, Individual #210, and Individual #326) (0%) did the PST provide a risk action plan to provide adequate supports for these individuals to minimize their identified health risks. Additional information is provided in Sections I.2, I.3, O.1, O.2, O.3, O.4, O.5 and O.6. | |
| 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><br>According to State policy, all individuals who received enteral nutrition would receive an annual Aspiration Pneumonia/Enteral Nutrition Evaluation. Assessment information was to be obtained from the PCP, RN, Habilitation Therapies, Dietary, and PST members. The Nurse Case Manager would compile the APEN evaluation document. The major elements of the APEN Nutrition Evaluation were:<br>▪ History to be completed by Primary PCP and RN, including diagnosis, comorbidities, history of aspiration pneumonia, other respiratory infections/conditions, hospitalizations for aspiration pneumonia/respiratory conditions, tracheostomy, reflux, emesis, and dental/oral heath issues (to be completed by dentist);<br>▪ Risk Level - Health Status to be completed by Team (risk level and rationale);<br>▪ Method of eating to be completed by PCP and Dietician (nasogastric tube, gastrostomy tube, jejunostomy tube, type of enteral feeding and oral eating);<br>▪ Reason/rationale for enteral eating to be completed by PCP, RN, and Habilitation Therapies;<br>▪ Diagnostic tests performed to be completed by PCP, RN, and Habilitation Therapies;<br>▪ Attempts to return to oral or least restrictive method of eating to be completed by Habilitation Therapies;<br>▪ Current treatment;<br>▪ Analysis of findings to be completed by team;<br>▪ Recommendations;<br>▪ Measurable outcomes; and<br>▪ Action plan.<br><br>The evaluation format stated: "not all sections will be applicable to every individual."<br><br>Based on the review of 11 individual records (Individual #151, Individual #214, Individual #190, Individual #176, Individual #189, Individual #113, Individual #315, Individual #301, Individual #278, Individual #286, and Individual #68), who were identified at high risk for aspiration, enterally nourished and/or received supplemental tube feedings, ten (91%) of these 11 individuals had received an APEN evaluation, although the intent of the APEN evaluation was not been achieved. The individuals | Noncompliance |

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| | | within this sample were selected from the CCSSLC: Individuals who receive nutrition through non-oral methods, dated 6/10/11. The following are examples of the concerns that were noted:<br>▪ An individual rated at high risk for aspiration and who received a gastrostomy tube on 5/4/11 did not have an APEN evaluation completed.<br>▪ The APEN evaluations did not provide adequate assessment and/or documentation to support the appropriateness of receiving enteral nutrition, justification to continue receiving enteral nutrition, or current strategies that had been implemented to determine the appropriateness of a less restrictive approach to eating.<br><br>The purpose of an APEN Evaluation was to determine if receiving nutrition by tube was medically necessary, and, where appropriate, to implement a plan to return the individual to a less restrictive form of receiving enteral nutrition and/or a return to oral feeding. The APEN evaluations did not evaluate the medical necessity of the tube, and/or determine if a less restrictive approach to receiving enteral nutrition was possible and, if appropriate, recommend the development and implementation of a plan to return an individual to oral eating. In multiple APEN evaluations, there was not an adequate assessment to address the individual's potential and/or present strategies to transition to a less restrictive approach to enteral nutrition. Many of the APEN evaluations recommended no change to the individual's nutritional status, which did not support the intent of the APEN evaluation.<br><br><u>People who receive enteral nutrition and/or therapeutic/pleasure feedings are provided with PNMPs that include the components listed above.</u><br>Based on a review of the 11 records, individuals were provided with a PNMP that:<br>▪ In 11 of 11 records (100%), positioning instructions for wheelchair and alternate positions instructions were included.<br>▪ In 11 of 11 records (100%), transfer instructions were included.<br>▪ In seven of 11 records (64%), staff instructions were provided to identify the prescribed time an individual was to remain upright after receiving enteral nutrition. Individual #189, Individual #301, Individual #286, and Individual #68's PNMPs did not provide staff instructions for time to remain upright after receiving enteral nutrition.<br>▪ In seven of 11 records (64%), strategies for medication administration were included. Individual #189, Individual #315, Individual #278 and Individual #286 needed additional staff instructions for medication administration.<br>▪ In seven of 11 records (64%), strategies for oral hygiene were included. Individual #189, Individual #301, Individual #278 and Individual #68 needed staff strategies for oral care. | |

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| | | ▪ In 11 of 11 records (100%), individual adaptive equipment was included.<br>▪ In ten of 11 records reviewed (91%), bathing/showering positioning and instructions were included. Individual #189's PNMP did not have instructions for bathing/showering.<br>▪ In none of 11 records (0%), personal care instructions for elevation during checking and changing were included.<br>▪ In 11 of 11 records reviewed (100%), communication strategies were included.<br><br>The HT Department should develop a checklist of required PNMP components and complete audits to ensure PNMPs contain required components.<br><br>The draft Head of Bed Elevation (HOBE) Assessment Protocol, undated, stated: "All individuals who require elevation for GERD, enteral eating, respiratory/breathing concerns, medication administration, oral care, hygiene, etc. must be evaluated for a range of appropriate elevation levels. A maximum and minimum elevation is determined to accommodate various activities." Individuals within this sample met the criteria for the implementation of a HOBE assessment. The results of the HOBE assessment will necessitate changes to individuals' PNMPs to identify the appropriate elevation range to support safety during activities throughout the 24-hour day.<br><br><u>The need for continued enteral nutrition is integrated into the PSP.</u><br>Based on a review of the 11 individuals' PSPs who received enteral nutrition, none (0%) of the individuals' PSPs documented the rationale for the continued need for enteral nutrition, attempts to return the individual to oral intake, or the least restrictive method of receiving nutrition.<br><br><u>A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT).</u><br>The DADS At-Risk Individuals policy (Policy Number 006, dated 11/02/10) stated: "a regular risk assessment and management system will be used to identify persons at risk of illness and injury." A component of the At-Risk Individuals policy required "a comprehensive integrated assessment performed at least annually and as indicated for individuals who have a long history of/or recent hospitalization for aspiration pneumonia and for individuals who receive enteral nutrition. The assessment is designed to reduce the incidence of aspiration pneumonia and its complications and to assess continued need for enteral eating." All individuals who were enterally nourished were to be evaluated using the APEN evaluation format. According to the documentation provided, ten of the eleven individuals within this sample had received an annual APEN evaluation, but these evaluations were not adequate, as documented above. | |

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| | | Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake.<br>Per report, no individuals were participating in pleasure/therapeutic feeding program. | |

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

1. The PNMT would benefit from having a physician assigned to the PNMT to provide support and consultation prior to, during and after PNMT meetings. (Section O.1)
2. The State should provide Facility Administration, in collaboration with the Habilitation Therapy Director, support to identify additional resources to reduce the caseloads of the OT, SLP, and Dietician to enable these professionals to fulfill their PNMT responsibilities. (Section O.1)
3. The addition of another dietician would be of beneficial to lower the current caseloads of the two dietitians, and enable the dietician assigned to the PNMT to lessen her caseload and provide additional support to the PNMT members and individuals on the PNMT caseload. (Section O.1)
4. A continuing education tracking system for PNMT members and other therapists should be implemented to consistently document attendance through training rosters and/or certificate of completion for state-sponsored webinars, off-site clinical instruction, and conferences. This tracking system should be reviewed regularly to ensure that Core and Alternate PNMT members are attending state-sponsored clinical instructions webinars and community continuing education. (Section O.1)
5. PSTs should receive additional training to understand and implement the guidelines documented in the Referral Process to PNMT Protocol. This training should detail the criteria for referral of individuals to the PNMT; indicators for immediate referral to the PNMT; information to be provided to the PNMT for individuals being referred; philosophy of the PNMT process; and explanation of the PNMT process, including the components of the comprehensive assessment, development of action plans, and integration of PNMT action plans into PSPs and related documents, such as the PNMP, Behavior Support Plan, Health Management Plan, etc. (Section O.1)
6. To support successful implementation of the PNM process for those individuals at highest risk with complex health, physical and nutritional support needs:
    a. The PNMT should clearly document on the PNMT evaluation and action plan when and why the referral was made for an individual.
    b. As a first step in the assessment phase, the PNMT should review and re-score, if appropriate, the Integrated Risk Rating Form that the PST completed to determine the individual's current status of risk.
    c. When the PNMT revises an Integrated Risk Rating Form, the individual's team should be involved, and this should be documented through a PSPA.
    d. The PNMT comprehensive assessment should incorporate the findings of a HOBE assessment for those individuals at high risk of choking, aspiration, and respiratory concerns.
    e. The PNMT should review the APEN evaluation to determine if strategies have been recommended to transition an individual to a less restrictive approach to enteral nutrition, and/or implementation of therapeutic/pleasure feedings leading to return to oral eating.
    f. The PNMT comprehensive assessment should reflect an assessment of the individual's identified high-risk and medium-risk indicators.
    g. The PNMT comprehensive assessment analysis should provide the justification for recommendations and measurable outcomes.
    h. PNMT Action Plans should be integrated with relevant Health Management Plan(s) to identify individual baseline clinical indicators that support wellness.
    i. PNMT Action Plans should be proactive and identify the clinical health indicators that might indicate an onset of an illness. This information should be integrated into the Health Management Plan(s) and documented in Integrated Progress Notes.
    j. The PNMT Action Plans should identify the frequency of hands-on assessment by identified PNMT members to support a proactive approach for wellness.

k. The PNMT Action Plans should include comprehensive recommendations for aspiration.
l. The PNMT Action Plan recommendations should be implemented in a timely manner.
m. The PNMT Action Plans should support proactive interventions to eliminate and/or minimize infirmary, emergency room and/or hospital admissions.
n. The PNMT Action Plan interventions/recommendations and measurable outcomes should answer the questions who, what, where, when and why.
o. A PSP Addendum should incorporate the PNMT Action Plan into the PSP. (Section O.2)

7. The development and implementation of PNMPs should incorporate the following information:
   a. Individuals identified at high risk for identified health risk indicators should have a PNMP to provide essential staff strategies to reduce/minimize these high risk factors. The provision of a PNMP for these individuals should be standard operating procedure.
   b. The PNMPs of individuals who receive enteral nutrition, have been diagnosed with aspiration pneumonia, and/or are at risk of aspiration pneumonia should include staff instructions for medication administration, oral hygiene, and personal care (i.e., checking and changing) to ensure individuals are not in a flat, supine position while receiving personal care.
   c. PNMP strategies should be integrated within an individual's nursing care/health management plan, with competency-based training and performance check-offs provided to nursing staff to support nurses during medication administration, as well as other procedures requiring attention to individual triggers, adaptive equipment, positioning, and presentation techniques.
   d. For individuals who must be elevated and not be placed in a flat supine position, current strategies in PNMPs should be reassessed to identify appropriate elevation levels. PNMPs should reflect safe elevation range strategies in every environment for those individuals who are at risk of aspiration pneumonia, have a diagnosis of GERD, and/or other related health risk indicators (i.e., respiratory concerns). The degree of elevation for wheelchairs, alternate positioning, bathing/showering, medication administration, and oral hygiene should be clearly defined in writing and with photographic instructions.
   e. The recommended time for an individual to remain upright after a meal for those who eat orally, and/or were enterally nourished should be an essential staff instruction included on the PNMPs.
   f. Attention should be given to photographic instructions for wheelchair and alternate positioning to promote optimal alignment and support within these positions.
   g. Medication administration instructions should include positioning instructions, use of adaptive equipment, and instructions to support prescribed diet texture and fluid consistency for medication(s).
   h. Positioning for the individual and staff during oral care should be clearly defined.
   i. If an individual has a meal refusal, the PNMP should define the amount of food/fluid refused, which would potentially trigger the administration of a supplement. When an individual's risk factor for weight is recognized as high, the PNMP should be modified to provide a threshold for the number of meal refusals that would trigger a PSPA to review current strategies and/or establish new strategies.
   j. The PNMP should identify high risk factors. (Section O.3)
8. The PNMT should document in and read the Integrated Progress Notes to ensure implementation and staff compliance with the PNMT Action Plan. (Section O.3)
9. When the PNMT discharges an individual, there should be a PSPA meeting to present and discuss the PNMT Discharge Plan. This plan should continue to support the implementation of staff strategies (nursing, therapy and direct support professionals) to minimize identified health risk indicators. (Section O.3)
10. To prevent and address hospitalizations (i.e., changes in status) of individuals that the PNMT supports:
    a. The PNMT Action Plan should provide strategies that alert the PNMT and nursing staff when an individual might be in the initial stages of illness;
    b. The goal of the PNMT should be proactive with an individual's health status and, hopefully, prevent hospitalization(s);

c. The PNMT should be aggressively involved while an individual is hospitalized, and not go into action only post hospitalization; and
d. The PNMT should develop a transition plan to prepare for their return from the hospital to CCSSLC Infirmary, as well as from the Infirmary to their home. (Section O.3)

11. To support mealtime safety, the Facility should:
    a. Provide competency-based training to mealtime supervisors/coordinators and monitors, as provided to PNMP Coordinators, including a mealtime training curriculum with specific learner objectives and competencies to provide foundational knowledge and skills related to ensuring safety at mealtimes in the following areas:
        i. Mealtime position and alignment;
        ii. Diet texture and fluid consistency;
        iii. Presentation techniques to enhance nutritional intake and hydration;
        iv. Care and use of adaptive equipment;
        v. Aspiration and choking precautions and rationale;
        vi. Understanding a swallow study;
        vii. Risk indicators and problem solving; and
        viii. Techniques to promote optimal levels of independence and skill acquisition during mealtimes.
    b. Develop and implement competency-based performance check-offs for mealtime supervisors/coordinators and monitors to ensure PNMPCs are competent with mealtime learner objectives.
    c. Develop competency-based training and performance skills check-off for mealtime supervisors/coordinators and monitors.
    d. Establish a validation and re-revalidation process for mealtime monitors, which involves auditing mealtime supervisors/coordinators to ensure competency with mealtime indicators.
    e. Establish protocols for implementation of a mealtime monitoring schedule, and auditing of completed mealtime monitoring forms to formulate corrective strategies to address individual-specific and/or systemic areas of deficiencies for specific indicators. This process should be integrated into the Facility's QA/QI and Risk Management systems.
    f. Establish compliance benchmarks for mealtime monitoring results to celebrate success. If monitoring results fall below established benchmarks, determine what action will be necessary, such as staff re-training and/or an administrative directive to correct deficiencies that appear to be systemic.
    g. Ensure a heightened mealtime monitoring schedule for individuals identified at high risk, such as individuals at risk due to aspiration pneumonia, respiratory concerns, choking, weight, fluid imbalance, etc. (Section O.4)
12. The PNMT should provide individual-specific competency-based training and performance check-offs to ensure prescribed and updated PNMP strategies are implemented by appropriate staff, including nursing, supervisors, and direct support professionals. (Section O.5)
13. As was recommended in the previous compliance report, a Facility policy should be developed to ensure a system is in place to monitor staff implementation of PNMT Action Plans and PNMPs, including dining plans. At a minimum, such a policy should include:
    a. Definition of a monitoring process to cover staff providing care in all aspects in which an individual is determined to be at risk (i.e., bathing, tooth brushing, personal care, alternate positioning, wheelchair positioning, medication administration, etc.);
    b. A requirement that all monitoring forms provide instructions for individual monitoring indicators to support consistency in monitoring and inter-rater reliability;
    c. Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability;
    d. Formal schedule for monitoring to occur;
    e. A requirement that individuals at highest risk to be monitored at greater frequency to minimize and/or reduce identified risk factors;
    f. Auditing process of completed monitoring forms to identify forms completed accurately, and analysis of individual-specific concerns and systemic issues;
    g. Feedback loop identified in which deficiencies are noted and shared with appropriate supervisory staff to ameliorate deficiencies; and

h. Establishment of thresholds for staff re-training. (Section O.6)

14. 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 should be clearly recorded, utilized for monitoring, and analyzed to determine the efficacy of the supports provided at both the individual-specific and systemic levels. This information should be integrated into the Facility's QA/QI, Incident Management and Risk Management systems. (Section O.6)
15. The PNMT and PSTs should integrate measurable, functional outcomes into action plans and skill acquisition programs, and provide documentation on a monthly basis to address the progress of individuals relative to their action plans and skill acquisition programs. (Section O.7)
16. Aspiration Pneumonia/Enteral Nutrition Evaluations should evaluate the potential for moving an individual to a less restrictive form of receiving enteral nutrition. (Section O.8)
17. Information gained from the APEN evaluations should be integrated, as appropriate, into individuals PSPs, Risk Action Plans, nursing care plans and PNMPs. Any plans developed to modify the individual's feeding should be accompanied by measurable, functional outcomes, which should be used to measure the efficacy of the plan. (Section O.8)

| SECTION P: Physical and Occupational Therapy | |
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| 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:<br>▪ **Review of Following Documents**:<br>o Presentation Book for Section P;<br>o Presentation for July 2011 for Settlement Agreement Monitoring Team Visit for Section P, undated;<br>o The following documents: OT/PT Evaluations, OT/PT Consultations for the past year, supporting documentation for individuals receiving direct OT/PT services, PST Integrated Risk Rating Form, PST Action Plan for Risk, PSP and PSPAs for the past year, PNMP with pictures, PNMP Clinic Notes for the past year, PNMP and person-specific monitoring for the past two months, competency-based training for staff, Community Living Discharge Plan (CLDP), Habilitation Therapies Individual Report from Data Base; OT/PT therapy plan with progress notes, and wheelchair/seating assessment, for the following 18 individuals: Individual #133, Individual #353, Individual #266, Individual #244, Individual #50, Individual #269, Individual #372, Individual #94, Individual #323, Individual #65, Individual #276, Individual #221, Individual #327, Individual #3, Individual #16, Individual #213, Individual #110, and Individual #203;<br>o OT/PT Evaluation for Individual #71, Individual #78, Individual #96, Individual #169, and Individual #341;<br>o OT/PT related spreadsheets, consult database, 2008 through 2011;<br>o Settlement Agreement compliance report, from 6/10 through 5/11;<br>o PNMP Clinic minutes (template), revised 2/22/11;<br>o Person-specific PNMP check sheet (template), revised 5/11/11;<br>o Home Equipment check sheet (template), revised 4/12/11;<br>o Wheelchair Evaluation (template), undated;<br>o Mat Assessment for seating and positioning (template), undated;<br>o Wheelchair/Mobility/Assistive Equipment Work Order (template), undated;<br>o PNMP (template), revised 5/25/11;<br>o Policies/procedures related to OT/PT supports and services, dated 10/7/09;<br>o List of OT, COTA, PT, PTA, and AT staff, undated;<br>o Continuing education completed by OTs and PTs, since last on-site visit, from 1/11 through 5/11;<br>o List of individuals who use wheelchair as primary mobility, dated 6/2/11;<br>o List of individuals with transport wheelchair, dated 6/21/11;<br>o List of individuals with other ambulation assistive devices, dated 6/22/11;<br>o List of individuals with orthotics and/or braces, dated 6/2/11;<br>o List of individuals who have had a decubitus/pressure ulcer during past year, from 12/10 through 5/11;<br>o PNM Maintenance Log, used to track modifications on adaptive/assistive equipment, from 12/10 through 5/11; |

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| | ○ OT/PT Assessments (template), undated;<br>○ Five (5) most current OT/PT Assessments, multiple dates;<br>○ Tracking Log of completed assessments, from 12/10 through 5/11;<br>○ Wheelchair Seating and PNM Clinic Assessments (template), undated;<br>○ Most current Wheelchair Seating/PNM Clinic Assessments for multiple individuals, from 3/11 through 7/11;<br>○ OT/PT Monitoring Forms for multiple individuals, May 2011; and<br>○ List of individuals receiving direct OT/PT services and focus of intervention, undated.<br>▪ **Interviews with**:<br>○ Dr. Angela Roberts, Habilitation Therapies Director;<br>○ Rosie Cortez, OTR;<br>○ Tami Loudermilk-Flores, OTR;<br>○ Nancy Droke, OTR; and<br>○ Paul Osborne, PT.<br>▪ **Observations of**:<br>○ Residences and dining rooms Coral Sea, Atlantic and Pacific. |
| | **Facility Self-Assessment:** The CCSSLC Plan of Improvement/Self Assessment, updated 6/29/11, provided comments/status for Section P. The Facility had identified itself as being in noncompliance with each of the provisions for this section. This was consistent with the Monitoring Team's findings. This document also provided a summary of some of the action plans on which the Facility was working to achieve compliance.<br><br>The Plan of Improvement provided some narrative descriptions of actions the Facility had or was taking to move towards compliance within each of the four sections, but did not present a comprehensive assessment of compliance with each of the indicators. The POI did not include data from its self-assessment reviews, and/or the status of inter-rater reliability. As the Facility moves forward in its self-assessment process, it will be important to ensure that data is used in meaningful ways to assist in identifying areas in which improvements are needed. |
| | **Summary of Monitor's Assessment:** CCSSLC had five budgeted positions for Physical Therapy. At the time of the review, one and a half positions were unfilled. There were two appropriated positions for Physical Therapy Assistants, but from the documentation submitted it was difficult to tell if both of these positions were filled, and/or if one was filled and the other position was vacant.<br><br>Staffing was potentially one factor that resulted in the inadequate provision of occupational and physical therapy supports to individuals. As is documented throughout this section of the report, individuals were not receiving needed supports. In sum, therapists were not active members of the PSTs, as evidenced by their collective absence from annual PSP meetings, insufficient provision of direct therapy, lack of a provision of an update when a change in status occurred, insufficient development and integration of therapy recommendations into formal skill acquisition programs, lack of development of instructional programs for PNMP Coordinators and/or staff, and the lack of development of informal strategies to reinforce assessment recommendations and measurable outcomes. |

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| | The OTs and PTs attended a variety of continuing education courses and conferences, which included Wheelchair and Bed Positioning for the Geriatric Patient; a Neuro Rehabilitation Conference; Managing Dysphagia: Essential Assessment, Diagnosis and Treatment Strategies; Beckman Oral Motor Assessment and Interventions; and Meeting the Needs of Latino Children with Communication Disorders.<br><br>Numerous issues were noted with regard to the assessment process, as well as the provisions of therapeutic supports. Direct and indirect therapy interventions were not analyzed, during the assessment and/or update process, or in clinical progress notes to determine if progress was being made and/or if changes needed to be instituted. Justification for therapy interventions was not outlined in the analysis of findings section of the assessments to provide a rationale for functional recommendations, measurable outcomes, and intervention strategies. Programs implemented by PNMP Coordinators were not justified in the OT/PT Evaluation through assessment and analysis of findings to provide a rationale for recommendations and intervention strategies. In addition, therapy programs were not integrated into individuals' PSPs in the form of skill acquisition programs or staff service objectives. Therapy plans were not integrated through skill acquisition programs, and reinforced through the use of informal therapy supports throughout the 24-hour day. Monthly and/or quarterly documentation was not consistently found to justify the initiation, continuation, and/or discontinuation of programs implemented by the PNMP Coordinators. |

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| P1 | By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner. | <u>The Facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience.</u><br>According to the current census, there were 272 individuals living at CCSSLC. A document entitled "Current Therapy Staff with Titles, Current Caseloads, and License Numbers," undated, was submitted. Based on documentation, there were five budgeted positions for Occupational Therapy, of which one and a half positions for were unfilled. There were two budgeted positions for Certified Occupational Therapy Assistants (COTA), and these positions were filled.<br><br>CCSSLC had five budgeted positions for Physical Therapy (PT), but Facility Administration had approved the hiring of part-time contract PTs, which accounted for a sixth PT. At the time of the review, one and a half positions were unfilled. There were two positions for Physical Therapy Assistants, but from the documentation submitted it was difficult to tell if both of these positions were filled, and/or if one was filled and the other position was vacant. The following chart represented the current therapists' caseloads, as reported for 272 individuals: | Noncompliance |

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| Occupational Therapist(s) (OT) and Certified Occupational Therapy Assistants (COTA) | Current Caseloads and Responsibility |
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| OT #1 | Lead OT and supported 81 individuals in Pacific |
| OT #2 | Core PNMT member and supported 83 individuals in Coral Sea |
| OT #3 | Alternate PNMT member and supported 112 individuals in Atlantic |
| OT #4 | Contractor, and was identified as a "floater" and did not have a caseload |
| OT #5 | Vacant |
| COTA #1 | Supported 112 individuals in Atlantic |
| COTA #2 | Supported 83 individuals in Coral Sea |
| **Physical Therapist(s) (PT) and Physical Therapy Assistant (PTA)** | **Current Caseload** |
| PT #1 | PNMT Chairperson and supported PNMT caseload of 21 individuals |
| PT #2 | Alternate PNMT member and supported 81 individuals in Pacific |
| PT #3 | Supervised Wheelchair Department and supported 83 individuals in Coral Sea |
| PT #4 | Contractor and supported 112 individuals in Atlantic |
| PT #5 | Contractor was identified as a "floater" and did not have a caseload |
| PT #6 | Vacant |
| PTA #1 | Supported 112 individuals in Atlantic |
| PTA #2 | Wheelchair Shop Supervisor |

Staffing was potentially one factor that resulted in the inadequate provision of occupational and physical therapy supports to individuals. As is documented throughout this section of the report, individuals were not receiving needed supports. In sum, therapists were not active members of the PSTs, as evidenced by their collective absence from annual PSP meetings, insufficient provision of direct therapy, lack of a provision of an update when a change in status occurred, insufficient development and integration of therapy recommendations into formal skill acquisition programs, lack of development of instructional programs for PNMP Coordinators and/or staff, and the lack of development of informal strategies to reinforce assessment recommendations

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| | | and measurable outcomes.<br><br>The OTs and PTs, minus the contract PTs, attended an adequate variety of continuing education courses and conferences, which included Wheelchair and Bed Positioning for the Geriatric Patient; a Neuro Rehabilitation Conference; Managing Dysphagia: Essential Assessment, Diagnosis and Treatment Strategies; Beckman Oral Motor Assessment and Interventions, and Meeting the Needs of Latino Children with Communication Disorders. The contract PTs did not submit documentation for continuing education. Contract therapists should be required to submit documentation of continuing education.<br><br>As stated in the previous report, OTs and PTs, who were members of the Core and Alternate PNMT, should attend State-sponsored webinars as well as document their participation with State PNM consultants.<br><br>Per report, two of the 272 individuals (Individual #133 and Individual #323) were receiving direct OT/PT services from a therapist. One of these individuals (Individual #133) had transitioned to the community, but a Facility PT continued to provide supports through the Facility until a contract could be established with the community provider. In the Atlantic residences, PNMP Coordinators were implementing OT/PT programs for 12 individuals, and staff were implementing them for six individuals. In the Pacific Unit, PNMP Coordinators implemented programs for 29 individuals, and staff implemented programs for an additional 45 individuals. In the Coral Sea residences, PNMP Coordinators implemented programs for 31 individuals, and staff implemented them for an additional 65 individuals.<br><br>Eighteen (18) records were reviewed, including those for: Individual #133, Individual #353, Individual #266, Individual #244, Individual #50, Individual #269, Individual #372, Individual #94, Individual #323, Individual #65, Individual #276, Individual #221, Individual #327, Individual #3, Individual #16, Individual #213, Individual #110, and Individual #203. These 18 individuals had identified needs related to, but not limited to significant overweight status, movement, mobility, range of motion, independence, regression of functional skills, a change in status such as unplanned weight loss, choking, falls, fractures, identified high risk indicators, admission to the Infirmary, emergency room or hospital, and community transition. However, as is discussed in further detail below, CCSSLC was not providing them with adequate, appropriate, and functional OT/PT services.<br><br><u>All individuals have received an OT/PT screening. If newly admitted, this occurred within 30 days of admission.</u><br>Since the last review, there were five individuals (Individual #71, Individual #78, | |

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| | | Individual #96, Individual #169, and Individual #341) admitted to CCSSLC. These individuals received an OT/PT evaluation within 30 days of admission, but these evaluations did not "consider health risk indicators in a clinically justified manner."<br><br><u>All people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification.</u><br>The CCSSLC OT/PT Evaluation template, undated, included the following sections with instructional information within the sections:<br>▪ General information, including statistical information, diagnosis and pertinent history, medications/precautions, and method of communication;<br>▪ Behavioral consideration;<br>▪ Motor/functional evaluation/PNMP, including physical management information, reflexive/orthopedic abnormalities, range of motion, muscle tone/strength, handling/transferring, mobility/locomotion, respiratory function, sensorimotor function, fine motor function, and activities of daily living;<br>▪ Oral motor/eating ability/nutritional status, including nutritional status, physical/positioning considerations, oral/developmental abnormalities, oral control, diet texture/method of feeding, behavioral considerations, eating equipment, and mealtime techniques;<br>▪ Assistive/supportive devices;<br>▪ Summary; and<br>▪ Recommendations for community placement, as well as discipline-specific and skill acquisition training.<br><br>The major revision to the OT/PT Evaluation template was within the recommendation section. Therapists were to include recommendations regarding whether community placement was appropriate, and identifying supports and justifications; discipline-specific recommendations; and any skill acquisition training recommended. The Monitoring Team recommends that the following guidance should be incorporated into the CCSSLC OT/PT evaluation and update templates:<br>▪ Assessment processes should be sufficiently discrete to identity an individual's functional skills, interests, and preferences via observation and clinical assessment to support the individual in the areas of life, work and leisure;<br>▪ Assessments should address health risk indicators and risk action plans, if related to OT/PT;<br>▪ Assessment data should be analyzed to identify an individual's strengths, abilities, and potentials for skill acquisition;<br>▪ There should be an analysis of findings to provide a rationale for recommended functional objectives and intervention strategies;<br>▪ Recommendations for objectives or action plans should include criteria that | |

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| | | would enable the team to assess and monitor implementation to ensure efficacy of objective and/or program;<br>▪ As appropriate, recommendations should be integrated into an individual's PSP through formal skill acquisition programs and informally through the daily activity schedule;<br>▪ Documentation should be present to justify initiation, continuation, or discontinuation of direct and/or indirect therapy supports; and<br>▪ A process should be delineated for implementing changes in an individual's supports when progress is made or a lack of progress is noted. The lack of progress would identify a re-evaluation timeframe.<br><br>HT Tracking Receipt of Annual Assessments identified the following fields: name of individual; apartment; PSP date; date annual assessment is due (10 days prior to the PSP); Speech; OT/PT; Audiology; Dietary, and PNMP date (assessments are due 30 days after PSP date). The Director of Habilitation Therapy used this database to ensure assessments were completed in a timely manner prior to the annual PSP meeting. The HT Director utilized this report to track timely completion of therapy assessments, and took action if reports were not completed per the established guidelines.<br><br><u>If receiving services, direct or indirect, the individual is provided a comprehensive OT and/or PT assessment every three years, with annual interim updates or as indicated by a change in status.</u><br>Based on a subset of the sample previously identified, none of these 15 individuals (Individual #133, Individual #353, Individual #266, Individual #244, Individual #50, Individual #269, Individual #372, Individual #94, Individual #323, Individual #65, Individual #276, Individual #221, Individual #327, Individual #3, and Individual #203) (0%) had an OT/PT Evaluation and/or update that addressed a change in status.<br><br>The following provides a summary of the Monitoring Team's concerns, as well as recommendations:<br>▪ Individuals who had transitioned to the community (Individual #133 and Individual #203) did not have comprehensive OT/PT evaluations to provide adequate information to community providers. For example, Individual #133's OT/PT Evaluation Discharge Report, dated 5/25/11, was not comprehensive, because it did not identify many important factor, including, but not limited to, her level of risk, or sufficient historical and current information to manage her Milroy's disease (congenital lymphedema), effectively. Although her Community Living Discharge Plan discussed treatment provided at CCSSLC to manage her Lymphedema, the CLDP Community Living Data did not identify the name of a community physical therapist, which placed her at significant health risk. Individuals who transition to the community should receive a | |

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| | | timely comprehensive, proactive OT/PT Evaluation, which gives community providers historical and current information, including the interventions provided, as well as defining the efficacy of the supports provided to the individual. Most importantly, these evaluations should discuss significant medical issues and health risk indicators in a clinically justified manner, and present strategies to minimize/reduce identified health risk indicators.<br>▪ Individuals who experience a choking incident requiring use of the abdominal thrust should receive an OT/PT update. An individual (Individual #269) who had experienced two choking incidences requiring use of the abdominal thrust (i.e., 12/31/10 and 3/8/11) did not have an OT/PT evaluation/update to address these significant health concerns.<br>▪ Individuals who experience a change in status with multiple falls should receive an OT/PT update to determine their current status and implement strategies to minimize their falls and fall risk (e.g., Individual #372 and Individual #94). Individual #372's Integrated Risk Rating Form, dated 12/20/10, documented she had 46 falls from 12/27/10 to 1/3/11. Her OT/PT Evaluation, dated 4/29/11, discussed her history of multiple falls, but did not complete an analysis of her history of falls and/or implement a procedure to document her falls with specific indicators, which should have lead to the development of proactive recommendations to minimize and/or reduce her high incidence of falls.<br>▪ Individuals who were admitted to the Infirmary, emergency room and/or the hospital with a diagnosis of pneumonia, but were not referred to the PNMT should have received an OT/PT update, including review of the appropriateness of the PNMP (e.g., Individual #221 and Individual #327). This did not occur.<br>▪ Individuals who sustained a fracture should have received an OT/PT update to review the appropriateness of their PNMP, and to determine if prescribed strategies were sufficient to minimize the risk of fractures (e.g., Individual #323 and Individual #3). However, this did not occur.<br>▪ Individuals who experienced an unplanned weight loss and/or were below their Ideal Body Weight Range (e.g., Individual #266, Individual #244 and Individual #50), and individuals who experienced coughing during mealtime and were referred to nursing, should also be referred to OT for the completion of an OT/PT update to review the appropriateness of their dining plan and PNMP strategies (e.g., Individual #65). However, this did not occur.<br>▪ Individuals admitted to the Infirmary as the result of a change in health status, should have received an OT/PT Update to reassess the appropriateness of their dining plan and PNMP strategies (e.g., Individual #276). The Monitoring Team observed Individual #276 as he received his breakfast and his medication. The hospital had changed his fluid consistency to nectar. Although the nurse was | |

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| | | thickening his liquids, his PNMP did not have a stated fluid consistency.<br>▪ The OT/PT Evaluation should address strategies for individuals who exceeded their weight range by over 20%, and placed them at high risk for multiple health concerns (e.g., Individual #353 and Individual #133). However, this had not occurred.<br>▪ Individuals with unplanned weight loss and a low BMI, which placed them in the underweight category, should have received an OT/PT Update to reassess the current dining plan and PNMP strategies to minimize and/or reduce their high and/or medium risk status for weight (e.g., Individual #266, Individual #244 and Individual #50). However, this had not occurred.<br><br><u>Medical issues and health risk indicators are included in the assessment process with appropriate analysis to establish rationale for recommendations/therapeutic interventions.</u><br>A subset of 16 individual records from the original 18 individual record sample was reviewed. None of the 1 OT/PT evaluations reviewed (Individual #353, Individual #266, Individual #244, Individual #50, Individual #269, Individual #372, Individual #94, Individual #323, Individual #65, Individual #276, Individual #221, Individual #327, Individual #3, Individual #16, Individual #213, and Individual #110) (0%) addressed medical issues and identified health risk indicators that would have an impact on the analysis conducted to provide a rationale for recommendations/therapeutic interventions.<br><br><u>Evidence of communication and or collaboration is present in the OT/PT assessments.</u><br>Based on record review, 16 of the 16 OT/PT Evaluations (Individual #353, Individual #266, Individual #244, Individual #50, Individual #269, Individual #372, Individual #94, Individual #323, Individual #65, Individual #276, Individual #221, Individual #327, Individual #3, Individual #16, Individual #213, and Individual #110) (100%) included signatures of the OT and PT, as well as the date. | |
| 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 | <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><br>Based on a review of three individuals (Individual #16 - standing and ambulation to maintain weight-bearing status and independence; Individual #213 - to maintain arm movement and completed by a PNMP Coordinator; and Individual #110 - oral stimulation for facial muscle strengthening and stimulation), who were selected from the submitted list of individuals receiving direct/indirect OT/PT services, for none of the three (0%) was the OT/PT program recommended in their OT/PT Evaluation Update and/or Consultation Report, and/or integrated into their PSPs through skill acquisition programs. | Noncompliance |

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| | 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. | Numerous issues were noted with regard to the assessment process, as well as the provisions of therapeutic supports. Direct and indirect therapy interventions were not analyzed, during the assessment and/or update process, or in clinical progress notes to determine if progress was being made and/or if changes needed to be instituted. Justification for therapy interventions was not outlined in the analysis of findings section of the assessments to provide a rationale for functional recommendations, measurable outcomes, and intervention strategies. Programs implemented by PNMP Coordinators were not justified in the OT/PT Evaluation through assessment and analysis of findings to provide a rationale for recommendations and intervention strategies. In addition, therapy programs were not integrated into individuals' PSPs in the form of skill acquisition programs or staff service objectives. Therapy plans were not integrated through skill acquisition programs, and reinforced through the use of informal therapy supports throughout the 24-hour day. Monthly and/or quarterly documentation was not consistently found to justify the initiation, continuation, and/or discontinuation of programs implemented by the PNMP Coordinators.<br><br>Therapists should have reviewed the Physical/Nutritional Management Data forms that PNMP Coordinators completed to determine the efficacy of the program, but this did not occur. There also should have been a process for implementing change in an individual's supports when progress was made and/or an absence of progress. There should have been a timeframe for re-evaluation. Staff should reinforce these programs by incorporating them into the daily activity schedules to increase learning opportunities and skill acquisition.<br><br><u>Within 30 days of development of the plan, it is implemented.</u><br>Per documentation submitted (i.e., list of individuals receiving direct OT and/or PT services-XIII.14), PNMP Coordinators implemented direct OT and/or PT services for three individuals (Individual #16 - "standing, ambulation [to] maintain weight bearing status and independence;" Individual #213 - "arm activities to maintain arm movement;" and Individual #110 - "oral stimulation [for] facial muscle strengthening and stimulation"), but there were no formal programs/plans developed and implemented (0%) to address identified interventions.<br><br><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><br>Based on documentation provided, none of the three individuals (Individual #16, Individual #213 and Individual #110) (0%) with direct and/or indirect PT services had their plans integrated into the PSP.<br><br><u>On at least a monthly basis or more often as needed, the individual's OT/PT status is</u> | |

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| | | reviewed and plans updated as indicated by a change in the person's status, transition (change in setting), or as dictated by monitoring results.<br>The three individuals in the record sample who were identified as receiving therapy interventions did not have a formal program/plan developed, nor did OTs/PTs review these interventions on a monthly basis to justify the continuation and/or discontinuation of the interventions.<br><br>In addition, Individual #357 transitioned from Atlantic to Ribbonfish. She used a power chair to navigate independently within multiple environments. During the onsite review, Individual #357 was returning from work to her residence for lunch, and requested that the Monitoring Team member leave the wooden gate open so she would be able to enter. The presence of this wooden gate rendered the entrance to her residence inaccessible without assistance from another individual. This inaccessibility compromised her independence. During the transition planning for this move, PST members should have identified this barrier and discussed another residential possibility or eliminated the barrier to support accessibility and her independence within her new residence. | |
| P3 | Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that staff responsible for implementing the plans identified in Section P.2 have successfully completed competency-based training in implementing such plans. | Staff implements recommendations identified by OT/PT.<br>Multiple examples are provided above with regard to Section O.4 of the Settlement Agreement with regard to staff not following PNMPs, which OTs and PTs had recommended.<br><br>Staff successfully complete general and person-specific competency-based training related to the implementation of OT/PT recommendations.<br>Based on review of individual records, direct support professionals were identified as competent to implement comprehensive OT/PT interventions and supports as outlined in the PNMPs and other activity plans for none of 16 individuals reviewed, who were a subset of the original record sample. (0%). | Noncompliance |
| P4 | Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the | System exists to routinely evaluate: fit; availability; function; condition and effectiveness of all adaptive equipment/assistive technology.<br>An Action Plan for Section P4, dated 5/17/11, indicated that the following steps had been completed:<br>▪ Therapists will perform an annual comprehensive evaluation/review of all prescribed PNMP adaptive/assistive equipment during the PNMT clinic;<br>▪ Policy regarding all PNMP equipment and protocol for PNMP Clinic will be developed;<br>▪ Therapists attendance will be documented through signature on sign-in sheet;<br>▪ All PNMP prescribed assistive equipment will be assessed on an annual basis for fit, availability, function, condition and effectiveness; | Noncompliance |

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| | treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions. | ▪ A documentation process will be established for resolution of problems with fit, availability, function and condition of prescribed equipment; and<br>▪ PNMPs will incorporate prescribed footwear as needed.<br><br>The Action Plan documented the completion of a policy "regarding all PNMP equipment and protocol for PNMP Clinic," but no policy was submitted for review. The PNMP Clinic Minutes form incorporated the preceding action steps, and appeared to incorporate the components of an adequate annual review of adaptive/assistive equipment. However, a review of PNMP Clinic Minutes completed for individuals within the sample did not provide evidence that the forms were completed appropriately.<br><br>PNMP Coordinators were to complete Monthly Home Equipment Check Sheet form, revised 4/12/11, monthly in their assigned residences. The form tracked the following equipment: home loaner wheelchairs, Arjo lifts, slings, home/shared communication devices, walkers/standers, bathing trolleys/tables, shower chairs/benches, and spare equipment (helmets, gait belts, dining equipment). The form had been revised to include instructions for the completion of the form. Upon completion of the form, PNMP Coordinators were:<br>▪ To notify supervisor(s) if a problem was identified;<br>▪ Estimated/target resolution date was to be provided for appropriate, timely follow-up;<br>▪ If the problem could not be corrected by the PNMP Coordinator, appropriate staff must be contacted to resolve the problem;<br>▪ Upon resolution, the PNMP Coordinator and/or therapist would document how and when the problem was resolved;<br>▪ Forms were to be forwarded to HT administrative assistant for documentation purposes and then forwarded to the respective therapist; and<br>▪ Therapists were to review all forms, follow-up on resolved issues, and sign/date form when all problems/concerns have been resolved.<br><br>The Monthly Home Equipment Check Sheet form should include the presence of wedges and custom bathing device developed by the Wheelchair Department for bathing/showering trolleys. In addition, the therapists should conduct validation reviews to ensure PNMP Coordinators were monitoring equipment appropriately.<br><br>Monthly Person-Specific PNMP Check Sheet form, revised 5/1/11, was to be completed every month by PNMP Coordinators for every individual with a PNMP within their respective homes. The form had been revised and was highlighted to identify revisions to the form. These revisions included instructions for the completion of the form, as well as some changes with regard to the equipment reviewed. Therapists should conduct validation reviews to ensure PNMP Coordinators are monitoring PNMP | |

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| | | assistive equipment appropriately.<br><br>Proper Completion of Person Specific PNMP Check Sheet and Monthly Home Equipment Check Sheet in-service was conducted for PNMP Coordinators on 4/1/11. PNMP Coordinators were administered a competency-based test for Monthly Person Specific PNMP Check Sheet and Home Equipment forms at the end of the in-service.<br><br>PNMP Clinic Minutes form, revised 2/22/11, recognized the following fields:<br>▪ Status of risk ratings (high, medium, low and/or no risk) for choking, aspiration, skin integrity, falls, fractures, and other including rationale;<br>▪ List of adaptive equipment/dining equipment with check boxes for continue, discontinue, and modify, fit, function and effectiveness and a section for condition;<br>▪ PNMP programs with check boxes for continue, discontinue, modify, implemented and effectiveness;<br>▪ Physical therapy (evaluation and/or update) with check boxes for wheelchair assessment, pressure mapping and adaptive equipment reviewed;<br>▪ Occupation therapy (evaluation and/or update) with check boxes for dining plan reviewed and dining equipment reviewed;<br>▪ Speech therapy (evaluation and/or update) with check boxes for communication reviewed, augmentative/alternative communication; environmental control reviewed; and communication dictionary reviewed;<br>▪ Recommendations, priority level, responsible person, date initiated, date completed;<br>▪ Therapist's signatures; and<br>▪ Risk Factor Chart (for rationale) for choking, aspiration, skin integrity, falls and fractures.<br><br>Four (Individual #65, Individual #269, Individual #50, and Individual #266) of the 14 individual records reviewed with PNMPs (Individual #266, Individual #244, Individual #50, Individual #269, Individual #372, Individual #94, Individual #65, Individual #276, Individual #221, Individual #327, Individual #3, Individual #16, Individual #213, and Individual #110) (29%) documented the completion of the PNMP Clinic Minutes form, but the following concerns were noted:<br>▪ PNMP Clinic Minutes Risk Rating Form section was not consistently completed to include the rationale;<br>▪ PNMP Clinic Minutes did include a comprehensive list of PNMP assistive and dining equipment;<br>▪ The condition of ortho shoes for an individual stated: "need new," but it was unclear why the fit, function, and effectiveness was marked yes on the form;<br>▪ The condition section of the form was left blank for multiple pieces of adaptive | |

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| | | equipment;<br>▪ Multiple pieces of dining equipment was placed on a single line;<br>▪ Individuals who had positioning programs were not reviewed;<br>▪ Sections of the form had not been completed; and<br>▪ Recommendations were made, priority level was assigned, and an initiation date documented, but there was no documentation of a completion date.<br><br>The Facility should develop a policy and/or procedures for the PNMP Clinic Minutes form to ensure individuals' adaptive/assistive equipment is reviewed annually for fit, availability, function, condition, and effectiveness.<br><br><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><br>Systemic issues related to monitoring are discussed above with regard to Section O.6 of the Settlement Agreement.<br><br><u>On a regular basis, all staff are monitored for their continued competence in implementing the OT/PT programs.</u><br>Systemic issues related to monitoring are discussed above with regard to Section O.6 of the Settlement Agreement. Hundreds of Habilitation Therapies PNMP Observation and Training Roster(s) were submitted that were completed during the "last month." No formal analysis had been completed to identify individual-specific and/or systemic issues related to staff compliance and/or non-compliance.<br><br><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 (as discussed further with regard to Section O.5 of the Settlement Agreement)</u>.<br>Systemic and individual-specific issues related to training staff are discussed above with regard to Section O.5 of the Settlement Agreement.<br><br><u>Responses to monitoring findings are clearly documented from identification to resolution of any issues identified (as discussed further with regard to Section O.4 of the Settlement Agreement).</u><br>Systemic and individual-specific issues related to monitoring are discussed above with regard to Section O.6 of the Settlement Agreement.<br><br><u>Safeguards are provided to ensure each individual has appropriate adaptive equipment and assistive technology supports immediately available.</u><br>As discussed above, adequate safeguards were not in place to ensure each individual had appropriate adaptive and assistive technology supports. | |

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| | | Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses the identified needs (as discussed further with regard to Section O.5 of the Settlement Agreement).<br>As is discussed above with regard to Section O.5 of the Settlement Agreement, adequate training and monitoring of staff on individual-specific plans was not being completed.<br><br>Data collection method is validated by the program's author(s).<br>For none of the three individuals (0%) receiving direct OT/PT services implemented by PNMP Coordinators was the data collection method validated by the program's author. | |

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

1. The following guidance should be integrated into the OT/PT Evaluation template:
    a. Assessment processes should be sufficiently discrete to identity an individual's functional skills, interests, and preferences via observation and clinical assessment to support the individual in the areas of life, work and leisure;
    b. Assessments should address health risk indicators and risk action plans, if related to OT/PT;
    c. Assessment data should be analyzed to identify an individual's strengths, abilities, and potentials for skill acquisition;
    d. There should be an analysis of findings to provide a rationale for recommended functional objectives and intervention strategies;
    e. Recommendations for objectives or action plans should include criteria that would enable the team to assess and monitor implementation to ensure efficacy of objective and/or program;
    f. As appropriate, recommendations should be integrated into an individual's PSP through formal skill acquisition programs and informally through the daily activity schedule;
    g. Documentation should be present to justify initiation, continuation, or discontinuation of direct and/or indirect therapy supports; and
    h. A process should be delineated for implementing changes in an individual's supports when progress is made or a lack of progress is noted. The lack of progress would identify a re-evaluation timeframe. (Section P.1)
2. The Facility should develop and implement audit protocols to ensure OT/PT Evaluations follow established guidelines as outlined in the OT/PT evaluation template. (Section P.1)
3. Updates should be completed when an individual experiences a change in status. (Section P.1).
4. With regard to the provision of direct and indirect therapy services:
    a. Direct and indirect therapy interventions should be analyzed, during the assessment and/or update process, as well as in clinical progress notes to determine if progress is being made and/or if changes need to be instituted;
    b. Justification for therapy interventions should be outlined in the analysis of findings section to provide a rationale for functional recommendations, measurable outcomes, and intervention strategies;
    c. As appropriate, therapy plans should be integrated through skill acquisition programs, and reinforced through the use of informal therapy supports throughout the 24-hour day. These supports should be defined in an individual's PSP;
    d. Monthly documentation should justify the initiation, continuation or discontinuation of assessment recommendations, and reflect the status of measurable outcomes;
    e. Quarterly documentation should be provided for the provision of indirect supports; and
    f. There should be a formal process for implementing changes in an individual's supports, when progress is made and/or a lack of

progress is noted, including a timeframe for re-evaluation. (Section P.2)

5. The Monthly Home Equipment Check Sheet form should include the monitoring of wedges and the custom bathing device that the Wheelchair Department develops for bathing/showering trolleys. (Section P.4)
6. The Facility should develop a policy and/or procedures for the PNMP Clinic Minutes form to ensure individuals' adaptive/assistive equipment is reviewed annually for fit, availability, function, condition, and effectiveness. (Section P.4)

| SECTION Q: Dental Services | |
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| | **Steps Taken to Assess Compliance:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o CCSSLC Dental Policies: Dental Services Q.16: Annual Dental Examination, revision 6/9/11; Dental Services Q.19: Integrated progress note and dental documentation, pending approval; Dental Services Q.20: Tooth brushing, pending approval; and Dental Care Services Q.21: Chlorhexidine with suction brush protocol, pending approval;<br>o Dental Peer Review Committee minutes, communication prior six months: Draft: Dental management strategies for patients treated with bisphosphonates;<br>o CCSSLC New Admissions – Dental Services provided between 12/1/10 and 5/31/11;<br>o Lists of individuals who within the past six months were seen for dental services other than for the annual exam, date of visit, and reason or type of visit;<br>o Individuals identified to have refused dental treatment between 12/1/10 and 5/31/11;<br>o Individuals identified to have missed appointments between 12/1/10 and 5/31/11;<br>o Individuals identified to have required extractions between 12/1/10 and 5/31/11;<br>o Individuals identified to have required emergency dental treatment between 12/1/10 and 5/31/11;<br>o Individuals identified for preventative dental care between 12/1/10 and 5/31/11;<br>o Individuals identified for restorative dental work between 12/1/10 and 5/31/11;<br>o List of individuals who within the past six months were due for annual dental exams, whether they have had exams, and whether the dentist was able to complete those exams;<br>o Most recent comprehensive exams, including copy of dental office record and copy of record from active record for the same visit for the following: Individual #26, Individual #78, Individual #71, Individual #369, Individual #277, Individual #250, Individual #269, Individual #96, Individual #315, and Individual #195;<br>o Extraction Report – off campus practitioners, between 12/1/10 and 5/31/11;<br>o Copy of any oral surgery consultations, progress notes referencing referral to oral surgery, anesthesia reports, consents, post procedure exam, and follow up notes for the past six months for following: Individual #145, dated 5/6/11; Individual #242, dated 1/14/11; Individual, dated #325 1/28/11; Individual #167, dated 5/23/11; Individual #277, dated 1/25/11; Individual #157, dated 4/7/11; Individual #16, dated 2/28/11; Individual #118, dated 12/3/11; Individual #155, dated 1/21/11; Individual #300, dated 4/5/11; Individual #139, dated 3/30/11; Individual #69, dated 12/10/10; Individual #51, dated 1/18/11; Individual #6, dated 5/9/11;<br>o List of abbreviations used in all dental records/reports;<br>o For the past six months, any data summaries used by the Facility related to dental services, and/or QA/QE reports, including the Quarterly Trending reports, for 12/1/10 through 2/28/11, and 3/1/11 through 5/31/11; and the monthly trending reports for 12/10 through 5/11;<br>o Dental Services Department, monthly trending report, dated 6/11;<br>o Attendance tracking sheet for dental appointments for the past six months: Dental |

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| | Services Department monthly tracking report, dated 6/2/11;<br>o Individuals identified to have refused dental treatment between 12/1/10 and 5/31/11, dated 6/9/11;<br>o List of those who have not seen dentist in one year and reason;<br>o List of those who have outstanding need for dental x-rays, and type of x-ray that is needed to fulfill requirements/recommendations;<br>o Guidelines for prescribing dental radiographs, from American Dental Association, dated November 2004;<br>o Individuals identified to have missed dental appointments, between 12/1/10 and 5/31/11;<br>o List of "no shows"/missed appointments per building per month, from December 2010 to May 2011;<br>o List of refusals per building per month, from December 2010 to May 2011;<br>o List of interventions per individual for missed appointments;<br>o CCSSLC Policy: Residential Services W.5: Participating in Unit Incident Management Team Meeting, revision date 4/27/11, approval date 4/28/11, implementation date 4/28/11:<br>o Unit Incident Management Review Team Meeting report/template;<br>o Coral Sea Unit Incident Management Review Team Meeting report, dated 5/31/11;<br>o Pacific Unit incident Management Review Team Meeting report, dated 5/31/11;<br>o Atlantic Unit Incident Management Review Team Meeting report, dated 5/27/11;<br>o CCSSLC dental appointments – overnight missed appointments report, from 4/18/11 to 4/19/11, with follow up sample of PSPA for Individual #166, dated 4/26/11;<br>o CCSSLC Dental Appointments – overnight missed appointments report between 5/24/11 and 5/25/11, with follow up integrated progress note for Individual #91;<br>o QMRP, IDT minutes that review, assess, develop, and implement strategies for dental visit refusals and "no shows" last six months, including: CCSSLC dental appointments – overnight missed appointments reports for the following dates: between 5/12/11 and 5/13/11(Individual #106), 5/4/11 and 5/5/11 (Individual #62), 5/2/11 and 5/3/11 (Individual #174), 4/28/11 and 4/29/11 (Individual #187), 4/25/11 and 4/26/11 (Individual #298), 4/26/11 and 4/27/11 (Individual #238), 5/5/ 11 and 5/6/11 (Individual #359), 5/3/11 and 5/4/11 (Individual #20);<br>o PSPAs for the following: Individual #106, dated 5/19/11; Individual #62, dated 5/11/11; Individual #174, dated 5/9/11; Individual #187, dated 5/3/11; Individual #298, dated 5/2/11; Individual #238, dated 4/28/11; Individual #357, dated 5/27/11; Individual #359, dated 5/11/11; and Individual #20, dated 5/9/11;<br>o Individuals identified to have required emergency dental treatment between 12/1/10 and 5/31/11, including coy of integrated progress note of emergency visit;<br>o Sedation usage report (general anesthesia/conscious sedation), from 12/1/10 to 5/31/11, report dated 6/6/11;<br>o Supporting documentation for Total Intravenous Anesthesia (TIVA) use for the following: Individual #369, dated 5/16/11; Individual #277, dated 5/17/11; Individual #155, dated 5/17/11; Individual #376, dated 5/17/11; Individual #87, dated 5/16/11; and Individual |

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| | #228, dated 5/16/11;<br>o For the past six months, copies of any correspondence concerning restraint and sedation use: Working List of referrals to psychology, QMRP, etc., printed 6/7/11; and email correspondence from the Dental Department to the Psychology and Psychiatry Departments, dated 12/23/10, 2/21/11, and 4/11/11;<br>o For ten individuals given dental pre-treatment sedation, copies of consent, dental notes, restraint checklist, and sedation care plan, for the following: Individual #19, dated 5/19/11; Individual #284, dated 5/9/11; Individual #273, dated 5/9/11; Individual #22, dated 5/31/11; Individual #210, dated 5/12/11; Individual #212, dated 5/25/11; Individual #333, dated 5/12/11; Individual #350, dated 5/5/11; Individual #65, dated 5/31/11; and Individual #141, dated 5/24/11;<br>o Sedation usage report between 1/1/10 and 5/31/11;<br>o Dental pre-treatment sedation assessments for the following: Individual #145, dated 6/7/11; Individual #184, dated 4/4/11; Individual #223, dated 6/2/11; Individual #131, dated 4/7/11; Individual #168, dated 2/16/11; Individual #19, dated 6/2/11; Individual #366, dated 5/20/11; Individual #272, dated 4/15/11; Individual #214, dated 2/9/11; Individual #155, dated 3/30/11; Individual #376, dated 9/28/10; Individual #211, dated 3/9/11; Individual #356, dated 2/1/11; Individual #87, dated 3/30/11; Individual #328, dated 5/4/11; Individual #228, dated 3/16/11; Individual #139, dated 6/3/11; Individual #77, dated 2/16/11 and 6/2/11; and Individual #156, dated 6/3/11;<br>o Percentage of individuals utilizing general anesthesia/IV sedation for dental exam and treatment, from 12/10 through 5/11;<br>o Percentage of individuals utilizing oral sedation for dental visits, from 12/10 through 5/11;<br>o CCSSLC: Percentage of individuals utilizing mechanical restraints, from 12/10 to 5/11;<br>o Extraction report – all practitioners, report generated 6/7/11, with supporting documentation;<br>o Oral hygiene ratings between 12/1/10 and 5/31/11, generated 6/3/11;<br>o Corrective action plans related to oral hygiene ratings: Quality Assurance/Quality Improvement Council meeting minutes, dated 4/23/11; Dental Section Meeting minutes, dated 4/7/11; and Step-by-step guidelines, oral hygiene checklist, Dental Services policy Q.20: tooth brushing;<br>o List of Individuals who receive Strident Treatment (Suction Toothbrush utilized), dated 6/3/11;<br>o Desensitization plans implemented since last monitoring visit;<br>o Copy of annual dental assessment completed in last 30 days and for the prior year;<br>o Working list of annual exam and previous annual exams;<br>o Copy of annual dental summary provided for the PSP, most recent summaries for 10% of individuals, with dental section of integrated risk rating form;<br>o Current Facility Dental Hygiene Ratings, dated 5/31/11;<br>o Dental emergency log, from 2/11to 6/11;<br>o CCSSLC policy: Dental Services Q.22 Management of Acute Illnesses and Injury, pending |

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| | approval;<br>o CCSSLC policy: Dental Services Q.23 24-Hour Nursing log, pending approval;<br>o Presentation Book for Section Q;<br>o Dental Services QA Report, Texas Health Monitoring Instrument totals for 1/31/11, 2/28/11, 3/31/11, 4/30/11, 5/31/11, and 6/30/11;<br>o Smoking information for the individuals at CCSSLC, Dental Nutrition for the individuals at CCSSLC, Oral Care for the Individuals at CCSSLC;<br>o Training rosters for hands-on training on oral care for individuals, dated 2/10/11, 2/11/11, 2/18/11, 3/4/11, 6/24/11, and 7/1/11;<br>o Training rosters for video on oral care for individuals, dated 2/10/11, 2/18/11, 2/25/11, 4/8/11, 4/13/11, 4/22/11, 4/29/11, 5/6/11, 5/13/11, 5/20/11, 5/27/11, 6/3/11, 6/17/11, 6/24/11, 7/1/11, and 7/8/11;<br>o Unit staff presentation "Dental Team;"<br>o New Hire Program: Oral Hygiene Instructions;<br>o Dental Refusal Process (current), Dental Refusal Process (ideal);<br>o Email correspondence (psychology, dental, administration) concerning oral hygiene, from 2/1/11 through 2/7/11;<br>o Dental conference call, dated 4/29/11; and<br>o Oral hygiene scale, San Antonio SSLC.<br>▪ **Interviews with**:<br>o Enrique Venegas, DDS, Dental Director |
| | **Facility Self-Assessment:** The Facility determined that it was not in compliance with either of the subsections of Section Q. However, according to the Plan of Improvement, several action steps had been completed to assist the Facility in progressing toward compliance. Since the Monitoring Team's last visit, the Facility reported that:<br>▪ For Section Q.1, a campus-wide dental QA monitoring program continued to provide data for trend analysis. This occurred monthly. Additionally, a plan of action was developed to measure comprehension of dental education material for the direct support professionals. The Chief Psychologist proposed a Desensitization Specific Program Objective format on 1/29/11.<br>▪ For Section Q.2, the Dental Department assisted in teaching direct support professionals proper tooth brushing and positioning to reduce the risk of aspiration pneumonia. The oral hygiene index rating system was changed to be consistent with the new State dental standard. Completion of timely annual assessment and dental staff attendance at PSPs were tracked each month. An interdisciplinary dental desensitization committee met several times in the prior six months. By 6/11, recommendations for community placement, and skill acquisition training were to be incorporated into the PSP dental assessments.<br><br>In addition to providing detailed narrative information about steps taken to comply, it should be noted that the Dental Department made good use of monitoring/audit data, as well as other available data streams in its section of the POI. QA data was clearly being collected and reviewed monthly. In the Facility's self-assessment, the data was broken down into meaningful categories, which helped to show both the |

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| | strengths and weaknesses of the system, as well as assist the Facility in identifying where additional work was needed. For example, data was provided with regard to timeliness of assessments, missed appointments and the reasons, information about the use of pre-treatment sedation, and results of the oral hygiene index ratings, including a breakdown by unit. The Facility should continue to expand the foundation it has laid for its self-assessment processes for Section Q. In addition to expanding the indicators being reviewed, the Facility should discuss the analysis of the information, the identification of areas needing attention, as well as steps planned or taken to make needed improvements. |
| | **Summary of Monitor's Assessment:** Although the Facility remained out of compliance with both subsections of Section Q, the Dental Department continued to make progress with regard to both sections.<br>▪ There was continued tracking of refusals and "no shows", with increased communication and response from the residences, including development of PSPAs in response to repeated refusals.<br>▪ A tracking log was developed for emergency visits.<br>▪ A member of the Dental Department attempted to attend each PSP meeting.<br><br>The oral hygiene ratings indicated some overall regression across campus, with challenges in those individuals with noncompliant behaviors. There also was continued training needs for direct support professionals. The Dental Department created a training program for new employees and a separate education program for current employees.<br><br>Efforts to develop and implement interventions to minimize the use of sedating medications, including the development of desensitization plans remained in their infancy. |

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| Q1 | Commencing within six months of the Effective Date hereof and with full implementation within 30 months, each Facility shall provide individuals with adequate and timely routine and emergency dental care and treatment, consistent with current, generally accepted professional standards of care. For purposes of this Agreement, the dental care guidelines promulgated by the American Dental Association for persons with developmental disabilities shall satisfy these standards. | The Dental Department consisted of a Dental Director, a second dentist, three dental consultants, two dental hygienists, a dental assistant, and two dental technicians.<br><br><u>Annual Assessments</u><br>The Dental Department submitted information indicating that there were no outstanding annual exams at the Facility. All individuals had been seen within the calendar year. Additionally, there were three individuals newly admitted to CCSSLC for which dental new admission/annual assessments were completed within 30 days.<br><br>The Dental Department submitted a list of annual assessments completed in the last six months, and the date of the previous annual assessment. This allowed a mechanism for determining the timeliness of the annual assessments. The two most recent annual assessment dates were listed for 124 individuals. The individuals who were newly admitted were removed from the tabulation. Seven names were listed for which the previous date indicated an error in database management (for instance, the date of the prior visit was after the most recent annual), leaving 117 names for use in determining | Noncompliance |

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| | | timeliness. A total of 14 individuals had their most recent annual assessments completed more than 365 days from the prior annual assessment. The compliance rate was 103 out of 117 (88%).<br><br>A more recent list was submitted separately of those annual dental assessments completed for the month of May 2011, as well as the individual's prior year assessment date. A total of 35 individuals were listed, and 31 out of 35 (89%) were completed in a timely manner.<br><br>A separate list entitled "Working annual due exam Dec-May and when completed 6-11" indicated there were 125 individuals scheduled for annual exams. The two lists were similar, differing only by one individual. This suggested improvement in database accuracy and management.<br><br>Copies of annual dental summaries were submitted for 10% of the individuals CCSSLC supported. The annual dental summaries, which had been distributed to the PST for review and discussion at the time of the annual PSP, included several important details. The scheduled appointments in the last year were noted, with a breakdown as to the number of prophylactic care appointments, examinations, restorations, and missed/refused appointments. Any x-rays taken and the type of x-ray were documented. The current and prior oral hygiene ratings were listed. The periodontal condition, level of mobility, listing of teeth with tooth decay, and listing of missing teeth were documented. The medication name and dosage of sedation was listed, along with a determination of effectiveness. A brief comment was entered under behavior assessment. A description of living options needs was provided. A dental risk assessment rating was assigned. These last two areas also were listed in the dental section for the integrated risk rating form. The only exception was for Individual #339, in which the dental section rationale of the Integrated Risk Rating form did not match the living option needs section of the annual dental summary.<br><br>Data was submitted indicating whether individuals had a current set of bitewing x-rays or full mouth x-rays, or if there were no current x-rays in the dental record. The list totaled 296 individuals, but after exclusion of those no longer residing at CCSSLC, there were 273 individuals followed by the Dental Department as of 6/3/11. Of these, 104 had no current x-rays according to the Dental Department. This was a compliance rate of 169 out of 273 (62%). A number of steps might need to be taken to improve this compliance rate, such as the successful implementation of desensitization programs.<br><br><u>Oral Hygiene</u><br>Due to increased risk in those with severe dysphagia caused by tooth brushing, the Dental Department had continued to offer suction tooth brushing as a part of oral | |

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| | | hygiene treatment. A list of 44 individuals was submitted for whom suction tooth brushing was utilized. This list was printed on 6/3/11.<br><br>Oral hygiene data was submitted. Due to the dental peer review standardization of the oral hygiene rating system, the prior oral hygiene index had to be adapted to the statewide system (adapted from the Oral Hygiene Scale – San Antonio State Supported Living Center). This reversed the rating numbers, but also collapsed the "very poor" and "poor" ratings into one "poor" rating. The most recent Facility oral hygiene data was analyzed. From the one-year of data, 27% of the individuals campus-wide were considered to have good hygiene. An additional 41% had a fair oral hygiene rating, and 32% had a poor rating. This was similar to a year ago with respect to the good oral hygiene rating and fair oral hygiene ratings. From this, it appeared that the progress had plateaued. The Dental Department identified a group of more skilled or independent individuals who refused to comply. Several issues might have been a factor, including peer pressure, etc. With such complex behavioral challenges, the Dental Department is encouraged to discuss such individuals with the Psychology Department to consider amending the BSP to reflect additional steps to be taken to enhance compliance and cooperation.<br><br>The campus-wide data was broken down into three residential areas. In Atlantic, 26% of the individuals had good oral hygiene. For Coral Sea, this was 32%, and in Pacific it was 23%. In Atlantic Unit, the poor oral hygiene rate was 38%, in Coral Sea was 26%, and in Pacific, it was 33%.<br><br>The Dental Department submitted a separate listing of annual exams over the past six months, which included oral hygiene ratings. From this, a most recent oral hygiene rating across campus was calculated. There were a total of 161 names submitted. Of these 16% had a good oral hygiene rating, 41% had a fair oral hygiene rating, and 43% had a poor oral hygiene rating. As this is the most recent campus-wide data, this suggested a loss of momentum in improving oral hygiene, and this preliminary information suggested a regression rather than progress. For instance, the campus-wide good oral hygiene rating submitted above (which exceeded six months in some instances) was 27%. The more up-to-date 16% good oral hygiene rating suggested a regression, and suggested the need to further review the reason for a worsening of oral hygiene across the campus. Emails (February 2011) from dentistry, administration and psychology discussed the poor oral hygiene in an individual and the lack of tooth brushing.<br><br>The Dental Department submitted information concerning action steps to improve oral hygiene. At a meeting of the Quality Assurance/Quality Improvement Council on 4/13/11, under Section Q, there was notation that there were dental concerns related to | |

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| | | poor oral hygiene ratings at Coral Sea. A week earlier, at a Dental Section meeting of 4/7/11, several steps were outlined to improve oral hygiene care, although it was not specific to Coral Sea. Action Steps included a "Step-by-step toothbrush guideline" poster, training of residential coordinators and team leaders concerning tooth brushing, implementing post-meal tooth brushing, creating an "oral hygiene checklist," and a weekly review by dental professionals to check oral hygiene in the residences and to compare with previous oral hygiene rating information. A policy was written entitled Dental Services Q.20: Tooth brushing, which was submitted, but remained pending approval at the time of the document submission.<br><br>As part of the program to improve oral hygiene, the Dental Department created and implemented a "New Hire" educational program entitled "Oral Hygiene Instructions," followed by a New Hire Oral Care Post Test. The unit staff received a presentation entitled "Dental Team," followed by a Unit staff Oral Care post-test (two separate tests were submitted). Training of staff occurred on 2/10/11, 2/18/11, 2/25/11, 4/8/11, 4/13/11, 4/22/11, 4/29/11, 5/6/11, 5/13/11, 5/20/11, 5/27/11, 6/3/11, 6/17/11, 6/24/11, 7/1/11, and 7/8/11. Hands-on training of staff occurred on 2/10/11, 2/11/11, 2/18/11, 3/4/11, 6/24/11, and7/1/11. The projected completion date of training direct support professionals was 12/31/11. There also were three teaching modules directed at the individual: Oral Care for the Individuals at CCSSLC, Smoking Information for the Individuals at CCSSLC, and Dental Nutrition for the Individuals at CCSSLC. It was not clear from the information provided if any of the hands-on training also was targeting teaching the individual, or if hands-on training followed the video training. Given the significant time and resources the Dental Department dedicated to teaching oral hygiene, it is recommended that there be a clear document trail of teaching the staff, including the numbers of staff targeted for training, and the percentage of staff trained over time, as well as the number of individuals targeted for teaching and the percentage of those individuals trained. A goal should be established as to how many staff or individuals should be trained in a month or quarter, and the data should determine if the goal is accomplished.<br><br>The Dental Department submitted a list of individuals completing preventive dental care from 12/1/10 through 5/31/10. During this time period, there were 241 appointments completed. A total of 193 individuals were listed for these 241 appointments.<br><br>The Dental Department submitted a list of individuals completing dental restorative work from 12/1/10 through 5/31/11. During this time period, there were 45 appointments for 26 individuals.<br><br>The Dental Department generated a dental extraction report for all extractions, on or off campus. An oral surgeon performed extractions for 12 individuals, and the CCSSLC | |

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| | | dentist completed them for 14 individuals. Of these 14 individuals, 10 required TIVA and four did not require TIVA. The number of teeth extracted by the oral surgeon ranged from one tooth to eight teeth. For those individuals for whom the CCSSLC dentist performed extractions under TIVA, one tooth to seven teeth were extracted (six of the ten individuals had one tooth extracted). For those extractions completed in the dental office without TIVA, each had one tooth extracted.<br><br>Separately, information was submitted for the extractions performed by an oral surgeon at an off–campus site. Because the procedure occurred off-site, it was important for the Dental Department to receive complete information for the dental record on these cases. There were 17 individuals scheduled for oral surgery procedures. Of these, two were too combative to cooperate with the visit, and one refused. This left a total of 14 individuals (a difference of two individuals from the set of data discussed in the prior paragraph). Of these 14 individuals: all had a dental office visit note reviewing the need for oral surgery; all clearly listed the number of teeth extracted (except for one individual, Individual #300, in which it was difficult to determine if eight or nine teeth were extracted); all but one included an anesthesia note indicating the medication and dosage administered (13 out of 14); all had a copy of the current consent; 12 out of 14 (86%) included a copy of the oral surgery report; 12 out of 14 (86%) included a post-procedure dental note; and five out of14 (36%) had a follow-up dental office visit note.<br><br>The Dental Department submitted information concerning dental emergencies from 12/1/10 through 5/31/11. During this time period, 25 individuals underwent 41 emergency appointments. For the emergency exams, copies of the integrated progress notes concerning the emergency visit were submitted. The department created a dental emergency log, with entries beginning February 11, 2011. This listed the date the chief complaint was recorded, as well as the scheduled date and time in the dental office. There was a column allowing additional information to be recorded, such as diagnosis. A column was added in March 2011 to indicate resolution of the problem. Fifteen emergency dental visit IPNs were reviewed. The following recommendations are suggested to ensure clarity to the documentation:<br>▪ There should be a notation of when (date and time) the discomfort was first documented to have occurred in the residence or elsewhere, when the dental office became aware of this discomfort (date and time), date and time of the office visit (this was clearly indicated currently), a clear statement as to whether pain or discomfort is present, and if there is pain or discomfort, the pain medication prescribed or reason not to order medication for pain, and an initial diagnosis.<br>▪ Indicating these points in consistent subsections of the IPN, similar to the SOAP note used for the medical progress note, would assist in providing clarity and in documenting quality care. | |

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| | | ▪ Tracking these areas in the dental emergency log would provide information as to timeliness of response, as well as whether sufficient attention was given to pain control. | |
| 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. | This section of the report includes a number of sub-sections that address the various requirements of this provision of the Settlement Agreement. These include the development of dental policies and procedures, provision of dental records to PSTs, refusals and missed appointments, tracking of use of sedating medications and restraints, and interventions to minimize the use of sedating medications.<br><br><u>Dental Policies and Procedures</u><br>A number of policies were submitted, which were in various stages of implementation, including:<br>▪ Dental Services Q.16: Annual Dental Examination, revised 6/9/11;<br>▪ Dental Services Q.19: Integrated progress note and dental documentation, pending approval;<br>▪ Dental Services Q.20: Tooth brushing, implemented pending approval;<br>▪ Dental Services Q.21: Chlorhexidine with suction brush protocol, pending approval;<br>▪ From statewide dental peer review committee: Draft of Dental management strategies for patients treated with bisphosphonates, undated;<br>▪ Dental Services Q.22: Management of Acute Illnesses and Injury, pending approval. This document is discussed later in this section; and<br>▪ Dental Services Q.23: 24-Hour nursing log. This document is discussed later in this section.<br><br>To assist in integrating acute dental needs into the health care provided at CCSSLC, the Dental Department drafted two policies which were pending: "Dental Services Q.22: Management of Acute illnesses and Injury," and "Dental Services Q.23: 24-hour nursing log." These applied to all staff, but were designed to ensure acute dental needs were addressed and followed by nursing and all CCSSLC staff. They provided guidance to the Facility for the need for integrated clinical care to meet Dental Department needs, and also provided guidance to the Dental Department staff concerning acute care needs and expectations and responsibilities of other departments concerning dental health care needs.<br><br>Further the annual dental summary added a section to address community placement, discipline specific recommendations and skill acquisition training.<br><br>The Dental Department engaged in a quality assurance process, with completion of the | Noncompliance |

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| | | dental services QA report (using the Texas Health Monitoring Instrument), on 1/31/11, 2/28/11, 3/31/11, 4/30/11, 5/31/11, and 6/30/11. As an example, based on the 5/31/11 data, the dental hygienist reviewed eight dental records. Annual assessments were determined to be timely. Pre-treatment sedation occurred in five out of eight individuals. The outcome of dental appointments was provided, including cancellations, "no shows", and refusals. The cancellations were further categorized, as well as the "no show" appointments.<br><br>In addition, a summary of dental hygiene was provided for the entire campus, and then broken down by unit. The Dental Department also tracked attendance of staff from the Dental Department at the annual PSP meetings. For the month of May 2011, there were 18 PSP meetings, and a member of the Dental Department attended all of the meetings. Previous months attendance were as follows: January 63%, February 77% March 89%, and April 89%. This allowed for improved and timely communication, as well as increased collaboration and integrated dental care. Presentation at the monthly Performance Evaluation Team meeting allowed administration to learn of areas needing cooperation from other departments, such as providing reasons for the "no shows" and cancellation of appointments.<br><br><u>Provision of Dental Records to PSTs</u><br>The most recent comprehensive exams for 10 individuals were submitted for review. A copy of the dental record of this visit and a copy of the active record documentation for the same appointment were requested to determine if all information was available to the PST in the active record that was available in the dental office record. A few discrepancies were noted, and it could not be determined if these were copying errors in submitting documents, or reflected gaps in available information in the active record. Information was not labeled according to its origin, and it was assumed the "do not remove" copy was in the active record. Individual #71, Individual #96, and Individual #78 had a "Permanent Dentition" form in the dental office record, but not in the active record. Individual #96 had an additional entry on the Dental Progress/Treatment Record Work Completed, dated 5/26/11, which was not in the active record. Individual #277 had a "vital signs flow sheet" for only one record, and Individual #26 had a typed annual dental summary of 5/2/11 that was in one file (presumably the dental office record), but not the other (the active record). Individual #269 had a 5/5/11 "Dental Progress/Treatment Record work completed" entry in one record, and a 6/2/11 entry in the other (dental office record). The most current entry was not available to the active record. Of 10 records submitted, six had discrepancies between the active record and the office record. This was a compliance rate of four out of 10 (40%). The Dental Department should ensure all information available in the dental office record is available in the active record. If there is a need for additional information to be available | |

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| | | in the dental office that would not be appropriate for the active record (e.g., actual x-ray films, internal department documents), a dental policy should be created to clarify this issue and ensure consistency throughout the record system. Otherwise, information in the two records should be identical.<br><br><u>Missed Appointments</u><br>The Dental Department submitted a list of individuals that refused dental treatment. A list from 12/1/10 through 5/31/10 documented 35 individuals. These should be among the priority individuals that the Dental Department should review to determine whether or not there is a need for a desensitization program.<br><br>Data was submitted that identified the number of dental appointments completed, the number cancelled, the number of "no shows," and the number refused per month and quarter. For the June through August 2010 quarter, 69% of appointments were completed as scheduled, 13% were cancelled, 9% were considered "no shows", and 4% were refusals. For the September through November 2010 quarter, 84% of appointments were completed as scheduled, 8% were cancelled, 3% were considered "no shows", and 2% were refusals. For the December 2010 through February 2011 quarter, 80% of appointments were completed as scheduled, 11% were cancelled, 2% were considered "no shows", and 6% were refusals. For the most recent quarter (March through May 2011), 86% of the appointments were completed as scheduled, 6% were cancelled, 3% were considered "no shows," and 4% were refusals. The last three quarters had shown no significant change in trend. It is recommended that the Dental Department continue to monitor for trends. Additionally, reviewing the cancelled appointments for ways to reduce this percentage might improve the appointment completion rate.<br><br>The Dental Department submitted a report entitled "Individuals Identified to have missed dental appointments." This list also identified when the appointment date was rescheduled. A list of 108 missed appointments was submitted. Of these missed appointments, 28 appointments (26% of the total missed appointments) were rescheduled within 14 days. Twenty-four appointments (22% of the total) were rescheduled from day 15 to one month after the missed appointment. For 36 appointments (33% of the total missed appointments), the rescheduled date was between one and two months after the missed appointment date. For 15 appointments (14% of the total missed appointments), the date the appointment was rescheduled was between two and three months after the missed appointment date. For 5% of the missed appointments, the rescheduled date was greater than 3 months following the missed appointment date. The Dental Department should review the length of time between the missed appointment date and the rescheduled appointment date that is offered. It is | |

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| | | recommended that the system be flexible and adaptable enough to absorb missed appointments within 30 days, as a preliminary goal, with an additional 30 days to accommodate the needs of the individual and the Dental Department. However, communication of furloughs to the Dental Department from the residence should be completed prior to the dental appointment, in order for appointments to be rescheduled ahead of time rather than becoming a missed appointment.<br><br>Data was analyzed to determine the residences of the missed appointments, which were not refused appointments. The following residences had non-refusal missed appointments from December 2010 through May 2011: Dolphin - two, Pompano - four, Ribbonfish - four, Sailfish - two, Kingfish – six, Seahorse - one, Angelfish - two, and Porpoise - two. For the same time period, the following residences had missed dental appointments due to refusals: Dolphin - six, Pompano - 11, Ribbonfish - one, Sailfish - six, Kingfish - 15, Seahorse - none, Angelfish - nine, and Porpoise - five.<br><br>A list of individuals that were identified to have refused dental treatments was submitted, along with the type of appointment that was refused. Fifty-five appointments were listed. It included 24 appointments for cleaning, 10 appointments for cleaning with some other reason listed (example: cleaning/x-rays), and 11 appointments for restorations. There were 11 individuals that refused two appointments, and four individuals refused three times.<br><br>A process to track and notify the residences of missed appointments had been developed, and a documented response became part of this process. A policy was revised and approved as part of this process: Residential Services W.5: Participating in Unit Incident Management Team meeting, revision 4/27/11, approval 4/28/11, implemented 4/28/11. On a daily basis, the RN was to review the campus coordinator log, campus nurse log, and aspiration triggers data sheets to report several nursing and medical concerns, including medical and dental refusals. The QMRP also reviewed medical restraints, and medical and dental sedation. Electronically, the residences were sent an "Overnight Missed Appointments Report" discussed in the next paragraph. From these various routes of communication, all residences were informed of all cases of missed dental appointments. These were then discussed at the Unit Incident Management Review Team Meeting held each morning. Included in this document was a list of "scheduled on campus medical and dental appointments," "scheduled off campus medical and dental appointments," as well as "medical appointment refusals," and "dental appointment refusals." These reports were generated each business day for each unit. From this information, a PST meeting was to be held and a PSP addendum created (if appropriate) to address the missed dental appointment. This information was then stored electronically and available for the Dental Department to review progress. | |

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| | | This electronic sharing of missed appointment information with the residences the next day, and a response back to the Dental Department available through the intranet system assisted in providing information about the many reasons for the missed appointments. A separate list of "no show" appointments was generated on 6/3/11 for the time period 12/1/10 through 5/31/11. The number of "no show" appointments totaled 111 according to this list, which was not identical to an earlier list referenced in this section on which 108 "no show" appointments were listed for this time period, but the difference was considered minimal. Of the 111 "no show" appointments, the reasons noted were as follows: weather – nine, individual was sick - 18, isolation (infection control) – eight, furlough - seven, nursing issue – six, staffing issue in the residence – 16, refusal – nine, behavior – three, transportation – two, the specialist report was outstanding – six, the PCP consult was outstanding – three, dental clinic issues – six, schedule conflict – six, and unknown – four. This had allowed the Dental Department to begin to address the number of "no shows" in areas that were under the control of the Facility, such as nursing issues, staffing issues, transportation, outstanding reports, dental clinic issues, and schedule conflicts.<br><br>For missed appointments, a PSP addendum was created with a specific plan. Samples of the document "Dental Appointments – Overnight Missed Appointments Report" were submitted. The PST of the individual, for whom the appointment was missed, was responsive to the information received. However, in some instances, it was not clear whether the change would resolve the " no show." For instance:<br>▪ In the PSP Addendum of 5/2/11 for Individual #298, it was noted she missed an appointment because she was sleeping and refused to go. The appointment was rescheduled for 6/16/11 at 8:30 a.m. However, it was not documented if she usually sleeps late or this was an unusual occurrence. If she sleeps late, the next appointment was apt to be refused as well. There was no discussion about providing an appointment later in the day.<br>▪ For Individual #238, there was a missed appointment due to being on furlough. The appointment was rescheduled for 4/26/11 (the missed appointment was from 4/25/11). However, there was no discussion confirming he had returned, and there was no information concerning a systems resolution of the problem of the residence's failure to communicate with the Dental Department when there was a planned furlough. Without a system in which the Dental Department is provided advance notice of furloughs so that appointment dates could be changed, the missed appointment rate will continue to reflect known planned furloughs.<br><br>The Dental Department was able to provide quarterly and monthly trend graphs and | |

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| | | tables for the prior six months concerning dental attendance. This information was user-friendly, and made it easy to determine which residences were most problematic concerning refusals, as well as determine the main cause of "no show" appointments. The Atlantic Unit had the highest number of cancelled, "no show", and refused appointments. Relative to the total number of appointments in each unit, the Pacific Unit had the highest percentage of cancellations. The attendance data was then broken down into specific residences, allowing the Dental Department and the units to focus attention on certain residences needing further review and action.<br><br>A few recommendations would assist in clarifying the data presentations provided. For each quarter, there was a color graph demonstrating the reasons appointments were missed. However, the key only included the first eight reasons to the left of each shift shown. There were other color bars, some with significant heights, which had no key, and this information could not be interpreted. A table entitled: "Type of Services Provided" needed further clarification. At the top right hand corner, the data was stated to have been from 3/1/11 through 5/31/11, but the data was June, July, and August (fiscal year 2010). The FY 2011 data appeared complete. One of the categories in the left hand column was labeled simply "dental," and needed further definition. The data entered on two "treatment refused" lines did not add up to the data matched to the date in the "Dental Attendance" tables for the same time period for any of the months. The reason was not indicated. It might have been refusal of specific treatments, but this was not clear. If this was for specific treatments, given the long and otherwise complete list, the reason for not including a treatment refusal for the annuals/cleaning section was not indicated. Overall, this suggested the need for review of the data format to ensure easy interpretation of information, as well as to determine accuracy before finalizing for distribution to remove any errors of labeling of dates or data entry inconsistencies.<br><br><u>Sedation</u><br>The Dental Department submitted information concerning the use of oral sedation for dental exams and treatments. The percentage of actual appointments kept that required oral sedation were as follows: December 2010 - 7.57%, January 2011 - 7.59%, February 2011 - 7.33%, March 2011 - 6.63%, April 2011 - 4.79%, and May - 8.29%. For the six month time period, this averaged 7.03% of appointments that were completed required oral sedation.<br><br>The Dental Department submitted information concerning the use of general anesthesia/IV sedation. The percentage of total appointments that were kept during the six month period were as follows: December 2010 - 4.55%, January 2011 - 7.59%, February 2011 - 6.00%, March 2011 - 2.76%, April 2011 - 5.99%, and May 2011 - 4.97%. For this six-month period, this averaged 5.31% of appointments that were completed | |

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| | | required general anesthesia/IV sedation. General anesthesia/TIVA was performed on the following dates: 12/8/10 (four cases), 1/26/11 (four cases), 1/27/11 (two cases), 2/22/11 (four cases), 2/23/11 (three cases), 3/23/11 (four cases), 4/20/11 (four cases), 4/21/11 (four cases), 5/16/11 (four cases), and 5/17/11 (three cases).<br><br>There were no mechanical restraints utilized for dental appointments from 12/1/10 through 5/31/11.<br><br>To ensure justification and adequate documentation for use of sedation during dental visits and procedures, 19 records were reviewed for pre-treatment sedation assessments. Focus was on notation in the integrated progress notes and/or the dental progress/treatment record of adequate assessment. Of the 19 records that were submitted, all 19 documented behaviors that made it unsafe to complete the dental treatments or procedures necessary. Of the 19, 15 (79%) specifically stated the individual was a "sedation challenge." The reason for all 19 not being identified as specifically needing sedation could not be determined. Of the 19, 10 were recommended for dental desensitization. The reason for all 19 not being recommended for dental desensitization could not be determined.<br><br>The Dental Department submitted dental records for 10 individuals that were given pre-treatment sedation. These dental records were reviewed and the following information was documented (based on the information submitted): 10 (100%) had completed consent forms, 10 (100%) had a dental note describing the procedural visit (100%), 10 (100%) listed the specific medications and dosages, 10 (100%) documented the level of effectiveness of the sedation, nine (90%) completed a restraint checklist form, three (30%) completed a sedation care plan (pre and post procedure), and nine (90%) documented tooth brushing instructions for the individual or staff member. It is recommended that a standardized packet of forms (including the sedation care plan and restraint checklist) be completed for all individuals at the time of the office visit for which sedation was administered.<br><br>The Dental Department submitted dental records for six individuals that underwent TIVA. All had TIVA clearance by the PCP, all had TIVA clearance by the dental anesthesiologist, all had consent, all had a dental note describing the procedure, all had an annual dental exam completed (based on the exam under TIVA), all had completion of a dental record initial examination report, all had completion of a periodontal chart, all had completion of an anesthesia record, al had completion of a vital signs flow sheet, and all had completion of a restraint checklist. For five out of six dental records (83%), a postoperative note was submitted. A dental note discussing need for TIVA at a prior visit or "no show" log information was submitted for four out of six individuals (67%). It is | |

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| | | recommended that a post operative dental note be completed on each individual receiving TIVA to ensure there are no adverse sequelae, and that this is documented in the record.<br><br><u>Interventions to Minimize the Use of Sedating Medications</u><br>One of the initial steps in a desensitization program is to identify individuals with potential need, including those that are unable to cooperate and participate in dental care, whether in the residence or in the dental clinic. As part of this initial identification process, the Dental Department each month referred individuals that would benefit from increased cooperation with dental procedures. For September 2010, four individuals were identified. In October 2010, three individuals were identified. In November 2010, eight individuals were identified. For December 2010, 22 individuals were identified. For 2011, the total referrals per month were the following: January had 10 referrals, February had 16 referrals, March had 18 referrals, April had 17 referrals, and May had 16 referrals. Since September 2010, there had been a total of 114 referrals for desensitization programs.<br><br>The referrals were made to both the Psychology and Psychiatry Departments. The Dental Department submitted copies of related email correspondence. These were dated 12/23/10, 2/21/11, and 4/11/11. Although it was not possible to match the numerous attachments to individuals in all cases, it did appear there was great variance between when an individual was nominated for desensitization, and when the referral was made. For instance, it appeared that an email referring Individual #329 was made in 2/21/11, but she had been identified on 12/27/10. An email referring Individual #37 was sent on 4/11/11, but the decision from the Dental Department had been on 3/2/11. This was consistent with the document "working list of referrals to psychology, QMRP, etc.," in which the email referral date was listed as well as the nomination date for each individual. It appeared that for some nominated individuals, there was a lapse of approximately two months before the referral was made. For individuals referred from 4/11/11 through 5/31/11, the working list indicated email correspondence had not been completed as of the date it was printed, which was 6/7/11. The Dental Department should review the timeliness of communication from the time a decision is made that an individual might benefit from dental desensitization, to notification of the Psychology and Psychiatry departments to ensure communication is efficient and accomplished in a timely manner.<br><br>As part of an interdisciplinary support system, CCSSLC Psychological and Behavioral Services held a work group meeting on 2/9/11 to discuss desensitization plans. Additionally, a listing of the current dental refusal process and ideal process were submitted, although this document was undated. This document outlined a system for | |

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| | | improving the refusal rate by providing more guidance as each refusal occurred, with PSPA development at the time of the third refusal. The document clearly stated the role of the Psychology Department in developing and implementing the individualized desensitization plans. Due to confusion on the part of direct support professionals, a follow-up meeting occurred on 2/23/11, with the focus of discussion on the difference between the definition of restraint, and the use of physical guidance or redirection when assisting an individual with tooth brushing. On 4/14/11, the workgroup was restructured, with focus on documentation format, and discussion of monthly monitoring/progress notes concerning desensitization.<br><br>The Dental Department submitted a table indicating there were no new desensitization plans created in the six months prior to the Monitoring Team's visit. This suggested that the names the Dental Department submitted during this time had had no development or review for changes since the lists were submitted by email. The Dental Department should meet with the Psychology Department to discuss ways to reduce delays in desensitization plan development for these individuals. | |

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

1. For individuals with behavioral challenges and poor oral hygiene, the Dental Department should collaborate with the Psychology Department to implement additional steps to improve compliance with tooth brushing. (Section Q.1)
2. The Dental Department should review the potential reasons for plateauing or worsening of oral hygiene ratings across the campus (i.e., lack of progress). (Section Q.1)
3. The Dental Department should maintain and analyze data on the number of staff trained, and the percentage of staff (those for whom training is required) that complete training, and report these numbers on a monthly basis. The same should be done for the individuals served. (Section Q.1)
4. For emergency visits, additional documentation should be maintained, including the date and time the discomfort was first documented to have occurred in the residence or elsewhere, and when the dental office became aware of this discomfort (date and time.) Documentation should indicate if there is pain or discomfort, and, if so, the pain medication prescribed or the reason for not providing pain medication. An initial diagnosis should be stated clearly. Providing this information in the IPN in a SOAP format would provide clarity to the documentation. (Section Q.1)
5. The emergency log should include a column in which to indicate adequacy of pain control (if there was pain, and if medication was prescribed for pain). (Section Q.1)
6. The Dental Department should ensure all information available in the dental office is available in the active record. For information in the dental office that would not be appropriate for the active record, a dental policy should be created to provide clarity and consistency for the entire record system. (Section Q.2)
7. The Dental Department should review the cancelled appointments for ways to reduce this percentage of the total appointments scheduled, and actions should be taken, as appropriate. (Section Q.2)
8. The Dental Department should review the length of time between the missed appointment date and the rescheduled appointment date that is offered. The system should be flexible and adaptable enough to absorb missed appointments within 30 days, as a preliminary goal, with an

additional 30 days to accommodate the needs of the individual and the Dental Department. (Section Q.2)

9. The Dental Department should review the data presentation formats to ensure easy interpretation of information. Complete keys for the graphs should be included. (Section Q.2)
10. A standardized packet of forms (including the sedation care plan and restraint checklist) should be completed on all individuals at the time of the office visit for which sedation was administered. (Section Q.2)
11. A postoperative dental note should be completed on each individual receiving TIVA to ensure there are no adverse sequelae. (Section Q.2)
12. The Dental Department should review the timeliness of communication from the decision that an individual might benefit from dental desensitization to notification of the Psychology and Psychiatry departments. (Section Q.2)
13. The Dental Department should meet with the Psychology Department to discuss ways to reduce delays in desensitization plan development for these individuals. (Section Q.2)
14. The Facility should continue to expand the foundation it has laid for its self-assessment processes for Section Q. In addition to expanding the indicators being reviewed, the Facility should discuss the analysis of the information, the identification of areas needing attention, as well as steps planned or taken to make needed improvements. (Facility Self-Assessment)

| **SECTION R: Communication** | |
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| 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:<br>▪ **Review of Following Documents**:<br>o Presentation Book for Section R;<br>o Presentation for July 2011 Settlement Agreement Monitoring Team Visit for Section R, undated;<br>o The following documents: SLP Evaluation, SLP Communication Program, Supporting documentation for implementation of communication program, PSP and PSPAs for past year, Behavior Support Plan, SLP consultations for the last year, competency-based training, person-specific monitoring, Communication Dictionary, person-specific monitoring for communication systems, and Daily Schedule, for the following 12 individuals: Individual #297, Individual #251, Individual #136, Individual #20, Individual #285, Individual #38, Individual #83, Individual #21, Individual #24, Individual #363, Individual #290, and Individual #321;<br>o Speech Evaluation for Individual #71, Individual #78, Individual #96, Individual #169, and Individual #341;<br>o Continuing education completed by SLP since last site visit, 12/10 through 6/11;<br>o List of SLP and Audiology Staff, undated;<br>o List of Individuals with Augmentative/Alternative Communication (AAC) devices, dated 6/10/11;<br>o Communication Master List, undated;<br>o Alternative and Augmentative Communication (AAC) Screening forms (blank), undated;<br>o AAC Evaluation and SL Assessment forms (templates), undated;<br>o Five most current AAC and SLP Assessments, along with corresponding PSPs, dated from 12/10 through 6/11;<br>o Tracking Log of completed assessments, from 12/10 through 6/11;<br>o Monitoring Tools for AAC and SLP programs (template), revised 5/1/11;<br>o Completed Monitoring forms for multiple individuals during past month, June 2011;<br>o Settlement Agreement Compliance Reports, from 6/1/10 through 5/31/11;<br>o AAC-related spreadsheets, dated 6/1/11;<br>o List of individuals receiving direct speech services and focus of intervention, undated;<br>o List of individuals with behavioral issues and coexisting severe language deficits, dated 6/10/11;<br>o List of individuals with PBSPs and replacement behaviors related to communication, dated 6/10/11; and<br>o Person-specific PNMP check sheet (blank), revised 5/11/11.<br>▪ **Interviews with**:<br>o Dr. Angela Roberts, Habilitation Therapy Director;<br>o Linda Merryman-Scifres, SLP;<br>o Noela Morales, SLP;<br>o Maurie Hazlewood, SLP; and |

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| | ○ Dora Barbosa, SLPA (Speech Language Pathology Assistant).<br>▪ **Observations of**:<br>○ Residences and dining rooms Coral Sea, Atlantic and Pacific. |
| | **Facility Self-Assessment:** The CCSSLC Plan of Improvement, updated 6/29/11, provided comments/status for Section R. Compliance ratings for each of these sections were documented as noncompliance. This was consistent with the Monitoring Team's findings. This document also provided a summary of some of the action plans on which the Facility was working to achieve compliance.<br><br>The Plan of Improvement provided some narrative descriptions of actions the Facility had or was taking to move towards compliance within each of the four sections, but did not present a comprehensive assessment of compliance with each of the indicators. The POI did not include data from its self-assessment reviews, and/or the status of inter-rater reliability. As the Facility moves forward in its self-assessment process, it will be important to ensure that data is used in meaningful ways to assist in identifying areas in which improvements are needed. |
| | **Summary of Monitor's Assessment:** Per report, there were two budgeted SLP positions, but Facility Administration had approved two additional SLP positions.<br><br>Staffing was potentially one factor that resulted in the inadequate provision of speech and communication supports to individuals at CCSSLC. In sum, therapists were not active members of the PSTs, as evidenced by the SLPs' absence from annual PSP meetings, insufficient time to provide direct therapy, the lack of development and integration of therapy recommendations into formal skill acquisition programs, the lack of development of instructional programs for PNMP Coordinators and/or staff, and the insufficient development of informal strategies to reinforce assessment recommendations and measurable outcomes.<br><br>The SLPs attended a variety of continuing education courses and conferences, which included Beckman Oral Motor Assessment and Intervention; Managing Dysphagia: Essential Assessment, Diagnosis and Treatment Strategies; and the Texas Assistive Technology Network Statewide Conference 2011. Therapists should participate in the state-sponsored seminars, when presented, to increase their knowledge in providing supports to individuals with significant physical and nutritional support needs.<br><br>A review of the CCSSLC Master Speech Plan revealed that SLP evaluations had been completed for 22 of 58 individuals (38%) identified as Priority Level 1; three of 92 individuals (3%) with Priority Level 2, eight of 122 individuals (7%) identified as Priority 3, and none of 10 individuals (0%) in Priority 4. The CCSSLC Speech Department should conduct a critical review of the current status of the SLP assessment completion rates for individuals within the priority levels to assess the projected completion dates in reference to the Settlement Agreement timelines for Section R. In addition, the completed SLP assessments did not meet the requirements for the Settlement Agreement with specific emphasis on augmentative/alternative communication.<br><br>The Monitoring Team commends the HT Department for implementing monitoring of communication |

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| | devices consistently, but as stated in the previous report, there was no Facility policy developed for communication devices and AAC devices.<br><br>The Facility Speech Language monitoring policy required a number of additions. It should incorporate the following:<br>▪ Definition of monitoring process to ensure communication equipment is available, functioning, and effective for the individual;<br>▪ Reference to instructions provided on the form;<br>▪ Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability;<br>▪ Formal schedule for monitoring to occur;<br>▪ Auditing process of completed monitoring forms to identify forms completed accurately, and analysis of individual-specific concerns and systemic issues;<br>▪ Feedback loop identified in which deficiencies are noted and shared with appropriate supervisory staff to ameliorate deficiencies; and<br>▪ Establishment of thresholds for staff re-training. |

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| R1 | Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs. | In this section of the report, each indicator of compliance is underlined, and the narrative that follows summarizes the Monitoring Team's findings.<br><br>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.<br>Per report, there were two budgeted SLP positions, but Facility Administration had approved two additional SLP positions. The following chart illustrates the caseloads and responsibilities of the SLPs:<br><br>**Current SLPs** / **Current Caseloads and Responsibilities**<br>SLP #1 — Core PNMT member, Supervised a SLP working to achieve master level certification, and supported 83 individuals in Coral Sea<br>SLP #2 — Lead SLP and supported 81 individuals in Pacific<br>SLP #3 — Contractor and supported 112 individuals in Atlantic<br>SLP #4 — Working on SLP certification and supported 42 individuals in Coral Sea under the supervision of a SLP.<br><br>The total number of individuals that the Facility indicated SLPs were supporting totaled | Noncompliance |

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| | | 318, which exceeded CCSSLC's census of 272.<br><br>Staffing was potentially one factor that resulted in the inadequate provision of speech and communication supports to individuals at CCSSLC. In sum, therapists were not active members of the PSTs, as evidenced by the SLPs' absence from annual PSP meetings [only five of the 15 annual PSPs for individuals in the record review had SLP attendance (33%)], insufficient time to provide direct therapy [only two individuals at CCSSLC were receiving direct speech services (less than 1%)], lack of development and integration of therapy recommendations into formal skill acquisition programs, lack of development of instructional programs for PNMP Coordinators and/or staff, and the insufficient development of informal strategies to reinforce assessment recommendations and measurable outcomes.<br><br>The SLPs attended a variety of continuing education courses and conferences, which included Beckman Oral Motor Assessment and Intervention; Managing Dysphagia: Essential Assessment, Diagnosis and Treatment Strategies; and Texas Assistive Technology Network Statewide Conference 2011. Therapists should participate in the state-sponsored seminars, when presented, to increase their knowledge in providing supports to individuals with significant physical and nutritional support needs.<br><br><u>Communicative Aides and Speech Generating Devices (SGDs) (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><br>Twelve (12) individual records were reviewed, including: Individual #297, Individual #251, Individual #136, Individual #20, Individual #285, Individual #38, Individual #83, Individual #21, Individual #24, Individual #363, Individual #290, and Individual #321. Two individuals in the sample (Individual #297 and Individual #251) were reported to be receiving direct speech services. The remaining 10 individuals in the sample were reported not to be receiving direct speech supports, but were in need of direct and/or indirect functional communication supports. For example:<br>▪ Many of the individuals at CCSSLC did not have a functional means of communication. For example:<br>o The Monitoring Team observed Individual #136 in the dining room and in his residence. Staff did not engage Individual #136 with his communication board on his lap tray, nor did Individual #136 use his communication board to communicate with staff. His Speech Language Evaluation, dated 5/19/11, 5/23/11, and 5/24/11, stated: "although [Individual #136] was capable of using his communication board effectively, he preferred to use other means of communicating with people, including verbalizations, gestures, body language etc., and only | |

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| | | referred to his board as a last resort." His SLP evaluation did not complete a comprehensive augmentative/alternative communication evaluation to assess his strengths, potentials, and abilities with a variety of communication systems.<br>The Speech Language Evaluation process must be sufficiently discrete to identify an individual's functional skills, interests and preferences through observations and clinical assessment with an analysis of assessment data in a manner that identifies an individual's strengths and potentials for skill acquisition, and, most importantly, in the area of augmentative/alternative communication.<br>▪ CCSSLC Restraints Quarterly Trending Report, from 3/1/11 to 5/31/11, documented that Individual #20 was restrained eight times. Individual #20 was ranked as Priority 2 (Individuals with a Behavior Support Plan and/or Autism who do not speak) on the Master Speech Plan. He received a SLP screening in October 2009. The HT Speech and Language Statement documented: "Although this PSP was scheduled, due to formatting of the Master Speech Plan, communication skills will be addressed within 3 years." The Master Speech Plan identified individuals as Priority Level 1 as "individuals with a Significant Life Changing Event which affects their communication abilities." The Monitoring Team would assume that an individual who had been restrained eight times within a quarter would quality as a life-changing event and should be considered a Priority Level 1. The HT Speech Pathologists should collaborate with the psychologists to identify those individuals who were users of restraints, and provide functional communication supports to these individuals, if appropriate.<br>▪ The following individuals were identified as Priority Level 1 on the Master Speech Plan: Individual #285, Individual #38, Individual #83, Individual #21, Individual #24, Individual #363, Individual #290, and Individual #321. Priority Level 1 was defined as individuals with a Behavior Support Plan and/or Autism, who do not speak and individuals with a significant life-changing event that affected their communication abilities. These individuals' SLP evaluations did not provide a comprehensive assessment of their potentials for the use of low to high tech augmentative/alternative communication systems.<br><br>Per report, two of the 272 individuals residing at CCSSLC (less than 1%) were receiving direct SLP services. Documentation was requested to support the provision of direct speech services to these individuals (Individual #297 and Individual #251). The Monitoring Team discussed these individuals in the Monitoring Report for CCSSLC, dated February 25, 2011. The concerns reported in the previous report continued to prevail. The Monitoring Team will not repeat the details of the previous findings here, but encourage Facility staff to reference the previous report. However, as recommended in that report:<br>▪ Individuals receiving direct speech therapy should have a comprehensive SLP | |

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| | | assessment, which is sufficiently discrete to identify an individual's functional skills, interests and preferences through observation and clinical assessment within natural environments.<br>▪ The assessment should include an analysis of assessment data in a manner that identifies an individual's strengths and potentials and to provide a rationale for recommendations.<br>▪ As appropriate, these recommendations and strategies should be integrated into the individual's PSP to promote multiple learning opportunities and success with a functional communication system through skill acquisition programs.<br>▪ There should be multiple opportunities within the daily schedule (home, work and leisure) to practice identified communication skills leading to success.<br>▪ The speech therapist should report on a monthly basis through established documentation methods defined in the communication program. The COTA, PTA, and/or PNMP Coordinator might contribute to the monthly documentation with therapy oversight. Justification should be provided for the continuation, revision and/or discontinuation of the communication program.<br>▪ In addition, the PSP should support a non-negotiable directive that these communication systems should be present and available for these individuals in all natural environments (i.e., home, work and leisure). | |
| 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><br>None of the 12 records reviewed (Individual #297, Individual #251, Individual #136, Individual #20, Individual #285, Individual #38, Individual #83, Individual #21, Individual #24, Individual #363, Individual #290, and Individual #321) (0%), for individuals identified with severe expressive/receptive language deficits and in need of AAC systems, were provided ongoing direct support by an SLP to facilitate functional communication. Examples of concerns are provided with regard to Section R.1 of the Settlement Agreement.<br><br>The CCSSLC HT: Speech Therapy Master Speech Plan for Comprehensive Assessments documented the "CCSSLC Speech Department was assessing individuals according to the monthly PSP/PFA/Quarterly Calendar. Individuals who are considered Priority Level 1 are currently being assessed prior to their annual Person Support Plan meetings." Individuals in other Priority Levels who had a scheduled PSP meeting were to receive: " a Master Plan Statement which indicated that they will be assessed within the next 2 ½ years." The CCSSLC Master Speech Plan identified the following levels:<br>▪ Priority Level 1 = Individuals with a BSP (Behavior Support Plan) and/or Autism who did not speak and individuals with a significant life-changing event, which affected their communication abilities;<br>▪ Priority Level 2 = Individuals with a BSP and/or Autism who did speak;<br>▪ Priority Level 3 = Individuals without a BSP and/or Autism who did not speak; | Noncompliance |

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| | | and<br>▪ Priority Level 4 = Individuals without a BSP and/or Autism who did speak.<br><br>There were no timelines for the completion of assessments associated with the priority levels.<br><br>Ten individuals in the sample (Individual #297, Individual #136, Individual #285, Individual #38, Individual #83, Individual #21, Individual #24, Individual #363, Individual #290, and Individual #321) were ranked as Priority Level 1. The remaining two individuals (Individual#251 and Individual#20) were identified as Priority Level 2.<br><br>The following HT Speech and Language Statement was submitted for individuals prior to a PSP: "Although this PSP was scheduled, a Master Speech Plan for Assessment has been implemented which prioritized and identifies residents based on AAC needs, behaviors, injuries, and diagnosis. Due to formatting of the Master Speech Plan, communication skills will be assessed within 3 years. Please notify the Speech Department if a life changing event or a regression in communication skills and abilities occurs so that [insert name of individual] can be assessed sooner. The Speech Therapist has reviewed the previous assess/update/screening which continues to be appropriate as no changes in communication skills and abilities have occurred. Please refer to last year's Speech report (attached). If needed, a Communication Dictionary Form will be submitted at the PSP."<br><br>The CCSSLC Communication Assessment Master Plan identified 58 individuals as Priority Level 1, 92 individuals as Priority Level 2, 122 individuals as Priority Level 3, and 10 individuals as Priority Level 4, for a total of 282 individuals. At the time of the review, the current census of CCSSLC was 272 individuals. A review of the CCSSLC Master Speech Plan revealed that SLP evaluations had been completed for 22 of 58 individuals (38%) identified as Priority Level 1; three of 92 individuals (3%) with a Priority Level 2, eight of 122 individuals (7%) identified as Priority 3, and none of 10 individuals (0%) in Priority 4. The CCSSLC Speech Department should conduct a critical review of the current status of the SLP assessment completion rates for individuals within the priority levels to assess the projected completion dates in reference to the Settlement Agreement timelines for Section R. In addition, as noted above, completed SLP assessments did not meet the requirements for the Settlement Agreement, which places specific emphasis on augmentative/alternative communication. These assessments will need to be redone to meet the Settlement Agreement requirements.<br><br>The major revision to the Speech/Language Evaluation template was within the recommendation section. Therapists were to include recommendations regarding whether community placement was appropriate, and identifying supports and | |

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| | | justifications; discipline-specific recommendations; and any skill acquisition training recommended.<br><br>With regard to the assessment process, the following domains and/or guidance should be incorporated into the SL Evaluation and SL Evaluation Update template:<br>▪ Guiding questions within sections of the SLP evaluation to prompt therapists to include pertinent information;<br>▪ Assessment process should support the PSP process within the areas of living, working, and leisure;<br>▪ Description of significant health care issues and risk indicators, including discussion of the impact of health care issues and risk indicators on performance, and current and/or future therapeutic intervention;<br>▪ Assessment process should be sufficiently discrete to identify an individual's functional skills, interests and preferences via observation and clinical assessment and completed within natural environments;<br>▪ Assessment data should be analyzed to identify an individual's strengths, abilities, and potentials for skill acquisition;<br>▪ Discussion of efficacy of direct and indirect functional communication strategies;<br>▪ Analysis of findings to provide a rationale for functional recommendations and intervention strategies; and<br>Additional guidelines to ensure:<br>▪ Integration of recommendations into an individual's PSP;<br>▪ Documentation to justify initiation, continuation, or discontinuation of direct and/or indirect therapy supports; and<br>▪ Process for implementing change in an individual's supports when progress is made or there is a lack of progress. The lack of progress should identify a re-evaluation timeframe.<br><br>To ensure SLPs use a consistent approach during the evaluation process, additional guidelines should be developed to supplement the format. Also, to ensure SL Evaluations follow established guidelines, the Facility should develop and implement an audit protocol. In addition, the development of procedures defining the SL update process when an individual experienced a change in status would be beneficial.<br><br><u>All people have received a communication screening or assessment within 30 days of admission, readmission or change in status.</u><br>Since the previous review, five individuals (Individual #71, Individual #78, Individual #96, Individual #169, and Individual #341) were admitted to CCSSLC. These individuals received a Speech Language (SL) evaluation within 30 days of admission.<br><br><u>Programs, goals and objectives related to the acquisition or improvement of speech or</u> | |

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| | | language are written by the SLP.<br>In none of two records reviewed (Individual #297 and Individual #251) (0%), for individuals reported to be receiving direct speech therapy services, were measurable, functional outcomes developed, and documented on a monthly basis, and/or supported through the PSP process.<br><br>As noted above with regard to Section R.1, SLPs were completing evaluations that did not recommend direct supports for individuals who presented with severe communication deficits, but had documented potentials and abilities for functional communication. The goal for an individual with an augmentative/alternative device should be to provide the supports necessary for multiple, intense opportunities for learning (formal and informal) to successfully utilize the device in a variety of natural environments. The integration of functional communication recommendations on a formal (skill acquisition programs) and/or informal basis (integrated into daily activities) within an individual's PSP and multiple environments is necessary to ensure a device becomes an integral part of how an individual communicates on a daily basis.<br><br>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.<br>A number of pieces of documentation were reviewed to determine if adequate collaboration had occurred between the Speech and Psychology Departments for individuals who had BSPs and would benefit from AAC. However, none of these illustrated adequate collaboration. More specifically, BSC Weekly Minutes documentation was submitted for the BSC Meeting conducted on 4/26/11, which documented the attendance of one SLP. There were no additional meeting minutes submitted to document collaboration with the SLPs and Psychologists.<br><br>A list entitled Individuals with PBSPs and Prioritized Speech Levels included eight of the individuals within the record sample:<br>▪ Individual #38, Individual #285, Individual #297, Individual #83, Individual #363, Individual #321, Individual #136, and Individual #290 were identified as Priority Level 1, defined as life-changing event, high risk for injuries, and had a BSP and/or Autism who did not speak;<br>▪ In addition, Individual #251 and Individual #20 were identified as Priority Level 2 defined as individuals with a BSP who spoke.<br><br>For none of the ten individuals within the record sample (0%) (Individual #297, Individual #251, Individual #136, Individual #20, Individual #285, Individual #38, Individual #83, Individual #363, Individual #290, and Individual #321) with BSPs was there documented collaboration between the psychologist and SLP in the development of | |

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| | | the PBSPs, or completion of a comprehensive SL Evaluation to provide relevant assessment information for the development of a BSP. For example:<br>▪ The Master Speech Plan identified the following individuals within the record sample who did not have a comprehensive SLP evaluation: Individual #251. Individual #20, Individual #285 and Individual #38 which resulted in the SLP not providing relevant, current assessment information to assist the psychologist in the development of a PBSP; and<br>▪ The Master Speech Plan identified the following individuals within the record sample as having a completed SLP evaluation: Individual # 297 (12/2/10), Individual #136 (5/30/11), Individual #83 (5/9/11), Individual #363 (4/27/11), Individual #290 (5/16/11), and Individual #321 (4/26/11). However, these evaluations did not support a comprehensive assessment of the feasibility of the use of augmentative/alternative communication systems to provide relevant, accurate assessment data of an individual's strengths, abilities and potentials for functional communication.<br><br>The HT Department is commended for working with Psychology and Dental staff to support the Dental Desensitization Program. The CCSSLC HT: Speech Department Support of Desensitization Program with Psychology and Dental documented: "The Speech Assistant and Speech PNMP Coordinator created a video showing the sequence of events from entering and leaving the building where Dental Office is located, to seeing the staff, seeing the examination room and the equipment used. This will assist others who are not able to relate to the picture system schedule due to their receptive language abilities. This is a 'draft' video and will be refined and edited." The photograph and pictures were presented to the Behavior Review Committee for the Desensitization Program on 4/19/11.<br><br><u>Policy exists that outlines assessment schedule and staff responsibilities.</u><br>The Facility did not have a policy that outlined an assessment schedule and staff responsibilities. | |
| R3 | Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication | <u>Communication information is not only present in the PSP, but integrated into the daily schedule.</u><br>Communication interventions were not integrated into individuals' daily schedules.<br><br><u>AAC devices are portable and functional in a variety of settings.</u><br>For individuals with intellectual disabilities, the use of AAC devices has the ability to change the way an individual is able to communicate their needs in the classroom, home, work, and leisure environments, through increasing participation, allowing the individual to make choices, and enhancing functional communication skills. Most importantly, when an individual has learned how to use an AAC device to communicate | Noncompliance |

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| | interventions that are functional and adaptable to a variety of settings. | successfully, the perceptions and stereotypes of a familiar and/or unfamiliar communication partner changes from not believing the individual would be able to communicate to exploring multiple strategies to communicate with an individual.<br><br>Ten of the 12 records reviewed (Individual #297, Individual #251, Individual #136, Individual #285, Individual #38, Individual #83, Individual #21, Individual #24, Individual #363, and Individual #290) revealed the presence of high-tech electronic devices (i.e., Dynavox), low-tech (i.e. picture communication board, objects), and Communication Dictionaries, but the following concerns were noted:<br>▪ The use of these devices was not consistently integrated into PSPs and/or daily schedules; and<br>▪ No competency-based training was initiated to document staff competency with the use of these devices.<br><br><u>AAC devices are individualized and meaningful to the individual.</u><br>For the two individuals receiving direct speech services (Individual #297 and Individual #251), the record did not indicate how the direct speech language services would be individualized, and did not encourage the use of speech generating devices beyond the direct speech services sessions to ensure these devices were meaningful and functional for the individual. No formal communication programs had been developed with individualized strategies for staff to implement to reinforce what was being learned in direct speech therapy related to the individual's AAC device. The absence of formal integration of the AAC communication devices in their daily schedules did not support the AAC devices being functional and meaningful to the individual, and/or provide multiple opportunities to practice the use of their AAC device.<br><br><u>Staff are trained in the use of the AAC device.</u><br>Staff had not received competency-based training and/or performance check offs for AAC devices. | |
| 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 | <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><br>The Presentation Book for Section R presented an Action Plan which documented the following steps:<br>1. "Complete an analysis of all current documents and monitoring forms related to communication devices to ensure consistency across all documents;<br>2. Develop policy/protocol to define the communication monitoring system with performance indicators that are clearly defined. Document a consistent approach to monitoring communication devices;<br>3. Meet the Superintendent [Facility Director] and QMRP Coordinator to ensure | Noncompliance |

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| | 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. | that the PNMP, SLP evaluation and PSP support consistency across all documents;<br>4. QMRP Coordinator to train QMRPs on revised PSP process which will include references to PNMNP, SLP evaluation, etc.;<br>5. Monitoring system is in place that tracks the presence of the AAC; working condition of the AAC; the implementation of the device and effectiveness of the device. Will be tracked in the PNMP Clinic by therapists. Monitoring covers the use of the AAC during all aspects of the person's daily life in and out of the home. Validation checks are built into the monitoring process and conducted by the plan's author; and<br>6. Ensure the HT Database is populated with monthly data."<br><br>The Action Plan in the POI indicated that action steps 1, 3, and 5 were completed.<br>The Monthly Person-Specific PNMP Check Sheet, revised 5/1/11, incorporated monitoring of communication devices, communication dictionaries, and hearing devices. The PNMP Coordinators were to complete person-specific PNMP check sheets for every individual on a monthly basis within their respective residences. This form had written instructions present.<br><br>The Monthly Home Equipment Check Sheet, revised 4/12/11, incorporated the monitoring of home/shared communication devices. The PNMP Coordinators were to use this form on a monthly basis in their respective residences. Instructions had been developed for this form and were present on the form.<br><br>The HT Database was able to provide a Communication Equipment Monitoring Report for a specific individual, which would identify the device monitored, status, condition to be addressed, responsible staff, home and residential unit, date monitored, and name of monitor(s).<br><br>Twelve of the 12 individual records reviewed (Individual #297, Individual #251, Individual #136, Individual #20, Individual #285, Individual #38, Individual #83, Individual #21, Individual #24, Individual #363, Individual #290, and Individual #321) (100%) documented monitoring of communication devices. However, as noted below, the monitoring forms indicated that all monitoring had occurred in the residences. The following additional observations were noted:<br>▪ Individual #251's Monthly Person-Specific PNMP Check Sheets for May and June 2011 documented her communication device was being used, but during multiple observations across reviews, the Monitoring Team did not observe Individual #251 with her communication system.<br>▪ Individual #136's Monthly Person-Specific PNMP Check Sheets documented his | |

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| | | communication board was being used and effective. The Monitoring Team observed Individual #136 on multiple occasions and did not observe him and/or staff attempting to engage him with his communication board.<br><br>The Monitoring Team commends the HT Department for implementing monitoring consistently in the residences, but as stated in the previous report, there was no Facility policy developed for communication devices and AAC devices.<br><br>The Facility Speech Language monitoring policy should incorporate the following:<br>▪ Definition of monitoring process to ensure communication equipment is available, functioning, and effective for the individual;<br>▪ Reference to instructions provided on the form;<br>▪ Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability;<br>▪ Formal schedule for monitoring to occur;<br>▪ Auditing process of completed monitoring forms to identify forms completed accurately, and analysis of individual-specific concerns and systemic issues;<br>▪ Feedback loop identified in which deficiencies are noted and shared with appropriate supervisory staff to ameliorate deficiencies; and<br>▪ Establishment of thresholds for staff re-training.<br><br><u>Monitoring covers the use of the AAC during all aspects of the person's daily life in and out of the home.</u><br>The Monthly Person-Specific PNMP Check Sheet, revised 5/1/11, identified the locations of monitoring performed as home, classroom, vocational, off home and other. Reviews of the monitoring forms completed for the 12 individuals in the record sample documented all monitoring forms were completed in the residence. The monitoring policy should formalize the schedule to ensure that monitoring occurs in the classroom, at work, off campus, and other locations.<br><br><u>Validation checks are built into the monitoring process and conducted by the plan's author.</u><br>There was no evidence that validation checks were built into the monitoring process and conducted by the plan's author. | |

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

1. Individuals receiving direct speech therapy should have a comprehensive SLP assessment, which is sufficiently discrete to identify an individual's functional skills, interests and preferences through observation and clinical assessment within natural environments. (Section R.1)
2. The assessment should include an analysis of assessment data in a manner that identifies an individual's strengths and potentials and to

provide a rationale for recommendations. (Section R.1)

3. As appropriate, these recommendations and strategies should be integrated into the individual's PSP to promote multiple learning opportunities and success with a functional communication system through skill acquisition programs. (Section R.1)
4. There should be multiple opportunities within the daily schedule (i.e., home, work and leisure) to practice identified communication skills leading to success. (Section R.1)
5. In addition, the PSP should support a non-negotiable directive that these communication systems should be present and available for these individuals in all natural environments (i.e., home, work and leisure). (Section R.1)
6. Progress notes should be completed for individuals receiving direct speech services, and the notes should justify the initiation, continuation or discontinuation of speech therapy supports, including an analysis to determine the efficacy of the direct therapy supports provided. If progress was not made, recommendations and/or objectives should be revised, or other steps taken to remedy the situation (e.g., staff training, or methods to ensure consistent implementation of programs). (Section R.1)
7. The following domains and/or guidance should be incorporated into the SL Evaluation and SL Evaluation Update template:
    a. Guiding questions within sections of the SLP evaluation to prompt therapists to include pertinent information;
    b. Assessment process should support the PSP process within the areas of living, working, and leisure;
    c. Description of significant health care issues and risk indicators, including discussion of the impact of health care issues and risk indicators on performance, and current and/or future therapeutic intervention;
    d. Assessment process should be sufficiently discrete to identify an individual's functional skills, interests and preferences via observation and clinical assessment and completed within natural environments;
    e. Assessment data should be analyzed to identify an individual's strengths, abilities, and potentials for skill acquisition;
    f. Discussion of efficacy of direct and indirect functional communication strategies;
    g. Analysis of findings to provide a rationale for functional recommendations and intervention strategies; and

    Additional guidelines to ensure:
    a. Integration of recommendations into an individual's PSP;
    b. Documentation to justify initiation, continuation or discontinuation of direct and/or indirect therapy supports; and
    c. Process for implementing change in an individual's supports when progress is made or there is a lack of progress. The lack of progress should identify a re-evaluation timeframe. (Section R.2)
8. Individual communication programs should be integrated into PSPs through skill acquisition programs, as well as individuals' BSPs to ensure the AAC device is meaningful to the individual, and the individual has a voice in multiple environments. (Section R.2)
9. To ensure SL Evaluations follow established guidelines, the Facility should develop and implement an audit protocol. (Section R.2)
10. The Facility Speech Language monitoring policy should be modified to incorporate the following:
    a. Definition of monitoring process to ensure communication equipment is available, functioning, and effective for the individual;
    b. Reference to instructions provided on the forms to support consistency and inter-rater reliability;
    c. Identification, training, and validation process for monitors to achieve accurate scoring and a high level of inter-rater reliability;
    d. Formal schedule for monitoring to occur;
    e. Auditing process of completed monitoring forms to identify forms completed accurately, and analysis of individual-specific concerns and systemic issues;
    f. Feedback loop identified in which deficiencies are noted and shared with appropriate supervisory staff to ameliorate deficiencies; and
    g. Establishment of thresholds for staff re-training. (Section R.4)

| **SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs** | |
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| 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:<br>▪ **Review of Following Documents**:<br>o Presentation Book and Opening Visit Presentation Notes, Section S, completed by Bruce Boswell, Director of Active Treatment and Interim Acting Chief of Behavioral Services;<br>o Skill acquisition plan development training roster, dated 6/28/11;<br>o Person Directed Planning and Active Treatment – Implementing and Documenting Active Treatment Programs Policy, draft policy, implemented 12/31/10, and revised 11/15/10;<br>o Habilitation, Training, Education, and Skill Acquisition: Implementing and Documenting Active Treatment Programs, approved 11/8/10, and implemented 12/8/10;<br>o CCSSLC Plan of Improvement, Section S, dated 9/27/10;<br>o Revised skill program format, undated;<br>o CCSSLC Plan of Improvement, dated 6/20/11;<br>o CCSSLC Skill Acquisition Plans Review Committee meeting minutes, dated 4/5/11;<br>o For Section S.1, Skill Acquisition Plans, Personal Support Plans, PSP Monthly Reviews, as available, for: Individual #379, Individual #200, Individual #174, Individual #114, individual #153, Individual #109, Individual #24, Individual #16, and Individual #372;<br>o For Section S.1, Selected Skill Acquisition Plans for: Individual #379 (tooth brushing skill plan, dated 3/25/11); Individual #200 (crossing the street, dated 3/1/11), Individual #174 (carrying keys for recycling bin, dated 5/3/11), Individual #114 (first aid knowledge, dated 5/18/11), Individual #153 (adaptive equipment, dated 3/24/11), Individual #109 (anger management skills, dated 6/2/11), Individual #24 (demonstrate happiness, dated 7/9/11), Individual #16 (playing keyboard, dated 4/1/11), and Individual #372 (cleaning adaptive equipment, dated 5/26/11);<br>o For Section S.2, Personal Support Plans and Personal Focus Assessments, as available, for: Individual #379, Individual #58, Individual #200, Individual #275, Individual #9, Individual #174, individual #114, Individual #268, Individual #153, Individual #109, Individual #24, Individual #16, Individual #155, and Individual #7;<br>o PSP Assessment/Discussion/Skill Plan Link Monitoring Tool template;<br>o PSP Assessment/Discussion/Skill Plan Link Monitoring Tool as completed and provided for: Individual #363, Individual #114, Individual #282, and Individual #72;<br>o CCSSLC 5-Minute Engagement Monitoring: Level of Compliance – Monthly Comparison by Units, dated 6/23/11;<br>o CCSSLC 5-Minute Engagement Monitoring: Level of Compliance – CCSSLC Audits, dated 6/23/11;<br>o CCSSLC 5-Minute Engagement Training, dated 6/29/11;<br>o CCSSLC Active Treatment Meeting Minutes, dated 6/28/11 and 7/7/11;<br>o PSP Addendum for: Individual #106, dated 5/19/11; Individual #268, dated 6/7/11; Individual #158, dated 6/16/11; and Individual #323, dated 6/27/11; |

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| | o Vocational assessments, as provided, for: Individual #254, Individual #78, Individual #224, Individual #90, Individual #371, Individual #122, Individual #372, Individual #383, Individual #226, Individual #318, and Individual 213;<br>o Vocational Assessments Completed in the past years, dated June 2011;<br>o Templates of past and current CCSSLC Vocational Assessment, undated;<br>o List of all instances of formal skill training provided in the community settings, as provided, dated 12/1/11 through 5/31/11;<br>o Summary of outing and activity participation for each residential program from 12/1/10 through 5/31/11;<br>o Community Specific Program Objectives Meeting, dated 6/22/11;<br>o Facility Community Action Plan, dated June 2011;<br>o PSP Addendums from PST meeting discussing lack of community integration, as provided, for: Individual #284, Individual #316, Individual #122, Individual #179, Individual #64, and, Individual #270;<br>o Education and Training Assessments, as provided, for: Individual #72, dated 5/3/11, and Individual #71, dated 5/24/11;<br>o Socially Responsible Behaviors Classrooms Breakdown of Group Names, dated July 2011;<br>o Skill Acquisition Training Curriculum;<br>o Skill Acquisition Plan and Community Placement Rationale/Supports Training for Behavioral Services Staff, dated 4/5/11;<br>o Section S and the Data and Treatment Workgroup – Outcome and Action Plan for Competency-based Training for PBSPs and Skill Acquisition Plans;<br>o PSP Facilitation Tool template, undated;<br>o PSP Facilitation Tool, provided example of "John Doe," dated 5/11/11;<br>o PSP Facilitation Tool training documentation, dated 5/12/11;<br>o Assessment Inclusion in PSP Development Checklist template, dated 6/21/11;<br>o Assessment Inclusion in PSP Development Checklists as provided for: Individual #68, dated 6/23/11; Individual #294, dated 6/30/11; and Individual #67, dated 6/30/11;<br>o Training documentation for PSP policy and process, dated 4/26/11 and 4/28/11;<br>o Competency Check for Skill Acquisition Plan template, undated;<br>o Competency Check for Skill Acquisition Plan: Level of Compliance Active Treatment Staff Monthly Average for May 2011, dated 6/18/11;<br>o Competency Check for Skill Acquisition Plan: Level of Compliance, date range 5/1/11 through 5/31/11, dated 6/18/11;<br>o Competency Check for Skill Acquisition Plan: Level of Agreed Compliance - Active Treatment Staff and Active Treatment Coordinators, date range 5/1/11 through 5/31/11, dated 6/18/11;<br>o Competency Check for Skill Acquisition Plan: Level of Compliance Active Treatment Staff Monthly Average for May 2011, dated 6/18/11;<br>o Training documentation for Treatment Integrity Skill Plan Checklist, dated 6/20/11;<br>o Miracle League of Corpus Christi game schedules, dated 3/26/11 through 8/4/11;<br>o Van dimension diagrams (5); and |

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| | ○ Training documentation for Day Programs – engagement/community skill plans, dated 6/29/11.<br>▪ **Interviews with**:<br>○ Iva Benson, Facility Director; Mark Cazalas, Assistant Director of Programs; and Bruce Weinheimer, State Office Coordinator, on 7/11/11;<br>○ Dr. Robert Cramer, Clinical Psychologist; Bruce Weinheimer, State Office Coordinator, and Erin Lewis, on 7/11/11;<br>○ Bruce Boswell, Active Treatment Director and Interim Acting Chief of Behavioral Services, Bruce Weinheimer, State Office Coordinator; and Judy Sutton, incoming Director of Behavioral Services, on 7/12/11;<br>○ Dr. Robert Cramer, Clinical Psychologist; Erin Lewis; and Bruce Boswell, Active Treatment Director and Interim Acting Chief of Behavioral Services, on 7/12/11;<br>○ Meeting with PST to discuss at-risk issues for Individual #247, on 7/12/11;<br>○ Bruce Boswell, Active Treatment Director and Interim Acting Chief of Behavioral Services; Rachel Rodriquez, QMRP Coordinator; and Jim Sibley, Ric Savage, and Sally Schultz, State Consultants, on 7/12/11;<br>○ Daniel Dickson, Quality Assurance Director; Araceli Metehuala, Program Compliance Monitor; and Karen Ryder, Program Compliance Monitor, on 7/13/11;<br>○ Meeting with PST to discuss at-risk issues and process for Individual #275, on 7/13/11;<br>○ Bruce Weinheimer, and Judy Sutton, incoming Director of Behavioral Services, on 7/13/11;<br>○ Kimberly Benedict, Program Coordinator; Sandra Martinez, SRB/ALS Supervisor; Pat Zygorski, The Harbor classroom teacher; Savana Kirk; and Judy Sutton, incoming Director of Behavioral Services, on 7/14/11;<br>○ Robyn Palmer Blue, M.A., BCBA, and Judy Sutton, M.A., BCBA, incoming Director of Behavioral Services, on 7/14/11;<br>○ Dr. Robert Cramer, Clinical Psychologist, and Judy Sutton M.A. BCBA, incoming Director of Behavioral Services, on 7/14/11;<br>○ Bruce Boswell, Active Treatment Director and Interim Acting Chief of Behavioral Services, and Judy Sutton M.A. BCBA, incoming Director of Behavioral Services, on 7/14/11; and<br>○ Jim Sibley, Ric Savage, and Sally Schultz, State Consultants, on 7/14/11.<br>▪ **Observations of**:<br>○ Observation and discussion with staff members at the Behavioral Support Committee Meeting, on 7/12/11;<br>○ Observation and discussion with staff members at the Skill Acquisition Review Committee meeting, on 7/13/11;<br>○ Personal Support Team members at the Personal Support Plan (PSP) Meeting for Individual #353, on 7/14/11;<br>○ PBSP training conducted by Psychological Assistant, on 7/14/11;<br>○ Observation of treatment integrity checks of skill program implementation for individuals at Apartment 517 and Apartment 522B, on 7/14/11;<br>○ Onsite direct observation, including interaction with direct support professionals, and |

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| | other professionals including residence coordinators, psychologists, psychology assistants, home team leaders and assistants, active treatment supervisors, active treatment specialists, community integration specialists, vocational coordinators, rehabilitation therapy technicians, and/or QMRPs were conducted throughout the morning, day, and/or evening hours at the following residential and day programming, and habilitation sites:<br>▪ Apartment 516 (Sanddollar), on 7/11/11;<br>▪ Apartment 522A (Kingfish 1), on 7/11/11;<br>▪ Apartment 522D (Kingfish 4), on 7/11/11;<br>▪ Apartment 522 C (Kingfish 3), on 7/11/11;<br>▪ Apartment 524A (Ribbonfish 1), on 7/12/11 and 7/13/11;<br>▪ Miracle Field, on 7/12/11;<br>▪ Ribbonfish 2, on 7/13/11;<br>▪ Apartment 524D (Ribbonfish 4), on 7/13/11;<br>▪ Apartment 514 (Dolphin), on 7/13/11;<br>▪ Apartment 522B (Kingfish 2), on 7/13/11;<br>▪ Apartment 517 and 522B, on 7/14/11;<br>▪ Angel Day Program, on 7/15/11;<br>▪ The Harbor Program for Individuals with Autism, on 7/15/11; and<br>▪ The Outer Reef Day and Vocational Program, on 7/15/11. |
| | **Facility Self-Assessment:** As previously noted, the Facility developed a Plan of Improvement with regard to Section S of the Settlement Agreement. This POI contained outcomes, action steps, required evidence, facility target dates, completion status, judgment on current noncompliance or substantial compliance, and additional comments. According to the current POI, CCSSLC indicated that it was in noncompliance with all Sections within Habilitation, Training, Education, and Skill Acquisition Plans (Sections S.1 to S.3). This finding was consistent with the Monitoring Team's review.<br><br>As previously reported, the Facility also developed a self-assessment tool based on the Monitoring Teams' Section S rubric. Current verbal reports, as well as documentation provided indicated that QA staff and active treatment staff members had been completing ongoing regular reviews. This included the completion of 48 Section S monitoring tools between March and May 2011. Scores on these reviews, as reported in the POI, ranged from 14% to 35%, with a total compliance score of 28%. However, it was unclear how overall compliance scores were being calculated, because the indicators on the tools had not been weighted, and the tools were not designed to provide an overall score. Verbal reports with staff completing these tools indicated that this process was still in its development phase. The auditors continued to meet (i.e., multiple conciliation meetings had been held), and were continually revising the tool and process to ensure more accurate measurement (i.e., less subjectivity), as well as more valid quality indicators. |
| | **Summary of Monitor's Assessment:** Overall, progress was observed in many areas of habilitation, training, education and skill acquisition programs as CCSSLC undertook efforts to improve the services and |

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| | supports provided to individuals the Facility served. Although changes have been observed over the course of previous reviews, many areas required additional support and improvement to adequately address components of the Settlement Agreement.<br><br>The quality of skill acquisition plans had continued to improve. This improvement was likely due to the ongoing refinement of the skill plan format, continued trainings and oversight on the development, implementation, and monitoring of skill plans, as well as continued refinement of the PSP process. Previously observed concerns regarding the adequacy of elements of skill plans, however, continued to be noted. In addition, current observation and documentation provided suggested that current processes (e.g., critical peer review, implementation of monitoring tools) played an important role in developing quality plans that were driven by and integrated within the PSP. In general, the foundation for continued improvement and refinement of skill plans was in place and future progress is expected.<br><br>Efforts to improve engagement and active treatment were also evident. Progress was reflected in the current onsite estimate of engagement, as well as in the ongoing active treatment monitoring (e.g., including engagement and integrity of skill plan implementation). Not only did these processes allow ongoing monitoring, they also prompted corrective action. Concerns were noted in how the integrity checks were implemented. Improvement in on-campus settings for day and vocational programming, as well as the continued emphasis on community integration was also noted. Although improving, notably at Miracle Field, opportunities for off-campus supported employment continued to increase at a slower than desired rate.<br><br>Previous Monitoring Team reports raised concerns about the adequacy of some of the assessments utilized (e.g., PALs, PFA, Vocational, etc.). Although similar concerns were currently noted with the PFA, improvement in the vocational assessment was noted. However, inconsistencies and concerns within these assessments evidenced a need for further refinement. The opportunities and processes for situational assessments needed particular focus.<br><br>Training of staff continued to be an area of concern. Previous reviews and more recent observations continued to produce mixed findings regarding staff knowledge of and competencies in implementing and monitoring the integrity of skill acquisition plans.<br><br>Overall, improvement in integrating individuals more fully into the community, including opportunities for formal skill training, continued to be noted. Ongoing monitoring appeared effective in prompting corrective action, when community integration supported through the day programs recently decreased. |

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| S1 | Commencing within six months of the Effective Date hereof and with full implementation within two | Continued progress was noted in the area of habilitation training and services.<br><br>At the Monitoring Team's previous visit, the CCSSLC policy Habilitation, Training, | Noncompliance |

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| | 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. | Education, and Skill Acquisition: Implementing and Documenting Active Treatment Programs, dated 12/8/10, had been revised and utilized as the foundation for the new skill acquisition plan (also known as "skill plan") format. However, this policy remained in draft form, because the statewide skill acquisition work group continued to work on a standardized skill plan format and process. The new CCSSLC format and process, however, was formally initiated on 11/1/10, and since that time, all PSPs were expected to utilize the new skill plan format. Since the Monitoring Team's last visit, no changes in the policy were reported.<br><br>At the time of the last review, it was evident that qualitative changes in the format of skill acquisition programs had occurred. The new format included the addition of content areas targeting: 1) a task analysis; 2) specific teaching steps and conditions; 3) operational definitions of targeted responses; 4) schedules for training and data collection; 5) procedures following correct and incorrect responding; 6) strategies to promote generalization and maintenance; 7) specific identification of discriminative stimulus; 8) data summary sections, including graphs; and 9) a rationale highlighting the link between assessment and intervention.<br><br>Revisions in related responsibilities for the development, training, and monitoring of skill plans also was evident at the last review. These changes prescribed that the PST was responsible for identifying the targets of skill acquisition programs, and the Active Treatment Program Coordinators were responsible for their development. Once developed, Active Treatment Supervisors (primarily) and, in some cases, other clinical staff (e.g., Psychologists/Assistant Psychologists or RN Case Managers) trained direct support professionals. As of the Monitoring Team's most recent visit, this process remained in place.<br><br>Review of a sample of skill plans at the Monitoring Team's last visit found significant improvement compared to previous skill plans. However, deficiencies across all sections of the new format also were noted. As specifically described in the Monitoring Team's previous report, concerns within sampled skill plans included: 1) inaccurate or incomplete rationales; 2) objectives that were inconsistent with those identified within the PSP; 3) behavioral objectives that could not be met as written; 4) redundant or unclear instructions within the methodology; 5) task analysis that were too broad, or included information better suited for other sections; 6) fading sequences or prompting hierarchies that were incomplete or insufficient; 7) inadequate or insufficient trials necessary for effective teaching; 8) vague discriminative stimuli; 9) inadequate instructions following incorrect responding; 10) inadequate directions regarding data collection; 11) insufficient prescription of differential reinforcement; 12) lack of specificity regarding generalization; 13) lack of diversity in types of chaining; and 14) lack of preference assessments and use of individualized reinforcers. | |

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| | | Following recommendations included in the Monitoring Team's last report, the skill plan format was revised and implemented on 5/1/11. According to verbal reports and summary documentation the Facility provided, revisions within this new format included refinement to the sections on maintenance and generalization, provision of a standardized fading sequence, increased training trials, as well as more detail regarding error correction. State Office Consultants provided subsequent training on skill programming for Program Coordinators, and in January 2010, a new review process, entitled the Skill Acquisition Review Committee, started weekly meetings to review skill plans that had been developed and provide critical feedback.<br><br>It appeared that a substantial number of skill plans had been developed since the Monitoring Team's last visit. According to the POI, dated 6/20/11, at least 91 skill plans were developed since the Monitoring Team's last visit (i.e., between February and May 2011). A sample of these newly developed skill plans were selected for review. That is, nine (10%) skill plans implemented within the last six months (i.e., for individuals who had PSPs since the Monitoring Team's last review) were examined.<br><br>In general, current findings were consistent with those noted in previous Monitoring reports. More specifically, as reported following the Monitoring Team's previous visit and found during the current review, concerns remained regarding the adequacy of skill acquisition plans. It should be recognized that progress was noted with regard to adherence to the template, and addition and completion of requisite content areas (i.e., the plans included necessary elements, including task analysis, generalization and maintenance, etc.). Therefore, the necessary foundation appeared to be in place to support continued refinement. However, at the current time, the content of the elements included within the plans required further improvement. The Monitoring Team recognizes that the process of developing the competencies necessary to write, implement, and monitor these skill plans takes time. Progress in the quality of the plans has indeed been observed. It continues to be expected that, as competencies develop through continued writing and critical peer review, the quality of the skill plans will continue to improve over time.<br><br>In an effort to be more concise and provide more utility, an initial general and brief overview of the plans sampled is provided below followed by an in-depth examination of three of the skill plans. The specific skill plans reviewed are identified above in the Review of Following Documents section. The following summarizes the concerns noted:<br>▪ Of the skill plans sampled, only six (67%) clearly referenced the selected skill program in the PSP, including the action plan (the three exceptions were Individual #379, Individual #114, and Individual #372). The dental hygiene/tooth brushing preparation skill plan for Individual #379, for example, | |

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| | | was not identified within the action plan of the current PSP.<br>▪ In addition, three plans either did not include a task analysis (i.e., Individual #24), or the task analysis provided appeared too broad to support success (i.e., Individual #109, Individual #114, and Individual #372). A task analysis should include only one task/skill and sufficient specification of stimulus-response chains to support effective teaching.<br>▪ Included behavioral objectives and operational definitions continued, at times, to be vague (i.e., Individual #379, Individual #200, and Individual #16).<br>▪ Some plans (e.g., Individual #372, and Individual #174) inadvertently had multiple discriminative stimuli (Sd). That is, there was one specific instruction listed as the Sd, however, an additional instruction was often found within the teaching strategies.<br>▪ The frequency of some trials (i.e., sufficiency of trials) appeared to be inadequate to support learning for some plans (e.g., Individual #379, and Individual #24).<br>▪ Overall, more specification needs to be added to staff instructions following incorrect responding. That it, it was still unclear in most plans how to support responding (e.g., what level of prompt to use) immediately following an incorrect response.<br>▪ This might be related to the lack of specification regarding a prompting hierarchy within some plans (e.g., Individual #379, and Individual #200). The Monitoring Team questioned the sequence of prompting (most-to-least) in the current plans and strongly recommends that the sequence be changed (to least-to-most). This order, of course, could be changed, if there was a rationale provided, for example, to support errorless learning.<br>▪ In some plans, information to support maintenance was not found (i.e., Individual #379, Individual #200, Individual #153, and Individual #16), or the information was combined within the section on generalization (e.g., Individual #372). To support better discrimination and specificity, the Monitoring Team recommends that more detailed information on maintenance and generalization be provided in separate sections.<br>▪ Overall, many plans contained unnecessary or redundant information. For example, information regarding differential reinforcement was found in multiple sections for Individual #200, and inaccurate instructions (i.e., "if [Individual] does not open the door …") were found in a tooth-brushing program for Individual #379.<br><br>Every plan reviewed had room for improvement. However, the following provides a detailed review of just a couple. The "Looking both ways before crossing the street" skill program for Individual #200 could be improved in a number of ways. The plan did contain a rationale that indicated the basis for the skill plan, and it was identified as part of the action plan on the PSP, dated 2/10/11. However, the behavioral objective | |

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| | | appeared to be excessively long (i.e., 1 trial per month for 6 months). Rather, an objective of "… 3 consecutive trials at the identified step of the task analysis …" In addition, the behavioral objective was vague and included a prompt. In addition, the operational definition typically should not include prompt levels, but just an objective description of what the response looks like. The Sd might be confusing, because it prompts a subsequent step. A more appropriate Sd might be "cross the street safely." Scoring incorrect responses was vague, because the teaching instructions directed staff to "…model the behavior, provide additional instruction to try again two more times before entering a '-' on the data sheet …" In general, the multiple staff prompts interspersed into the task analysis and teaching strategies (e.g., "wait for staff to indicate its safe," "stop when staff indicate," "… staff will verbally indicate to [Individual #200] to stop before they approach any intersection" did not appear to support independent performance in the future. The consequence for incorrect responding basically re-stated what was already provided in the teaching strategy, and did not reference reinforcement (i.e., differential reinforcement) at all. Data collection could have been more clear by prescribing collection of "+" or "-" on only the first trial, and should have occurred more than once a month. Teaching trials should happen as often as possible or appropriate (for this objective at least weekly). More specification was needed to support generalization, and information regarding maintenance needed to be included. Lastly, data collection should assist in determining whether or not the objective was met, as well as accurately reflect performance as documented.<br><br>Likewise, the tooth brushing skill plan for Individual #379 could be improved in a number of ways. Most importantly, this objective was not included with the PSP. More specifically, no reference to this skill-programming objective could be found (i.e., it was not listed within the Action Plan or PSP discussion). When reviewing the actual plan, the behavioral objective should not include any reference to prompt levels, and the criterion was too long (i.e., six months). Consideration should be given to using "success in three consecutive trials" to go to the next step of task analysis, or to a less restrictive level of prompting. Operational definitions typically should only include objective description of what the response looks like when it is exhibited. Such as "following the SD, she will turn the cold water tap with her right or left hand until water pours out." The teaching schedule, identifying the training schedule as "…daily in the morning…" appeared appropriate. However, the PSP monthly review had two graphs, including one graph for the 6 a.m. to 2 p.m. shift and one graph for 2 p.m. to 10 p.m. shift. It was unclear why data was collected during the 2 p.m. to 10 p.m. shift (although more trials and data is usually better), when it was not indicated (or found). The materials section should have included where the items were placed (e.g., on the sink). The discriminative stimulus appeared to be appropriate. However, the teaching instructions included an additional verbal instruction (e.g., "… ask her to turn on the cold water"). This second verbal instruction was problematic as it might make fading of prompts potentially more | |

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| | | challenging (i.e., increase the likelihood of prompt dependence), and might make accurate data collection (i.e., on prompt level) more error prone. The task analysis, although simple and straightforward, appeared to be missing some steps (e.g., pick up toothbrush, pick up toothpaste). The initial prompting level, as well as prompt hierarchy was not evident. That is, typically, teaching trials would start with the least restrictive prompt level and, if a response were incorrect, staff would then provide more support (i.e., the next, more restrictive prompt level) to facilitate successful responding. The teaching instructions included inaccurate information (i.e., "If [Individual #379] does not open the door"). Obviously this appeared to be a cut-and-paste error. Consequence for incorrect responding should have been more specific (e.g., how many times do you try again? What level of prompting is appropriate?). Data collection could be more clear by prescribing collection of "+" or "-" on only the first trial. More specification was needed to support generalization, and information regarding maintenance should have been included. Lastly, data collection should assist in determining whether or not the objective was met, as well as accurately reflecting performance as documented. More specifically, the May 2011 PSP monthly plan review did not appear to target only two trials per week (appeared to graph total successes per month), and appeared to graph inaccurate data (i.e., May data sheet indicated 11 successful trials and the graph reflected only two). In addition, it was unclear why June data would be graphed in a May report.<br><br>The vocational skill plan (i.e., carrying the keys to the recycling bin) for Individual #174 appeared to be much improved compared to earlier plans. In this case, it appeared that the recent format revision (in response to the Monitoring Team's recommendations) was helpful in prompting needed content. One way to improve this skill plan would be to refine the task analysis. Currently, it was too broad, and it included pre-requisite behaviors that were not well defined. In addition, the targeted response was dependent upon staff prompting him to keep the keys. It would be better to frame this task analysis as a response he would be able to complete independently from beginning to end. In addition, more specification regarding opportunities for teaching was needed. That is, the current description was vague (i.e., "Training should occur weekly. Training should be attempted up to three times during the training period"), and information regarding the "teaching period" was not provided. In addition, the consequences for incorrect responding should be more specific. That is, it was unclear why two more trials would be necessary, and the level of prompting was not specified. Data collection could have been more clear by prescribing collection of "+" or "-" on only the first trial, and should occur more than once a month. Lastly, although information was provided on generalization and maintenance, it would be helpful to split the directions and offer clear instructions to ensure each.<br><br>The Monitoring Team continues to recognize the significant effort that has been made to change the nature of skill acquisition programming. It is expected that staff will continue | |

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| | | to improve their skills in writing, training, and implementing these plans. Observation and documentation evidenced that the ongoing weekly Skill Acquisition Review Committee continued to be a valuable resource for peer review and support while developing these new plans. This diverse multi-discipline workgroup appeared poised to continue to critically evaluate these plans and increase their quality over time. The active contribution of psychology, including BCBAs, and other disciplines (e.g., speech-language) would likely enhance these skill programs, as well as the development (or use) of other quality assessments (e.g., The Assessment of Basic Language and Learning Skills, as described with regard to Section K.8 of the SA, or the dental anxiety checklist as described with regard to Section C.4 of the Settlement Agreement), as well as alternative evidenced-based practices (e.g., functional communication training or picture exchange communication system, as described with regard to Section K.8 of the Settlement Agreement).<br><br>In addition, the new PSP Assessment-Discussion-Skill Plan Link Monitoring Tool (ADSL Monitoring Tool) was developed since the Monitoring Team's last visit and appeared, based on documentation provided, to assist in identifying whether: 1) preferences, needs, and recommendations identified in assessments were reflected in the PSP deliberations; 2) skill acquisition plans targeted areas that had been identified in the assessments; 3) skill acquisition plans targeted areas that had been prioritized in the PSP; and 4) deliberations in the PSP linked the assessment to skill acquisition plans. This tool was piloted on four PSPs that were completed in May, and the results indicated that, on average, just over half (i.e., 62.5%) of the items were completed correctly. Therefore, it appeared that PSTs were still struggling with conducting the revised PSP process with integrity and accurately documenting the team's deliberations. Although scores were likely not as high as anticipated, the new PSP process was still relatively new, and this new tool will help ensure that teams identify and prioritize skill plans through the accepted team process.<br><br>Similarly to the Monitoring Team's previous visits, observations during the July 2011 site visit evidenced a continued effort to promote engagement in recreational, leisure and other activities across residential and day programs. The Monitoring Team measured engagement across many sites 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. As previously noted, the definition of engagement was very liberal, and included active (e.g., blowing bubbles, coloring, painting nails, etc.) and passive forms (e.g., listening to the radio, watching TV, etc.) of engagement. The table below provides specific information on observed levels of engagement (individuals engaged: total number of individuals) in relation to staff-to-individual ratios across residential programs. | |

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| | | Engagement Observations | |

| *Location* | *Engaged* | *Staff-to-individual ratio* |
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| Sand Dollar | 3:4 | 2:4 |
| Sand Dollar | 0:4 | 0:4 |
| 522 A | 3:3 | 1:3 |
| 522A | 1:1 | 1:1 |
| 522D | 4:4 | 1:4 |
| 522 C | 6:8 | 2:8 |
| 522C | 1:1 | 0:1 |
| 524 A | --- | 1:9 |
| 524A | 6:8 | 3:8 |
| 524 B | 1:1 | 1:1 |
| 524 D | 2:2 | 3:2 |
| 524D | 4:4 | 2:4 |
| 514 | 1:1 | 1:1 |
| 522 B | 6:6 | 3:6 |
| Angel Day Treatment | 5:5 | 2:5 |
| Miracle Field | 2:2 | 1:2 |

Overall engagement was 83%. 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, individuals in wheelchairs were orientated toward the television or a radio, and although they were scored as engaged, it was difficult to determine if they were watching or listening. This form of engagement was considered passive engagement and is less preferred than active engagement. Current observations also noted more examples of individuals engaged in skill programming activities.

Once again, direct observation by the Monitoring Team during the recent onsite visit evidenced completion of a "5-Minute Engagement Monitoring Form." This was consistent with an observation from the Monitoring Team's previous visit. Interviews with staff continued to suggest that these observations provided an efficient estimate of engagement, and, more importantly, provided opportunities to provide feedback to direct support professionals. Since the last visit, a database had been developed to manage engagement data, and allow examination of current estimates and trends over time. This system appeared fairly flexible, because it allowed review by month and by program. As noted in Section S.1 on the Plan of Improvement, a total of 186 engagement monitoring forms were completed between February and May 2011, with average facility-wide engagement scores for February, March, April, and May of 84%, 72%, 65%,

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| | | and 57%, respectively. Upon closer examination of the data collected, active treatment staff believed that some of the scores overestimated engagement within one unit (i.e., Pacific residences), because the majority of sessions were completed in day habilitation settings. As a result, additional training was held with active treatment staff to ensure more representative sampling. In addition, as a result of the first report generated from this new database, active treatment team meetings were held on 6/28/11 and 7/7/11, and subsequent action plans were developed. These plans included the use of more conspicuous schedules, the facilitation of community outings, increased frequency of engagement monitoring tools and performance feedback, acquiring more active treatment equipment and supplies, and additional trainings for direct support professionals. It appeared that this system to monitor engagement was fully functional and providing meaningful data that, when necessary, prompted responsive and corrective action from active treatment staff. As increasing assessments are completed across all settings, this database will allow examination of engagement throughout the Facility, including residences, day programs and work sites. The Monitoring Team looks forward to subsequent reviews of this system, and updates on its effectiveness in maintaining reasonable levels of engagement within all settings.<br><br>As found during the Monitoring Team's previous and current visits, the current day and vocational habilitation and sheltered work programs on campus offered individuals opportunities for meaningful work. This included work on and off campus in enclave or supported employment positions. As discussed in the Monitoring Team's previous reports, however, concerns were noted with the number of individuals who did not leave their residence to attend day or vocational programs. In response to the Monitoring Team's previous recommendations, evidence suggested that the PST teams worked to identify barriers to attending day programs (away from individuals' residences), and had targeted a number limiting variables, including, for example, the need for transportation and adequate programming space.<br><br>During the Monitoring Team's current and previous visits, progress was noted related to options for transportation (which is discussed more with regard to Section S.3 of the Settlement Agreement), as well as in developing on-campus programming settings that would allow all individuals to participate in day/vocational programs out of their residences. For example, previous observations evidenced the opening of new programming space in the Pacific residence and the Bike Shop, as well as inclusion of individuals from the Atlantic Unit at the Adult Life Skills Building, and some individuals from the Coral Sea program at day programming in the Gymnasium. Currently, substantial programming space, including the Angel Day Program Training Center and The Harbor, had been developed for individuals living in the Pacific Unit. Additional day and vocational programming space, including The Outer Reef, also had been developed for individuals at Coral Sea. It was reported that these new programs were in their | |

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| | | "infancy stage," and, therefore, staff were still "working out the bugs." These new settings appeared, however, spacious and likely to support diverse programming. In addition, a new classroom, called Serenity Zone, was developed in the SRB program for individuals interested in retirement or a more relaxed environment. The Monitoring Team will be excited to see how these programs grow and expand to offer all individuals learning opportunities in the future.<br><br>At the Monitoring Team's previous visit, documentation evidenced that PSTs had started the process of identifying variables that prohibited individuals from participating in off-site day or vocational programs. At that time, PSTs were strongly encouraged to examine these reasons, and, when appropriate, develop individualized interventions to support individuals in accessing programming outside of their residential programs. Current documentation continued to evidence PSTs meeting to implement this process. Documentation provided for four individuals (i.e., Individual #106, Individual #268, Individual #158, and Individual #323) indicated that PSTs had met to discuss reasons why individuals did not leave their residences, and to problem-solve in an attempt to develop meaningful support and solutions to facilitate attendance at off-residence programs. It is recommended that these identified challenges and potential solutions be integrated within behavioral programming. That is, behavioral strategies should be developed and integrated with PBSPs for individuals who repeatedly refuse to attend day or vocational programming. In addition, PST should ensure that there are available measures in place that would allow ongoing review of progress. Data on work refusals and/or percentage of time at day or vocational programming could be monitored to estimate performance over time. Indeed, CCSSLC would benefit from collection of data targeting programmatic refusal across all programs.<br><br>The Monitoring Team's previous reviews have noted concerns with the limited opportunities for individuals to work off campus in competitive employment positions. From the time of the baseline to the Monitoring Team's previous visit, it appeared that potential opportunities had only grown from approximately seven to 11 supported employment positions within community-based sites. One change that was predicted to facilitate the identification and placement within community-based positions was CCSSLC's decision in December 2010 to join the statewide Employment First Initiative pilot program. It was expected that this collaborative effort between the Texas Department of Aging and Disability Services and local community-based providers should enhance opportunities for individuals at CCSSLC to obtain competitive employment positions. Currently, according to verbal reports as well as Section S presentation notes and the POI, it appeared that 12 individuals had secured employment positions since the last visit. This included concession positions at Miracle Field, local Holiday Inn, catering company, and animal shelter. In addition, one position was created on campus. Overall, according to current estimates provided in documentation | |

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| | | submitted, a total of 15 people were currently employed in community settings (i.e., reflecting approximately 10% of individuals who work). At the current time, provided documentation indicated that approximately 12 new jobs were obtained in the community since the last review, which was viewed by the Monitoring Team as good and needed progress. However, it was unclear if individuals previously employed in community settings were some or all of those who obtained these new positions, or if all the new positions went to individuals not yet employed in community settings. Therefore, the exact number of new individuals currently working in community settings is unknown.<br><br>One of the primary challenges to community integration identified during previous visits was the limited availability of transportation. At the last review, three new vans, which were purchased to support community integration and supported employment, were available, as of 11/1/10, to support community integration activities and supported employment. In addition, at the previous review, increasing access to public transportation options for individuals served was noted. Currently, verbal reports as well as documentation indicated that in July 2011, six new vans were to be purchased. | |
| 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. | Progress had been noted in the area of assessment to support habilitation.<br><br>During previous reviews, the transition from utilizing the Personal Focus Worksheet: Individualized Assessment Screening Tool (PFW) to the Personal Focus Assessment (PFA) had been noted. The PFA was described as a more comprehensive assessment that, like the PFW, facilitated the identification of an individual's goals, interests, likes/dislikes, achievements, and lifestyle preferences across a wide range of areas. The PFA replaced the PFW in October 2010. Currently, this assessment was intended to inform the PSP planning process by functioning as the primary screening device that assisted with the identification of necessary assessments.<br><br>In an attempt to examine how the PFA was currently utilized, 14 individuals with PSPs completed within the last six months were selected. Of these 14 individuals, 13 (93%) had a PFA completed within the last year. The exception was a PFA that was not dated (i.e., Individual #9) and, consequently, it was not possible to determine when the assessment was completed. This assessment, however, was still included in the sample and reviewed. Of the 13 dated documents, 13 (100%) were completed several months prior to the PSP meeting. Unfortunately, one of these PFAs (i.e., Individual #109) was missing the last four pages of the assessment, and was subsequently not included within the current sample. In general, of the 13 PFAs reviewed, documentation indicated that only nine (69%) appeared to be fully completed. That is, items were not fully completed on some sampled PFAs (e.g., Individual # 379, Individual #174, Individual #114, and Individual #16). Surprisingly, only three (23%) provided a summary of preferences | Noncompliance |

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| | | determined to be most important during the assessment. Most of the assessments, 11 PFAs (85%), identified needed assessments, but only one of these PFAs accurately identified the PST member responsible for completion of the assessment, as well as the due date. Lastly, only eight (62%) of the provided PFAs had signed signature pages included.<br><br>During previous reviews, the Monitoring Team examined the Positive Adaptive Living Skills (PALS) assessment as it was completed for each individual concurrent with their annual PSP meeting. However, according to verbal reports, the use of this assessment was being discontinued. That is, the PALS was to be replaced by another assessment, called the Functional Skills Assessment, in late July 2011. As a result, the Monitoring Team's current review did not include reviews of completed PALS assessments. Subsequent reviews will closely examine the newly completed Functional Skills Assessments.<br><br>As noted in the Monitoring Team's previous reports, significant changes had occurred within the PSP process. These changes included the revisions of policies, assessments, and skill acquisition plans, as well as modifications in the roles and responsibilities of PST members, especially the QMRPs and active treatment staff (i.e., program coordinators, supervisors, etc.). At the time of the Monitoring Team's most recent review, no significant changes in current written policies were reported. However, it appeared that revisions to the current policies would be appropriate given all of the recently noted changes. For example, based on recent verbal reports, it appeared that several revisions were made to the Education and Training Assessment over the past year, and the Community Outing Preference Assessment did not appear to be utilized anymore. As previously noted, the latter assessment was referenced in the Habilitation, Training, Education, and Skill Acquisition policy for Ensuring Community Integration, and reference to the Educational and Training assessment was not found in any of the available policies. Therefore, clarification in current policy regarding the utilization of these assessments would be helpful.<br><br>As noted during the Monitoring Team's last visit, the previous vocational assessment had recently been revised and a draft version had just started to be utilized. This revised vocational assessment, entitled the CCSSLC Vocational Assessment, 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 previous review, these assessments were being piloted and no assessments were available for review. | |

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| | | Provided documentation indicated that a total of 130 vocational assessments had been completed since January 2010, and approximately 59 vocational assessments had been completed since the Monitoring Team's last visit. To examine the recently revised format, 11 vocational assessments were selected from the documents provided. This sample represented 19% of those completed since the last visit. Overall, these assessments closely adhered to the revised format, including the completion of new content areas targeting: 1) recommendations regarding skill planning; 2) prior work experiences, including situational assessments; and 3) skill acquisition performance data over the past year. However, inconsistencies and concerns noted across these assessments, including within these new areas, including:<br>▪ Of those sampled, 10 (91%) were completed using the new template. That is, one of the assessments (i.e., Individual #122, completed on 2/7/11) utilized the previous format. As a result, this assessment did not include content targeting the areas described above (e.g., vocational data and situational assessment information).<br>▪ Although the majority (91%) of assessments included at least one recommendation on skill planning, these appeared to reflect a less than individualized ("cookie cutter") approach, because more than one assessment referenced "gathering work materials" as the skill planning goal. It would be more meaningful and functional if the skill planning recommendations targeted more individualized goals that appeared to be a pre-requisite toward their own employment vision. For example, in some cases (e.g., Individual #78, Individual #372, Individual #283, and Individual #213), a general statement was provided "… until [Individual's] work preferences are developed into a specific job, [Individual] could learn how to gather his work materials independently," which suggested working on an identified skill until a job was found. Instead, the pre-requisite skills associated with the individual's vision could be identified and the skill program could target one or more of these.<br>▪ In some cases, it was difficult to connect previous and current work experiences, data provided within the assessment, and recommendations with the identified long-term vision. For example, the vision listed for Individual #254 was "… he would like to have a job as a mover with a moving company." However, the link between the assessment, previous and current work competencies, and future pre-requisite steps were not integrated and identified within current recommendations. This is one example where the skill planning recommendation (e.g., targeting "edging") was not consistent with the overall employment vision, but more consistent with current job placement. In the end, in order to assist individuals obtain their dream jobs (or an approximation thereof), individuals should be supported to learn the skills necessary to be successful in these positions.<br>▪ There were inconsistencies found in some assessments (e.g., Individual #78, | |

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| | | Individual #254) where the "other" option was not available within the occupational interest survey section. In many cases (e.g., Individual #224, Individual #90, Individual 226), having the "other" option was necessary due to limitations within the available choices. For example, Individual #78 had a vision of working in the Walmart video department selling videos. However, a corresponding item did not appear to be available on the provided options. In this case, the "other" option would be helpful to the PST. Review of the revised template indicated that the "other: selection was included. Therefore, when the vocational assessments are completed, assessors should ensure that the revised format is followed closely.<br>▪ In many cases (e.g., Individual #318, Individual #226, and Individual #372), it was challenging to interpret the data provided on graphs within the assessment due to insufficient descriptors. For example, vocational data was provided for Individual #254, but available information was not descriptive enough to support interpretation. More detail was necessary to show how the data related to the assessment. In addition, in some cases, data related to skill programming was not included as required (e.g., Individual #224, Individual #90, and Individual #122). Overall, graphic display of data associated with skill plans requires the same adherence to accepted graphing conventions to ensure efficient and effective interpretation (more specific guidelines are discussed with regard to Section K.4 of the Settlement Agreement).<br>▪ In general, the assessments were comprehensive and contained substantial amounts of information. As described, in most cases, it appeared that effort had gone into providing historical information on situational assessments. However, it seemed that the majority of situational assessments included assessments of individuals within positions and/or settings on campus. Although this might be desirable for some individuals on campus, it also should be evident that these assessments are completed in community settings for others as well. That is, it was noted that some individuals (e.g., Individual #213) had been provided an opportunity to "try out" a created job on campus. This appeared to be a good first step toward approximating actual jobs in the community. However, staff should remain vigilant that conducted assessments, including identified visions, skill planning recommendations, and other derived information, are not biased or limited by opportunities available on campus. Subsequently, future vocational assessments should aim to "think out of the box," and pursue potential community settings as the foundation for situational assessments to expand employment visions as well. In addition, consideration should be given to providing more structure or standardization to situational assessments to ensure the integrity of the assessment, consistency across staff, and adequate exposure to new positions for individuals at CCSSLC. | |

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| | | As previously noted, 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, as well as when used as a foundation to identify meaningful day/vocational programming or supported employment options. Lastly, it was noted that additional changes to the current vocational assessment are likely once the State's comprehensive functional assessment work group finalizes their anticipated revisions. Once completed, Facilities are expected to implement this assessment statewide. | |
| S3 | Within three years of the Effective Date hereof, each Facility shall use the information gained from the assessment and review process to develop, integrate, and revise programs of training, education, and skill acquisition to address each individual's needs. Such programs shall: | | |
| | (a) Include interventions, strategies and supports that: (1) effectively address the individual's needs for services and supports; and (2) are practical and functional in the most integrated setting consistent with the individual's needs, and | Progress was noted regarding the development, training, and monitoring of individualized and functional skill acquisition plans.<br><br>Documentation indicated ongoing training on the PSP process, as well as skill acquisition plan development of active treatment staff, as well administrative, and staff from other disciplines. This included review of the PSP policy and process with administrative staff, including discipline coordinators and quality assurance staff on 4/26/11, and QMRPs on 4/28/11. In addition, as presented with regard to Section S.1, State Office Consultants provided supplemental training targeting skill programming for program coordinators. Training on the PSP process and skill plan development, as well as the role of psychological assessment in community placement was also held with psychology staff on 4/5/11. I n addition, in January 2010, a new critical peer review process, entitled the Skill Acquisition Review Committee, started weekly meetings to closely examine developed skill plans and to provide feedback and ongoing coaching and refinement. Overall, CCSSLC had been active in ensuring staff had received necessary training to understand recent changes and develop the skills to implement and monitor the new PSP process.<br><br>Substantial work also had been completed in developing more standardized forms and procedures to ensure that the revised PSP process occurred as intended. That is, the PSP Facilitation Tool was developed as a resource for QMRPs to help guide the PST members during the PSP to develop action plans, based on assessment recommendations and identified preferences, which supported effective, individualized and functional skill plans. According to the POI, this new tool was implemented recently on 5/12/11, when | Noncompliance |

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| | | QMRPs were trained on its utilization. It was currently unclear, however, if this tool had been utilized in any recent PSPs.<br><br>As a check to ensure a link between assessments and developed action plans, a second checklist entitled the Assessment Inclusion in PSP Development Checklist was recently developed on 6/21/11. It appeared that the intent of this checklist was for it to be completed after the PSP meeting as a method to monitor the integrity of the PSP process, as a form of performance feedback for QMRPs, and as a prompt to initiate corrective action, if needed, through a subsequent PST meeting (documented as a PSP addendum). Several examples of these completed checklists were provided. However, it was unclear if these checklists generated any type of quantitative score that could be monitored over time. If so, these scores could be utilized to monitor and compare performance of PSTs, QMRPs, residential programs, and/or the entire Facility.<br><br>Documentation indicated the development of a draft skill acquisition training curriculum (i.e., the "Skill Plan Training Guide") to facilitate new staff training at New Employee Orientation. This new training was designed to cover each section of the skill plan template, as well as specific elements of the prompt hierarchy. The development of this training curriculum appeared to be the product of a recently developed workgroup, comprised of behavioral services and active treatment staff, charged with developing a system for competency-based training of PBSPs and skill plans. Provided documentation evidenced an initial comprehensive action plan outlining the development of training curriculums, videos, iLearning modules, training forms, and related policies. According to documentation, several of these action steps recently had been initiated. At the current time, each action step was scored as "in process." Future Monitoring Team reviews will be necessary to examine the ongoing process of this work group as they endeavor to improve the competency-based training for all SSCCLs direct support professionals.<br><br>In addition, and perhaps most importantly, ongoing integrity checks were completed to monitor the degree to which direct support professionals implemented the plans as written. Evidence indicated that active treatment staff had conducted several integrity checks of skill plans (called "audits"). According to the POI, nine audits recently were completed across four units. Scores from these audits were collected and entered into a new database. The scores for each item, collapsed across audits, appeared to be averaged, and then displayed. As a result, an overall level of compliance score (for May and June) was determined (using each item average). According to documentation, the overall estimated integrity for May and June was 97% and 91%, respectively. According to additional documentation as well as observations during the recent monitoring visit, these scores likely overestimated the level of actual implementation integrity. More specifically, inter-observer agreement (IOA) scores reflected inconsistency across | |

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| | | observers for several items (i.e., item #2, #3, #9, #10, and #14). Interestingly, these items corresponded to observed limitations in current skill plans as evidenced earlier in this report (as discussed with regard to Section S.1). Documentation also indicated that it was discovered that completed integrity checks might not have been completed accurately. That is, auditors might have scored the ability of direct support professionals to read rather than implement the plans. As a result, on 6/20/11, additional training was provided to program coordinators to ameliorate this misunderstanding.<br><br>At the time of the current onsite review, a member of the Monitoring Team observed two active treatment staff conducting two skill plan competency checklists. This provided an opportunity to observe the utilization of the template, as well as to view staff conducting IOA probes of their audits. Overall, the auditor's interaction with direct support professionals and the selected individuals was very friendly, positive, and professional. And, at times, the active treatment staff provided corrective feedback and coaching to direct support professionals. However, these observed integrity checks appeared inadequate in several ways. First, the auditors appeared unsure of approximately four items on the checklist. That is, they had reported difficulty discriminating between item #11 and #12. In addition, they did not fully understand how to score items #13 and #14. On one of the audits, the auditors began their integrity check while an individual was already engaged in the targeted skill program. As a result, they were unable to accurately judge some items (e.g., whether or not the Sd was used accurately). Lastly, it appeared at times that the auditors did not score items independently and often discussed items before scoring them. Although this approach is appropriate in a training situation, this will not provide accurate IOA estimates. Overall, it appeared that the active treatment staff required more training and support in accurately completing this audit and IOA.<br><br>Brief on-site reviews continued to note concerns with the consistency of data collection. In some cases, data appeared to be collected accurately. July behavioral data, for example, was recorded across 100% intervals for Individual #275, and data for a randomly selected skill program was completed 100% of intervals for Individual #228 and Individual #214. However, data appeared inconsistently recorded for others. For example, skill planning data was either missing or incomplete (i.e., for five out of five skill plans targeted for completion at the residence) and behavioral data appeared missing for over half of the intervals for Individual #372, and Individual #9. Similarly, data was not recorded as prescribed, for example, for the desensitization plans for Individual #137 (i.e., zero out of four intervals were completed), Individual #214 (i.e., two out of four intervals not completed), or the desensitization data sheet was missing (i.e., July data sheet for Individual #268).<br><br>In addition, mixed reviews continued to occur with knowledge of behavioral | |

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| | | programming. For example, direct support professionals provided accurate knowledge of target and replacement behaviors when interviewed regarding some individuals, but could not correctly identify where behavioral data should be recorded, identified replacement behaviors that were not actually in the PBSP, or described skill programming activities that were not included in the PSP. Or, as previously noted, several staff appeared reluctant or had difficulty answering simple questions without accessing appropriate documentation. These observations suggested continued inconsistency across staff in the knowledge and implementation of behavioral and skill programming for individuals living at CCSSLC (additional information is provided with regard to Section K.11). | |
| | (b) Include to the degree practicable training opportunities in community settings. | Progress was noted in the area of providing skill acquisition in the community.<br><br>Since the Monitoring Team's last visit, efforts to provide ongoing training for individuals in the community were noted. It appeared that active treatment staff met to discuss challenges in implementing skill plans in the community and developed action plans to overcome identified challenges, including better planning and scheduling of training-orientated community trips. In addition, a Facility community action plan was implemented in June 2011. This plan prescribed that every individual living at CCSSLC would have at least monthly learning opportunities in community settings, and tasked PST teams to identify any barriers, as well as the supports necessary to overcome them. This plan also outlined and described: 1) the use of posted community calendars listing identified weekly activities; 2) the weekly integration of Adult Life Skills and Socially Responsible Behavior classes into community settings; 3) how the skill plans would be documented within the PSP; and 4) the focus on developing work opportunities in the community based on each individual's vocational assessment.<br><br>Over the course of the Monitoring Team's previous visits, progress had been observed in the number of individuals with formal opportunities to engage in skill acquisition programs within the community. Documentation from previous and the current review indicated an increasing progression of approximately 8%, 30% and 68% of all individuals at CCSSLC with skill acquisition programs designed for implementation in community settings as of July 2010, January 2011, and July 2011, respectively.<br><br>Documentation indicated that a formal process was in place to monitor skill programming in the community. More specifically, data across months (12/10 to 5/11) for individuals by residence was collected and displayed. This data appeared to reflect each individual with a formal skill programming targeting implementation in the community, and the days each month that the training was conducted. Summary data, based on this individual data, could be produced to reflect trends per residence, unit, or | Noncompliance |

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| | | Facility over time. In addition, data could be supplemented with an indication of the measure of success on these programs to indicate the number of programs (per program, unit, or system wide) that were demonstrating successful responding over time.<br><br>For individuals not actively participating in community activities, evidence suggested that PSTs had met and discussed the underlying reasons for why community integration was not appropriate or possible. The PSP addendums provided for these individuals (e.g., Individual #284, Individual #316, Individual #122, Individual #179, Individual #64, and Individual #270) discussed a consistent rationale for lack of community integration. That is, underlying respiratory needs that necessitated the availability of supplemental oxygen. Reports indicated that, due to the unavailability of portable oxygen equipment, individuals were not candidates for community inclusion. The Monitoring Team strongly encourages CCSSLC to obtain the equipment necessary to support the safe community integration, even for short amounts of time, for these individuals. That is, although the rationale appeared prudent with the current status of unavailable equipment, this identified barrier to community integration would seem to be easily addressed with the appropriate supports.<br><br>As described, summary data of community outings was very comprehensive. This data indicated the number of total community outings between 12/1/10 and 5/31/11 for each residential program. In addition, it indicated the number of outings per person and the location of the outings. In addition, a median and range score was provided. This data was helpful in gaining a better understanding of the nature of community outings experienced by individuals served at CCSSLC. However, it was noted in this data that not every person was listed in every residence. It would be appropriate to list all individuals even if they do not have any community outings. This would ensure an accurate picture of available community outings and participation for everyone. In addition, it was noted that some of the community locations were listed more than once. Listing a particular setting more than once inflates the estimate for numbers of locations visited. This measure should reflect the diversity of settings and not how often each setting is visited. The Monitoring Team looks forward to the refinement of this data collection, and perhaps, the ongoing graphic display of this data over time to demonstrate increasing community integration.<br><br>Lastly, documentation revealed that engagement and training in the community had recently decreased within day programs. As a result, on 6/29/11, additional training had been completed. | |

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

1. The rationale for each skill acquisition program should be conspicuously described. This includes ensuring that the rationale is accurate, complete, and consistent with the PFA and/or PSP. In addition, the rationale should very briefly highlight how an identified preference or need was addressed or included in the program (i.e., unless this information is conspicuously outlined in the PSP). (Section S.1)
2. Each developed or selected task analysis should be "test trialed" through direct observation (i.e., observe the individual trying the new skill when supported by staff) and individualize, as appropriate. This should be completed prior to implementing (training) the skill program. (Section S.1)
3. The identification of specific prompt levels should be eliminated within behavioral objectives, because this appears to necessitate more frequent revisions of the program. If including reference to a prompt level is desired, something more general should be used (e.g., " … at the specified prompt level") in the behavioral objective and prescribe/track the necessary prompt level on the data sheet. However, in the end, it might be more efficient to assume (and perhaps indicate) an independent level of responding (following the initial instruction) when writing most behavioral objectives. (Section S.1)
4. A more flexible and immediate criterion should be used within behavioral objectives. That is, the commonly observed "…for three consecutive months" criterion is much too long when performance improves quickly or not at all. An alternative criterion, for example, could include a level of performance for "three consecutive trials." (Section S.1)
5. Redundancy of information across sections in the skill acquisition plans should be avoided. It is assumed that, with frequent use/repetition, staff will learn the format of the plans and know where to look for information. Instructions, discriminative stimuli, error correction or reinforcement procedures, for example, are not necessary under the methodology section if they are sufficiently described in other sections. (Section S.1)
6. Efforts should be made to ensure that each task analysis is adequate, that is, not subjective or overly comprehensive or complex (i.e., not trying to do too much). (Section S.1)
7. Programming for generalization should include more specification regarding the procedures used to promote generalization. It is not sufficient to merely suggest that the skills are likely to generalize to any independent living situation. (Section S.1)
8. Programming for maintenance should include more specification. (Section S.1)
9. Whenever appropriate, a "least-to-most" fading sequence (prompt hierarchy) should be used instead of a "most-to-least." If "most-to-least" is used, a rationale should be provided. (Section S.1)
10. Because a discriminative stimulus can be an instruction ("Patrick, it is time to brush your teeth") or an antecedent stimulus (e.g., the toothpaste and toothbrush on the bathroom sink), both should be very clearly described and be specific relative to the desired response. It is also helpful when these antecedent stimuli naturally occur in the environment. In addition, when targeting a specific step within a task analysis, the prior step is the discriminative stimulus, so, an additional instruction or verbal prompt should not be introduced just prior to this step, because it is unnecessary and perhaps counterproductive. (Section S.1)
11. When appropriate, more frequent teaching opportunities should be prescribed for skill acquisition programs. Frequency of implementation should be daily or multiple times per week. Exceptions might include skills that individuals perform in community-based settings, which may be difficult to access on a daily schedule. (Section S.1)
12. The error correction procedures should be standardized across all skill acquisition plans, when appropriate. Staff instructions should include specification on the method of prompting (most-to-least or least-to-most), determination of the initial prompt level, description of how/when staff provide a prompted trial, and procedures for reinforcement following a prompted correct response. (Section S.1)
13. Differential reinforcement should be used when implementing skill acquisition plans. Highly preferred reinforcers should immediately consequent correct responding following an instruction or discriminative stimulus. Reinforcers (perhaps less preferred reinforcers) should also immediately consequent correct responding following a prompted trial. Reinforcers should not follow incorrect responding. These differences in provision of reinforcement should be obvious and easy for staff to implement. (Section S.1)
14. Reinforcement procedures must be part of every skill acquisition plan and reinforcers should be individualized, when appropriate. (Section S.1)

15. Preference assessments should be regularly completed with all individuals, and the results should be conspicuously noted in skill acquisition plans, PBSPs, etc. (Section S.1)
16. In addition to forward chaining, backward chaining should be considered, as well as total task presentation, when appropriate. Backward chaining and total task presentation allow the individual to experience the complete task analysis each trial. The selection of teaching methodology, obviously, will depend on individual skill level as well as the complexity of the program. Total task is often recommended for tasks that are not too long or too complex. In addition, forward and backward chaining often are recommended for individuals with more limited abilities. (Section S.1)
17. A pilot should be completed with skill acquisition data sheets that are completed during each learning trial to address the inadequacy of the current weekly data collection system, which is not responsive enough for individuals who proceed quickly through a task analysis. (Section S.1)
18. Teaching sessions should be prescribed, and the description of the data collection system should be accurate, especially when data is not collected each trial. Perhaps utilizing the term "teaching trials," when indicating when the program should be implemented and "data collection" or "testing trial" when recording performance. (Section S.1)
19. 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 the new skill acquisition plan format or the previous SSOs, if these types of plans remain in effect. (Section S.1)
20. Based on continued regular estimates of engagement across all residential, vocational and day program settings, and the resulting summarized engagement data, as necessary, corrective feedback or action plans should be developed and implemented. (Section S.1)
21. An expectation should be set that adults of working age participate in full days of programming and/or vocational opportunities. Of course, this should 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. (Section S.1)
22. The PSTs of individuals currently not attending a day or vocational program away from their residential unit should meet to identify the barriers to their participation and problem-solve to assist, as appropriate, individuals in overcoming such obstacles. PSTs should review such reasons and justifications regularly (and document these in the PSP), as well as progress made in assisting individuals to overcome such obstacles. (Section S.1)
23. As appropriate, behavioral supports should be developed for individuals to support their participation in meaningful day and vocational programs. (Section S.1)
24. Clarification should be made to current policies regarding the utilization of the Education and Training Assessment and the Community Outing Preference Assessment. (Section S.2)
25. With regard to vocational assessments:
    a. Skill planning recommendations should target more individualized goals that are a pre-requisite toward their own employment vision;
    b. A more direct connection should be drawn between the previous and current work experiences, data provided within the assessment, and recommendations with the identified long-term vision;
    c. In order to assist individuals obtain their dream jobs (or an approximation thereof), individuals should be supported to learn the skills necessary to be successful in these positions;
    d. When the vocational assessments are completed, assessors should ensure that the revised format is followed closely;
    e. Graphs within the vocational assessments should be improved to ensure accuracy, easy interpretation, and comprehensiveness;
    f. Future vocational assessments should aim to "think out of the box," and pursue potential community settings as the foundation for situational assessments to expand employment visions as well; and
    g. More structure and/or standardization should be provided to situational assessments to ensure the integrity of the assessment, consistency across staff, and adequate exposure to new positions for individuals at CCSSLC. (Section S.2)

26. 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. Special consideration should be given to promoting the effective collaboration between speech services, psychology and active treatment as assessments and interventions, including formal skill acquisition plans, continue to be developed and refined overtime. This type of collaboration, for example, would seem especially beneficial in assisting the new Harbor program in identifying and using evidenced based assessments and interventions. (Sections S.1 and K.8)
27. The Facility should examine, develop, and monitor systems necessary to provide effective competency-based training for direct support professionals on the implementation of skill acquisition and behavior support plans. (Section S.3.a)
28. Necessary equipment (e.g., portable oxygen) should be purchased to support the safe integration of individuals into the community. (Section S.3.b)
29. Graphing progress on skill acquisition programs should continue for all individuals. Generally accepted graphing conventions should be used when displaying data in PSP Monthly Reviews, or within other documents (e.g., Vocational Assessments) (specific recommendations regarding graphing are offered with regard to Section K). (Section S.2)
30. Community outing data should include the average number of outings per week (or month) for each individual and residence. Individuals who do not go out should be included when summarizing the data. (Section S.3.b)

The following is offered as an additional suggestion to the State and Facility:

1. A spreadsheet should be created that tracks community-based supported employment. This should identify each individual, the setting(s) in which they work, the number of hours worked per week (average and range) per site, and the dates of employment per site. New positions each month (or quarter) should be highlighted.

| SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs | |
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| | **Steps Taken to Assess Compliance:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o Statement that there had been no changes to State or Facility policies since the previous review;<br>o Community Placement Report for period between 12/1/10 and 5/31/11, dated 6/21/11;<br>o List of individuals assessed for placement between 6/1/10 and 5/31/11, dated 6/3/11;<br>o List of individuals currently referred for community placement, dated 6/21/11;<br>o List of individuals who have had a Community Living Discharge Plan (CLDP) developed since the last review, undated;<br>o List of individuals who have requested community placement, but have not been referred, dated 6/7/11;<br>o List of individuals who have not been referred for placement solely due to LAR preference, dated 6/5/11;<br>o Major obstacles identified for individuals' movement, dated 6/3/11;<br>o List of individuals transitioned to community settings since the last review, undated;<br>o Statement that: "There were no individuals who returned from a community residential placement since the last onsite review," undated;<br>o List of individuals transferred to other SSLCs, dated 6/24/11;<br>o List of Alleged Offenders between 12/1/10 and 5/31/11, dated 6/3/11;<br>o Position Descriptions for:<br>▪ Admission/Placement Coordinator;<br>▪ Placement Coordinator; and<br>▪ Post Move Monitor;<br>o Statement that: "There is no assessment for Community Placement;"<br>o Exhibit C from DADS Policy #018.1: Living Options Discussion Record, dated 3/31/10;<br>o List of training/educational opportunities for past 12 months, undated;<br>o Personal Support Plans, Sign-in Sheets, Assessments, Personal Support Plan Addenda, (PSPAs), Personal Focus Assessments (PFAs), skill acquisition and teaching programs, and any monthly and/or quarterly reviews for the following individuals: Individual #154, Individual #282, Individual #160, Individual #363, Individual #331, Individual #299, Individual #277, Individual #114, Individual #175, and Individual #281;<br>o Questions to Ask Providers, undated;<br>o Sample of completed Questions to Ask Providers;<br>o Training rosters and curricula for:<br>▪ Community Referral Process/New CLDP, dated 3/10/11;<br>▪ QMRP In-service, dated 4/1/11;<br>▪ Community Living Options Information Process (CLOIP) Training, dated 4/12/11;<br>▪ Living Options, dated 4/25/11 and 4/26/11; and |

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| | ▪ Home and Community Services (HCS), dated 4/28/11;<br>o Making Informed Choices: Community Living Options Information Process, dated April 2008;<br>o Explanation of Mental Retardation Services and Supports, dated April 2008;<br>o Emails, agenda, handouts and sign-in sheet for QMRP Coordinator/Active Treatment Coordinator Conference Call – Obstacles to Moving to a Community Setting, dated 4/13/11;<br>o Post Move Monitoring Activities sections of the CLDPs for Individual #206, Individual #23, Individual #203, Individual #51, and Individual #133;<br>o PSPAs related to post-move monitoring for Individual #206, Individual #133, Individual #203, Individual #51, Individual #230, and Individual #351;<br>o Plan of Improvement for Section T.1.g, dated 7/8/11;<br>o Section T: Review of Post-Move Monitoring Level of Compliance, from 3/1/11 to 6/30/11;<br>o Section T: Review of Post Move Monitoring CCSSLC Level of Compliance – Monthly Trend Comparison by Home, from 3/1/11 to 6/30/11;<br>o Section T: Review of Post Move Monitoring CCSSLC Level of Compliance – Monthly Trend Comparison, from 3/1/11 to 6/30/11;<br>o Section T: Review of CLDP Level of Compliance – Monthly Trend Comparison, from 3/1/11 to 6/30/11;<br>o Section T: Review of CLDP CCSSLC Level of Compliance – Monthly Trend Comparison, from 3/1/11 to 6/30/11;<br>o Section T: Review of CLDP CCSSLC Level of Compliance – Monthly Trend Comparison by Home, from 3/1/11 to 6/30/11;<br>o Section T: Review of CLDP CCSSLC Level of Compliance – Monthly Trend Comparison by Residential Unit, from 3/1/11 to 6/30/11;<br>o Section T: Review of Living Options Level of Compliance, from 3/1/11 to 6/30/11;<br>o Section T: Review of Living Options CCSSLC Level of Compliance – Monthly Trend Comparison, from 3/1/11 to 6/30/11;<br>o Section T: Review of Living Options CCSSLC Level of Compliance – Monthly Trend Comparison by Home, from 3/1/11 to 6/30/11;<br>o Section T: Review of Living Options CCSSLC Level of Compliance – Monthly Trend Comparison by residential Unit, from 3/1/11 to 6/30/11;<br>o Section T: Review of Living Options Inter Rater Report - Audit of Compliance, from 3/1/11 to 6/30/11;<br>o Validity Checks Between Internal and External Audits for Time Period from 3/1/11 to 6/30/11;<br>o Community Living Discharge Plans (CLDPs), including individuals' most recent PSP and related assessments for Individual #206, Individual #51, Individual #133, Individual #203, Individual #351, and Individual #230;<br>o Post Placement Monitoring – CCSSLC, dated 6/5/11;<br>o Pre-Move and Post-Move Monitoring documentation for the following: Individual #51, Individual #230, Individual #351, Individual #203, Individual #344, Individual #11, |

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| | Individual #185, Individual #27, Individual #133, and Individual #206; and<br>o Presentation Book for Section T, including (in addition to documents already listed):<br>▪ Action Plan for Sections T.1.a and T.1.b.2;<br>▪ CCSSLC Tour Activity, dated 6/10/11;<br>▪ Action Plan for Sections T.1.b and T.1.c;<br>▪ Sign-in sheets for CLDP meetings;<br>▪ List of comprehensive assessments within 45 days prior to transition, undated;<br>▪ Pre-move site review documentation;<br>▪ Selection of individuals from monitoring tool, dated 3/11;<br>▪ Sample of completed monitoring tools;<br>▪ Action Plan for Section T.2; and<br>▪ Alternate discharge information for Individual #317, and Individual #6.<br>▪ **Interviews with**:<br>o Dora Flores, Admissions Director;<br>o Sandra Vera, Post-Move Monitor (PMM);<br>o Yvonne Recio, Placement Coordinator;<br>o Rachel Martinez, QMRP Coordinator; and<br>o Bruce Boswell, Director of Day Programs.<br>▪ **Observations of**:<br>o PSP meetings for Individual #234; and<br>o Post-Move Monitoring visits for Individual #133. |
| | **Facility Self-Assessment:** The Facility's POI provided some helpful narrative description of the activities the Facility had undertaken since the last review to reach compliance with the Settlement Agreement. The Facility's Presentation Book for Section T also included information that was valuable to the Monitoring Team as it attempted to learn about the progress that had been made.<br><br>The Facility generally found that it remained out of compliance with most of the provisions of Section T, which was consistent with the findings of the Monitoring Team. However, the Facility found itself to be in compliance with five provisions. The only provision with which the Monitoring Team agreed the Facility had reached compliance was with regard to Section T.1.h, which related to the submission of a community placement report. It appeared with the remaining four, the Facility was viewing the requirements of the provisions too narrowly. For example:<br>▪ For Section T.1.b.2, which related to the education of individuals and families, the Facility did not take into account the more individualized educational activities that needed to be planned and implemented through action plans in individuals' PSPs, as well as more creative activities Facility-wide.<br>▪ For Section T.1.e, which requires the Facility to verify through the MRA, or otherwise, that the essential supports are in place prior to the individual's departure from the Facility, although progress had been made in defining essential and non-essential supports, none of the CLDPs included a comprehensive set of supports. The Facility's focus in determining compliance appeared to be related to the process for verifying such supports prior to the individual's |

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| | transition. As the Facility noted, this had improved with the involvement of the Post-Move Monitor.<br>▪ For Section T.1.f, which requires the Facility to implement a quality assurance system for Section T, although progress had been made, some concerns remained about the monitoring processes, and the data collected was not yet being used to effectuate change.<br>▪ For Section T.2, it appeared that the Facility was reviewing the completion of the post-move monitoring visits as opposed to the quality of the reviews, and the adequacy of the follow-up activities.<br><br>It should be noted that the POI included no monitoring data. It was unclear how the Facility had reached its conclusions related to compliance without such data, particularly because QA data was available to assist in this process. As the Facility's self-assessment process expands, it will be important to include such data in the POI to substantiate compliance findings. |
| | **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.<br><br>At the time of the review, although assessments prepared for annual PSP meetings had begun to include the assessor's recommendation regarding transition to the community, individuals' PSPs did not include a summary or conclusion with regard to the professional team members' determination with regard to whether or not community placement was appropriate. 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.<br><br>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. No aggregate reports were yet available.<br><br>CCSSLC had begun to implement the revised Community Living Discharge Plan process. Overall, the revised form was more comprehensive, included more information, and provided more direction to PSTs than did the previous form. However, it still was not resulting in the development of adequate transition plans, which included the necessary protections, support, and services to ensure the individual's health and safety. Since the previous review, six individuals had transitioned to the community. Of these six individuals, four had experienced significant adverse outcomes within the first 90 days of transition. One had died; three had experienced a total of four psychiatric hospitalizations, most of which also involved police contact and/or arrest; and one had engaged in unauthorized departures from his community home, which placed him as well as community members at significant risk of harm. Based on a review of the CLDPs for these individuals, as well as the post-move monitoring information, significant concerns were |

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| | noted with regard to the transition plans, as well as the quality of supports community providers offered to these individuals.<br><br>Post-move monitoring had been completed in a timely manner for all of the individuals who had transitioned to the community. The Post Move Monitor's comments often provided a thorough description of the methods used to evaluate the item and the findings (e.g., interviews, document reviews and observations). However, some concerns were noted with the thoroughness and/or completeness of the monitoring for some individuals.<br><br>The post-move monitoring identified some issues with regard to the provision of services at the community sites. Not all of these items were addressed thoroughly 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 to the State, and the needs of others with developmental disabilities. | As reported in previous reports, on 3/31/10, DADS issued a revised policy entitled "Most Integrated Setting Practices." This State policy accurately reflected the provisions contained in Section T of the Settlement Agreement. The policy's stated purpose was 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 included components to ensure that any move of an individual to the most integrated setting was consistent with the determinations of professionals that community placement was appropriate, that the transfer was not opposed by the individual or the individual's LAR, and that the transfer was 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.<br><br>With regard to the availability for funding 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 timeframe.<br><br>As noted in previous reports, one issue that appeared to delay individuals' referral to the community at times was a Mental Retardation Authority (MRA) representative not being | Noncompliance |

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| | | at a meeting at which the team decided a referral should be made. Based on documentation the Facility provided (i.e., TX-CC-1107-XVI.4), four individuals had not been referred to the community due to the MRA not being present at their annual PSP meeting. When the reason for a referral not being made is due to the lack of an MRA representative's presence at a meeting, all efforts should be made to schedule a meeting as soon as possible at which all necessary participants are present.<br><br>At the time of the review, although assessments prepared for annual PSP meetings had begun to include the assessor's recommendation regarding transition to the community (e.g., Individual #114, and Individual #331), individuals' PSPs did not include a summary or conclusion with regard to the professional team members' determination with regard to whether or not community placement was appropriate. In fact, in none of the 10 PSPs reviewed (0%) had teams documented the joint determination of the professionals regarding whether or not transition to the community was recommended. 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: | Since the last review, the Facility had made some revisions to some of its policies related to Section T of the Settlement Agreement. However, it was anticipated that the State Office was going to issue an updated policy related to Most Integrated Setting in the near future, which likely would require modifications to be made to Facility policies. The three Monitoring Teams submitted comments on the DADS draft policy for the State's consideration.<br><br>The Facility remained out of compliance with the implementation of the policy. This is discussed below with regard to each of the subsections of provision T.1.b of the Settlement Agreement. As a result, an overall finding of noncompliance has been made for Section T.1.b. | Noncompliance |
| | 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 | As noted above with regard to Section F of the Settlement Agreement, CCSSLC had continued to make efforts to improve PSPs. The PSP format included a section entitled the "Optimistic Living Vision for…" This section included discussion regarding the individual's and his/her LAR's awareness of community options, their preferences for a specific living option, obstacles identified by the PST, and the supports and services the individual needed in various areas. A review was conducted of a sample of 10 PSPs. The findings related to this review are discussed below with regard to the two requirements included in this provision, including: 1) the identification in the PSP of 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 | Noncompliance |

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| | 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. | individual's needs; and 2) identification of the major obstacles to the individual's movement to the most integrated setting, and identification and implementation of strategies to overcome such obstacles.<br><br><u>Identification in PSPs of Needed Protections, Services, and Supports</u><br>As was discussed with regard to Section F of the Settlement Agreement individuals' PSPs did not consistently identify all of the protections, services, and supports that needed to be provided to ensure safety and the provision of adequate habilitation. Some of these issues related 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, and psychology and dental/medical), 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).<br><br>As has been reiterated since the baseline review, 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 three 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; 2) given the extensive histories of many individuals served by CCSSLC, it is important to have one document that summarizes the most relevant historical and current information about an individual to ensure that none of the important components of treatment are lost in the transition process; and 3) 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, and non-essential supports are provided in a timely and complete manner. As is clear from review of recent transitions, when all of the necessary protections, supports, and services are not outlined in the PSP, it is much more difficult to ensure the individual's safe transition.<br><br>Based on a review of 10 PSPs, none of the plans reviewed (0%) included a comprehensive list of the protections, supports, and services needed to support the individual. Often this appeared to be due to staff's assumptions that supports were being provided at the SSLC, and that they did not need to be spelled out in detail. In other instances, the continuing deficits in assessments from various disciplines appeared to stymie the teams' ability to create a comprehensive list. In other instances, the lack of integration across disciplines and lack of incorporation of the various plans (e.g. BSPs, | |

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| | | PNMTs, health care plans, psychiatric treatment plans, communication plans, etc.) continued to result in incomplete PSPs. Previous reports have provided detailed examples of concerns related to PSPs. The Facility is encouraged to review the Monitoring Team's previous reports in relation to Sections F and T of the Settlement Agreement, as well as to critically analyze recent transitions to the community, and identify supports that were missing from PSPs and CLDPs.<br><br><u>Identification of and Plans to Overcome Obstacles to Transition to Community</u><br>As noted above, the PSP format included a section on obstacles identified by the PST. In addition, the State Office has standardized a list of obstacles/barriers to community transition to assist in the analysis of information collected from PSTs throughout the SSLC system. Shortly before the Monitoring Team's visit, State Office staff had provided training to PSTs on obstacles, and their identification in PSPs, as well as related action plans.<br><br>A staff member from the local MRA also was providing training to each PST. The goal was to educate team members more about what was and was not available in the community. Staff reported that the initial session had gone well, and staff had engaged in a substantial amount of valuable discussion with the MRA representative. Additional training sessions were being scheduled for the remaining units.<br><br>In reviewing the sample of 10 PSPs, some obstacles were identified. Of the 10 PSPs reviewed, eight should have had obstacles defined. The remaining two individuals had been referred for transition to the community. Of the eight remaining plans, none (0%) included an adequate list of obstacles. The problems associated with the lists of obstacles included the following:<br>▪ Many did not conform with the State Office's standardized list (e.g., Individual #154, Individual #363, Individual #175);<br>▪ Many were not adequately justified (e.g., Individual #154 likely not adjusting well to change, Individual #363 being too costly to support in the community);<br>▪ When there was guardian objection to community transition, at times, the team engaged in no further discussions about obstacles (e.g., Individual #282 and Individual #331);<br>▪ When guardians or individuals objected, adequate inquiry did not occur with regard to specifically what their concerns were (e.g., Individual #282); and<br>▪ At times, the team indicated no obstacles existed, but the individual was not referred for transition (e.g., Individual #160 and Individual #299).<br><br>Moreover, action plans to overcome the obstacles identified generally were not present. Of the eight PSPs, one (13%) included an action plan to overcome obstacles identified. Even when a plan was present, it was not adequately individualized. For example, the | |

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| | | one plan found for Individual #363 stated that information would be provided to the guardian about community tours. This was not individualized to address her guardian's specific concerns about community transition. Based on interviews, Facility staff recognized that this was an area that continued to need improvement.<br><br>The Monitoring Team has provided numerous examples in previous reports regarding the concerns related to the identification of obstacles, and the lack of plans to overcome them. The Facility is encouraged to review the previous reports.<br><br>CCSSLC remained at the beginning stages of identifying obstacles to community transition, and developing plans to overcome such obstacles. This deficiency, in addition to PSPs that did not adequately identify individuals' needs for protections, supports, and services, resulted in a finding of noncompliance with this provision of the Settlement Agreement. | |
| | 2. The Facility shall ensure the provision of adequate education about available community placements to individuals and their families or guardians to enable them to make informed choices. | As described in previous reports, CCSSLC had engaged in a number of activities to provide education about community placements to individuals and their families or guardians to enable them to make informed decisions. Based on documentation provided, this had taken a number of forms, including:<br>▪ On October 27, 2010, the Admissions and Placement Department hosted a Home and Community-Based Services HCS provider fair. The providers represented offered services in a variety of counties.<br>▪ Visits to community group homes and day programs continued to occur every other Friday with assistance from the Active Treatment Department and Nueces County Mental Health Mental Retardation (MHMR) Authority. These were open to individuals, families/guardians, or staff who wanted 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. Between January and May 2011, approximately 17 such trips reportedly occurred. Many individuals were listed as having participated on these trips.<br><br>A positive enhancement to this process included the development of a list of questions that individuals might want to ask community providers. The list offered some basic questions addressing leisure activities, supports provided, numbers of people living in the home, and the provider's experience. It was a good start, and could be expanded upon based on experience with its use. At the time of the review, only a few had been completed.<br>▪ Individuals and their guardians also were provided information through the Mental Retardation Authority Community Living Options Information Plan | Noncompliance |

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| | | process. This occurred regularly as part of the individual planning process.<br>▪ On 4/28/11, Facility Staff, along with MRA staff from Nueces County and Coastal Plains, made a presentation to which staff as well as family members and individuals were invited. The topic areas covered included eligibility for services, and descriptions of the types of services available, including Home and Community-Based Services (HCS), ICFs/MR, and State Supported Living Centers. Permanency Planning also was discussed.<br>▪ As indicated in previous reports, CCSSLC was 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 might have.<br><br>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 Optimistic Living Vision section of the 10 PSPs reviewed occasionally mentioned exposing an individual and/or his/her guardian further to community options, but the plans to overcome the obstacles identified in this area often were not present or adequately individualized.<br><br>As in its previous reports, the Monitoring Team encourages the Facility 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. 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.<br><br>In its POI, the Facility indicated it was in compliance with this provision. This was not consistent with the Monitoring Team's finding. Although the Facility was continuing to complete some of the basic activities related to education, little progress had been made since the last review in individualizing the process. The individualization of this process is key to ensuring that individuals and their guardians have been provided education that allows them to make an informed choice, as required by the Settlement Agreement. | |
| | 3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of | As is discussed above with regard to Section T.1.a of the Settlement Agreement, the individuals' PSPs reviewed did not document an independent assessment or determination by the professionals on the team of the individuals' appropriateness for transition to the most integrated setting appropriate to meet their needs. | Noncompliance |

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| | 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 Facility had begun to implement the State Office's plan to have each professional member of the PST document his/her recommendation regarding the individual's ability to transition to the community in the assessments completed prior to annual PSP meetings. These assessments also were to identify supports that the individual would need in a community setting. As noted earlier, the assessments for a few of the PSPs reviewed included some recommendations related to community transition, and based on discussions with staff, this new initiative had been clearly communicated at CCSSLC.<br><br>As was discussed at the parties' meeting in June, in addition to assessors providing recommendations in each of their assessments, the determination of the professionals on the team should be documented clearly in the PSP. It was early in the implementation of this new process. As would be expected, the PSPs reviewed did not yet include such documentation. | |
| 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: | At the time of the last review, the Facility had just begun to implement the revised CLDP process. Although progress had been made, the CLDPs continued to need significant improvement.<br><br>In the previous compliance report, the Monitoring Team made a number of recommendations regarding the revised CLDP format. Based on discussions with Facility staff, it appeared that the State Office, working in conjunction with the SSLCs, was in the process of making additional changes to the format. The recommendations previously made will not be made here, but can be referenced in the last report.<br><br>The Facility continued to provide training to staff on the CLDP process. Based on documentation provided, all PSTs had been offered training on the community referral process, including the development of the CLDPs, as well as the post-move monitoring processes.<br><br>Community Living Discharge Plans were reviewed for all six individuals who had transitioned from the Facility to the community since the Monitoring Team's last onsite review, representing 100% of this group of individuals. These included the CLDPs plans for Individual #51, Individual #206, Individual #133, Individual #351, Individual #203, and Individual #230.<br><br>With regard to the timeliness of the Community Living Discharge Plans, four of the six (67%) included documentation to show that they were developed sufficiently prior to the individual's transition. The two plans that did not include such documentation (Individual #351 and Individual #203), and appeared to have been developed only three weeks prior to the individuals' transitions were developed shortly after the Monitoring | Noncompliance |

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| | | Team's previous visit. It appeared that since that time, the Facility had added information to the face sheet of the CLDP to identify when the plan first was initiated, and each date on which it was revised. For the remaining four plans, the initiation date was very close to the referral date, and many revision dates were noted. This was a positive development.<br><br>The Facility continued to make progress in this area, but remained out of compliance. | |
| | 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, none of the six plans reviewed (0%) clearly identified a comprehensive set of specific steps that Facility staff would take to ensure a smooth and safe transition, and when such steps were identified, they often were not sufficiently detailed or measurable. Some examples of the general concerns noted across all plans included:<br>▪ Many of the plans identified the need for training for community provider staff. However, none of them defined which community provider staff needed to complete the training (e.g., direct support professionals, management staff, clinicians, day and vocational staff, etc.), and/or what level of mastery of the information was required (e.g., demonstration of competence).<br>▪ Plans also did not specify the method of training, for example, if it would be necessary for community provider staff to shadow CCSSLC staff, and/or show competency in actually implementing a plan, such as a BSP. For some individuals, specific components of their PSPs should be targeted for more intensive training of community provider staff, or, at a minimum, evidence that the community provider staff have the competencies necessary to safely support the individual.<br>▪ Missing from all of the plans was any requirement that collaboration occur between the Facility clinicians currently working with the individual and the community clinicians who would assume responsibility for supporting the individual (e.g., medical staff, nurses, therapists, psychologists, etc.). For many individuals, this would be necessary to ensure ongoing coordination of care.<br>▪ Similarly, no coordination was specified as needing to occur between current and future residential or day/vocational staff.<br>▪ None of the plans described CCSSLC's staff's involvement in evaluating potential sites at which individuals would be served (e.g., Habilitation Therapies staff to ensure adequate accessibility and/or equipment, Psychology Department staff to determine if safety issues could be addressed in specific settings, and/or if modifications needed to be made to existing plans to address changes in environment).<br>▪ None of the plans addressed any role that CCSSLC staff or community provider staff might play in assisting the individual to make the transition. For example, | Noncompliance |

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| | | there appeared to be no consideration about the need for CCSSLC staff to follow the individual into the community for any period of time (e.g., the first day or longer), or to check in by telephone on occasion. Likewise, no action steps were provided in any of the CLDPs for community provider staff to visit the individual at CCSSLC. Different individuals have different reactions to transitions. However, teams should be cognizant of the stress that transition can cause, and should build mechanisms into CLDPs to reduce this to the extent possible. | |
| | 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. Particularly in the plans developed shortly after the Monitoring Team's last review, terms used to identify responsibility frequently were "[Community-Based Services] provider" or "CCSSLC PST." These were not sufficient to identify the specific staff responsible.<br><br>For the more recently developed plans, names had been to be added for the community provider staff and/or a title for CCSSLC staff (e.g., RN Case Manager). CCSSLC had made progress towards compliance with this provision | 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, all six (100%) included documentation that the plans had been reviewed with the individual and/or the LAR. | Substantial Compliance |
| T1d | Each Facility shall ensure that each individual leaving the Facility to live in a community setting shall have a current comprehensive assessment of needs and supports within 45 days prior to the individual's leaving. | As the Monitoring Team has noted in previous reports, issues existed with regard to both the availability of assessments, as well as their quality. In various other sections of this report, the Monitoring Team included transition assessments in their sample of assessments reviewed. Consistently, the Monitoring Team found them to be inadequate to provide the PSTs with adequate information with which to develop an adequate CLDP or to offer community providers with the information necessary to ensure a safe and successful transition for the individual. Commentary with regard to the adequacy of assessments for these purposes can be found with regard to Sections L, M, and O of the Settlement Agreement.<br><br>The following information that is repeated here from Section M exemplifies the issues related to inadequate assessment processes for individuals transitioning to the community. Of the Nursing Discharge Summaries that nursing completed for five | Noncompliance |

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| | | individuals including: Individual #351, Individual #51, Individual #203, Individual #133, and Individual #206:<br>▪ None (0%) adequately addressed the health/mental health issues of the individuals.<br>▪ There was adequate information contained in none (0%) of the Nursing Discharge Summaries that would guide the subsequent community staff in providing the needed nursing or medical care to the individual.<br>▪ A current nursing assessment was conducted for none (0%) of the individuals prior to transferring to the community.<br>▪ There was adequate documentation specifically identifying nursing interventions needed for all health/mental health issues in none (0%) of the cases reviewed.<br><br>In the tragic case of Individual #351, he was discharged from the Facility to the community on 2/15/11. However, the date of the Nursing Discharge Summary, which was the same form as the Comprehensive Nursing Assessment, was 12/20/10, and provided little to no information regarding the individual's health status related to his diagnoses of Diabetes Insipidus, Obesity, and Asthma. The assessment contained no information addressing the nursing interventions that were needed to care for this individual. There was essentially no information contained in the Nursing Discharge Summary that would guide the subsequent community staff in providing the needed nursing care to the individual. In addition, there was no indication that a current nursing assessment was conducted prior to the individual transferring to the community. Also, there was no indication that any HMPs were sent to the community staff regarding Individual #351 health/mental health issues, although the quality of the HMPs would have been questionable. There was no indication that teaching and information was provided to the community staff regarding the individual's medical diagnoses, specifically the Diabetes Insipidus, and what signs and symptoms they needed to be aware of and regularly monitor. Unfortunately, as noted in the autopsy report, less than two months after transitioning to the community, Individual #351 died from dehydration associated with Diabetes Insipidus.<br><br>In the Monitoring Team's previous reports, it was recommended that, particularly with regard to the transition of medical and other clinical information, that a summary 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.) to facilitate the transition of this information to community medical care providers. More details regarding specifically what this should include can be found in the Monitoring Team's previous report. | |

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| | | With regard to tracking the availability and timeliness of assessments, the Facility provided a copy of a list of assessments, with dates, for each of the individuals who transitioned to the community since the previous review. This was a helpful snapshot. It showed that for each individual, one or more assessment was missing, and several were completed after the CLDP was finalized. Of particular concern, for only two out of five individuals (40%) had an updated medical assessment been completed. Likewise, QMRPs had updated assessments for only three out of five individuals (60%), and vocational assessments only were updated for one individual (20%).<br><br>In addition to significant quality issues related to the assessments available, there continued to be assessments that were not updated, or were updated after the individual's CLDP was finalized. | |
| 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. Although progress definitely was being made, the Facility continued to struggle with this process. On a positive note, PSPs were being revised to begin to identify essential and nonessential supports. If done correctly, this should greatly assist teams when it is time to plan for an individual's transition to the community. The current format of identifying these supports after the individual was referred for transition made it more difficult due to the generally short timeframes from referral to transition.<br><br>At the time of the current review, 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 made it difficult for thorough and meaningful monitoring to occur prior to and after the individual's transition to the community. Likewise, teams did not consistently identify non-essential supports or do so in measurable ways.<br><br>In none of the six plans reviewed (0%) was a comprehensive set of essential and non-essential supports identified in measurable terms. The Monitoring Team has provided many examples of concerns in previous reports. The following summarizes the general concerns noted:<br>▪ Generally, teams were not visualizing the individual with no supports at all, and then identifying each and every support that was needed to assist the individual to be successful in a particular community environment(s). Due to the current inadequacies of the PSPs, teams needed to start at the beginning, and describe the full array of supports the individual needed and wanted. Once these were listed, the CLDP needed to identify how they would be provided in the community, by whom, when, with what frequency, and for how long. This could only be accomplished reviewing current assessments, which, as noted above, | Noncompliance |

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| | | were inadequate, and then asking each team member what they did for the individual hourly, daily, weekly, monthly, quarterly, and annually. Based on this knowledge, the foundation for the CLDP could be built.<br>▪ Although clinical services (e.g., nursing, psychology, therapy, etc.) were often now referenced in the CLDPs, the intensity of the supports was not identified, nor were the qualifications or the roles clearly defined. Supports defined as "psychologist will review BSP," or "the provider will provide medical care to support good health" were inadequate. Teams were not clearly identifying what these supports entailed for the individual at CCSSLC, and then defining in the CLDP how functionally equivalent supports could be provided in the community.<br>▪ In removing any support that the individual utilized at the Facility from the array of support that would be provided in the community, teams should justify why the support is not needed in the community. For example, when an individual's BSP was discontinued, no justification was provided.<br>▪ Teams were not factoring in modifications that needed to be made to current programs or plans, and writing this into the essential or nonessential supports. As one example, when an individual who has a known desire to obtain food moves from the Facility, where certain controls, such as a central kitchen, are in place, to a community home in which the kitchen is stocked with food and available at all times, teams should identify what supports need to be introduced (e.g., modifications to the current PBSP, environmental controls, staffing supports, etc.) to approach this change in a proactive manner.<br>▪ Often plans required that community staff be trained on existing plans. As noted above, concerns existed with regard to the lack of expectations for the quality or outcomes of this training.<br>▪ In addition, few, if any, plans identified an essential or nonessential support for the plans to be implemented (e.g., nursing care plans, health management plans, PNMPs, and PBSPs).<br>▪ Many of the individuals reviewed had specific health care indicators that needed to be monitored and reported (e.g., constipation, input/output, seizures, weight, meal refusals, psychiatric symptoms, etc.). However, few, if any supports were included in the CLDPs to ensure that specific staff were responsible for monitoring such indicators, and when specific criteria were met, reporting these to health care staff.<br>▪ None of the plans identified crisis intervention plans, and/or how the current methods for dealing with crises at the Facility needed to be modified in a community setting.<br>▪ Direct support staffing ratios and requirements (i.e., supervision level) were sometimes, but not always specified.<br>▪ In reviewing assessments, albeit incomplete, many recommendations were not specifically addressed in CLDPs (e.g., specific medical follow-up, adherence to | |

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| | | weight reduction programs, etc.).<br>▪ Generally, day and vocational supports were not well defined.<br>▪ Supports that needed to be provided across day and vocational programs, as well as residential programs (e.g., nursing, psychology, therapy, etc.) generally were not included as part of the day/vocational component.<br>▪ Issues continued to be noted with regard to the measurability of supports identified. Although this had improved significantly, the issue was not completely resolved.<br><br>Of the six individuals who had transitioned to the community since the Monitoring Team's last review, four had experienced significant adverse outcomes within the first 90 days of transition. One had died; three had experienced a total of four psychiatric hospitalizations, most of which also involved police contact and/or arrest; and one had engaged in unauthorized departures from his community home, which placed him as well as community members at significant risk of harm. Based on a review of the CLDPs for these individuals, as well as the post-move monitoring information, significant concerns were noted with regard to the transition plans, as well as the quality of supports community providers offered to these individuals. The Facility is strongly encouraged to conduct reviews of any significant adverse outcome for an individual who transitions to the community. Such reviews should be conducted in the spirit of identifying ways in which improvements can be made to prevent negative outcomes in the future. As was discussed in some detail while at the Facility, good transition planning requires the commitment of the entire PST, as well as those tasked with primary responsibility for developing the CLDPs. The entire team should be involved in critical, but constructive reviews of issues that individuals have experienced once they transitioned to the community.<br><br>With regard to Monitoring by the MRA or other means to ensure essential supports are in place prior to an individual's transition, the MRA's review appeared 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 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 did not represent adequate proof that the essential services required by the CLDPs were in place. None of these forms, for the sample reviewed, provided any additional documentation to show that the MRA | |

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| | | representatives had actually confirmed that the individualized essential supports were in place.<br><br>However, the Facility had begun to implement the new process of having the Post Move Monitor conduct a pre-move site visit designed specifically to determine if the essential supports were in place. A review was conducted of six individuals' pre-move site visit documentation. All six (100%) appeared thorough, and included each essential support listed in the individual's CLDP. They identified the evidence that had been reviewed to determine that the essential support was in place. They also appeared to have been completed in a timely manner, generally on the date of the individual's transition. The process will become more complicated as more essential supports are appropriately identified in individuals' CLDPs. As noted in the previous report, this is substantial progress, however, in meeting this requirement of the Settlement Agreement.<br><br>Overall, a finding of noncompliance was made for this component of the Settlement Agreement. Although progress was noted with regard to the pre-move confirmation of essential supports, substantial work was still needed in adequately delineating the essential and non-essential supports in individuals' CLDPs. | |
| 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. | At the time of the last review, the Facility had just begun using the monitoring tools that had been modified based on the Monitoring Teams' audit tools. At the time of this most recent review, the Facility continued to conduct audits using these tools. The QA Department conducted reviews of CLDPs, and the Post Move Monitoring Process. The QA Department, and the Post-Move Monitor and Placement Coordinator conducted reviews of the Living Options component of Section T.<br><br>Areas in which progress had been noted included:<br>▪ Validity checks were being conducted between the QA Department auditor, and the Post-Move Monitor and Placement Coordinator. This was a good attempt to ensure inter-rater reliability. The format, for example, for reviewing the results was very easy to interpret. However, as is discussed in other sections, a standard inter-rater reliability methodology should be used statewide, and focus needed to be on ensuring that not only were the results of the monitoring similar, but that also they were accurate. In other words, if both auditors were incorrect in their assessment of an indicator, high inter-rater reliability would be present, but the data still would not be valid.<br>▪ The Facility, thought its training database, also had developed a user-friendly format for displaying the results of monitoring activities. It provided a printout of the results of each indicator, which could be viewed over a period of months, allowing comparisons to be easily made.<br>▪ Particularly for the QA audits completed of the Living Options component | Noncompliance |

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| | | significant issues related to, for example, the teams' identification of adequate, individualized supports and services, were identified. Other areas in which problems were noted included the identification of obstacles to transition, and development of strategies to address them. These findings were consistent with those of the Monitoring Team.<br><br>Areas in which continued efforts needed to be made included:<br>▪ As noted above, none of the data was yet being incorporated into the Facility's self-assessment/POI.<br>▪ As also noted above, inter-rater reliability had not yet been established, nor had the accuracy of the monitoring data.<br>▪ As detailed in the Monitoring Team's report on Austin SSLC, dated 7/7/11, the Monitoring Team continues to have concerns about the adequacy of the guidelines provided to reviewers. Efforts to improve these are necessary to ensure accuracy in monitoring as well.<br>▪ Analysis of the data, and development of appropriate corrective action plans had not yet occurred to the extent necessary. The Admissions Placement Coordinator shared an action plan to address Section T.1.g, related to the Facility's obstacles report. This was an important area in which to focus. However, as identified through the Facility's own monitoring, the Monitoring Team's findings, as well as the concerns identified for individuals who transitioned to the community, corrective action plans needed to be developed to address other areas, including but not limited to the adequate development and implementation of CLDPs.<br><br>A concern identified during the review was a new process that State Office was putting in place. Reportedly, State Office consultants would be completing monitoring of post-move monitoring that fell outside of CCSSLC's local area. At the time of the Monitoring Team's review, CCSSLC appeared to be conducting this monitoring effectively. The advantage of having a CCSSLC QA staff conduct this monitoring was that she could participate in CLDP meetings, and have a better familiarity of the individual and his/her needs. This appeared to enhance the monitoring of post-move monitoring activities.<br><br>Although progress had been made in this area, the Facility was continuing to develop and implement quality assurance processes necessary to assess its implementation of Section T. The Facility should continue to expand its monitoring activities in this area, including modifying, as appropriate, the monitoring tools, particularly to improve the guidance provided to auditors; training staff who will conduct the monitoring on the review tools and their implementation; ensuring the reviews accurately evaluate quality as well as the presence or absence of items; and establishing inter-rater reliability. In addition, the Facility should analyze information resulting from monitoring activities, and, as | |

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| | | appropriate, develop, implement, and monitor action plans to address concerns identified. Such plans should include action steps, person(s) responsible, timeframes for completion, and anticipated outcomes. | |
| T1g | Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature. | Although some progress was being made in this area, the State and Facility were still in the beginning stages of implementing this provision of the Settlement Agreement. The Facility had not yet generated an annual report to State Office. The obstacle data CCSSLC submitted to the Monitoring Team was extremely limited. It included nine individuals, with the obstacles identified for three individuals being the MRA was not present at the meeting; for four, that the LAR's choice was for the individual to remain at CCSSLC; and for two, that community options were being explored, which did not appear to be an obstacle.<br><br>Progress that had been made included:<br>▪ The State had developed a list of standard obstacles that teams would be asked to utilize. On 5/16/11, the Monitoring Panel provided the State Office with comments on the draft revised Most Integrated Setting policy, including the list of obstacles. In general, though, this list should assist in standardizing the data collected, which in turn should provide the State Office with better information about protections, supports, and services that should be enhanced in the community, as well as concerns that individuals and LARs have regarding transition to the community.<br>▪ The Facility provided documentation of a conference call held on 4/13/11, during which the State Office's standardized obstacles to moving to a community setting were presented to the Acting QMRP Coordinator, as well as Admissions Director, Post-Move Monitor, and Placement Coordinator.<br>▪ CCSSLC had drafted the action steps for a plan of improvement to address Section T.1.g. No timeframes had been assigned to the action plan. However, it appeared to set forth a reasonable plan for complying with this provision.<br><br>Although CCSSLC remained out of compliance with this provision, activities were underway to achieve compliance. It will be essential for PSTs to be trained adequately on the proper identification of obstacles in order for these efforts to be successful. | Noncompliance |
| 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 | In response to a document request, the Facility submitted to the Monitoring Team a Community Placement Report. For the time period between 12/1/10 and 5/31/11, the report listed:<br>▪ Current Referrals: Nine individuals were included on this list. At the time of the review, two of these individuals had transitioned to the community, and one individual's referral had been rescinded. | Substantial Compliance |

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| | listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive community services; and those individuals who have been placed in the community during the previous six months. For the purposes of these Community Placement Reports, community services refers to the full range of services and supports an individual needs to live independently in the community including, but not limited to, medical, housing, employment, and transportation. Community services do not include services provided in a private nursing facility. The Facility need not generate a separate Community Placement Report if it complies with the requirements of this paragraph by means of a Facility Report submitted pursuant to Section III.I. | ▪ Community Placements: Five individuals were included on this list, one of whom had died since moving to the community.<br>▪ Rescinded Referrals: One individual was included on this list. The reason for referral being was due to the individual's choice.<br><br>During December 2010, the Monitoring Panel requested some additional information regarding transition in order to capture categories of individuals who have either requested community transition, or whose teams have determined they can be appropriately placed in the community. For meetings occurring between 9/1/10 and 5/31/11, the report listed:<br>▪ Individual Prefers Community, Not Referred – LAR Choice: This list included six individuals.<br>▪ Individual Prefers Community, Not Referred – Other Reasons: This list included 10 individuals. For five of the individuals, the MRA was not present, which is a requirement for a referral being made. In these cases, the teams reportedly were required to reconvene a meeting at which the MRA could be present. It was unclear if this had occurred.<br><br>The Monitoring Panel asked that a final category be added that includes a list of names of individuals who would be referred by the team except for the objection of the LAR whether or not the individual himself or herself has expressed, or is capable of expressing, a preference for referral. As noted above with regard to provision T.1.a of the Settlement Agreement, professionals on individuals' teams need to make independent recommendations regarding the appropriateness of an individual for community placement. The State indicated that its data system did not include this information, but it was working toward being able to produce the data the Monitoring Panel requested. The Monitoring Team looks forward to reviewing this information in the future. | |
| **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 | <u>Timeliness of the Checklists</u><br>Post-move monitoring documentation was reviewed for seven individuals (Individual #51, Individual #230, Individual #351, Individual #203, Individual #344, Individual #27, Individual #133, and Individual #206). This sample represented all (100%) of the individuals for whom the CCSSLC Post-Move Monitor needed to complete reviews since the last review. For the seven individuals, 14 reviews should have been completed since the previous review. Of the 14 required visits, all (100%) had been documented as having been completed on time. | Noncompliance |

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| | individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency. | Although improvement was seen, documentation did not consistently show that visits had been made to both the residential and day sites of the individuals (e.g., seven-day monitoring for Individual #230 and Individual #351, and 45-day monitoring for Individual #344).<br><br>An additional concern noted related to the completion of the one to seven-day monitoring visit on the same day as the individual transitioned to the home, which for some individuals also was the date on which the Post-Move Monitor conducted the "pre-move" site visit (e.g., Individual #51 and Individual #203). This practice appeared to apply to individuals who moved outside of the Corpus Christi area, and likely was done to reduce travel time and costs. However, the Settlement Agreement appears to envision the pre-move certification of essential supports being in place as separate from the seven-day post-move monitoring requirement.<br><br><u>Content of Checklists</u>:<br>With regard to the content of the checklists, the checklists reviewed generally utilized the revised format, which was consistent with the format attached to the Settlement Agreement as Appendix C. A significant improvement was that the methodology being used to confirm the existence of necessary protections, supports, and services was generally stated. This was facilitated by the addition of an "evidence" column, which identified the evidence that the Post Move Monitor was expected to review during the monitoring process. A "comments" column also facilitated provision of an explanation of what was done to confirm compliance, as well as narratives describing both positive and negative findings. As discussed in the Monitoring Team's previous report, an overall concern was that there was no longer a "Yes/No/N/A" column on the checklist, and it was only by reading the narrative in the comments section that a determination could be made with regard to whether or not the essential and non-essential supports were in place.<br><br>The checklists reviewed generally were completed thoroughly. However, as noted in the Monitoring Team's previous reports, some concerns were noted with regard to ensuring and/or documenting that each essential and non-essential support was in place in a timely manner. More specifically:<br>▪ At times, requirements in the CLDPs included multiple requirements, and the monitoring completed did not address each of the separate requirements (e.g., for Individual #344 regarding list of dietary/nutrition requirements, and Individual #351's list of requirements related to psychiatry).<br>▪ In other instances, the Post-Move Monitor did not comment on specific supports that should have been in place (e.g., Individual #351 was supposed to see an endocrinologist, but monitoring form did not identify this as an issue; and | |

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| | | Individual #230 regarding skill acquisition goal at 45-day, and BSP at 90-day;); and<br>▪ At times, a support that was categorized as an "essential support," but was ongoing in nature, was reviewed initially, but not during each of the subsequent reviews (e.g., Individual #351, Individual #230, and Individual #51).<br><br>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 the issues that were being identified were followed through to conclusion. Notes identifying actions taken were documented on the forms. An important addition to this process was the expectation that teams would meet after each post-move monitoring visit was completed to review the report, and determine if additional action needed to be taken.<br><br>It is important to note that a number of Facility staff, including, but not limited to the Placement Coordinator and Post-Move Monitor had put forth substantial effort to respond to community providers requests for assistance, and to engage the individuals CCSSLC teams in helping to resolve issues that arose.<br><br>However, this was an area that required continued focus. Although many identified issues were addressed, gaps continued to exist (e.g., Individual #230 was noted to be gaining weight, and based on her BMI, this was a concern, but no specific intervention was recommended; and Individual #351 was exhibiting significant behavioral issues, but documentation did not show that CCSSLC advocated for the provider agency to improve the behavioral supports provided to him).<br><br>Overall, progress was being made with regard to this provision. The Facility had begun to use the new post-move monitoring process, which included a number of important improvements. Monitoring visits were being completed timely. Areas needing continued improvement to reach compliance included ensuring that monitoring visits include all of the sites at which essential and non-essential supports are provided, all essential and non-essential supports are reviewed and a rating is provided (i.e., Yes, No, N/A), and adequate follow-up is taken and documented. | |
| 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 | During the week of the on-site review, a member of the Monitoring Team accompanied the Post-Move Monitor on two post-move monitoring visits for Individual #133. It should be noted that the circumstances of one of these visits was extremely difficult. However, the Post-Move Monitor handled the situation quite professionally. Specifically, upon arrival at Individual #133's home, the police, who had been summoned by the community provider staff, arrived. The community provider staff had involved the police | Not Rated |

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| | 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. | due to their inability to address the individual's behavioral needs. Individual #133 had left the home, and was attempting to destroy a neighbor's property. Ultimately, the police took custody of the individual with the assistance of Emergency Medical Staff, and she was transported to a psychiatric unit.<br><br>Despite two attempts, including a visit to the individual's day program earlier in the week and the residential site visit described above, the Post-Move Monitor was unable to complete the full monitoring while the Monitoring Team was onsite. As a result, no monitoring report was available for review. Due to the inability of the Monitoring Team to witness a full post-move monitoring visit, and to review the resulting documentation, this provision has not been rated. | |
| **T3** | **Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations. | | |
| **T4** | **Alternate Discharges -** | | |
| | 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:<br>(a) individuals who move out of state;<br>(b) individuals discharged at the expiration of an emergency | At a parties' meeting on December 2 and 3, 2010, it was agreed that in addition to the categories listed in the Settlement Agreement, other circumstances resulting in an individual moving from a SSLC might fall under the category of "alternate discharges." One of these reasons was an individual transferring to another SSLC. Since the last review, two individuals had transferred to other SSLCs, including Individual #317 and Individual #6.<br><br>Based on a review of the discharge summaries completed for Individual #317 and Individual #6, they contained the categories consistent with the Centers for Medicare and Medicaid Services (CMS) requirements. They included a summary of the individual's developmental, behavioral, social, health, and nutritional status. However, in some cases, these summaries did not "accurately describe the individual, including his/her strengths, | Noncompliance |

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| | admission;<br>(c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe;<br>(d) individuals receiving respite services at the Facility for a maximum period of 60 days;<br>(e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission;<br>(f) individuals discharged pursuant to a court order vacating the commitment order. | needs, required services, social relationships and preferences" as required by the CMS guidelines [42 Code of Federal Regulations (CFR) §483.440(b)(5)(i), and W203]. In addition, the discharge plans did not appear to meet the CMS requirement [42 CFR §483.440(b)(5)(ii), and W205] to provide a discharge plan "sufficient to allow the receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement." The concerns noted included:<br>▪ The content of the summary information was limited, and did not appear to consistently provide all of the most recent information related to the individuals' strengths, needs, and preferences. For example:<br>o Individual #6 had behavioral issues that had the potential to place him or others at risk. Several past placements had been jeopardized by this behavior. Minimal information was provided regarding his PBSP, or other training, staffing supports, or counseling that had been effective while he was at CCSSLC to address his behavior. Given that this behavior, at times, had impacted his roommates, there was no discussion of any environmental controls or other supports to protect his roommates. The discharge summary included no recommendation for his BSP to continue.<br>o Minimal medical or nursing information was provided for either individual. For example, Individual #317 was prescribed a number of psychotropic medications, but minimal information was provided related to his psychiatric history or current status. It was unclear if either of the individuals had nursing care plans, or other health maintenance plans that needed continued implementation.<br>▪ The section of the transfer/discharge summary that identified "Referrals and/or Necessary Services Required in New Environment" included very minimal recommendations for each of the summaries reviewed. In fact, both stated that: "Upon his arrival to [name of State Supported Living Center], a complete reassessment of all needs/services should be completed in order to assist [name of individual] in acclimating to his new environment." Although reassessment might be necessary and appropriate, including this as the only recommendation was not helpful in ensuring that the receiving SSLC provided adequate supports and services until such time that reassessment could be completed.<br><br>The Facility was not in compliance with this provision due to the fact that it did not meet the CMS requirements for transition/discharge planning. | |

**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, and clearly documented in the PSP. 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. (Section T.1.a and T.1.b.3)

2. When the reason for a referral not being made is due to the lack of an MRA representative's presence at a meeting, all efforts should be made to schedule a meeting as soon as possible at which all necessary participants are present. (Section T.1.a)
3. As has been recommended in previous reports, with regard to policy:
    a. State policy, as well as Facility policy, should be modified to reflect the changes that have occurred regarding transition procedures so that expectations regarding practice are clearly delineated.
    b. In addition, as appropriate, the Facility should include in its local policies any Facility-specific details that are relevant to full implementation of the State policy. (Section T.1.b)
4. Teams should be provided with additional competency-based training on the identification of obstacles to movement of individuals to the most integrated setting appropriate to their needs and preferences. Such obstacles should be defined in terms of protections, services, and supports that currently are lacking or not available in the community. Obstacles also should be defined with sufficient detail to allow the State to identify and address issues related to the current community system. For example, certain services or supports might be lacking in a particular area of the State where the individual or LAR wants the individual to live, the timeliness with which services can be accessed in the community (e.g., certain types of medical services) might be an issue, etc. Such detail is essential to ensuring that the State has the information necessary to make changes. (Section T.1.b.1)
5. Likewise, when an individual or LAR indicates that they do not want to consider transition to the community, it is important to document the specific reasons for this. For example, reasons could range from concerns about quality of community services, rates of turnover in community settings, concerns about the individual leaving comfortable surroundings, types of services that are not available, etc. Such information needs to be collected and analyzed by the Facility and the State. (Section T.1.b.1)
6. 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 PSP to document that individuals and their families are making informed decisions with regard to an individual's living options. (Section T.1.b.1)
7. The Facility should add creative and individualized educational activities to meet the needs of various individuals and families/guardians, including action plans in individuals' PSPs designed to meet their specific needs. Consideration should be given to developing a written plan that identifies the actions that will be taken, persons responsible and timeframes for completion. (Section T.1.b.2)
8. Given that from a normalization perspective, when people move, often one of the hardest aspects is leaving friends behind, and typically plans would be made to help stay in touch with important colleagues or friends, as appropriate, it would be important to include such activities in individuals' transition plans. (Section T.1.c.1)
9. Essential and non-essential supports should be better defined in Community Living Discharge Plans. Likewise, the role of the Facility staff in the transition and discharge process should be better defined. (Sections T.1.c.1 and T.1.e)
10. Particularly with regard to the transition of medical and other clinical information, a summary should 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.) to facilitate the transition of this information to community medical care providers. (Section T.1.d)
11. The State and Facility should conduct critical analyses of the transition planning and implementation processes for any individuals who return to the Facility, who require more restrictive levels of placement from their community setting (e.g., die, are arrested, are transferred to a mental health hospital after transitioning to the community), or whose community transitions are in jeopardy. (Section T.1.e)
12. With regard to monitoring activities related to the Facility's performance with this section of the Settlement Agreement, the Facility should:
    a. Modify, as appropriate, the monitoring tools, particularly to improve the guidance provided to auditors;

b. Ensure the reviews accurately evaluate quality as well as the presence or absence of items;
c. Establish inter-rater reliability; and
d. Analyze information resulting from monitoring activities, and, as appropriate, develop, implement, and monitor action plans to address concerns identified. Such plans should include action steps, person(s) responsible, timeframes for completion, and anticipated outcomes. (Section T.1.f)

13. In order to adequately ensure that all essential and non-essential supports are in place, monitoring visits should be conducted in all settings to review protections, supports, and services are being provided. (Section T.2.a)
14. With regard to the revised post move monitoring checklist format:
    a. A column should be added to provide a clear rating of whether or not an item/activity was present or had been completed (i.e., Yes, No, N/A).
    b. As the format is populated for each individual, the information in the CLDP should be broken down into indicators that measure one outcome. This would assist in ensuring that when a rating is provided, it is clear what is present, and what remains as an outstanding issue. (Section T.2.a)
15. The action plans that are part of post-move monitoring checklists should be more focused on resolving the issues identified. (Section T.2.a)
16. 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 T.2.a)
17. Given the varying purposes of the monitoring activities required by the Settlement Agreement, pre-move and post-move monitoring activities should not occur on the same day. (Section T.2.a)
18. CCSSLC should review the transition/discharge summary process that it is using for individuals who undergo "alternate discharges" to ensure that the requirements set forth by CMS are met, including a process that:
    a. "[A]ccurately describes the individual, including his/her strengths, needs, required services, social relationships and preferences" [42 Code of Federal Regulations (CFR) §483.440(b)(5)(i), and W203]; and
    b. Provides a discharge plan "sufficient to allow the receiving facility to provide the services and supports needed by the individual in order to adjust to the new placement" [42 CFR §483.440(b)(5)(ii), and W205]. (Section T.4)

| SECTION U: Consent | |
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| | **Steps Taken to Assess Compliance:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o CCSSLC Policy on Consents – UU.3: Ensuring Individual Rights, revised 12/8/10;<br>o Individuals Identified Without a LAR [Legally Authorized Representative] Prioritized by Family/Contact Visitation Frequency, dated 11/24/10;<br>o Presentation Book for Section U, including:<br>▪ POI/Self Assessment for Section U;<br>▪ Settlement Agreement Cross Referenced with ICF/MR Standards – Section U Consent Guidelines audit tool, revised 12/10;<br>▪ Settlement Agreement Cross Referenced with ICF/MR Standards – Section U Consent audit tool, revised 12/10;<br>▪ Social Supports Questionnaire with directions and training roster, dated 5/23/11;<br>▪ QA/QI Council Meeting Minutes, dated 5/12/11, 5/24/11, 6/15/11, and July 8, 2011;<br>▪ Sample of completed Social Supports Questionnaires;<br>▪ State Supported Living Center Guardianship Resource Log, dated June to July 2011;<br>▪ Corpus Christi Guardianship Log, dated June 2011;<br>o Texas Guardianship Statute - Probate Code, Chapter XIII. Guardianship, Sections 601 through 700;<br>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;<br>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<br>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.<br>▪ **Interviews with**:<br>o Daniel Dickson, Quality Assurance Director; and<br>o Karen Forrester, Human Rights Officer (HRO). |
| | **Facility Self-Assessment:** In its POI, the Facility 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. Although compliance had not been achieved, the POI indicated that staff had taken steps to attempt to develop a prioritized list of individuals requiring guardianship, and was awaiting final State policy on the subject. The POI also indicated that efforts were underway to attempt to identify potential guardianship resources. |

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| | **Summary of Monitor's Assessment:** DADS State Office was still in the process of finalizing policies on guardianship and consent that were expected to provide guidance to the Facilities with regard to the implementation of this Settlement Agreement requirement. Although CCSSLC staff reported that progress was being made, the final policies had not been issued. As discussed below, this resulted in minimal progress being made at the Facility level.<br><br>At the time of the review, the process for assessing individuals' "functional capacity to render a decision" and provide informed consent was still not being completed using an adequate standardized tool. However, it was anticipated that the State Office policy would set forth a methodical approach for screening individuals to determine a possible need for assistance in decision-making, and, as appropriate, assessing in more detail individuals' functioning in this area. In the meantime, the Facility had developed a Social Supports Questionnaire to assist in screening individuals, and determining the priority level for individuals needing guardians. Although these efforts were positive steps in beginning to involve individuals' teams in the screening and prioritization processes, a more comprehensive screening process, as well as more objective criteria for prioritization should be developed and implemented to meet the Settlement Agreement requirements.<br><br>Since the last review, no guardians had been identified for individuals who needed them. CCSSLC had made efforts to identify potential guardianship resources, but, at the time of the review, no viable resources had been identified. It will be essential that adequate resources be identified to address this need. |

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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 | As reported in the Monitoring Team's previous reports, although CCSSLC 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 needed to make additional efforts.<br><br>Staff indicated that DADS State Office was still in the process of finalizing policies on guardianship and consent that were expected to provide guidance to the Facilities with regard to the implementation of this Settlement Agreement requirement. CCSSLC staff had worked with the State Office and the Human Rights Officers from other SSLLCs to review the draft policy and discuss additional changes, as well as implementation of the policies.<br><br>Once the State Office policy is finalized, CCSSLC should review and revise, as necessary, its policies. Concerns related to the Facility's policies have been discussed in the Monitoring Team's previous reports. Since the last review, the Facility had made progress in this area by revising its policy with regard to recruitment of Human Rights | Noncompliance |

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| | decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources. | Committee members. In fact, the Facility had successfully recruited new members to the HRC, including some additional community members who were not Facility employees. This was an important step given the role the HRC played in reviewing restrictive procedures.<br><br>As noted by Facility staff during the on-site review, implementation of the policy the State Office was developing will require significant effort and changes to a number of practices at the Facility, including more intense involvement of individuals' PSTs in assessing individuals' "functional capacity to render a decision" and provide informed consent. At the time of the review, this process was still not being completed using an adequate standardized process, but it was anticipated that the State Office policy would set forth a methodical approach for screening individuals to determine a possible need for assistance in decision-making, and, as appropriate, assessing in more detail individuals' functioning in this area. This likely will require CCSSLC to modify further its policies and procedures to ensure thorough implementation of the State policy.<br><br>At the time of the review, as part of the annual individualized planning process, individual teams at CCSSLC continued to identify whether an individual had a Legally Authorized Representative or not. It appeared that individual teams reviewed the Rights Assessment, that was 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.<br><br>In addition, the Human Rights Officer had developed, and the QA/QI Council had approved a Social Supports Questionnaire to assist in screening individuals, and determining the priority level for individuals needing guardians. Although these efforts were positive steps in beginning to involve individuals' teams in the screening and prioritization processes, a more comprehensive screening process, as well as more objective criteria for prioritization should be developed and implemented to meet the Settlement Agreement requirements. In reviewing a small sample of Social Supports Questionnaires, it was unclear how teams had distinguished between individuals with high, medium, and low priorities for guardianship. For example, some of the individuals who had been identified at medium priority had similar profiles to individuals who had been identified as having a high priority need for a guardian (e.g., Individual #142 and Individual #103 had similar profiles, but were rated as having high and medium priority level, respectively). The instructions for the questionnaire did not provide guidance in this area.<br><br>Since the last review, using the information gained through the implementation of the Social Supports Questionnaire, the Facility had reprioritized the list of individuals | |

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| | | needing guardians. Based on the previous review, the prioritized list provided to the Monitoring Team included 208 individuals. Based on the census at the time of 283 individuals, this resulted in an estimated 73% of the individuals at CCSSLC being in need of guardians. During the most recent review, the newly prioritized list of individuals included only 154 individuals, or 56% of the 273 individuals residing at the Facility. These significant discrepancies in numbers illustrate the need for a more objective method for identifying individuals' need for guardianship. Likewise, as noted above, the process for prioritization should be based on more standardized criteria. The revised list included:<br>▪ A total of 24 individuals identified as having a high priority for guardianship;<br>▪ An additional 109 individuals at medium priority; and<br>▪ Another 21 with low priority.<br><br>As noted in previous reports, the Texas Guardianship Statute recognized guardianship as a restrictive procedure that required due process. The statute also offered 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 an individual to make informed decisions, or increase their capacity to make such decisions. The Social Supports Questionnaire included questions to begin to have teams think about areas in which individuals might be able to make decisions, as well as ways in which individuals were able to communicate their choices or decisions. Another positive development was the scheduling of staff training by the DADS Guardianship Program on the various guardianship options, as well as alternatives to guardianship.<br><br>Progress was being made, but the Facility remained out of compliance with this component of the Settlement Agreement. Although the Facility had a prioritized list, an adequate standardized process for determining individuals' functional capacity to render informed decisions still was not being used. In addition, although teams were becoming more involved in the process, including the identification of an individual's priority level for guardianship, sufficient criteria were not in place to standardize the process across teams. Once the State Office policy is finalized, the Facility is encouraged to implement it expeditiously. | |
| U2 | Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those | Based on interviews with Facility staff and review of documentation, since the last review, no guardians had been identified for individuals who needed them.<br><br>The Human Rights Officer had engaged in some efforts to identify potential guardianship | Noncompliance |

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| | individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities. | resources, including contacting a couple of the other SSLCs to discuss their efforts in recruiting guardians, and contacting the Intellectual Developmental Disability Local Authority. However, according to CCSSLC staff, there were no known guardianship resources available in the area. For example, Facility staff had not been able to identify any for-profit or nonprofit guardianship entities to which referrals could be made.<br><br>As noted above, the current list of individuals requiring guardians included 154 names. Although, as also discussed above, given the lack of adequate assessments, it was not clear if this was an accurate number, it will be essential that adequate resources to address individuals' need for guardians be identified.<br><br>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 would be ordered (i.e., full or limited guardianship). 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. The State should finalize the State Office policy on guardianship and consent, and implement it as soon as possible. In doing so, 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 alternatives to guardianship, including 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 and/or revise its policies related to guardianship and informed consent 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 re-prioritize the list, as appropriate.
5. CCSSLC staff should collaborate with staff from other SSLCs to identify and implement potential initiatives and resources for identifying

guardians.

6. 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 | |
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| | **Steps Taken to Assess Compliance:** The following activities occurred to assess compliance:<br>▪ **Review of Following Documents**:<br>o CCSSLC Policies related to record keeping that had been revised since last review, including:<br>▪ V.2: Filing, revised 5/26/11;<br>▪ V.3: Security of Records and Using a Special Binder in Each Active Record Area, revised 3/31/11;<br>▪ V.4: Unified Record, revised 3/31/11;<br>o List of Persons Responsible for Management of Records;<br>o Description of Quality Assurance Procedures, undated;<br>o Plans of correction resulting from record audits for last three months: "No Evidence;"<br>o CCSSLC Master Table of Contents of Policy and Procedure manual, dated 6/22/11;<br>o Master Record Order and Guidelines: Historical Records, revised 11/19/10;<br>o Master Record Order and Guidelines: Active Record Purged from Units, dated 3/10/11;<br>o Master Record Order and Guidelines: Inactive Records, dated 3/10/11;<br>o Active Record Order and Guideline, revised 2/4/11;<br>o Table of Contents of Individual Notebook;<br>o Quality Assurance Checklists completed for last 10 records reviewed by Facility staff; and<br>o Active Records Documentation Logs, dated 6/2/11; and<br>o Presentation Book for Section V.<br>▪ **Interviews with**:<br>o Elena Menchaca, Unified Records Coordinator;<br>o Lily Rodriguez, Unified Records Coordinator; and<br>o Daniel Dickson, Director for Quality Assurance. |
| | **Facility Self-Assessment:** Based on a review of the Facility's POI, with regard to Section V of the Settlement Agreement, the Facility found that it remained out of compliance with all of the sub-provisions. This was consistent with the Monitoring Team's findings.<br><br>As is described in further detail below with regard to Section V.3 of the Settlement Agreement, the Unified Records Coordinators and the QA Department continued to conduct regular record reviews. The Facility recognized that in addition to reviews of the presence of items in records, it also needed to assess quality of items.<br><br>The Facility had begun to use some data to substantiate its findings related to compliance. However, the data provided appeared to be an overall score, and did not allow distinctions to be made between the Facilities compliance with the various requirements of the Settlement Agreement. For example, the POI stated: "For February 2011, March 2011, and April 2011, Section V audits show 66% level of compliance for V.1." Section V.1 has a number of distinct requirements, because it references Appendix D of the Settlement |

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| | Agreement. It could not be determined from this overall number whether, for example, concerns continued to exist with active records, master records, or Individual Notebooks, and, if so, what those issues were. |
| | **Summary of Monitor's Assessment:** As the State issued modifications to the Table of Contents for the Active Record, the Facility had developed and implemented plans to make revisions to the active records across campus. CCSSLC continued to maintain Individual Notebooks. The final phase of the process involved the conversion of individuals' historical files to the Master Record format State Office issued, which the Facility continued to work towards.<br><br>The Facility had developed an Active Records Documentation Log. It identified typical items to be filed for each discipline. The log allowed a record to be maintained of when departments submitted documents, and when they were filed.<br><br>As is discussed throughout this report, policies and procedures necessary to implement the Settlement Agreement were in various stages of development. The Director for Quality Assurance continued to maintain a tracking system to assist in ensuring that Facility policies were consistent with State Office policies.<br><br>CCSSLC was conducting reviews of at least five records each month. 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.<br><br>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. |

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| V1 | Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D. | At the time of the Monitoring Team's review, two file clerks were assigned to each unit. The file clerks assisted with the maintenance of the records. As indicated in the Monitoring Team's previous report, all individuals' Active Records had been converted to the new Table of Contents. Since that time, the State Office had issued a revision to the Table of Contents, and a plan had been developed an executed to make the needed changes in the active records across campus. File Clerks continued to have responsibility for maintaining the Active Records, for the most part. As noted in the previous report, one exception was that direct support professionals on the overnight shift filed Observation Notes daily. They transferred them from the Individual Notebooks to the Active Records on a daily basis. This assisted in ensuring that important information related to individuals' health and behavioral status was regularly available in the active record. | Noncompliance |

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| | | CCSSLC had Individual Notebooks for individuals prior to the conversion process, and reportedly, all Individual Notebooks were in place. Residential Coordinators were responsible for maintaining the notebooks. The file clerks removed data related to individuals skill plans and PBSPs on a monthly basis, and filed it in the active records.<br><br>The final phase of the process involved the conversion of individuals' historical files to the Master Record format State Office issued. Facility staff indicated this continued to be a work in progress.<br><br>Although it was very positive that the underlying infrastructure for the records was in place, from a limited review of records while on site, it was noted that a number of documents were not in the active records and had to be obtained from the units. Specifically, several Nursing Quarterly Assessments, Nursing Annual Assessments, and Nursing Health Management Plans were not found in the records. Of 13 records reviewed, five (38%) contained the appropriate nursing documentation. As recommended with regard to Section M.1, the Facility should determine if missing nursing documentation is a product of issues related to the timely filing of documents in the records, or nursing staff not completing the required documentation or not submitting it to be filed. Once these questions are answered, then appropriate corrective actions should be implemented addressing the identified issue(s).<br><br>A mechanism that had been put in place in late May to address issues such as this one was the use of the Active Records Document log. Its use was described in the revised CCSSLC Policy #V.2 on Filing, dated 5/26/11. It identified typical items to be filed for each discipline. The log allowed a record to be maintained of when departments submitted documents, and when they were filed. It should assist in addressing issues, such as the one identified above related to nursing documentation.<br><br>With regard to the security of records as referenced in Appendix D of the Settlement Agreement, it was the expectation that records were maintained in a locked file cabinet to which staff in the homes had access. Since the last review, some modifications had been made to the policies and procedures to ensure adequate access to the records, as well as maintain sufficient security. At the time of the review, it appeared that issues related to necessary access had been resolved.<br><br>As noted in the previous report, the Facility had an Active Record Check out procedure. This procedure went 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. This policy addressed an essential component of maintaining control over the security of the records. One step that was not clearly identified in the policy was if or when checks would be completed to ensure that all records had been returned to the residence, for | |

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| | | example, at the end of every business day.<br><br>The Facility continued to make progress in this area. In addition to ensuring that the records are maintained properly, the completion of the Master Record conversion is necessary for compliance with this component of the Settlement Agreement. | |
| V2 | Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement. | As is discussed throughout this report, policies and procedures necessary to implement the Settlement Agreement were in various stages of development. The Director for Quality Assurance maintained the tracking system designed to assist in ensuring that Facility policies were consistent with State Office policies.<br><br>At the time of the previous review, the Policy and Procedure Committee reviewed all draft policies. Since then, the QA/QI Committee had assumed responsibility for reviewing and approving any draft policies. The QA Director, Settlement Agreement Coordinator, Assistant Director of Programs, and Facility Director continued to complete a preliminary review to ensure adherence to State Office requirements as well as Settlement Agreement, and regulatory requirements. As appropriate, these manager and/or the QA/QI Committee made recommendations to the policies' authors, and approval for policies was provided when all recommendations had been addressed. | Noncompliance |
| 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, continued to be in the beginning stages of development.<br><br>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 2011 visit:<br>▪ The two Unified Record Clerks each were conducting monthly reviews of at least five Individual Notebooks and five Active Records. The review tool they used was designed to ensure that proper content was present and in the correct order. It did not fully address the quality issues identified in Appendix D of the Settlement Agreement. A review of the completed forms for the last 10 reviews conducted showed that issues were being identified. A shared folder had been developed on the Facility's server to allow the monitoring results to be shared with PSTs with the expectation that needed corrections be made. The Unified Records Clerks continued to use email to follow-up on needed changes.<br>▪ The Quality Assurance Office completed review of a subsample of records that the Unified Records Clerks also had reviewed. This review was conducted using a different tool that addressed more of the requirements of Section V. | Noncompliance |

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| | | Efforts had begun to ensure that those conducting the audits had been properly trained, and that there was adequate inter-rater reliability. As noted in other sections of this report, it is essential that inter-rater reliability be established using a standardized process. In addition, accuracy of monitoring is essential. This will require the development of adequate instructions and clear criteria for rating items on the audit tools.<br><br>Based on interviews with staff, trending of information gathered from such reviews had not yet identified issues requiring review and attention. Based on a review or the raw data, as well as concerns that the Monitoring Team noted while on site, issues existed, which needed to be addressed. The next step of analyzing the data collected will provide important information, and should result, as appropriate, in action plans to address areas of concern.<br><br>Although the Facility was making progress in this area, continued efforts were needed to ensure that all of the components of the requirements set forth in Appendix D of the Settlement Agreement were addressed through the monitoring. In addition, tracking of corrective actions and review of data to identify and address trends were also in the development phases. | |
| 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:<br>▪ As noted above with regard to Section V.1, with regard to nursing documentation, documents still had to be obtained from the units and were not readily available in the active records.<br>▪ 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. As a result, this data was not available to teams or clinicians as they made treatment decisions.<br>▪ As discussed with regard to Section F of the Settlement Agreement, PSPs continued to lack evidence of teams making data-based decisions.<br>▪ Likewise, as noted with regard to Section M.1, nursing staff were not consistently documenting information in integrated progress notes, including for example assessments of individuals' status and the results of hospitalizations. This also was the case for PNMT members. The Integrated Progress Notes were designed as one of the major mechanisms for ensuring that adequate information was available when treatment and training decisions are | Noncompliance |

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| | | made. Efforts should be made to ensure that PST members, as well as other appropriate staff, document in and utilize the Integrated Progress Notes in a manner that results in the provision of integrated, quality care to the individuals CCSSLC supports. | |

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

1. CCSSLC should finalize conversion of the Master Records to the new Table of Contents. (Section V.1)
2. CCSSLC should modify its policy on the security of records to ensure that all records have been returned to the residence, for example, at the end of every business day, or within a reasonable time period. (Section V.1)
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. (Section V.2)
4. Efforts should ensure that the staff responsible for conducting record audits are provided with necessary training, adequate guidelines and criteria are included in the audit tools, and inter-rater reliability should be established. (Section V.3)
5. Monitoring of records should result in action steps/plans to address individual as well as systemic issues as they are identified. As appropriate and necessary, such action plans should include action steps, person(s) responsible, timeframes for completion, and anticipated outcomes. As the plans are implemented, they should be monitored to ensure the desired outcomes are being achieved. If not, the plans should be modified. (Section V.3)
6. Documents should be filed in a timely manner in the active records so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services. (Section V.4)
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. (Section V.4)
8. Efforts should be made to ensure that PST members, as well as other appropriate staff, document in and utilize the Integrated Progress Notes in a manner that results in the provision of integrated, quality care to the individuals CCSSLC supports. (Section V.4)

**List of Acronyms**

| Acronym/ Symbol | Meaning |
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| ≥ | Greater than or equal to |
| ≤ | Less than or equal to |
| AAC | Alternative or Augmentative Communication |
| ABA | Applied Behavior Analysis |
| ABC | Antecedent-Behavior-Consequence |
| ADLS | Assessment-Discussion-Skill Plan Link |
| ADOP | Assistant Director of Programs |
| ADR | Adverse Drug Reaction |
| AED | Antiepileptic Drug |
| AED | Automated External Defibrillator |
| AFO | Ankle Foot Orthotic |
| ALS | Adult Life Skills |
| A/N/E | Abuse/Neglect/Exploitation |
| APC | Admissions/Placement Coordinator |
| APEN | Aspiration Pneumonia Enteral Nutrition |
| AT | Assistive Technology |
| 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 |
| BSP | Behavior Support Plan |
| c | With |
| cc | Cubic Centimeters |
| CBC | Complete Blood Count |
| CCSSLC | Corpus Christi State Supported Living Center |
| CD | Communication Dictionary |
| C-Diff | Clostridium difficile |
| CDC | Centers for Disease Control |
| CE | Continuing Education |
| CLDP | Community Living Discharge Plan |
| CLOIP | Community Living Options Information Process |
| CME | Continuing Medical Education |
| CMP | Comprehensive Metabolic Panel |

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|---|---|
| CMS | Centers for Medicare and Medicaid Services |
| CNE | Chief Nurse Executive |
| CNS | Central Nervous System |
| COTA | Certified Occupational Therapy Aide |
| CPAP | Continuous Positive Airway Pressure |
| CPR | Cardiopulmonary Resuscitation |
| CPE | Comprehensive Psychiatric Evaluation |
| CRIPA | Civil Rights of Institutionalized Persons Act |
| CT | Computed Tomography |
| CTD | Competency Training Department |
| CV | Curricula Vitae |
| CWS | Certified Wound Specialist |
| DADS | Texas Department of Aging and Disability Services |
| DARS | Department of Assistive and Rehabilitative Services |
| d/c | Discontinued |
| DCP | Direct Care Professional |
| DFPS | Department of Family and Protective Services |
| DISCUS | Dyskinesia Identification System: Condensed User Scale |
| DNR | Do Not Resuscitate |
| DOJ | United States Department of Justice |
| DM-ID | Diagnostic Manual of Intellectual Disability |
| DRA | Differential Reinforcement of Alternative Behavior |
| DRO | Differential Reinforcement of Other Behavior |
| DRR | Drug Regimen Reviews |
| DRM | Dining Room Monitor |
| DRT | Dining Room Transporter |
| DSM-IV-TR | Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision |
| DSP | Direct Support Professional |
| DUE | Drug Utilization Evaluation |
| DVT | Deep Vein Thrombosis |
| ECU | Environmental Control Unit |
| EDO | Evening Duty Officer |
| EDWR | Established Desired Weight Range |
| EEG | Electroencephalogram |
| EGD | Esophagogaastroduodenoscopies |
| EKG | Electrocardiogram |
| EMS | Emergency Medical Services |
| ENT | Ear, Nose, and Throat |
| ER | Emergency Room |
| FACCWS | Fellow of The College of Certified Wound Specialists |
| FAST | Functional Analysis Screening Tool |
| FBI | Federal Bureau of Investigation |

| | |
|---|---|
| FDA | Federal Drug Administration |
| FNP | Family Nurse Practitioner |
| FTE | Full-time Equivalent |
| GERD | Gastroesophageal Reflux Disease |
| GI | Gastrointestinal |
| G-tube | Gastrostomy tube |
| G/J-tube | Gastrostomy/Jejunostomy or transgastric feeding tube |
| HCG | Health Care Guidelines |
| HCS | Home and Community-Based Services |
| HDS | Home Dining Supervisor |
| Hgb A1C | Hemoglobin A1C |
| HIV | Human Immunodeficiency Virus |
| HMP | Health Management Plan |
| h/o | History of |
| HOBE | Head of Bed Elevation |
| HRC | Human Rights Committee |
| hs | At night |
| HT | Habilitation Therapies |
| IBWR | Ideal Body Weight Range |
| IC | Infection Control |
| ICAP | Inventory for Client and Agency Planning |
| ICD | International Classification of Diseases |
| ICF/MR | Intermediate Care Facilities for persons with Mental Retardation |
| ID/DD | Intellectual Disabilities/Developmental Disabilities |
| IDT | Interdisciplinary Team |
| IED | Intermittent Explosive Disorder |
| ILASD | Instructor Led Advanced Skills Development |
| ILSD | Instructor Led Skills Development |
| IM | Incident Management |
| IMC | Incident Management Coordinator |
| IMT | Incident Management Team |
| IOA | Inter-observer Agreement |
| IPN | Integrated Progress Notes |
| IT | Information Technology |
| IV | Intravenous |
| J-tube | Jejunostomy feeding tube |
| LAR | Legally Authorized Representative |
| LON | Level of Need |
| LOS | Level of Supervision |
| LVN | Licensed Vocational Nurse |
| LRA | Labor Relations Alternatives |
| MAR | Medication Administration Record |

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|---|---|
| MAS | Motivation Assessment Scale |
| MBS(S) | Modified Barium Swallow Study |
| MD | Medical Doctor |
| mg | Milligrams |
| MH | Mental Health |
| MHMR | Mental Health Mental Retardation |
| ml | milliliters |
| MOM | Milk of Magnesia |
| MOSES | Monitoring of Side Effects Scale |
| MR | Mental Retardation |
| MRA | Mental Retardation Authority |
| MRSA | Methicillin-resistant Staphylococcus aureus |
| n | Sample of the Population Audited |
| N | Total Population Being Reviewed |
| NADD | National Association of Dual Diagnosis |
| NM | Nutritional Management |
| NMT | Nutritional Management Team |
| NOO | Nursing Operational Officer |
| NP | Nurse Practitioner |
| NPO | Nothing by Mouth |
| O2 | Oxygen |
| OCD | Obsessive Compulsive Disorder |
| OHR | Oral Health Rating |
| OIG | Office of Inspector General |
| ORIF | Open reduction internal fixation |
| OT(R) | Occupational Therapist |
| PA | Physician Assistant |
| PALS | Positive Adaptive Living Skills |
| PBSP | Positive Behavior Support Plan |
| PCM | Program Compliance Monitor |
| PCP | Primary Care Practitioner |
| PEG | Percutaneous Endoscopic Gastrostomy |
| PET | Performance Evaluation Team |
| PFA | Personal Focus Assessment |
| PIT | Performance Improvement Team |
| PMAB | Prevention and Management of Aggressive Behavior |
| PMM | Post Move Monitor |
| PNM | Physical and Nutritional Management |
| PNMP | Physical and Nutritional Management Plan |
| PNMPC | Physical and Nutritional Management Plan Coordinator |
| PNMT | Physical and Nutritional Management Team |
| PNS | Physical and Nutritional Supports |

| | |
|---|---|
| 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 Assistant |
| RAT | Review Authority Team |
| RATM | Review Authority Team Meeting |
| REACT | Respiration, Energy, Alertness, Circulation, and Temperature |
| RD | Registered Dietician |
| RN | Registered Nurse |
| ROM | Range of Motion |
| RPH | Registered Pharmacist |
| RRC | Restraint Reduction Committee |
| RT | Respiratory Therapist |
| RTT | Residential Treatment Technician |
| q | Each |
| QA | Quality Assurance |
| QA/QI | Quality Assurance/Quality Improvement |
| QDRR | Quarterly Drug Regimen Review |
| QE | Quality Enhancement |
| QI | Quality Improvement |
| QID | Four times a day |
| QMRP | Qualified Mental Retardation Professional |
| RN | Registered Nurse |
| SA | Settlement Agreement in U.S. v. Texas |
| SA | Speech Assistant |
| SAC | Settlement Agreement Coordinator |
| SAO | Skill Acquisition Objective |
| SAP | Skill Acquisition Plan |
| SAMS | Self-Administration of Medication |
| Sd | Discriminative Stimuli |
| SEPR | Supplemental External Peer Review |
| SFBA | Structural Functional Behavior Assessment |
| SIB | Self-Injurious Behavior |
| SLP | Speech and Language Pathologist |
| SOAP | Subjective, Objective, Assessment, and Plan |

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|---|---|
| SPCI | Safety Plans for Crisis Intervention |
| SPO | Specific Program Objective |
| SRB | Socially Responsible Behavior |
| SSLC | State Supported Living Center |
| SSO | Staff Service Objective |
| Stat | Immediately |
| STD | Sexually-transmitted disease |
| UGI | Upper Gastrointestinal |
| UIMRT | Unit Incident Management Review Team |
| UNT | University of North Texas |
| UTI | Urinary Tract Infection |
| TID | Three times a day |
| TIVA | Total Intravenous Anesthesia |
| TOC | Table of Contents |
| TSH | Thyroid Stimulating Hormone |
| TST | Tuberculin Skin Test |
| TWR | Temporary Work Reassignment |
| UA | Urinalysis |
| UTI | Urinary Tract Infection |
| VNS | Vagal Nerve Stimulator |
| WBC | White Blood Count |
| WC | Wheel Chair |