United States v. State of Texas

Monitoring Team Report

Corpus Christi State Supported Living Center

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I. Background

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

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

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

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

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

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 the tour, the Monitoring Team visited the State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents, as well as request additional documents for off-site review.
(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review, while other requests were for documents to be available when the Monitors arrived. The Monitoring Team made additional requests for documents while on site. In selecting samples, a random sampling methodology was used at times, while in other instances a targeted sample was selected based on certain risk factors of individuals served by the Facility. In other instances, particularly when the Facility recently had implemented a new policy, the sampling was weighted toward reviewing the newer documents to allow the Monitoring Team the ability to better comment on the new procedures.
(c) **Observations** – While on site, the Monitoring Team conducted a number of observations of individuals served and staff. Such observations are described in further detail throughout the report. However, the following are examples of the types of activities that the Monitoring Team observed: individuals in their homes and day/vocational settings, mealtimes, medication passes, Personal Support Team (PST) meetings, discipline meetings, incident management meetings, and shift change.
(d) **Interviews** – The Monitoring Team also interviewed a number of people. Throughout this report, the names and/or titles of staff interviewed are identified. In addition, the Monitoring Team interviewed a number of individuals served by the Facility.

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 addresses each of the requirements regarding the Monitors' reports that the Settlement Agreement sets forth in Section III.I, and includes some additional components that the Monitoring Panel believes will facilitate understanding and assist the facilities to achieve compliance as quickly as possible. Specifically, for each of the substantive sections of the Settlement Agreement, the report includes the following sub-sections:

(a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;
(b) **Facility Self-Assessment**: No later than 14 calendar days prior to each visit, the Facility is to provide the Monitor and DOJ with a Facility Report regarding the Facility's compliance with the Settlement Agreement.

This section summarizes the self-assessment steps the Facility took to assess compliance and provides some comments by the Monitoring Team regarding the Facility Report;

(c) **Summary of Monitor's Assessment:** Although not required by the 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:** A determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement, and detailed descriptions of the Facility's status with regard to particular components of the Settlement Agreement, including, for example, evidence of compliance or noncompliance, steps that have been taken by the Facility to move toward compliance, obstacles that appear to be impeding the Facility from achieving compliance, and specific examples of both positive and negative practices, as well as examples of positive and negative outcomes for individuals served;

(e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") is stated; and

(f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the Settlement Agreement. It is in the State's discretion to adopt a recommendation or utilize other mechanisms to implement and achieve compliance with the terms of the Settlement Agreement.

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

IV. Substantial Compliance Ratings and Progress

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

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

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

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

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

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

V. Executive Summary

The Monitoring Team's review of CCSSLC identified a number of areas of progress. At the same time, there were a number of areas in which adequate progress had not occurred. In some of these areas, plans had been developed and/or were being implemented to address the remaining issues. However, in some cases, more collaboration needed to occur within the Facility and/or with State Office staff to ensure adequate plans were developed and implemented to address outstanding issues.

The Monitoring Team recognizes that substantial effort is needed to achieve compliance, and that it can be easy to become discouraged. The Monitoring Team encourages the Facility to take time to celebrate the successes it has achieved, and put forth renewed effort in areas in which more focused solutions are needed. As the Facility tackles the areas in which problems continue to exist, it will be essential that the various departments work together, always keeping in mind the end goal of improving the lives of individuals the Facility supports.

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 onsite 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 onsite review was helpful in providing valuable information to assist the Monitoring Team in reviewing the Facility's status with regard to the Settlement Agreement.

The following is a brief summary of CCSSLC's status with regard to relevant the sections of the Settlement Agreement:

Restraints

- The State had issued a revised policy on restraint and training had begun on its revisions. The three Monitoring Teams will provide any comments on it jointly.
- The Facility's Avatar data system was not producing reliable restraint data and had not produced trend reports for June. The Monitoring Team learned that the Avatar system was being upgraded to allow direct entry of restraint reports, replacing the system of handwritten reports. The conversion process was underway. However, some issues still existed with reporting that needed to be addressed.
- The Facility was identifying issues with restraints that needed to be addressed, such as understanding what triggered the behavior that led to restraint so that they could be addressed. For example, one antecedent to restraint appeared to be the use of cigarettes: not having them, wanting them at unauthorized times, and not sharing them. For one woman, an antecedent condition was her desire to stay outdoors after 8 p.m. when the residences were supposed to be locked. The Facility needed to analyze its data on restraints to better understand these antecedents, and develop ways to address them systemically as well as individually.
- The assignment of restraint monitors had been changed, and the training of the additional monitors had been done. However, the list of trained restraint monitors was provided, but the names reported did not match the names of restraint monitors in the restraint documentation.
- In general, the Facility had systems in place for restraint reporting, monitoring, and review processes. Concerns were noted with regard to how well those systems were working, as well as with data integrity, and with regard to the adequacy with which staff described the antecedent- and consequence-based interventions used prior to the implementation of restraint.

Abuse, Neglect and Incident Management

- Actions to protect individuals who were involved in unusual incidents or allegation of abuse or neglect were taken quickly. Local procedures had been modified, and the related policy was being modified, to assure that staff alleged to have been abusive or neglectful were routinely put on temporary work reassignment (TWR) to remove them from direct contact with individuals served, or monitoring was put in place when alleged perpetrators were not identified or the case was handled as "streamlined" due to a an individual being identified as chronic caller. An Action Plan was in place to formally amend the Facility procedures.
- The Unusual Incident Report (UIR) had been modified to print out a list of alleged perpetrators so that it could be easily determined if they had been placed on temporary work reassignment.
- The UIR was further modified to include a chart to track the recommendations resulting from the investigation.
- The Review Authority Team notes were included in files to document the review of any actions taken.
- The records contained supervisory notes for UIRs indicating the Incident Management Coordinator (IMC) had reviewed and requested clarifications or additional investigation in some reports.
- The Facility was still in the process of developing and implementing a semi-annual audit of injuries;
- Although improvements were seen in the Facility's efforts to follow-up and track programmatic recommendations from investigative reports and document them to conclusion, this remained a work in progress. Full implementation was essential to potentially prevent recurrence of incidents and allegations.
- The Facility needed to expand the analysis and trending of data to determine where corrective action plans might be needed to address emerging trends in abuse/neglect findings.

Quality Assurance

- CCSSLC was in the process of amending its policies and procedures to align with the revised State Policy on Quality Assurance. There did not appear to be a current Quality Assurance Plan in place, although a plan had been provided and reviewed during the Monitoring Team's last review.
- Monitoring tools to measure quality had been adopted based on the tools the Monitoring Teams used, and adapted for use in the Facility. Some guidelines for the use of the tools had been written, and Program Auditors were using the tools in the field, meeting with discipline heads to share and compare results of monitoring, and developing ideas for improvements to the tools and guidelines. Continued work was needed with regard to inter-rater reliability, as well as the accuracy of the monitoring. Some sections of the Facility's Self-Assessment were using data gained from the monitoring tools as evidence of the Facility's compliance status. This should become a standard part of the assessment of each section of the Settlement Agreement.
- Initial efforts had been made to identify data available at the Facility. Some data that was being reported to the State Office could be used as the basis for developing key indicators. However, the Facility was in the initial stages of this process.
- The Quality Assurance/Quality Improvement (QA/QI) Council had been organized to develop, revise, and implement quality assurance procedures. During previous visits, the Performance Implementation Team (PIT)

and the Performance Enhancement Teams (PETs) were in evidence. During this visit, these teams appeared have been suspended with no minutes or meeting dates. Instead there were three groups of section leads that were supposed to be meeting to work on compliance issues. These groups were to report to the QA/QI Council, but it was not clear whether they were meeting and reporting.

- 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. However, while displaying the data over a year-long period was helpful, there was no actual trending or display of performance over time.
- Data for some of the sections had been analyzed and reported to the section leads and the QA/QI Council. However, for much of the data being collected, analyses had not been completed. Based on observation and review of documentation, it did not appear the QA/QI Council was yet using data effectively to identify issues requiring corrective action plans or effectively developing such plans.
- The next steps should include completing the Corrective Action Plan process, using the data system to report on information the monitoring activities generate, and developing a set of key criteria to measure progress on service outcomes.

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

- In May 2012, the State Office provided additional training on a revised ISP format and process to CCSSLC's Qualified Developmental Disability Professionals (QDDPs) and other team members. A revised ISP Meeting Guide (Preparation/Facilitation/Documentation Tool) was introduced to assist the QDDPs in preparing for the meetings and in organizing the meetings to ensure teams covered relevant topics. In addition, according to the new procedures, more pre-planning was to begin 90 days prior to the ISP meeting.
- At the time of the Monitoring Team's review, two teams had been selected to pilot the new process, including the new at-risk process. Two ISPs had been fully completed using the new process. Although the new process showed some improvements, as would be anticipated with a new process, more work was needed to continue to make necessary changes and refine the team meetings as well as the ISP documents.
- At CCSSLC, teams continued to be at a disadvantage, because they did not yet have adequate assessments from which to develop individuals' ISPs. In addition to problems with the quality of the assessments, teams were not consistently identifying the need for and/or receiving all of the necessary assessments. Although some improvement was being realized, a number of assessments continued to be submitted late, making it more challenging for QDDPs and others to complete preparation activities prior to the annual meetings. The Facility and State Office were taking some actions to address these concerns. Specifically, using a database in which information related to the timeliness of assessments was tracked, CCSSLC had begun reviewing this information

as part of its QA/QI Council activities, and discussing potential barriers and solutions. In addition to working on new formats for assessments, the State Office was developing a set of quality indicators, and it was anticipated CCSSLC's discipline heads would use these to evaluate the quality of the assessments.

- With regard to individuals' ISPs, although teams were identifying some preferences and strengths of individuals, these remained limited. In addition, teams were not yet effectively incorporating individuals' preferences and strengths into action plans, or using them creatively to expand individuals' opportunities or address their needs. Prioritization of individuals' needs was not evident in the ISPs reviewed. More individuals had action plans that addressed community skill acquisition plans, but these varied in quality.
- Some progress had been made in the expansion of the scope of measurable objectives, and efforts clearly were being made to improve the measurability and individualization of objectives and action steps. However, as the Facility recognized, these remained areas in which significant work was needed.
- Given the limited implementation of the new ISP process, it remained to be seen if the revised ISP Meeting Guide and process would result would result in ISPs that more comprehensively addressed the individual's array of needs. Based on the review of the two plans that used the revised process, some progress was seen with regard to the integration of a more comprehensive set of "protections, services and supports, treatment plans, clinical care plans, and other interventions." However, many supports were still missing or were inadequately defined. Teams will need continued training and coaching to implement the revised process fully.
- The Facility continued to develop its quality assurance system related to the ISP process. The QA Department as well as the QDDP Coordinator continued to monitor ISP meetings, as well as ISP documents and implementation. The system needed continued refinement, development and presentation of reports of the data collected that would be relevant to the various audiences, analysis of data, and development and implementation of corrective action plans, as appropriate.

<u>Integrated Clinical Services</u>

- The Facility had begun assessing itself in areas such as attendance, quality of Individual Support Plan Addenda (ISPAs) related to medical issues, and consult review. These were important areas. It remained unclear how this valuable information was shared with the Medical Department staff or other departments. The role of the Medical Director in providing guidance is important in this medical administrative area, and the continued lack of a Medical Director was problematic.
- The Facility had a number of forums in which integrated services could be facilitated, including, for example, the daily Integrated Clinical Services Meeting, ISP and ISPA meetings, and cross-discipline committees. However, many of these lacked the full participation of members, or did not result in adequate follow-through to develop integrated, interdisciplinary plans to address individuals' needs on either an individual or systemic level.
- Improvements had been made in primary care practitioners (PCPs) reviewing consultation reports in a timely manner. Although more work was needed, PCPs also were more often documenting their agreement or not with

recommendations. However, where additional work remained was in ensuring that interdisciplinary teams (IDTs) met, reviewed recommendations, and developed ISPAs, as appropriate.

Minimum Common Elements of Clinical Care

- Although CCSSLC was putting some systems in place to ensure that assessments and evaluations were completed timely, the systems continued to be in the development stage. In addition, the various databases collecting this information differed somewhat in the results related to timeliness of assessments. This might be due to the fact that the databases were being used for different purposes (e.g., annual ISP assessments as opposed to comparison to the date of the previous assessment). Change of status also was an area the Facility was trying to better define.
- With regard to accurate diagnoses, reviews the Monitoring Team completed of both medical diagnoses and psychiatric diagnoses found adequate justification for 100% and 95%, respectively. As a result, the Facility was found in compliance with this provision.
- Teams were not consistently identifying clinical indicators to measure the efficacy of treatment interventions for individuals at risk. Problems with the indicators included, at times, a lack of measurability. The quality of the indicators also was problematic in terms of telling the individuals' teams whether or not the individuals were doing better or worse, or remaining the same. Finally, individuals' teams often did not develop measurable indicators to address all of the individuals' areas of risk. Although the Facility had developed some At Risk Clinical Indicators Guidelines, these were not yet fully in use.
- The Facility still did not have an adequate system to effectively monitor the health status of individuals. As one example, as discussed with regard to Section M, although quarterly nursing assessments were being completed, they were inadequate. In addition, day-to-day nursing assessments were not adequate to ensure that changes in individuals' status were promptly identified and reported to the PCPs.

At-Risk Individuals

- Since the last review, the State Office had made revisions to the At-Risk Individuals policy (in draft form at the time of the review). Some of the changes included regrouping the Risk Guidelines so that the risk factors that were clinically inter-related regarding outcomes or provision of services and supports were listed together, and linking each risk factor with specific clinical indicators. In addition, the Integrated Risk Rating Form (IRRF) was revised to follow the same grouping sequence as the Risk Guidelines. Some additional revisions included replacing the Risk Action Plans for the identified high and medium risk indicators with Integrated Health Care Plans (IHCPs) designed to provide a comprehensive plan that will be completed annually; different forms regarding IRRF and the IHCP were developed addressing changes in status; the Aspiration Pneumonia Enteral Nutrition was revised as a data collection tool; and Trigger Data Sheets were developed to include observable and measurable clinical signs and symptoms that alert the staff to possible changes in status.
- In May 2012, two teams at CCSSLC had been trained on the new policy and processes, and had begun to pilot them. It was important that the new system was being piloted with two teams to determine any additional

implementation steps/changes that needed to be made, or any additional training that would be beneficial before broadening its scope to the entire campus. The many changes that had occurred with regard to the At-Risk system were reflected in the different ISP documents, and the varying quality of the IRRF indicated some confusion amongst the teams with the previous process. Developing a successful program on a small scale that can then be implemented across campus should reduce such issues. Staff from the pilot systems in two residences also could act as mentors to the other teams, another important step in providing consistency across campus and improving the quality of the process. Until now, the quality of the risk reviews and implementation process varied depending on the understanding and expertise of the various IDTs. Hopefully, the process will become more standardized, which should benefit the individuals residing at CCSSLC.

- From review of the ISP and addendum documentation, individuals' teams were having discussions of the individuals' status, and more pertinent clinical information was being included in the Integrated Risk Rating Forms than previously. However, the overall lack of clear documentation included in the ISPs, the Risk Action Plans, and the associated disciplines' assessments regarding what actions were taken in response to pertinent events or health issues, and the lack of dates and supporting documentation addressing actions and completion of action plans made the Monitoring Team's review of the At-Risk system difficult, and the lack of progress noted was troubling at this juncture of the compliance process.

Psychiatric Care and Services

- The Psychiatry Department had completed current Comprehensive Psychiatric Evaluations for all of the individuals receiving psychotropic medication, except for three recently admitted individuals. The locum tenens psychiatrist had two prolonged stays at the Facility that were devoted solely to the completion of the initial CPEs, as well as the annual updates. It was anticipated that the locum tenens Psychiatrist would return in the fall, prepare annual updates for the current CPEs, and complete initial CPEs for any individuals newly admitted.
- Although the Facility was actively recruiting for two open psychiatrist positions, the Consulting Psychiatrist recently had decreased his consulting time from 12 to eight hours per week, and it remained to be seen if this would have a negative impact on the Facility's efforts to meet the requirements of the Settlement Agreement.
- The psychiatry team had developed and implemented a psychiatric symptom tracking scale. This newly developed tool augmented the DSM-IV Diagnostic Checklists, which the Department previously had implemented. The full implementation of these initiatives, coupled with the Psychology Department's inclusion of a new section in their documentation entitled "Psychiatric Information" made it possible to differentiate the symptoms of the psychiatric disorder for which the psychotropic medication was prescribed from the challenging behaviors that were related to environmental or interpersonal factors.
- Consents were now obtained for each prescribed medication, which represented an improvement over the prior practice of pursuing consents for as many as four or five medications as a single package.
- At the time of the onsite review, the Psychiatry staff were just beginning an initiative to both attend the Individual Support Plan meetings for the individuals they followed, and also directly compose and place their

material into the ISP documentation. This was another important development, because the language of the Settlement Agreement specifies that a number of discussions, such as the risk discussion related to the psychotropic medications and whether they represent the least intrusive intervention, should occur in the context of the ISP and then be documented there as well.

- The effort to develop pre-treatment desensitization plans had progressed, but would still be classified as in the early stages of implementation. There was an effort to develop these plans for medical interventions as well. The selection of the best medication to use for pre-treatment sedation for a specific individual occurred annually in the context of the Psychiatric Clinics, which members of the Pharmacy and Dental Departments also attended so that they could discuss these issues with the entire treatment team.
- Although the rate of polypharmacy with psychotropic medications was down to 50 percent from 56 percent in 2010, this represented incremental progress. A primary recommendation of this report is that the Psychiatry Department increases its efforts to develop objective evidence to support the continued utilization of multiple medications for those individuals for whom they believe this is essential.
- CCSSLC continued to experience new admissions at the rate of approximately one individual every other month. To date, these had all been individuals who had not been able to be maintained in the community due to behavioral reasons and, thus, were admitted on multiple psychiatric medications. At the time of the onsite review, the range for the number of medications for these same individuals had decreased.

Psychological Care and Services

- Many behavioral services staff continued to progress through the necessary coursework as well obtain necessary supervision toward the BCBA certification. Concerns regarding the difficulty in accessing and utilizing the education leave hours as well as difficulty in reliably accessing course content were noted.
- Slight progress was noted in the area of peer review. Although attendance improved for some clinicians and counselors, participation by other professionals and key staff remained inadequate. External peer review processes had just been initiated.
- Continued progress in the use of a standardized monthly progress note was evidenced. This included continued improvement in the area of data display and ongoing PBSP monitoring, including the initiation of inter-observer agreement checks on behavioral data.
- Progress was evident in the completion of standardized intellectual assessments to ensure that psychological assessments were updated at least every five years. However, progress in the completion of scales of adaptive behavior was not as conspicuous. In addition, a new format entitled the Comprehensive Psychological Evaluation was developed to integrate the psychological assessment and the structural functional behavioral assessment. Although concerns were noted, this new format appeared promising.
- Limited progress was noted in the timely completion of psychological assessments for newly admitted individuals, as well as the provision of counseling supports to individuals referred for counseling.

- Progress was noted in the area of PBSPs with the development of a new and improved format that was currently being piloted. Active efforts were noted with regard to writing PBSPs so that they could be understood and implemented by direct support professionals.
- Lastly, some progress was noted in competency-based training. However, the provision of adequate training across the Facility for all individuals remained inadequate and, as currently designed, the nature of training was significantly resource-dependent and likely not sustainable.

Medical Care

- With regard to medical care, progress had been made in a number of areas. Preventive medical procedures such as colonoscopies and mammograms were tracked and completed at a relatively high rate (94 to 96%). Several trend analyses were available as a result of medical compliance monitoring. However, the internal quality improvement (QI)/medical compliance monitoring of clinical care was delayed due to a lack of guidance in choosing clinical indicators to be used for specific clinical conditions/diagnoses. At the time of the review, the Facility had no Medical Director to provide guidance in a number of areas, including medical compliance.
- The morning medical meeting, which was recently renamed as the Integrated Clinical Services Meeting, provided evidence that a basic process was in place to provide quality review and oversight of healthcare. However, a number of areas required further development and fine-tuning, such as ensuring documentation of the actual reason the group was making a referral to the IDT, when applicable. The morning team also needed to focus on asking critical questions, and conducting critical review of the ISPAs that resulted from their referrals. The documents the morning medical meeting produced provided a tracking mechanism. However, the quality of the tracking required further attention.
- In other areas, a template was needed for quarterly medical reviews that could be completed quickly and accurately. For most records reviewed, these had not been done.
- Although an external non-facility physician review had been conducted, the Facility had questioned its accuracy. Based on the Monitoring Team's review, concerns were noted with the potential thoroughness of the review of numerous records in a short period of time, as well as a lack of established inter-rater reliability amongst reviewers. In addition, although corrective action plans had been developed to address PCP-specific concerns, no documentation was available to show that follow-up had occurred. In addition, no systemic corrective action plans were developed or implemented.
- Although mortality reviews had been completed, documentation was not submitted to show that follow-up had occurred to address the recommendations they included.
- The Facility did not appear to have incorporated the clinical protocols/guidelines into the monitoring processes. In addition, the Medical Department was beginning to analyze some of the data it was collecting, but did not yet have a system for writing quarterly reports that focused attention on areas of strengths and weakness. For many of the functions and clinical areas for which the Medical Department was responsible, it will be important

to design key indicators or outcome measures to assist the Facility in identifying areas of high performance and areas requiring attention.

Nursing Care

- The Facility began implementation of nine additional nursing protocols, including Minimal Documentation, PICA, Seizures and Status Epilepticus, Abdominal Distention/Pain, Hypothermia, Temperature Elevation, Urinary Tract Infection, Enteral Feeding, and Post Anesthesia.
- Data generated by comparisons of the Infection Control Reports and the Pharmacy reports for the utilization of antibiotics reflected a very positive step forward in not only tracking discrepancies regarding Infection Control information to ensure data reliability, but also a positive increase in compliance regarding the accuracy of the documentation contained on the Infection Control Reports.
- In a positive step forward, the Facility indicated that blanks found on a review of the emergency cart checklists had significantly decreased from January to June 2012, since Risk Management, Respiratory Therapy, and Nurse Educators had been completing monthly spot checks of this area.
- The Monitoring Team's observations of nurses demonstrating the use of emergency equipment at the Infirmary, and Atlantic Kingfish 2 found that the nurses were familiar with the use and operations of the Facility's emergency equipment. It was clear that the consistent drills and spot checks regarding the emergency equipment were having very positive outcomes.
- The Facility had reinitiated a structured system using the Pharmacy Refill Sheets to track the medications being brought to the buildings in an attempt to reconcile the number of medications that were being returned to the Pharmacy without explanation.
- Although the Facility had made some positive steps forward in the areas noted above, the overall lack of progress, and in some areas, regression, found regarding the nursing care plans, the nursing assessments and documentation in response to changes in status, the quality of the quarterly and annual Comprehensive Nursing Assessments, and the unreliable systems regarding medication variance data were very concerning at this juncture in the review process. Some of the recent system changes, such as transitioning to an Integrated Health Care Plan represented positive forward movement. However, the Facility's decision to remove all the existing Health Maintenance Plans without modifying the current inadequate Risk Action Plans so that all the individuals who resided at CCSSLC would have an appropriate and clinically sound plan of care in place during the transition was troubling.

Pharmacy Services and Safe Medication Practices

- The Pharmacy Department had made considerable progress in providing structure and implementing internal monitoring processes. For example, ensuring an individual's allergies are consistent in all documents across campus was an important endeavor. Improvements in screening for medication that should not be given by Jejunostomy (J-tube) also had been implemented. The DUE program was strong, and the follow-up reviews indicated a positive impact on the practice patterns of the PCPs and on the quality of care of the individuals.

- However, considerable challenges remained. Timeliness of completion of the QDRR remained problematic, and a resubmission of "corrected" data remained incomplete. It did appear timeliness of QDRRs had improved, but lack of adequate statistical data became an obstacle in verifying this.
- Chemical restraint review remained a challenge in both obtaining the review form in a timely manner and in ensuring the Behavior Services Department's list of chemical restraints agreed with the Pharmacist's list of chemical restraints. In addition, adequate completion of the chemical restraint form was a continuing problem.
- Although a number of steps had been taken to reduce medication errors of administrative omissions [i.e., blanks in the medication administration record (MAR) for which the medication was administered] and true admissions, much work was needed on the numbers and reasons of returned medication. There was a paucity of statistical review for medication variances for pharmacy, nursing, and medical. A quarterly report of medication variances would be important to provide guidance to the Pharmacy Department in relation to follow-up interventions, as well as in educating the Facility Administration concerning the challenges of this area.
- Concerning adverse drug reaction (ADRs), nurses had been trained as well as the two dentists and four PCPs. As of 6/25/12, no ADRs had gone through the protocol/process. More recently, three potential ADRs were identified, but the Facility was in process of determining if they met the criteria of ADRs.

<u>Physical and Nutritional Supports</u>

- Although a list of PNM team members included a Registered Nurse (RN), Physical Therapist (PT), Occupational Therapist (OT), Registered Dietician (RD), and Speech Language Pathologist (SLP), prior to the Monitoring Team's visit, the PNMT SLP and PT resigned. Based on interview with the HT Director, the PNMT alternate SLP and PT assumed the vacant PNMT SLP and PT core positions until the vacant positions were filled and/or current therapists were assigned to a PNMT core position.
- Attendance by core and/or an alternate PNMT members for 46 meetings conducted during the time frame from 1/10/12 to 5/29/12 ranged from 65% for the RD to 85% for the RN. The PNMT member attendance was not adequate, because the PNMT was meeting without the required membership as outlined in the Settlement Agreement.
- The Facility IDTs were not consistently referring individuals to the PNMT, and/or the PNMT was not consistently initiating an assessment within five working days. Based on interview, the HT Director reported the IDTs would not be provided training on the draft PNMT Referral policy until the revised ISP and risk process had been implemented.
- A review of PNMT assessments and actions plans identified multiple missing components. In addition, individuals the PNMT discharged did not have adequate discharge plans as multiple components were missing.
- Lists presented by the Facility to identify individuals having physical and nutritional management problems were not accurate. When comparing lists the Facility provided of individuals with PNM needs with a list of individuals' risk ratings, some individuals with PNM needs as evidenced by a high and/or medium risk ranking

in choking, aspiration, falls, fractures, skin integrity and/or weight were not on the list of individuals having PNM needs.

- The Facility had updated its PNMP Directions to address the placement of medication administration instructions on the PNMP, add a more comprehensive list of adaptive equipment to the PNMP, and clarify that revision of a PNMP required the completion of an Assessment of Current Status, and completion of an in-service by the therapist with the PNMP Coordinator on the revised PNMP. These additions to the PNMP directions were positive. However, a review of PNMPs for individuals revealed PNMPs were missing components such as staff instructions to achieve safe elevation ranges in wheelchair and alternate positioning, bathing/showering, oral and dental care, and personal care. In addition, there was no Facility policy that specifically addressed the implementation of individuals' PNMPs off-campus (i.e., hospitalization, community outing, etc.).
- The Monitoring Team and the PNMT Nurse completed direct observations of the implementation of PNMP strategies in the Infirmary and residences for five individuals on the PNMT caseload. The PNMT nurse had to intervene with staff during every observation to correct staff's approach for wheelchair positioning, alternate positioning, mealtime fluid consistency and presentation techniques, and transfers. These observations revealed that staff were not competent in implementing individuals' PNMPs. However, in reviewing monitoring data for these same individuals, it did not identify similar problems.
- New staff continued to be responsible for completing 22 PNM foundational performance check-offs. Based on interview, the Facility annual refresher training was to be expanded. Current staff will be responsible for successfully completing performance check-offs for transfer lifts, two-person manual lift, bed positioning, mechanical lift, stand-pivot transfer, wheelchair positioning, adaptive dining equipment, thickening liquids, and mealtime safety.
- The Facility had not implemented an effectiveness monitoring system to assess the progress of individuals with PNM difficulties or provide evidence that interventions were modified if an individual was not making progress. More specifically, individuals' Risk Action Plans did not generate individual-specific clinical data to substantiate an individual progress or to assess if the individual was better or worse; monthly progress notes were not completed to report on the effectiveness of an individual's supports and services; individuals at high risk for aspiration had multiple months that aspiration pneumonia trigger data sheets had not been completed; and individuals' who experienced ongoing weight loss did not have their plans revised.
- APEN assessments for individuals who received enteral nutrition were not: following the Facility-established template and content guidelines; consistently completed within a 12-month period; including the participation of recommended disciplines; and/or providing justification that the continued use of the tube was medically necessary or assessing the individual's potential to receive a less restrictive form of enteral nutrition or transition to oral intake, if appropriate.

Physical and Occupational Therapy

- Based on a review of individuals' OT/PT assessments, they were missing important elements and, consequently, were not considered adequate OT/PT assessments.
- OT/PT direct interventions and/or programs were not integrated into individuals' ISPs. In addition, progress notes were not completed to provide the results of effectiveness review/monitoring of the individual's progress with direct and/or indirect OT/PT supports.
- No evidence of individual-specific competency-based training for the implementation of indirect OT/PT programs was provided. Based on interview with the HT Director, the Facility was in the process of developing objectives and performance check-offs to document this process.
- The Facility OT/PT Maintaining Adaptive - Assistive Equipment Policy #P.3 included some important components. However, it was missing the process for identification, training, and validation for monitors; the process of inter-rater reliability; and a process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic).

Dental Services

- The Dental Department had made considerable strides toward compliance. Although the Facility had not achieved compliance with either of the subsections of Section Q, several specific aspects of dental care had reached the level necessary for compliance, such as completion of annual exams and tooth-brushing instruction. Oral hygiene scores had continued to improve. It will be important for the Dental Department to sustain these efforts while it focuses on areas that remain in need of improvement.
- The quality of self-tooth brushing required review and intervention for those individuals that still had poor oral hygiene scores.
- Dental desensitization and other procedures to reduce the use of sedation remained underdeveloped after three years. Those that would benefit from desensitization had been methodically chosen, and recently, a small sample of these had been selected to begin the desensitization process.
- Quarterly reports reflecting the activity and progress of the Dental Department would be beneficial to the Dental Department and Facility Administration, but periodic reports were not part of the internal QA program of the Dental Department. The current software program had allowed the department to advance and make improvement. There were two to three years of data available and trend analysis was available. It appeared user-friendly and much information could be quickly queried from it. However, the new statewide system appeared to be replacing it, but the challenges of implementation were significant and the benefits to the Dental Department needed clarity. It will be imperative to be able to use the prior data and incorporate the prior data into the new system to continue to provide trend analysis.

Communication

- A Facility policy entitled CCSSLC – Communication Services, dated 10/7/09 existed. However, the Facility policy did not provide clear operationalized guidelines for the delivery of communication supports and services.

- Prior to the previous review, the Speech Department had established a Master Communication Plan schedule to re-assess each individual using a priority system and the revised SLP assessment format. However, the completion of this schedule was not in alignment with the Facility's annual ISP schedule. Due to the fact that every individual needed to be re-assessed with an updated SLP assessment format and content, the Speech Department made the decision to abandon the priority list and follow the Facility ISP calendar. Based on documentation submitted, this decision enabled SLPs to be contributing members of the IDT and support the individual. It was positive that IDT members and the individual would be provided with a current assessment prior to the annual ISP meeting to assist in annual planning. Unfortunately, individuals identified through the priority system in need of communication supports would have to wait for these services until their annual ISP meeting.
- An evaluation of individuals' SL comprehensive assessments revealed these assessments were missing some key components.
- Observations by the Monitoring Team and two Facility SLPs of individuals with AAC systems did not reveal the presence and/or use of the AAC system. In addition, individuals' skill acquisition programs did not support the use of an AAC system. Staff also had not been provided with individual-specific competency training and performance check-offs to demonstrate their competency in supporting individuals in the use of their AAC system in various environments and daily activities.

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

- Continued effort and related progress were noted in the area of habilitation training and services, in particular with regard to the development of skill acquisition plans (SAPs). However, it was evident that more robust support and expertise were needed to improve the quality of the SAPs, as well as to effectively monitor their implementation (i.e., using integrity checks) and individual progress (i.e., using ISP monthly progress notes) overtime.
- Lower than expected estimates of engagement were noted during the current review.
- Progress in supporting individuals in off-campus vocational positions was evident. This included active efforts at informal job exploration and the slow, but increasing trend in successfully placing individuals in meaningful employment positions in the community. This trend might be enhanced by increased completion of formal situational assessment within off-campus settings.

<u>Most Integrated Setting</u>

- Individuals' ISPs 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 ISPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports, and services, and that, as appropriate, these be transitioned to the community through the community living discharge plans.

- As noted in previous reports, one issue that appeared to delay individuals' referral to the community at times was a Local Authority (LA) representative not being at a meeting at which the team decided a referral should be made. New rules set forth the parameters for ensuring LA representatives were invited to meetings, notifications of the Admissions/Placement Coordinator of referrals made during meetings, informing the LA of referrals made in their absence, and holding an additional meeting should the LA have any questions or concerns about the referral. It was positive that with these new rules, an LA representative's inability to attend a meeting would not delay a potential referral.
- An increasing number of assessments prepared for annual ISP meetings had begun to include the assessor's recommendation regarding transition to the community. However, individuals' ISPs generally still did not include a summary or conclusion of 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.
- The Facility submitted monthly and quarterly aggregate totals of the obstacle categories State Office had identified. Based on interview, Facility staff indicated that education of individuals and their guardians had been identified as an area of need. However, they stated that formal analysis of all of the data was still in process. The Facility would soon be submitting its second annual report to the State, which should include an analysis of data collected thus far.
- Although the Facility had made some progress, Community Living Discharge Plans continued to inadequately define the necessary protections, support, and services to ensure the individual's health and safety. Many of the issues identified in the Monitoring Team's previous reports regarding deficiencies with the CLDPs had not yet been rectified. As a result, individuals transitioning to the community were potentially at risk due to the lack of adequately planned and implemented protections, services, and supports.
- 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 generally provided a thorough description of the methods used to evaluate the item and the findings (e.g., interviews, document reviews, and observations). This was further confirmed through an observation of a post-move monitoring review. During the course of the review, the Post-Move Monitor identified some serious issues. The Post-Move Monitor handled these issues professionally with community provider staff, and took appropriate steps to ensure the safety of the individual.
- The post-move monitoring activities identified some issues with regard to the provision of services at the community sites. In addition, one of the individuals who had transitioned to the community had experienced serious events, such as police contact. However, IDTs at CCSSLC did not document thorough follow-up or attempts to ensure that the individuals had the protections, services, and supports they needed.

Consent

- At the time of the review, the State Office Guardianship Policy had been disseminated, but the policy on consent remained in the development phase. CCSSLC had adopted the State Office policy and had begun to implement portions of the policy. Although teams at the Facility had completed Individual Support Plan Addenda to identify individuals' priority level for obtaining a guardian, a number of concerns were noted with the process. 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.
- Although problems were noted with the process the Facility used, CCSSLC generated a prioritized list of individuals needing guardians. It included a total of 263 names. Of these, 167 individuals were identified as adults with no guardians, but needing guardians.
- Since the last review, no guardians had been identified for individuals who needed them. CCSSLC had made efforts to identify potential guardianship resources. However, 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.
- On a positive note, the Facility was implementing an advocacy program. Advocates had been identified for two individuals. This potentially provided a resource to assist individuals in decision-making that was less restrictive than guardianship. CCSSLC also continued to provide support to the Self-Advocacy Group. Some of their activities involved assisting individuals to learn about their rights as well as decision-making.

Recordkeeping and General Plan Implementation

- CCSSLC continued to maintain Active Records as well as Individual Notebooks. Facility staff also continued to work to convert individuals' historical files to the Master Record format State Office issued. A significant amount of historical information had been sent to an outside vendor to maintain.
- The Facility continued to use 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.
- As is discussed throughout this report, policies and procedures necessary to implement the Settlement Agreement were in various stages of development. At the time of the last review, the Facility had developed systems to track draft policies through to finalization. Since the last review, the Facility had begun to use the system it had designed to track the training of staff on new or revised policies. A pilot project to maintain copies of updated policy manuals in various program and administrative locations also had been completed and was being rolled out across campus.
- CCSSLC was conducting reviews of more than the required five records each month. A Program Compliance Monitor from the QA Department also had been assigned. Efforts were being made to revise the tools and

develop guidelines to improve the reliability and validity of the monitoring results. The processes for identifying trends that needed to be addressed and putting plans in place to address problematic trends remained in the beginning stages of development. However, the Records Department continued to use its knowledge of problems with the records to work with some of the other departments on areas of need. For example, the Day Program Director was beginning to implement a plan to monitor skill acquisition data to identify missing data. The Chief Nurse Executive also had created a system to monitor nursing staff's entries into the Integrated Progress Notes (IPNs).

VI. Status of Compliance with the Settlement Agreement

SECTION C: Protection from Harm-Restraints	
Each Facility shall provide individuals with a safe and humane environment and ensure that they are protected from harm, consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: • **Review of Following Documents**: o DADS Policy #001.1, effective 4/10/12; o CCSSLC Self-Assessment, updated 6/25/12; o CCSSLC Action Plans, updated 6/25/12; o CCSSLC Provision Action Information, undated; o Presentation Book for Section C; o CCSSLC Restraints – Quarterly Trending Reports, from 1/1/12 to 5/31/12; o Individuals Restrained During Time Period Between 12/1/11 and 5/31/12, and 6/1/12 and 7/5/12; o Settlement Agreement Cross-Referenced with Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) Standards: C – Protection From Harm – Restraints Guidelines, revised January 2011; o CCSSLC: Do Not Restrain List (No entries), dated 5/29/12; o Restraint Reduction Committee Monthly Minutes, dated 1/5/12, and 2/9/12 (mislabeled as 2/9/11); o Restrictive Practices Committee Meeting Minutes, dated 3/21/12, 4/2/12, 4/4/12, 4/6/12, 4/13/12, 4/18/12, 4/20/12, 4/23/12, 4/25/12, 4/30/12, 5/2/12, 5/7/12, 5/9/12, 5/14/12, 5/16/12, 5/21/12, 5/23/12, 5/25/12, and 5/30/12; o DADS Employee Alpha Roster, dated 6/12/12; o DADTX Course Due/Delinquent, for Prevention and Management of Aggressive Behavior (PMAB) basic, as of 7/2/12; o Competency-Based Restraint Monitoring Training, including list of staff trained, undated; o Restraint Monitoring Training: Didactic and Demonstrative Scores, including list of staff trained, undated; o Sample #C.1 was chosen from the list of individuals restrained as a crisis intervention between 12/1/11 and 5/31/12. Complete documentation for each restraint was requested, including the Restraint Checklist, Face-to-Face/Debriefing Form, Safety Plan, all reviews of the use of the restraint, and any addendums to the individual's Individual Support Plan that resulted. The Monitoring Team originally requested a sample of 32 restraints. However, based on the documentation submitted, a sample of 25 restraints (of 156 or 16%) involving 10 people (of 26 or 38%) with restraints on the dates specified was reviewed, including: ▪ Individual #253 on 3/4/12 at 5:20 p.m., 4/11/12 at 1:05 p.m., 5/1/12 at 7:07 p.m., 5/17/12 at 12:22 p.m., and 5/27/12 at 8:14 p.m.; ▪ Individual #61 on 5/17/12 at 1:57 p.m., and 5/17/12 at 7:15 p.m.; ▪ Individual #300 on 2/1/12 at 7:15 a.m., 4/19/12 at 8:43 p.m., 5/7/12 at 6:15 p.m., and 5/4/12 at 8:13 a.m.; ▪ Individual #246 on 4/14/12 at 6:14 p.m., 9:15 p.m., 9:50 p.m. and 11:15 p.m.;

	▪ Individual #169 on 4/24/12 at 7:15 p.m. and 7:35 p.m., and 5/16/12 at 2:45 p.m.; ▪ Individual #109 on 2/13/12 at 10:41 p.m., and 5/9/12 on 4:12 p.m.; ▪ Individual #16 on 4/28/12 at a time not entered, and 5/7/12 at 6:20 a.m.; ▪ Individual #26 on 3/29/12 at 8:24 p.m.; ▪ Individual #238 on 5/28/12 at 8:37 p.m.; and ▪ Individual #55 on 4/20/12 at 7:20 a.m.; o Sample #C.2: The following documentation was obtained for a random sample of 25 staff on the DADS Employee Alpha Roster, dated 6/12/12: ▪ DADTX Course Due/Delinquent, for PMAB basic as of 7/2/12; ▪ DADTX Individual Training Records for the 25 staff in the sample, dated 7/10/12; o Sample #C.3: The Restraint Checklist, documentation of the monitoring of the restraint, any reviews of the use of restraint, any desensitization plan, the doctor's order for the restraint, and the monitoring schedule used were requested for the following individuals, selected from the list of 153 medical restraints involving 70 individuals that occurred between 12/1/11 and 5/31/12. The sample of 13 represented 19% of the individuals: ▪ Individual #221 on 4/13/12 at 12:15 p.m., and 5/23/12 at 8:00 a.m.; ▪ Individual #210 on 2/3/12 at 12:30 p.m.; ▪ Individual #147 on 4/25/12 at 3:15 p.m.; ▪ Individual #304 on 10/12/11 at 8:00 a.m.; ▪ Individual #198 on 4/3/12 at 6:30 a.m.; ▪ Individual #87 on 5/3/12 at 2:30 p.m.; ▪ Individual #141 on 4/1/12 at 9:30 a.m.; ▪ Individual #307 on 3/19/12 at 10:00 a.m.; ▪ Individual #225 on 4/16/12 at 7:50 a.m.; ▪ Individual #228 on 1/9/12 at 7:00 a.m.; ▪ Individual #156 on 5/30/12 at 2:30 p.m.; ▪ Individual #187 on 5/21/12 at 9:30 a.m.; and ▪ Individual #181 on 10/24/11 at 10:00 a.m.; o Sample #C.4: The Restraint checklist, Face-to-Face/Debriefing Form, any reviews of the use of restraint, documentation of contact between the psychologist and physician prior to the use of the restraint, and any changes to the ISP or Safety Plan as a result of the restraint for 25% (n = 3) of the 12 (N) of the instances on the list provided by the Facility (II.07.a) of individuals who were restrained with chemical restraint other than pre-treatment sedation between 12/1/11 and 5/31/12, including: ▪ Individual #253 on 5/3/12 at 3:06 p.m.; ▪ Individual #144 on 3/14/12 at 3:15 p.m.; and ▪ Individual #246 on 4/14/12 at 11:15 p.m.; o Sample #C.5: No one was reported to have been restrained off-grounds between 12/1/11 and 5/31/12. No sample was drawn; o Section C.4 sample of Positive Behavior Support Plans for: Individual #38, Individual #184, Individual #186, Individual #58, Individual #263, Individual #218, Individual #167, Individual #275, Individual #159, Individual #20, Individual #153, Individual #307,

	Individual #46, Individual #225, Individual #7, Individual #300, Individual #226, Individual #368, Individual #353, and Individual #315; o Sample #C.7 was chosen from the list of individuals restrained as crisis intervention between 12/1/11 and 5/31/12. This included review of Restraint Checklists, Face-to-Face Debriefing Reports, Safety Plan for Crisis Intervention (SPCI), Positive Behavior Support Plan (PBSP), Individual Support Plans (ISP), ISP Addendums, Monthly Behavioral Services Reviews, as provided, for the following three individuals with restraints on the dates specified: ▪ Individual #61 on 5/17/12 (1:57 p.m., 1:59 p.m., 2:03 p.m., 2:08 p.m., and 7:15 p.m.), and 5/18/12 (6:22 p.m., 6:26 p.m., and 6:36 p.m.); ▪ Individual #253 on 4/10/12 (7:53 a.m. and 12:00 p.m.), and 4/17/12 (6:21 p.m. and 6:26 p.m.); and, ▪ Individual #275 on 5/28/12 (3:05 p.m. and 3:25 p.m.), and 5/29/12 (4:47 p.m. and 4:59 p.m.); o Listing of Case Load Changes for Coral Sea – Desensitization Plan Pilot Cases; and o Medical and dental desensitization plans, related data sheets, dental/medical baseline for desensitization plans, and/or decision tree worksheets, as available, for the following: Individual #22, Individual #273, Individual #15, Individual #334, Individual #280, Individual #292, Individual #176, and Individual #146. • **Interviews with**: o Mark Cazalas, Facility Director; o Bruce Boswell, Assistant Director of Programs; o Judy Sutton, M.A., BCBA, Director of Behavioral Services; o Dr. Robert Cramer, Clinical Psychologist, o Everett Bush, Associate Psychologist V; o Dr. George Zukotynski, State Office Coordinator for Behavioral Services; o Cynthia Velasquez, Director for Quality Assurance (QA); o Araceli Matehuala, Program Compliance Monitor (PCM); o Brenda Fuller, Psychiatric RN; o Michelle Arteaga, Psychiatric RN; o Twenty staff members from various residential locations; and o Ten individuals in various residential and day locations. • **Observations of**: o Restrictive Practices Committee, on 7/11/12; o Residences: 522A, B, C, and D; 524A, B, C, and D; and 514; o Day and Vocational Programs in Buildings 512, 513 and 517; o Incident Management Review Team Meeting (IMRT), at 11 a.m. on 7/9/12; and o Interdisciplinary Team (IDT) meeting for Individual #341 on 7/11/12.
	Facility Self-Assessment: Based on a review of the Facility's Self-Assessment with regard to Section C of the Settlement Agreement, the Facility found that it was in substantial compliance with none of the eight provisions in Section C. This was consistent with the Monitoring Team's findings. ▪ The Facility's Self-Assessment for Section C included details drawn from the application of the Quality

	Monitoring Tool and referenced specific items on the tool to address the elements within each provision of the Settlement Agreement. The sample size had been increased to 30. This was a significant improvement over the record sample of five that was used for the last Self-Assessment. Information from other sources was reviewed to supplement the QA Tool data. ▪ The Self-ratings were comparable in most respects to those of the Monitoring Team. ▪ The Facility anticipated questions the Monitoring Team would raise, such as questions about the use of abdominal binders, changes in the data system, and the changes in the Do Not Restrain list, and provided some additional information. ▪ The Facility included Action Steps for each provision of the Settlement Agreement. The following concerns were noted: ▪ Action Steps were presented for each subsection of the Settlement Agreement. Action Steps were broadly stated with projected completion dates from three to six months or longer. Each Action step could have been broken down into intermediate steps. For example, for Section C.1, action step #1 was "determine if restraints are complete and accurate" and assigned the responsibility to the Director of Behavioral Services. The start date was 12/1/12, and completion date was 12/31/13. It was not clear how this was to be accomplished or why the date was so far out. Including intermediate steps would allow the Facility to determine if progress toward the goal was on track. ▪ It was not clear how The Corrective Action Plan Tracking related to the Self-Assessment and Action Plans.
	Summary of Monitor's Assessment: The State had issued a revised policy on restraint and training had begun on its revisions. The Monitors will comment on the revised policy at a future date. However, changes were noted with regard to the definition of restraints, and these changes have been addressed in this report. The Facility adopted a new Restraint Policy, on 6/1/12, and provided training to administrative, clinical, and direct support professionals on the new policy, as well as and new restraint documentation. Training of the new Restraint Policy also was integrated within New Employee Orientation (NEO) training. The Facility's Avatar data system was not producing reliable restraint data and had not produced trend reports for June. The Monitoring Team learned that the Avatar system was being upgraded to allow direct entry of restraint reports, replacing the system of handwritten reports, in a change similar to what was done with injury reporting. The conversion process was underway. However, some issues still existed with reporting that needed to be addressed. For example: ▪ The reporting process for a restraint that is implemented, released, and re-implemented in a short period of time required refinement. More specifically, in data submitted for this review, there were data system entries for multiple restraints, but only one report was available. ▪ The Facility needed to ensure that restraints were entered with the correct label rather than an "other." The Facility was identifying issues with restraints that needed to be addressed, such as understanding what triggered the behavior that led to restraint so that they could be addressed. For example, one antecedent to

	restraint appeared to be the use of cigarettes: not having them, wanting them at unauthorized times, and not sharing them. For one woman, an antecedent condition was her desire to stay outdoors after 8 p.m. when the residences were supposed to be locked. The Facility needed to analyze its data on restraints to better understand these antecedents, and develop ways to address them systemically as well as individually. The assignment of restraint monitors had been changed, and the training of the additional monitors had been done. However, there was some decline in the accuracy of documenting restraints as a result. The list of trained restraint monitors was provided, but the names reported did not match the names of restraint monitors in the restraint documentation. Areas of noted progress included the initiation of the Restrictive Practices Committee, which was developed through the integration of the Level of Oversight Committee and the Restraint Reduction Committee. This new committee appeared to offer the potential for more comprehensive oversight of both restrictive practices. The Desensitization Committee continued its efforts, including the development of a database of individuals requiring dental and/or medical desensitization as well as those with completed baselines. In addition, a pilot project was initiated examining and developing revised medical and dental desensitization plans. In general, the Facility had systems in place for restraint reporting, monitoring, and review processes. Concerns were noted with regard to how well those systems were working, as well as with data integrity, and with regard to the adequacy with which staff described the antecedent- and consequence-based interventions 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.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the	The Department of Justice has indicated an interest in certain statistics. In response to this request, the Monitoring Team has included some such numbers in this report, such as the following information related to numbers of restraints. The Monitoring Team is not in a position to verify these numbers, or provide in-depth analysis of these numbers. Clearly, it is the Facility's responsibility to conduct such analyses, and as these analyses have been made available to the Monitoring Team, they are discussed as appropriate with regard to the sections of the Settlement Agreement to which they apply. The following numbers are provided for informational purposes only, and are based on data available from the Facility at the time of the review. A review of the Trend Analysis Report for June 2012 showed:	Noncompliance

absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only restraint techniques approved in the Facilities' policies shall be used.

Type of Restraint	Date range	Date range
	September to August 2011 (12 months)	September to May 2012 (Nine months)
Personal restraints (physical holds) during a behavioral crisis	234	191
Chemical restraints during a behavioral crisis	41	30
Mechanical restraints during a behavioral crisis	No Data	No Data
TOTAL restraints used in behavioral crisis	275	221
TOTAL individuals restrained in behavioral crisis	No Data	No Data
Of the above individuals, those restrained pursuant to a Safety Plan	No Data	No Data
Medical/dental restraints	422	282
TOTAL individuals restrained for medical/dental reasons	No Data	No Data

During interviews, it was learned that the Avatar System was undergoing statewide changes and Trend Reports were not available for June 2012. Review of the reports submitted for Sample #C.1 indicated that the system's database contained errors, such as multiple entries for the same restraint, or incorrectly coded entries (physical or chemical restraints as "other"). Discussion with the Facility revealed that this was known and the imminent conversion to an electronic data system would assist in addressing these issues.

Prone Restraint

Based on review of the Facility's policy, prone/supine restraint was prohibited.

Based on review of the Quarterly Trend Report for Restraints, dated 5/31/12, prone restraint was not identified.

Based on staff interview, staff knew that prone/supine restraint was forbidden, and that while an individual was in restraint, if he/she moved into a prone/supine position, staff must either turn the individual to his/her side or end the restraint.

A sample, referred to as Sample #C.1, was selected (as described in the Documents Reviewed Section above). The sample was reduced in size from the original 32 restraints selected to 25 restraints, since that was the number of files submitted.

Based on a review of the restraint records for individuals in Sample #C.1 involving 10 individuals, none (0%) showed use of prone restraint.

		Other Restraint Requirements Based on document review, the Facility policies stated that restraints could 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. Restraint records the Facility submitted were reviewed for Sample #C.1 that included the restraint checklists, face-to-face assessment forms, and debriefing forms. The following are the results of this review: ▪ In 21 of the 25 records (84%), there was documentation showing that the individual posed an immediate and serious threat to self or others. Examples where this was not the case included: o Individual #61 on 5/17/12 at 7:15 p.m.: it was not clear what form the aggression to staff took. o Individual #300 on 4/19/12 at 8:43 p.m.: it was reported that the individual swung at staff and ran when she could not have a cigarette. The documentation did not contain information about why running was a threat (whether she was near the gate, for example). o Individual #300 on 5/7/12: it was not clear from the documentation what the aggression involved, making it difficult to determine how immediate and serious the threat of harm was. o Individual #238 on 5/28/12 at 8:37 p.m. was reported to have been chasing staff with a stick, but the report did not document an adequate description to allow determination of the seriousness of the threat, such as detail about the kind or size of the stick, or whether staff were able to keep a safe distance from the individual. ▪ For the 25 restraint records, a review of the descriptions of the events leading to behavior that resulted in restraint found that 16 (64%) contained appropriate documentation that indicated that there was no evidence that restraints were being used for the convenience of staff or as punishment. Examples where this was not the case included the following in addition to the four cases cited above: o Individual #253 on 3/4/12 at 5:30 p.m.: A chemical restraint was used after a basket-hold restraint was tried and failed. The information on this Restraint Checklist was incomplete, appearing to have relied on a prior report. If several restraints occurred in succession and all relied on the original description of behavior, they needed to be presented together to allow the reviewer to understand the full situation. Alternatively, each report needed to contain the essential facts about the behavior. o Individual #246 on 4/14/12 was restrained several times including chemical restraints. The reports of the restraints at 6:14 p.m. and 9:15	

		p.m. contained descriptive information about the type and intensity of behavior that caused the restraint. The reports at 9:50 p.m. and 11:15 p.m. did not, possibly relying on the descriptions in the earlier reports. However, if each restraint was to be reviewed as a separate event, each report needed to include the details of the behavior at the time of that particular event. o Individual #16 on 4/28/12 at an unspecified time, and on 5/7/12 at 6:20 a.m.: This individual was restrained with mittens for several hours each time. This was apparently done in conjunction with a Safety Plan, but there were no details and no Safety Plan was submitted. ▪ In 17 of the records (68%), there was evidence that restraint was used only after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. Examples where this was not the case included: o Individual #16 on 5/7/12 at 6:20 a.m.: mittens were applied as a restraint. The Restraint Checklist contained checked boxes for interventions attempted to avoid restraint, but with no order of attempt or period of time over which the alternatives to restraint were applied. This restraint might have been pursuant to a Safety Plan, but none was presented. o Individual #238 was reported to have been chasing staff with a stick. There was no indication of the time over which alternatives were tried or in what order. There were only check marks on the various boxes. Other reports where there did not appear to be sufficient information were: o Individual #253 on 3/4/12 at 5:20 p.m.; o Individual #300 on 4/19/12 at 8:43 p.m., and 5/7/12 at 6:15 p.m.; o Individual #16 on 4/28/12 time not recorded; o Individual #253 on 5/1/12 at 7:07 p.m.: and o Individual #16 on 5/16/12 at 2:45 p.m. Facility policies identified a list of approved restraints. ▪ Based on the review of 25 restraints, involving 10 individuals, 25 (100%) were approved restraints. An additional sample (Sample #C.7) was chosen from the list of individuals restrained as crisis intervention between 12/1/11 and 5/31/12. Of those listed, three individuals with more than three restraints in a 30-day period were randomly selected. This sample included Individual #61 (restraints on 5/17/12 and 5/18/12), Individual #253 (restraints on 4/10/12 and 4/17/12), and Individual #275 (restraints on 5/28/12 and 5/29/12). Specific restraints by date are listed above in the "Review of Following Documentation" section. Documentation requested for review included restraint checklists and face-to-face debriefing reports (for the dates selected), the PBSPs and SPCIs (i.e., that were in place at	

		the time of the restraints), PBSP and SPCI monthly summaries, the ISP and any ISPAs related to the restraints. Unfortunately, only some of the restraint reports were provided for Individual #253 and Individual #61, and no restraint reports were provided for Individual #275. In addition, other requested documentation for these three individuals, including ISPs, ISPAs (e.g., for more than three restraints in 30 days), PBSPs, and monthly data summaries, was not provided. As a consequence of the missing documentation, the Monitoring Team could not adequately evaluate the sampled restraints to determine whether or not progress had been made on this provision of the Settlement Agreement, particularly with regard to whether restraint was applied in the absence of or as an alternative to treatment and/or only after a graduated range of less restrictive options had been exhausted. Although documentation necessary for the Monitoring Team's evaluation of this item was not available, the most recent CCSSLC self-assessment, dated 6/22/12, revealed the Facility's review of its compliance on this provision of the Settlement Agreement. That is, self-assessment findings suggested that a majority (83%) of sampled restraint reports had missing information or data. More importantly, reports indicated that the use of less restrictive interventions prior to the implementation of restraint was found in only 70% of sampled restraint reports. Overall, based on this and other findings within the self-assessment, the Facility rated this provision as not in substantial compliance. This finding is consistent with the current finding of the Monitoring Team. Clear documentation was not consistently provided that individuals posed a danger to self or others, less restrictive alternatives were followed, or restraints were not used in the absence of adequate treatment. Based on the Monitoring Team's review, the Facility was not in compliance with this provision. This was consistent with the Facility's Self-Assessment.	
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The restraint records involving the 25 reports of restraint for 10 individuals in Sample #C.1 were reviewed. Of the 25 restraints, three individuals were released when the restraint could not be maintained, and three were chemical restraints and release time could not be determined. As a result, for a total of 19 restraints, the appropriateness of the time of the release could be assessed. Of these, 16 of the 19 individuals (84%) were released when the individual was not a danger. For the remaining restraints, it could not be determined whether they were released timely: ▪ One restraint for Individual #238 on 5/28/12 at 8:37 p.m. was coded as "release unsuccessful." It was not clear what this meant. ▪ Two restraints for Individual #16 on 4/28/12 time not recorded and 5/7/12 at 6:20 a.m. involved the use of mittens in accordance with a Safety Plan, but although requested, the plan was not submitted and it could not be determined if the requirements for release within the plan were met.	Noncompliance

		In the Monitoring Team's last report, concerns were expressed about the number of times individuals were released due to inability to maintain the restraint. After consultation with Facility psychologists and with the State Office's psychologist, it appeared that when a hold could not be maintained, the judgment on whether to attempt to restrain again would be made based on the behavior after the release. If the individual no longer presented a danger to himself or others, then no further restraint would be needed. To accurately conclude the documentation on the Restraint Checklist, the code for "unable to maintain restraint" should be checked. In the Monitoring Team last report, this provision was determined to be out of compliance, in part, based on the outstanding issue of the use of abdominal binders. State Policy #001.1, revised 4/10/12, changed the requirements for using mechanical restraint. The policy included definitions of mechanical restraint when used as medical restraint, and protective mechanical restraint to address self-injurious behavior. The policy included requirements for planning and documentation that would apply. While the Monitoring Team has not completed its review of the policy, the policy appeared to provide definitions of restraint, into which abdominal binders fell, and set forth the rules under which they may be used. This is discussed in further detail with regard to Section C.4. The Facility found that it was not in compliance with this provision. The Monitoring Team also found the Facility out of compliance due to the lack of supporting documentation in some records to indicate timely release from restraint.	
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:	As noted above the State Office had issued a revised policy on restraint, Policy #001.1 effective 4/10/12. The three Monitoring Teams will comment jointly on the policy. The Facility policies had not yet been revised to correspond to the State Office policy. However as of the last review, the Facility policy set forth: ▪ Policies governing the use of restraint; ▪ Approved verbal and redirection techniques; ▪ Approved restraint techniques; ▪ Adequate supervision of any individual in restraint, and ▪ Competency-based training requirements for staff prior to their use of restraints. CCSSLC Policy #C.2 was revised on 5/25/11, as noted in the last report, to provide for a Restraint Restriction List of individuals who could not be restrained, who had limitations on use of restraint, and who had Safety Plans. According to the policy, the list was to be displayed in each residence in the "attendant's station." 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 should assure timely review, and identification and correction of any problems with the use of the forms	Noncompliance

	approved verbal intervention and redirection techniques; approved restraint techniques; and adequate supervision of any individual in restraint.	or any issues raised within the forms. However, the unavailability of some Restraint Checklists, Face-to-Face/Debriefing Forms, and Chemical Restraint Reviews suggested that the process was not yet fully implemented. As described in the Monitoring Team's last report, review of the Facility's training curricula found adequate training and competency-based measures in areas of policy, verbal redirection techniques, approved restraint techniques, and supervision of individuals in restraint. However, the report noted that additional training was needed in the techniques of maintaining a restraint, when necessary. During the current review, no additional evidence of training revisions was presented, and that recommendation remains in place. Sample #C.2 was selected from a current list of staff. A description of Sample #C.2 is provided in Documents Reviewed section above. A review of the training transcripts for these staff showed that 25 out of 25 staff (100%) had been provided training on restraint and its related topics. Based on interviews with 20 direct support professionals, 20 were able to describe: ▪ Policies governing the use of restraint (100%); ▪ Approved verbal and redirection techniques (100%); ▪ Approved restraint techniques (100%); and ▪ Adequate supervision of any individual in restraint (100%). As of 7/2/12, the DADS Course Due/Delinquent report listed all staff that were supposed to have had PMAB Basic training or to have been retrained on an annual basis and were overdue for training. This report showed that 12 people, or about one percent of the approximately 859 staff at the Facility, were late with their annual training or had not received training. As noted above with regard to Section C.1 of the Settlement Agreement, 68% of the restraint records reviewed showed that restraint was only used after a graduated range of less restrictive measures had been exhausted or considered in a clinically justifiable manner. The Monitoring Team found that the Facility was not in compliance with this provision. Although the Facility was providing training to staff, its policies needed to be updated to address changes in the State Office policy. In addition, this provision requires that when restraint was used, it was the least restrictive option. The Facility's documentation was not sufficient to confirm that this was the case. The Facility Self-Assessment also concluded that the Facility was not in substantial compliance.	
C4	Commencing within six months of	As discussed in greater detail with regard to Section C.1, in 21 of the 25 records (84%),	Noncompliance

	the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	there was documentation showing that the individual posed an immediate and serious threat to self or others. Of the twenty PBSPs reviewed, 20 (100%) showed 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, as presented in the Monitoring Team's previous reports, the Facility policy did not allow for the use of restraint for reasons other than crisis intervention. Based on documentation the Facility provided for the 25 restraint records reviewed, the Monitoring Team could not determine if the restraint used was not in contradiction to the individuals' medical orders according to the "Do Not Restrain" list. The Do Not Restrain List provided for this review did not contain any names, even though as noted with regard to Section C.3, the Facility procedures called for such a list. Upon interview, it appeared that psychology and medical staff had determined that for the most likely restraints that might be used with any individual in a crisis situation, none would be contraindicated and no list was needed. While the Settlement Agreement does not require such a list, it does require that no restraint be used that is prohibited by the individual's medical orders. It was unclear how or if justification had been provided in medical orders for individuals previously on this list. Clearly, in the past, primary care practitioners (PCPs) had concerns about the use of restraint or certain types of restraint for some individuals. This would have appeared to be appropriate for individuals, for example, with diagnoses that would be exacerbated with the use of restraint, or for those with traumatic histories for whom restraint might cause further psychological harm. Removing these restrictions without adequate justification would be inappropriate. In addition, the Facility policy requires a Do Not Restrain List, and would need to be reconciled with this approach as well as with any new requirements that might be in the State Office Policy on Restraint. In the restraint samples for this report, no one was restrained with an abdominal binder. According to information in the Facility Self-Assessment (i.e., Section C.1), the Facility noted that "prior restraint policy did not specify the use of abdominal binders as restraint, the Facility's practice was to view them as restraint, this practice ceased and the data above is reflective of this change." In interview with the State Psychologist, it was learned that based on the revised policy, there were three ways to categorize the use of an abdominal binder: ▪ As a protective mechanical device when the team determined that the binder was used to protect the individual from injury associated with involuntary movement. An example was when an individual had a Jejunostomy feeding tube (J-tube), and due to the involuntary movements associated with spasticity, the tube was being dislodged. ▪ As a medical restraint when the binder was used to protect the individual from interfering with medical treatment, such as when a wound was sutured. Such use	

		would be subject to a medical order, and temporary until the medical treatment or healing was concluded. ▪ As a protective mechanical restraint when the individual was attempting to remove or interfere with a chronic condition, such as a J-tube insertion. When such restraint was used, there would need to be an action plan in the ISP to describe how the device would be faded over time, data on other interventions tried, and include one-to-one supervision among other requirements. The Facility reported in its Facility Self-Assessment that 11 individuals had abdominal binders, nine of which were being used as adaptive equipment and two were being used as restraint within the definitions in the newly revised state policy. The State Policy 001.1 appeared to preclude use of abdominal binders as adaptive equipment, instead allowing the three options noted above depending on the individual's circumstances. The Facility will need to be certain that any such devices are being used as described in the State Policy. Whether the Monitors agree with this approach will be determined when they provide responses to the most recent version of the Restraint Policy. It will be important for the Facility to assure that its local procedures are congruent with the State Office's revised policy. As noted in the Monitoring Team's previous reports and found once again, additional specification with regard to consequence-based interventions in many of the reviewed PBSPs would reduce the likelihood of staff using restrictive interventions when not prescribed. That is, the utilization of the term "physical redirection" and other related descriptions often appeared ambiguous and could likely lead to misinterpretation by staff. Several examples of ambiguous staff instructions were found within the current sample, including the PBSP for: Individual #38 which stated: "direct her hands away;" Individual #184 that directed: "if he does not comply within five minutes, staff should prompt him that they will be providing assistance with two staff escorting him to the bathroom area;" Individual #186 stated: "immediately move [Individual #186] away from others;" Individual #58 stated: "staff will verbally redirect him, then take him to a quiet area." In addition, some PBSPs (e.g., Individual #46) referred to the potential need, if escalation of unsafe behavior continued, to implement "agency-approved procedures." The Monitoring Team assumed that this referred to "PMAB techniques." In these cases, more specification in the PBSP regarding PMAB techniques as well as whether or not a Crisis Intervention Plan (CIP) (previously Safety Plan for Crisis Intervention) was in place would increase the likelihood that staff would find and/or utilize the appropriate intervention(s). In this case, Individual #46 did have a SPCI, although it was not mentioned in the PBSP. Similarly, Individual #20 had a SPCI but it was not mentioned in the PBSP. That is, the PBSP just stated: "if (Individual #20) becomes a danger to himself or others, PMAB interventions maybe needed." Overall, more specification in PBSPs would appear helpful in ensuring the appropriate interventions are implemented as intended.	

		Previous onsite visits evidenced a slow but ongoing evolution with regard to the development of desensitization plans. More specifically, reports from previous visits included the development of a multi-disciplinary Desensitization Workgroup as well as the ongoing revision of desensitization plans over time. However, these reviews did not reveal any significant improvements in the quality. That is, reviewed plans lacked individuation and typical components necessary for effective skill acquisition. Recent reports indicated that, as of 6/2/12, approximately 116 dental and 51 medical desensitization plans had been developed. However, according to summary documentation (i.e., Individuals with Desensitization Baselines, not dated), all of these plans were developed prior to the previous visit (January 2012) and did not have appeared to be revised. It should be noted, however, that several plans had been revised (as discussed below) and summary documentation had not been updated. Overall, however, most desensitization plans had not been revised and continued to lack sufficient quality as previously reported. The Monitoring Team's previous review revealed past efforts in training staff to identify individuals most likely to benefit from desensitization plans (i.e., utilizing the "Decision Tree Worksheet") as well as attempts to identify current levels of baseline responding (i.e., utilizing "Dental/Medical Baseline for Desensitization Plans" rubric). At the present time, according to provided summary documentation (i.e., Individuals with Desensitization Baselines), it appeared that at least 157 decision trees as well as approximately 118 baselines had been completed. These initial assessments appeared to assist in identifying the nature and severity of the impairment, which then informed more individualized interventions, if appropriate. That is, these efforts had also led to the identification of a substantial number of individuals (approximately 60) who did not appear to be appropriate for desensitization plans. Overall, these efforts appeared to facilitate more effective assessment and, consequently, more individualized and potentially effective intervention. It should be noted, however, that this system might not be "fool proof" as some individuals might be erroneously omitted, or, in some cases, might benefit from desensitization plans in the future. Consequently, regular evaluation by the ISP team (i.e., annual review at the ISP) is necessary to ensure that individuals are given the opportunity to benefit from least restrictive interventions. For example, as discussed with regard to Section F, the ISP for Individual #282 and IRRF indicated that the behavioral services staff said she was not a candidate for desensitization "because of her spasticity." However, the description of her resistance at dental appointments did not appear to be directly related to the spasticity. The IRFF stated: "During appointments she exhibits anxious (sic), has excessive movement and is resistive to exams, she bends at the waist as avoidance and grabs hands." She also was resistive to staff assisting her with brushing her teeth, but no proactive strategies to address this were included in her integrated health care plans. Since the Monitoring Team's previous visit, a new pilot project had been initiated in an effort to develop more individualized and effective medical and dental desensitization	

		plans. This included 16 individuals at Coral Sea and involved the development of revised dental or medical desensitization plans for each individual. At the time of the onsite visit, reports indicated that eight dental and eight medical desensitization plans were developed as part of this pilot. As requested, eight plans were provided for review. This reflected a sample size of 50% of the total number of recently developed desensitization plans. This sample included four dental and four medical desensitization plans. Of the eight plans reviewed, 100% were developed based on completed decision tree worksheets as well as dental/medical baseline assessments. Consequently, they appeared to identify more meaningful objectives based on each individual's observed performance. These individualized objectives appeared to be a substantial improvement over those found in previously reviewed desensitization plans. However, although the plans included more individualized objectives, intervention procedures remained the same across all plans. Indeed, the primary relaxation strategy found across all plans was the use of verbal calming techniques as well as social praise. Although this technique and form of reinforcement might work for some individuals, it might not work with others (e.g., those who do not communicate verbally). In addition, some of the plans continued to include objectives that were inadequate or perhaps unattainable. For example, the objective for Individual #334 stated: "… [Individual #334] will interact with dental personnel …" but did not adequately define "interact." Similarly, the objective for Individual #273 stated "… [Individual #273] will allow dental staff to polish his teeth …", but did not adequately define "allow." In addition, 100% of the plans appeared to identify objectives that were likely unattainable. That is, they included an objective that required 100% success across all trials for three consecutive months. This outcome appeared somewhat unrealistic. In addition to the above concerns, noted limitations of previously reviewed desensitization plans, that is, regarding the omission of elements critical to effective skill acquisition (e.g., prompting hierarchy, error correction procedures, generalization and maintenance programming), were consistent following review of the current sample of revised desensitization plans. Progress was noted in the efforts to develop an actual desensitization clinic within the Angelfish building. Onsite visit to this clinic evidenced the initial development of the space and necessary equipment. The Monitoring Team will look forward to reviewing the continued progress of this clinic as well as reviewing progress of the medical desensitization clinic at the next review. It should be noted that, although this space will likely resemble a clinic (i.e., with similar elements), behavioral services staff need to demonstrate its effectiveness as well as include strategies to support generalization to a more normalized clinical setting. The concern is that it could be an extra and artificial step that might impede ultimate success and actual normalization. Based on the Monitoring Team's finding, the Facility was not in compliance with this provision of the Settlement Agreement. Documentation of restraints needs to contain enough detail about the behavior to describe the crisis, and Facility procedures need to be amended if the use of the Do Not Restrain list is to be discontinued. Facility procedures	

		related to the use of abdominal binders should be revised to implement the revised state policy. In addition, 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.	
C5	Commencing immediately and with full implementation within six months, staff trained in the application and assessment of restraint shall conduct and document a face-to-face assessment of the individual as soon as possible but no later than 15 minutes from the start of the restraint to review the application and consequences of the restraint. For all restraints applied at a Facility, a licensed health care professional shall monitor and document vital signs and mental status of an individual in restraints at least every 30 minutes from the start of the restraint, except for a medical restraint pursuant to a physician's order. In extraordinary circumstances, with clinical justification, the physician may order an alternative monitoring schedule. For all individuals subject to restraints away from a Facility, a licensed health care professional shall check and document vital signs and mental status of the individual within thirty minutes of the individual's return to the Facility. In each instance of a medical restraint, the physician shall specify the schedule and type of monitoring required.	It was clear from the Action Plan for this provision that training of Restraint Monitors had been done, and a list of names of Restraint Monitors with test scores was submitted. However, it was not clear what the training curriculum involved. Based on review of training records, 101 staff at the Facility successfully completed the training to allow them to conduct face-to-face assessment of individuals in restraint. This list was provided as part of the "Presentation Book" at the beginning of the site visit. Based on a review of 25 restraint records (Sample #C.1), a face-to-face assessment was conducted: ▪ In 10 out of 25 incidents of restraint (40%) by an adequately trained staff member. Records that did contain documentation of this included (Bolded entries are for records that did not contain a Face-to-Face sheet): o Individual #253 on **4/11/2012 at 1:05 p.m.**, and 5/1/12 at 7:07 p.m.; o Individual #61 on 5/17/2012 at 7:15 p.m.; o Individual #300 on 2/1/2012 at 7:15 a.m., 4/19/12 at 8:43 p.m., and 5/7/12 at 6:15 p.m.; o Individual #246 on 4/14/12 at 6:14 p.m., and 9:15 p.m.; o Individual #169 and 5/16/12 at 2:45 p.m.; o Individual #109 on 2/13/12 at 10:41 p.m.; o **Individual #16 on 4/28/12 at a time not entered, and 5/7/12 at 6:20 a.m.**; o Individual #26 on 3/29/12 at 8:24 p.m.; o **Individual #238 on 5/28/12 8:37 p.m.**; and o Individual #55 on 4/20/12 at 7:20 a.m. ▪ In 19 out of 25 instances (76%), the documentation showed the assessment began as soon as possible, but no later than 15 minutes from the start of the restraint. Records that did not contain documentation of this included: o Individual #253 at 4/11/12 at 1:05 p.m.; o Individual #169 on 4/24/12 at 7:15 p.m.; o Individual #169 on 4/24 at 7:35 p.m.; o Individual #16 on 4/28/12 no time entered; o Individual #16 on 5/7/12 at 6:20 a.m.; and o Individual #238 on 5/28 at 8:37 p.m. ▪ In 20 instances (80%), the documentation showed that an assessment was completed of the application of the restraint. Records that did not contain documentation of this included:	Noncompliance

		○ Individual #253 on 5/17/12 at 12:22 p.m.: no comment on the inability of staff to maintain restraint; ○ Individual #253 on 4/11/12 at 1:05 p.m.: incorrect Face-to-Face form; ○ Individual #16 on 4/28/12: no Face-to-Face form; ○ Individual #16 on 5/7/12 at 6:20 a.m.: no Face-to-Face form; and ○ Individual #238 on 5/28 at 8:37 p.m.: no Face-to-Face form. ▪ In 14 instances (56%), the documentation showed that an assessment was completed of the circumstances of the restraint. Records that did not contain documentation of this included: ○ Individual #253 at 4/11/12 at 1:05 p.m.: incorrect face-to-face form; ○ Individual #253 at 5/1/12 at 7:07 p.m.: incomplete description of events preceding the restraint; ○ Individual #61 on 5/17/12 at 1:57 p.m.: incomplete information about events prior to restraint; ○ Individual #61 on 5/17/12 at 7:15 p.m.: individual was upset at the mention of her boyfriend's name, but there was no assessment of the context, what was said, and in what manner; ○ Individual #300 on 4/19/12 at 8:43 p.m.: individual ran, but there was no information on why running was cause for a restraint, and no comment on the cigarette usage that might be contributing to the behavior; ○ Individual #300 on 5/7/12 at 6:15 p.m.: there was no indication that the description of events prior to the behavior on the Restraint Checklist was inadequate or any information to supplement that information. ○ Individual #300 on 5/24/12: the individual became upset when repeatedly asked to take her medications. There was no explanation of why she needed to take the medications at that time or whether a delay might have been possible to allow her to calm down; ○ Individual #16 on 4/28/12: no Face-to-Face form; ○ Individual #16 on 5/7/12 at 6:20 a.m.: no Face-to-Face form; ○ Individual #238 on 5/28 at 8:37 p.m.: no Face-to-Face form; ○ Individual #26 on 3/29/12 at 8:24 p.m.: there was not enough information about what preceded the yelling, cursing, and aggression to understand the circumstances and the assessment did nothing to remedy this issue. There were no records for which physicians had ordered alternative monitoring. Based on a review of 18 restraint records for nine individuals for restraints that occurred at the Facility (i.e., Individual #253, Individual #169, Individual #109, Individual #26, Individual #238, Individual #55, Individual #61, Individual #300, and Individual #246), there was documentation that a licensed health care professional: ▪ Conducted monitoring at least every 30 minutes from the initiation of the restraint	

		in 14 (78%) of the instance of restraint. Records that did not contain documentation of this included: Individual #300, 5/24/12; Individual #246, 4/14/12; Individual #109, 5/9/12, and Individual #55, 4/20/12. ▪ Monitored and documented vital signs in nine (50%) episodes. Records that did not contain appropriate documentation of this included: Individual #300, 2/1/12, 4/19/12, 5/7/12, and 5/24/12; Individual #246, 4/14/12 (two episodes); Individual #169, 4/24/12; Individual #109, 2/13/12; and Individual #55, 4/20/12. Problematic issues resulted in noncompliance included the vital signs not recorded or marked as refused. As noted in previous reports, to obtain respirations, the individual's cooperation is not required. In addition, noncompliance with this indicator was found for individuals whose Restraint Checklists indicated that individuals had significantly high or low values for their vital signs, and did not include documentation that the vital signs were retaken to ensure the individuals were medically stable. ▪ Monitored and documented mental status in eight (44%) episodes. Records that did not contain appropriate documentation of this included: Individual #253, 5/1/12, and 5/27/12; Individual #61, 5/17/12 (two episodes); Individual #300, 4/19/12; Individual #246, 4/14/12 (two episodes); Individual #169, 4/24/12; Individual #238, 5/28/12; and Individual #55, 4/20/12. Problematic issues that resulted in noncompliance included either the mental status were not recorded, were generic such as "alert, oriented, and aggressive" without a specific description included, or it was marked as refused. Also, as repeatedly noted in previous reports, to obtain a mental status, the individual's cooperation is not required. From discussions with the Psychiatric Nurses who audit these areas, their findings were similar to the Monitoring Team's findings regarding the low compliance related to the documentation of vital signs, and mental status. However, nursing had not established a system to analyze these data and address the ongoing problematic issues found for the above data, and/or the data related to Section C.6 addressing the documentation of assessment by a licensed health care professional of any restraint-related injuries or other negative health effects. At the time of the review, the CNE confirmed no system was in place to ensure that nursing was regularly reviewing the data addressing nursing's role regarding episodes of restraint. As noted in the documents reviewed section, the Facility indicated that since the Monitoring Team's last review, no restraints had occurred off grounds. Sample #C.3 including 13 records was selected from the list of individuals who had medical restraint in the last six months. (Details regarding the sample are provided in the Documents Reviewed section.) For these individuals, the physicians' orders were reviewed as captured in the Sedation Care Plans, as well as documentation of monitoring.	

		▪ In 13 out of 13 (100%), the physician specified the schedule of monitoring required; and ▪ In 13 out of 13 (100%), the type of monitoring required was described in a "Sedation Care Plan" which was signed by a registered nurse, presumably on the orders of the physician. The Sedation Care Plan was a one-page form with details to be checked depending on the individual, and with spaces to record mental conditions at prescribed intervals. The Plan referred to the Restraint Checklist for the vital signs to be recorded every 15 minutes for two hours on every restraint. It was not clear when the two hours was to begin: after the medication was administered which would include the time the medical procedure was underway, or from the time the individual returned to his/her residence. ▪ Assuming that the intent was from the time the medication was administered, in all but three reports, the monitoring had not been carried out as specified in the Sedation Care Plan, because the documentation of monitoring on the Restraint Checklist was not carried out every 15 minutes for two hours. For example: o Individual #221 was given sedation at 12:15 p.m. for completion of a medical appointment. Monitoring was recorded at 12:30 p.m., 3:45 p.m., 4:15 p.m., 4:45 p.m. etc. The directions specified in the tool needed to be followed and documented. There was a space on the form for the doctor's name, which was not included in all records. There needed to be evidence that the schedule and type of monitoring were based on a physician's order as specified in the Settlement Agreement. Based on these findings, the Monitoring Team concluded that the Facility was in noncompliance with this provision. Evidence was necessary to confirm that all staff that perform the duties of restraint monitor, as identified on the Face-to-Face monitoring forms, are qualified to do so. Efforts to provide additional training to staff that fill out restraint checklists should continue to ensure that the quality of information on the checklists continues to improve. Of particular importance is the need to continue to work with staff to provide information about antecedents to the behavior that necessitates restraint. When using a Sedation Care Plan to indicate the frequency of monitoring following sedation, the instructions on the form should be followed. The Facility's Self-Assessment also found the Facility was not in compliance with this provision.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or	A sample (Sample #C.1) of 25 Restraint Checklists for individuals in non-medical restraint was selected for review. The following compliance rates were identified for each of the required elements: ▪ In 25 (100%), continuous one-to-one supervision was provided; ▪ In 24 (96%), the date and time restraint was begun (for Individual #16 on 4/28/12, no time was entered); ▪ In 23 (92%), the location of the restraint (it was not provided for Individual #246	Noncompliance

	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.	on 4/14/12 at 6:14 p.m., and Individual # 238 on 5/28/12 at 8:37 p.m.); ▪ In seven (28%), information about what happened before, including the change in the behavior that led to the use of restraint. Most Restraint Checklists provided insufficient specificity about what was happening before the behavior that led to restraint to determine what might have triggered the behavior (examples are provided with regard to Section C.5); ▪ In 11 (44%), the actions taken by staff prior to the use of restraint were sufficient to permit adequate review per Section C.8. Examples are provided with regard to Section C.5 regarding circumstances of restraint; ▪ In 16 (64%), the specific reasons for the use of the restraint were documented. In nine, reports the reasons did not include enough detail. For example: o Individual #253 on 3/4/12 at 5:20 p.m. was reported to be kicking and hitting staff. This took place in her bedroom. The needed detail was whether she was pursuing staff to kick them, and if she was not, why they needed to approach her. o Individual #61 on 5/17/12 at 1:57 p.m. and at 7:15 p.m., Individual #300 on 4/19/12 at 8:43 p.m. and on 5/7/12 at 6:15 p.m., and Individual #26 on 3/29/12 at 8:29 p.m. were similar to the previous bullet. o Individual #16 on 4/28/12 and on 5/7/12 was restrained with mittens pursuant to a Safety Plan, which was not provided. The Restraint Checklist did not provide details of the reason for the restraint. o Individual #238 on 5/28/12 at 8:37 p.m. was described as chasing staff with a stick. The missing detail was the size and type of stick, and whether or not staff were able to maintain a distance from the individual. ▪ In 25 (100%), the method and type (e.g., medical, dental, crisis intervention) of restraint; ▪ In 25 (100%), the names of staff involved in the restraint episode; ▪ Observations of the individual and actions taken by staff while the individual was in restraint, including: o In 23 (92%), the observations documented every 15 minutes and at release. Exceptions were Individual #16 who was restrained with mittens pursuant to a Safety Plan and who was monitored every 30 minutes for circulation. Most individuals were not restrained long enough to require 15-minute checks. o In 23 (92%), the specific behaviors of the individual that required continuing restraint. The exception being Individual #16. o In 23 (92%), 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, except Individual #16, where there were some indications of release for toileting and it was not clear if the individual was released for meals or if he was receiving nutrition via a tube.	

		o In 25 (100%), the level of supervision provided during the restraint episode; and o In 23 (92%), the date and time the individual was released from restraint, the exception being Individual #16. Based on a review of 18 restraint records for nine individuals for restraints that occurred at the Facility (i.e., Individual #253, Individual #169, Individual #109, Individual #26, Individual #238, Individual #55, Individual #61, Individual #300, and Individual #246): ▪ In none (0%), the results of assessment by a licensed health care professional as to whether there were any restraint-related injuries or other negative health effects was appropriately documented. Records that did not contain documentation of this included: Individual #253, 5/1/12, and 5/27/12; Individual #61, 5/17/12 (two episodes); Individual #300, 2/1/12, 4/19/12, 5/7/12, 5/24/12; Individual #246, 4/14/12 (three episodes); Individual #169, 4/24/12, and 5/16/12; Individual #109, 2/13/12, and 5/9/12; Individual #26, 3/29/12; Individual #238, 5/28/12; and Individual #55, 4/20/12. Problematic issues that resulted in noncompliance included either the Post Restraint Assessment section being left blank, lacking the appropriate documentation regarding an assessment, or lacking appropriate nursing documentation regarding injuries or the specific descriptions of injuries. In a sample of 25 records (Sample #C.1), restraint debriefing forms had been completed for 21 (84%). In the remaining records the form was not provided, or for Individual #253 on 4/11/12 at 1:05 p.m., the form was for the wrong restraint (i.e., hand-over-hand not chemical). ▪ Of note, most of the forms did not include the dates of the reviews by the Unit Review Teams and by the Incident Management Teams. A sample of 13 individuals subject to medical restraint was reviewed (Sample #C.3), and in none (0%) was there evidence that the monitoring had been completed as required by the physician's order as found in the Sedation Care Plan as described with regard to Section C.5. As described in the Documents Reviewed Section of this report, Sample #C.4 was selected using the list the Facility provided of individuals who had had chemical restraint since the last onsite review. Documentation for this sample of three individuals was reviewed. In three (100%), there was documentation that prior to the administration of the chemical restraint, the licensed health care professional contacted the psychologist, who assessed whether less intrusive interventions were available and whether or not conditions for administration of a chemical restraint had been met. The Facility was not in compliance with this provision. The primary reasons included the	

		lack of specific detail in the Restraint Checklists to explain the events prior to the behavior that caused the restraint, the actions taken by staff prior to the use of restraint to try to avoid the restraint, and the specific behavior than caused the restraint. In addition, those monitoring medical restraints needed to follow the instructions on the Sedation Care Plan. In its Self-Assessment, the Facility identified that it was not in compliance with this provision.	
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 documentation provided, Individuals Restrained During Time Period Between 12/1/11 and 5/31/12, dated 6/3/12, at least 11 individuals were placed in restraint more than three times in any rolling thirty-day period. Of these eleven, a sample of three individuals (reflecting a sample of 27%) was selected for review to determine if the requirements of the Settlement Agreement were met. This sample was the same sample as described previously (Sample #C.7) and included Individual #61 (restraints on 5/17/12 and 5/18/12), Individual #253 (restraints on 4/10/12 and 4/17/12), and Individual #275 (restraints on 5/28/12 and 5/29/12). Specific restraints by date are listed above in the "Review of Following Documentation" section. As previously presented (with regard to Section C.1), the majority of the requested documentation for this sample was not provided and, as a consequence, the Monitoring Team was not able to adequately evaluate the selected restraint reports and related documentation to determine whether or not progress had been made in regard Sections C.7.a through C.7.g of the Settlement Agreement as presented below. Overall, no evidence was provided to demonstrate that the IDT for any of the individuals sampled adequately reviewed the selected restraints that met the criterion of more than three restraints in a rolling 30-day period. The Monitoring Team's previous reports found evidence of the use of the structured ISP addendum (ISPA) designed to review and document the IDT's discussion and recommendations under these circumstances. However, based on the documentation provided, it did not appear that this ISPA format was used for any of the sampled individuals following the selected restraints. Subsequently, based on documentation provided, of the three individuals sampled, none (0%) of the individuals' teams met to review the restraints selected for review. Consequently, the Monitoring team found the Facility in noncompliance with this section of the Settlement Agreement. This finding of noncompliance appeared consistent with findings reported in Section C.7 of	Noncompliance

		the most recent CCSSLC Self-Assessment, dated 6/25/12. More specifically, the Facility self-review revealed significant limitations and inadequacies across all provisions within Section C.7 of the Settlement Agreement as discussed in greater detail below. It should be noted that documentation provided within the Section C.7 of the Presentation book revealed several examples of completed ISPAs following more than three restraints in a 30-day period (e.g., for Individual #297, dated 12/21/11 and 1/23/12; Individual #7, dated 2/2/12; and, Individual #253 dated 3/8/12). Consequently, given that the appropriate ISPA format was utilized with other individuals (or the same individual for different restraints), it was unclear why this ISPA format was not utilized following the restraints selected for the current sample. Of the three individuals reviewed, zero (0%) of the individuals' teams adequately reviewed the individual's adaptive skills. Of the three individuals reviewed, zero (0%) of the individuals' teams adequately reviewed the individual's biological, medical and psychosocial factors. These findings were consistent with the findings of the most recent CCSSLC Self-Assessment, dated 6/25/12, that indicated that provision C.7.a was not in substantial compliance due to essential elements missing from sampled documentation.	
	(b) review possibly contributing environmental conditions;	Of the three individuals reviewed, zero (0%) of the individuals' teams adequately reviewed the potential contributing environmental conditions. This finding was consistent with the findings of the most recent CCSSLC Self-Assessment, dated 6/25/12, that indicated that provision C.7.b was not in substantial compliance due to environmental variables not fully delineated in 66% of the sampled documentation.	Noncompliance
	(c) review or perform structural assessments of the behavior provoking restraints;	Of the three individuals reviewed, zero (0%) of the individuals' teams adequately reviewed and/or made recommendations to revise structural and functional behavior assessments. This finding was consistent with the findings of the most recent CCSSLC Self-Assessment, dated 6/25/12, that indicated that provision C.7.c was not in substantial compliance due to lack of adequate review or revision of SFBAs of those sampled.	Noncompliance
	(d) review or perform functional assessments of the behavior provoking restraints;	Of the three individuals reviewed, zero (0%) of the individuals' teams adequately reviewed and/or made recommendations to revise structural and functional behavior assessments. This finding was consistent with the findings of the most recent CCSSLC Self-Assessment, dated 6/25/12, that indicated that provision C.7.d was not in substantial compliance due to lack of adequate review or revision of SFBAs of those sampled.	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 individual's ISP;	Due to lack of provided documentation as requested, the Monitoring Team could not adequately review the PBSPs for the individuals in the sample. More specifically, in addition to the identified restraints (as listed above), the related PBSPs that were in place at the time of these restraints for the selected individuals were not provided as requested.	Noncompliance
	(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. As found during the Monitoring Team's previous visits, staff reports indicated that treatment integrity was being collected, but the data had not yet been summarized or systematically analyzed. As a result, it was not possible to confirm a high degree of treatment integrity as related to the implementation of PBSPs and SPCIs.	Noncompliance
	(g) as necessary, assess and revise the PBSP.	Of the three individuals reviewed, zero (0%) of the individuals' teams adequately reviewed and/or made recommendations to revise the PBSP. This finding was consistent with the findings of the most recent CCSSLC Self-Assessment, dated 6/25/12, that indicated that provision C.7.g was not in substantial compliance due to lack of specification regarding IST determination that PBSPs should be reviewed or revised.	Noncompliance
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review	CCSSLC's procedures included review of restraints, other than medical restraint, by the Unit Team and the IMRT within three business days; by the IDT to determine if any addenda to the ISP were needed, and by the Restraint Reduction Team to determine what additional actions might be needed and whether there was a systemic issue that required action. There appeared to be issues with distributing the Restraint Checklists and other	Noncompliance

	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.	documentation to the appropriate reviewing bodies, and assuring that the data was entered quickly and accurately into the Avatar data system. At the time of the site visit, Facility staff reported that that a new phase of the Avatar system was in the launch phase. This would allow the Restraint Checklists and associated information to be entered electronically and immediately rather than being hand-written for entry later. This system was said to be similar in design to the one in use for reporting injuries, which had resulted in improvements to the quality of that data. The Monitoring Team will observe this change at the next review. A sample of documentation related to 25 incidents of restraint was requested (Sample #C.1), including all reviews of the use of the restraint and any addendums to the individual's Individual Support Plan that resulted. This documentation showed that: ▪ In 16 (64%), the review by the Unit IDT occurred within three business days of the restraint episode, and this review was documented by signature on the Restraint Checklist. As noted below, full documentation of these reviews was not provided. ▪ In two (8%), the review by the IMRT occurred within three business days of the restraint episode, and this review was documented by signature on the Face to Face/Debriefing Form. As noted below, full documentation of these reviews was not provided. ▪ As described in Section C.5 of this report, in 15 (60%), the circumstances under which the restraint was used were determined and documented on the Face-to-Face Assessment Debriefing form, including the identity of the staff responsible for the review. ▪ Although the Monitoring Team request "all reviews" of the restraints in the sample, the documentation of the reviews by the Unit Team and the IMRT were not submitted for the records in the sample, only the Restraint Checklist/Debriefing forms, which provided limited information. As a result, it could not be determined whether the reviews were conducted by the Unit IDT and the IMRT, whether they were sufficient in scope and depth to determine if the application of restraint was justified, whether the restraints were applied correctly, and whether factors existed that, if modified, might prevent future use of restraint with the individual, including adequate review of alternative interventions that were either attempted and were unsuccessful, or were not attempted because of the emergency nature of the behavior that resulted in restraint. ▪ Since the documents describing the reviews by the Unit IDT and the IMRT were not submitted for Sample C.1, it could not be determined if the review conducted by the Unit IDT and the IMRT resulted in an additional referral to the IDT for review and consideration of possible changes in active treatment. ▪ It was noted in observation of an IMRT/Review Authority Team meeting that restraints were being reviewed and minutes taken of those reviews.	

		In March 2012, the Restraint Reduction Committee had been reformed as the Restrictive Practices Committee (RPC) to include review of Levels of Support as well as use of restraints. The RPC was scheduled to meet on Mondays to review behavioral restrictions, Wednesdays to review dental restraints, and Friday to review medical restraints. Minutes demonstrated that the RPC had been following that schedule in April and May. However, there were no new procedures to document the changes. Upon interview, it was explained that at one of the meetings mid-month, the committee reviewed trends in restraint use facility-wide. Meeting minutes contained minimal information about restraint reviews or trends across the Facility. The charts included in the minutes to track restraints reviews were not completed (e.g., the minutes for 3/30/12), and follow-up recommendations overdue to the Committee were not commented on. For this committee to show results, it will need to have clear procedures documented, and followed, with minutes that reflect the discussion and track any follow-up that results. Based on these findings, the Facility was not in compliance with this provision. In the Facility Self-Assessment, the Facility similarly found that it was not in substantial compliance. The restraint review process was overhauled in June 2011 and again in March 2012, and at the time of the review, it was not clear that each restraint was being reviewed on time and that the reviews were identifying areas in need of action and follow-up. The restraint review process should be firmly established and consistently implemented.	

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, including the order of the alternatives to restraint and the time involved in those efforts. (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 on the debriefing form. (Sections C.1 and C.3)
4. Data collected in the AVATAR system for restraints should be reviewed for inconsistencies and errors, and modified, as appropriate, so that it produces accurate information that can be relied on by management in making decisions about restraint use. (Section C.1)
5. Staff should be trained on the new electronic restraint reporting system to avoid duplicate and erroneous entries. (Section C.1)
6. Facility policy and practice that address the use of abdominal binders should be modified to comply with the revised State policy. (Section C.2)
7. When PMAB procedures are referenced in consequence-based intervention sections in PBSPs, a reference should be provided as to whether or not a SPCI is currently in place and to direct staff to related strategies prescribed within the SPCI. (Section C.4)
8. In PBSPs, the term "environmental redirection" should be clarified to include the specific type of prompt prescribed (i.e., verbal, gestural, and/or physical). (Section C.4)
9. In PBSPs, the term "physical redirection" should be more specific regarding the acceptable amount of physical force (i.e., that it does not include force over active resistance). (Section C.4)

10. The Facility should ensure that desensitization plans contain necessary elements for effective skill acquisition. (Section C.4)
11. A list of staff that have been trained as Restraint Monitors should be maintained with evidence of the training. (Section C.5)
12. The curriculum for training Restraint Monitors should be enhanced to ensure understanding of antecedent behaviors, documentation of alternatives that are tried prior to restraint, and the need to include indications of the time spent attempting to prevent the restraint. (Section C.5)
13. The Facility should ensure that restraints, such as medical restraints, have documentation to support alternative schedules of monitoring. (Section C.5)
14. The Facility should ensure that a licensed health care professional timely and regularly monitors, and appropriately documents the vital signs, and the mental status of an individual in restraints at least every 30 minutes from the start of the restraint episode, and for two hours except for a medical restraint pursuant to a physician's order. (Section C.5)
15. The Facility should develop and implement a system to ensure that auditing data regarding restraints is being regularly reviewed by nursing, and that plans of correction are implemented addressing the problematic issues identified. (Section C.5)
16. The Facility should ensure that nursing staff assesses and appropriately documents any restraint-related injury. (Section C.6)
17. 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)
18. The Facility should provide re-training for QDDPs and other IDT members that facilitate and document meetings when discussing the use of more than three restraints in a 30-day period. (Section C.7)
19. The Restraint Review Committee should follow its process for reviewing forms consistently and vigorously to identify errors and inconsistencies. (Section C.8)
20. The Unit Incident Management Review Teams should keep minutes or insert sufficient information into its log to document its review of incidents and any recommendations that are made, and track any changes that are needed so that it is clear when issues related to a restraint have been addressed. (Section C.8)

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Centers for Medicare and Medicaid (CMS) Intermediate Care Facility for Persons with Developmental Disabilities (ICF/DD) reports of 5/14/12 and 6/27/12; o CCSSLC Self-Assessment, updated 6/25/12; o CCSSLC Action Plans, updated 6/25/12; o CCSSLC Provision Action Information, undated; o Abuse/Neglect/Exploitation (A/N/E) Investigations between 1/1/12 and 5/31/12, dated 6/8/12; o Abuse/Neglect/Exploitation Investigations between 6/1/12 and 7/5/12; o CCSSLC Abuse Neglect and Exploitation – Monthly Trending Report, from 5/1/12 to 5/31/12; o Investigations Conducted Solely by Facility between 1/1/12 and 5/31/12, dated 6/8/12; o CCSSLC Unusual Incidents – Monthly Trending Report, from 5/1/12 to 5/31/12; o CCSSLC Injuries – Monthly Trending Report, from 6/1/12 to 6/30/12; o Individuals with Injuries for Reporting Period between 1/1/12 to 5/31/12 and 6/1/12 to 7/5/12; o CCSSLC Staff Status Tracking – by Date, dated 6/8/12; o "List of Seven CCSSLC clients who are currently on chronic caller list," undated; o Course Delinquency List for ABU0100, Abuse and Neglect, dated 7/2/12; o Course Delinquency List for UNU0100, Unusual Incidents, dated 7/2/12; o Adult Protective Services (APS) Training Transcript Crosswalk – Corpus Christi, undated; o APS Training Transcript Crosswalk – Corpus Christi for seven APS investigators, undated; o Chart of Facility Investigators and Campus Administrators with required investigation courses taken, undated; o Individual Training Records for eight Facility staff assigned to investigate unusual incidents, dated 6/7/12; o Individual Support Plan (ISP) Meeting (Facilitation and Documentation), dated 12/3/11; o CCSSLC Annual Employee Registry Check and Fingerprint Criminal History Submission, dated 10/6/11; o Pacific Unit Management Review Team Meeting Minutes for 5/7/12, o Memo from Jon Breseman re: Monitor vs. Temporary Work Reassignment (TWR), dated 3/12/12; o CCSSLC Coaching Guide, revised 11/28/11; o Sample #D.1 included a sample of 25 DFPS investigations of abuse, neglect, and/or exploitation with the Facility investigation reports. Twenty-three were drawn from the list of A/N/E Investigations During the Time Period 1/1/12 through 5/31/12. Two reports were drawn from those presented at the Incident Management Review Team

	(IMRT) meeting on 7/9/12, and contained only the DFPS report. Investigation records included: #41186437, #41227020, #41160939, #41280484, #41408352, #41197456, #41308284, #41470552, #41494346, #41572192, #41594760, #41678952, #41793852, #41868913, #41891452, #41982392, #42070572, #42119863, #42134752, #42160077, #42180405, #42211916, #42217152, #42357694, and #42341106; o Sample #D.2 included a sample of five investigation reports that were drawn from the list of Investigations Completed Solely By the Facility between 1/1/12 and 5/31/12. Investigation records included: #12-347, #12-261, #12-294, #12-330, and #12-354; o Sample #D.4 included sixteen Individual Support Plans, including those for: Individual #155, Individual #174, Individual #226, Individual #172, Individual #88, Individual #124, Individual #290, Individual #363, Individual #184, Individual #268, Individual #282, Individual #336, Individual #26, Individual #250, Individual #63, and Individual #228; and o Sample #D.6 included four of the DFPS investigations from Sample #D.1 where abuse or neglect was confirmed and two of the Facility investigations from Sample #D.2, including the following DFPS Investigations: #41186437, #41868913, #41891452, #42160077 and Facility investigations #12-261 and #12-354. ▪ **Interviews with**: o Mark Cazalas, Facility Director; o Bruce Boswell, Assistant Director of Programs; o Cynthia Velasquez, Director for Quality Assurance; o Jon Breseman, Incident Management Coordinator (IMC); o Araceli Matehuala, Program Compliance Monitor; o Twenty staff members from various residential locations; and o Ten individuals in various residential and day locations. ▪ **Observations of**: o Residences: 522A, B, C, and D; 524A, B, C, and D; and 514; o Day and Vocational Programs in Buildings 512, 513, and 517; o Incident Management Review Team Meeting, at 11 a.m. on 7/9/12; and o Interdisciplinary Team meeting for Individual #341, on 7/11/12.
	Facility Self-Assessment: The CCSSLC Self-Assessment indicated the Facility was in substantial compliance with 17 of the 22 provisions in Section D of the Settlement Agreement. The Monitoring Team found the Facility to be in compliance with 15 of the 22. To conduct the self-assessment, the Incident Management Coordinator reviewed the specific requirements of each provision and any separate elements within the provision by examining files, drawing samples, and visiting residences. There was no reference in the Self-Assessment to the use of the Quality Assurance Monitoring Tool, although references were made to sampling of documents that corresponded to the Quality Assurance sampling matrix. The application of the tool and the resulting comparisons of scores between the IMC and the QA Program Compliance Monitor would have offered authentication to the IMC's results or highlighted areas where additional work was needed.

	The Self-Assessment resolved most of the Monitoring Team's previous concerns by increasing the sample sizes used for determinations of compliance, and by including assessment of most of the specific elements within each Settlement Agreement provision. An example of this was in Section D.3.e that addressed the timeliness of the initiation and completion of investigations. This time the Facility reviewed timeliness and completion of the DFPS and the Facility investigations separately. In addition to the Self-Assessment, the Action Plans were reviewed. The Action Plans described action steps related to each provision of the Settlement Agreement and they continued to address some important issues, such as policy revisions. However work was still needed to reach the more difficult issues of implementation. For example, for Section D.2.h, which required mechanisms to prevent retaliation, the actions steps included displaying "Zero Tolerance" posters and assuring their replacement as needed, monitoring Unusual Incident Reports (UIRs) for evidence of retaliation, and reporting any identified instances to the Office of the Inspector General (OIG). What was needed was a description of how the UIRs would be monitored, how often, by whom, and what signs might trigger a report. In Section D.3.i, which required the implementation and tracking of actions taken to address disciplinary or programmatic changes and the outcomes of those actions, the steps focused on obtaining all recommendations from the Review Authority Team, which reviewed incidents, into the tracking log in the UIR reporting system. The next steps were to address those recommendations that were not followed, and to revise those that were implemented but not successful. The remaining unaddressed question was how the UIR system would collect information about whether recommendations had been followed and whether they were successful. The Facility provided the CCSSLC Provision Action Information. This document was designed to review the status of each provision of the Settlement Agreement since the first monitoring report with space to highlight current efforts to come into compliance. Review of the document for Section D found it included multiple entries, providing a clearer view of the activities engaged in to achieve compliance than during previous reviews.
	Summary of Monitor's Assessment: During this review, the Monitoring Team found the Facility to be in compliance with 15 out of 22 provisions of Section D, as opposed to the 14 provisions that were in compliance during the last review. Progress was noted in a number of areas. Highlights of that progress included: ▪ Actions to protect individuals who were involved in unusual incidents or allegation of abuse or neglect were taken quickly. Local practice had been modified to assure that staff alleged to have been abusive or neglectful were routinely put on temporary work reassignment to remove them from direct contact with individuals served, or monitoring was put in place when alleged perpetrators were not identified or the case was handled as "streamlined" due to a an individual being identified as chronic caller. An Action Plan was in place to amend the Facility procedures to reflect the modified practice and to match State Office Policy 021.1. ▪ The Unusual Incident Report had been modified to print out a list of alleged perpetrators so that it could be easily determined if they had been placed on temporary work reassignment. ▪ The UIR was further modified to include a chart to track the recommendations resulting from the

	investigation. ▪ The Review Authority Team notes were included in files to document the review of any actions taken. ▪ The records contained supervisory notes for UIRs indicating the IMC had reviewed and requested clarifications or additional investigation in some reports. Some of the areas in which improvements were necessary for the Facility to progress toward full compliance with the Settlement Agreement included the need to: ▪ Address the problem with timeliness of completion of Unusual Incident Reports; ▪ Develop and implement a semi-annual audit of injuries; ▪ Provide for follow-up on recommendations from investigative reports, and document them to conclusion. ▪ Expand the analysis and trending of data to determine where corrective action plans might be needed to address emerging trends in abuse/neglect findings.

#	Provision	Assessment of Status	Compliance
D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	Based on a recent agreement of the parties and the Monitors, Section D.1 has been interpreted to only address the development of a policy. Implementation of the policy is assessed in other Section D provisions. Given that CCSSLC had a policy that: ▪ Included a commitment that abuse and neglect of individuals would not be tolerated; and ▪ Required that staff report abuse and/or neglect of individuals. As a result the Facility was found to be in compliance with this provision.	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:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation,	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 his designee. This was consistent with the requirements of the Settlement Agreement.	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>and serious injury, as follows: 1) for deaths, abuse, neglect, and exploitation to the Facility Superintendent (or that official's designee) and such other officials and agencies as warranted, consistent with Texas law; and 2) for serious injuries and other serious incidents, to the Facility Superintendent (or that official's designee). Staff shall report these and all other unusual incidents, using standardized reporting.</td><td>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 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 Monitoring Team's last two reports, 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. The Action Plan for D.2.a of the Settlement Agreement called for revisions to be made to CCSSLC Policies #D.2 and DD.5 to make the necessary clarification. The revision process was not underway, but was projected to be completed by 8/31/12, an extension from the earlier plan to be completed by 1/31/12.

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, 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.

According to Facility data provided in response to the document request #III.16a-e, the following numbers of allegations had occurred at the Facility from January 1, 2010 to December 31, 2010, from January 1, 2011 through December 31, 2011, and from January 1, 2012 through May 31, 2012.

<table>
<tr><th></th><th>1/1/10 to 12/31/10</th><th>1/1/11 to 12/31/11</th><th>1/1/12 to 5/31/12</th></tr>
<tr><td>Total abuse allegations</td><td>688</td><td>836</td><td>210</td></tr>
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#	Provision	Assessment of Status	Compliance

Abuse substantiated	45	98	9
Total neglect allegations	176	211	95
Neglect substantiated	35	33	7
Total exploitation allegations	24	1	4
Exploitation substantiated	0	0	0

**Note that the numbers of allegations refer to the total number of calls received by DFPS, not the number of cases, since multiple reports were received on many individual incidents.*

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 12 months of 2011 was 20% (211/1048).

The percentage of A/N/E allegations that were substantiated/confirmed in the five months of 2012 was 5% (16/309).

Twenty-six of the A/N/E between 1/1/12 and 5/31/12 were determined to be "inconclusive," which meant there was no conclusion or definite result due to a lack of witnesses or other relevant information.

These figures suggested that while allegations increased from 2010 to 2011, in 2012 they were decreasing and the percentage of the allegations that were substantiated was dropping. While a decrease in allegations is generally positive, a decrease can signal inattention to reporting. The Facility should analyze the data in more depth to determine potential reasons for the fairly significant decrease, and develop action plans to address any areas of concern identified.

According to Facility data provided in response to the document request #III.16a-e:

Unusual Incidents	**1/1/10 to 12/31/10**	**1/1/11 to 12/31/11**	**1/1/12 to 5/31/12**
Deaths	5	8	7
Serious injuries	24	22	6
Sexual incidents	18	14	10
Suicide threat – credible	11	2	1
Unauthorized Departure	14	8	4
Choking	4	6	2

#	Provision	Assessment of Status	Compliance

Other	6	2	2

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.

Based on interviews with 20 staff responsible for the provision of supports to individuals, 20 (100%) were able to describe the reporting procedures for other serious incidents.

Based on a review of the 30 investigation reports included in both Sample #D.1 and Sample #D.2, a comparison of the date and time of the incident or allegation with the date and time of the report revealed:

- A total of 13 (43%) included evidence that cases of abuse, neglect, and/or exploitation or unusual incidents were reported within the timeframes required by Facility policy. Those that were not within the time frames included:
  - Facility-only case #12-330 (i.e., provided as a "Facility Only" case for this review. However, it was also investigated by DFPS). The reporter appeared to have been one of the individuals involved in the incident.
  - Of the DFPS investigations five were reported the same day as the incident, but beyond the one-hour limit, eight were reported between one and five days late and for three, the time of the incident was not established and it could not be determined whether the report was timely.
  - Upon review of the reports that were late to DFPS by one to five days, some examples of situations where staff knew about the possibility of abuse or neglect, but did not report timely included:
    - DFPS investigation #41868913, where an individual attempted to ingest paper that was left within his reach by staff. A nurse and another staff member saw the individual chewing on paper and intervened to remove it and piece it back together to assure that none was swallowed. The person in charge was notified, but no one filed a report of possible neglect until two days later. The investigation confirmed neglect. There were several witnesses to this event and yet they did not report. However, there was no indication in the file that the Facility Investigator made recommendations to assure that such an event would be reported in the future.
    - DFPS investigation #41891452 where an individual sustained bruises, a black eye and abrasions to his face while in the Infirmary with 24/7 nursing coverage and staffing support. No record was made of the injuries, and no one knew exactly when

#	Provision	Assessment of Status	Compliance
		or how they occurred or why they were not documented or reported until discovered the next day. Abuse and Neglect were found to be inconclusive. Three allegations of physical abuse were unconfirmed and two allegations of neglect were inconclusive. While staff were retrained in documentation, there was no information in the UIR file to indicate that staff had been retrained or otherwise held accountable for failure to report possible abuse/neglect. ▪ In DFPS investigation #42160077, an individual was sent from the Infirmary to a medical appointment with a staff member who had not been trained on the PNMP. The staff member, not knowing there was a two-person pivot procedure required by the PNMP, attempted a one-person transfer, which resulted in a fall. The fall was reported as an injury. However, neither the staff assigned to take the individual to his appointment, nor the nurse to whom he reported the fall reported the event as possible neglect until the next day. The sustained injuries were reported within one hour and 15 minutes and coded as "serious injury" (i.e., the resulting cut on the head required seven stitches.) However the IMC was not notified until the next day, and DFPS was not notified until approximately two hours later. DFPS found the Facility to have neglected the individual by failing to provide a system of transfer of responsibility that assured the staff member would have the necessary information to follow the PNMP. Steps were taken to address the identified problem. However, there was no indication that staff had been retrained or disciplined for failing to report the possible neglect for nearly a day. ▪ A total of 30 (100%) included evidence that cases of abuse, neglect, and/or exploitation were reported to DFPS and the Director. Whenever DFPS received an allegation, they reported to the Facility and the Director was informed within an hour. However, it was not clear that staff that might have reported an allegation to DFPS also had reported it to the Facility Director, as required. Since allegations to DFPS were anonymous, it was not known who the reporter was. However, in one case (Facility Case #12-261) the investigator discovered an additional incident had occurred that had not been reported. A number of issues with the Unusual Incident Report Form, which were identified at the Monitoring Team's visit in January 2012, had been corrected. At this visit, the reports contained charts indicating staff that had been placed on TRW; a specific place to record the review, actions, and any follow-up required by the IMRT/Review Authority Team; and	

#	Provision	Assessment of Status	Compliance
		a sheet was included in the file to record review and action taken by the Review Authority Team. It was not clear, however, that both the date the report of abuse was received from DFPS, and the dates, times, and names of individuals reporting, if known, were recorded in the UIR. Based on a review of 30 investigation reports included in Sample #D.1 and Sample #D.2, 30 (100%) contained a copy of the report using the required standardized format. Tracking of timely reporting remained an issue. Since reporting of allegations of abuse can be anonymous and might be made by individuals or citizens outside the Facility, the reporting timeframes cannot be enforced with them. Without the identities of reporters, it is often not possible to ascertain whether the witnesses to the incidents reported timely. There was no apparent tracking system for reports made to the Director or Designee. There was an action plan to develop such a tracking system. The Monitoring Team found the Facility to be in noncompliance due to the Facility's inability to track reporting, and the lack of follow-up when an investigation uncovered facts suggesting that staff failed to report timely. In addition, the Facility had not clarified its procedures to emphasize that reporting was to be verbal to the Director or designee as specified in the Facility's Action Plan for section D.2.a of the Settlement Agreement. The Facility found that it was not in compliance with this provision.	
	(b) Mechanisms to ensure that, when serious incidents such as allegations of abuse, neglect, exploitation or serious injury occur, Facility staff take immediate and appropriate action to protect the individuals involved, including removing alleged perpetrators, if any, from direct contact with individuals pending either the investigation's outcome or at least a well- supported, preliminary assessment that the employee poses no risk to individuals or the integrity of the investigation.	According to Section D.2 of the Facility Policy and Procedure Manual, any employee, agent or contractor must act to stop the abuse, secure medical treatment, secure evidence, and comfort the victim. According to Section D.3 of that policy, protections for the individual include immediately placing the alleged perpetrator on Temporary Work Reassignment, if the allegation involves physical abuse that results in injury, sexual abuse, or neglect that causes physical injury or death. Facility procedure D.3 did not appear to be consistent with Facility Policy #021.I.J that indicated that the Facility would immediately remove alleged perpetrators without qualifications. For the Facility procedure to be consistent with the Settlement Agreement the procedure would need to include provision for a preliminary assessment that the employee posed no risk to the individuals or the integrity of the investigation in order for them not to be removed from direct support duties. The Facility had not revised their local procedure D.3, although they had an action plan in place to do so. The Facility had issued an instruction on March 12, 2012 indicating the policy would be revised and that in the meantime, staff identified as alleged perpetrators would be placed on TWR. The only exception would be when the individual had been identified as making spurious allegations and DFPS had been authorized to conduct a streamlined investigation. In those cases, another option would be to put a monitor in place.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Based on a review of 25 investigation reports included in Sample #D.1, 34 alleged perpetrators should have been removed, and of these, 23 (68%) were removed from direct contact with individuals immediately following the Facility being informed of the allegation. The following provides more detail with regard to the Facility's actions: ▪ In 15 cases the alleged perpetrators were removed according to the UIR, but this could not always be confirmed in the Staff Status Log. ▪ In three cases, the alleged perpetrator was not known and monitoring was put in place in the home. ▪ Four cases were streamlined. In three of these cases, a monitor was put in place. In one, the Facility correctly elected to place the staff member on TRW even though DFPS had indicated it would be handled as streamlined. This was because the report had been made by the video surveillance staff rather than by the individual. ▪ In three cases, the Facility placed a monitor instead of removing the staff member. Two of these cases occurred prior to the IMC's March 12, 2012 clarifying memo. One case, DFPS case # 42211916, occurred after the memo, and although the allegations were unconfirmed, this did not follow the instructions in the memo. A review of the Staff Status Log in conjunction with the UIR indicated that staff removed from duty were not returned until the investigation was completed. The log would be more useful if it included the date the investigation concluded, a notation of whether abuse was confirmed, and an indication of whether staff was disciplined, terminated or retrained. Such additions would make it possible to review cases without having to compare dates with other reports. In the 15 investigation cases where staff had been removed, two staff had been dismissed when abuse was confirmed, according to the Facility report. The remaining 13 staff appeared to have been cleared for return to work after the investigation was complete. The Monitoring Team found the Facility was not in compliance. The Facility had not completed work on its procedure revision, although it had taken steps to assure that staff would be placed on TWR when an allegation of abuse or neglect was made. While the IMC took appropriate action to place staff on TWR, even though a case was designated as streamlined, when he realized that the allegation had come from a staff member, in other cases the Staff Tracking Log did not track the status of all staff named in the UIR. The Facility found itself to be in compliance with this provision. However, the Monitoring Team's findings did not support this.	
	(c) Competency-based training, at least yearly, for all staff on	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, as	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	described in previous reports. Review of the Course Delinquency List for course #ABU0100, Abuse/Neglect/ Exploitation, dated 7/2/12, revealed that six staff out of approximately 930 (less than 1%) were past due to receive retraining. 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: ▪ 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. ▪ The training provided adequate training regarding recognizing and reporting signs and symptoms of abuse, neglect, and exploitation. A random sample of 25 staff, listed as employed on the DADS Employee Alpha Roster, dated 6/12/12, was drawn to determine if their training on Abuse/Neglect/Exploitation was up-to-date. All 25 (100%) had evidence of having completed their A/N/E training. A random sample of four volunteers listed on "Volunteer List for CCSSLC" revealed that all four (100%) had completed web-based training for Volunteers at SSLCs, including training on A/N/E. Based on interviews with 20 staff: ▪ All 20 (100%) were able to list signs and symptoms of abuse, neglect, and/or exploitation; and ▪ All 20 (100%) were able to describe the reporting procedures for abuse, neglect, and/or exploitation, and for serious incidents. Based on these findings, the Monitoring Team found the Facility in substantial compliance with this provision. The Facility's findings were consistent with those of the Monitoring Team.	
	(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	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. A random sample of 25 staff, listed as employed on the DADS Employee Alpha Roster, dated 6/12/12, was drawn to determine if their Acknowledgment Forms on Abuse/Neglect/Exploitation were up-to-date. All 25 in the sample had current Acknowledgement Forms on file. The IMC had conducted checks on forms for all new employees since January 2012. He reportedly had found all forms to be in place.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
	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.	A random sample of four volunteers listed on "List of Volunteers" revealed that four (100%) had Acknowledgements on file. According to the Facility Self-Assessment, the Action Plan for this provision had been completed. In discussion with the IMC, it was clear that he was checking monthly to assure all new staff had signed their forms and staff who were due to renew their statements had done so. Based on these findings, the Facility was found to be in substantial compliance with this provision.	
	(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, Qualified Developmental Disability Professionals (QDDPs) 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 ISP meeting, and to provide a copy to the individual at the meeting. The QDDP was to describe the process to the individual at the meeting. In the Monitoring Team's previous reports, the findings related to the review of the flyer used to educate individuals and families about their rights with regard to reporting was discussed. It was found to be adequate. According to the ISP Meeting Guide (Preparation/Facilitation/Documentation Tool) Section III.E, the Abuse/Neglect/Exploitation Resource Guide was to be presented and explained to the individual at the annual ISP meeting. In the one annual ISP meeting observed, the individual was presented with a copy of the guide, and the advocate, who attended via phone, was told about the guide and a commitment was made to send her a copy. Based on a review of sixteen individuals' ISPs, (i.e., Individual #155, Individual #174, Individual #226, Individual #172, Individual #88, Individual #124, Individual #290, Individual #363, Individual #184, Individual #268, Individual #282, Individual #336, Individual #26, Individual #63, Individual #228, and Individual #250,), the ISP included documentation to show that fifteen of the individuals and their primary correspondents/LARs (94%) had been informed of the process of identifying and reporting unusual incidents, including abuse, neglect, and exploitation. For one individual (i.e., Individual #250), although the individual had been provided a copy, the ISP did not document that her parents, who were actively involved, had been given a copy or had it explained to them. This was important given that this individual appeared as if she would require assistance to recognize or report abuse and neglect.	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		In interviewing a sample of 10 individuals, all 10 were able to communicate well enough, and described what they would do if someone hurt them, or they had a problem with which they needed help. Of course, many individuals at CCSSLC cannot communicate well enough to report abuse, and must rely on their families and staff to report on their behalf. In reviewing Samples #D1 and #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. 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. The Facility had made progress. A sample of ISPs contained documentation that most individuals had had discussion of incident and abuse reporting at their annual ISP meeting, and they and their primary correspondents/LARs had been provided the required booklet. In addition the ISP meeting observed during the on site review included a discussion with the individual about the reporting process. The Monitoring Team concurs with the Facility that this provision is in substantial compliance.	
	(f) Posting in each living unit and day program site a brief and easily understood statement of individuals' rights, including information about how to exercise such rights and how to report violations of such rights.	According Section D.20 of Facility policy and procedure manual, all residences and day programs were to have the "Rights Poster" on display. 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. Many of the posters in evidence had been refreshed with the addition of a photo of the Human Rights Advocate and contact information. Observations by the Monitoring Team of a sample of residences and day programs on campus showed that all nine residences visited and three day programs sites reviewed (100%) had postings of individuals' rights in an area to which individuals regularly had access. In addition, all buildings housing offices or meeting places had signs posted. The Action Plan for this provision reported it had been completed. The IMC and Campus Administrators were monitoring for posters on their rounds and requiring the replacement of any missing posters. A list of poster locations had been drawn for the Campus Administrators' use to verify that posters were in place. Samples of the IMC's Evening Duty Officer (EDO) logs indicated consistency in checking for posters while	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		making rounds. As a result of these findings, the Monitoring Team made a finding of substantial compliance. This was consistent with that of the Facility.	
	(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. Based on a review of 25 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. Based on a review of five investigations completed by the Facility (Sample #D.2), one referral was made to law enforcement and became a DFPS investigation. The remaining four were not referred to law enforcement, because there was no apparent reason to suspect criminal activity. Meetings with OIG, DFPS, and CCSSLC were scheduled quarterly to exchange information and resolve any emerging questions. Minutes of the January 2012 meeting were provided. The April meeting was postponed due to workload factors, but the IMC was working to schedule the next meeting. These meetings appeared to afford all participants with an opportunity to discuss changes in practice and to avoid misunderstandings. Based on this review, referrals were being made to law enforcement and to the OIG on a regular basis. The Monitoring Team found the Facility in substantial compliance with this provision. The Facility had made the same finding in its self-assessment.	Substantial Compliance
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident	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 his designee. Phone numbers for other reporting alternatives also were provided in the policy. Based on interviews with the Facility Director, the following actions were being taken to prevent retaliation and/or to assure staff that retaliation would not be tolerated: ▪ If the Assistant Director for Programs received a report of retaliation, he forwarded it to the Office of the Inspector General. ▪ OIG would respond as to whether they would investigate. Based on Sample #D.1, it was clear that some individuals made allegations of abuse with	Substantial Compliance

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	in an appropriate or timely manner.	no fear of retaliation, and there were no indications in the investigation reports of a concern with retaliation. A list of staff that reported they had been retaliated against for good faith reporting of abuse was requested, and there were no names provided (Document Request #III.28). 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.29). The following describes actions that were taken in an attempt to prevent such retaliation in the future: ▪ Posters reminding staff that retaliation would not be tolerated were displayed throughout the Facility; ▪ Training emphasized the Facility's position on retaliation; and ▪ The stated practice was that any allegations of retaliation were referred to the OIG. Based on an anonymous polling of 20 staff, two indicated some concern that they might be retaliated against for reporting abuse, but did not share what those concerns were. The 20 staff interviewed appeared to understand the method for reporting possible retaliation and knew there were posters with numbers to call. In interview and in the evidence section of the Presentation Book for Section D, the IMC noted that staff members sometimes indicated they had been the victim of a false allegation or retaliation. However, these instances were found to be due to a personal or work-related issue and not to their good faith reporting of an allegation of A/N/E. Since the Facility had measures in place to prevent retaliation, procedures to handle any reported retaliation, and no indications were found in sample cases of possible retaliation taking place, the Monitoring Team found the Facility in substantial compliance with this provision. The Facility's self-assessment reported a consistent finding.	
	(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 ensure that significant resident injuries are reported for investigation, and to ensure that injuries that raise suspicions of abuse due to the nature or location of the injury (for example, bruises on the inner thigh might suggest sexual abuse), or the frequency of injury are reported for investigation. For example, an audit of injuries might reveal that one location on campus has an unusual record of injuries or that one individual has had an unusually high number of injuries. Such results showing significant resident injuries need to be investigated to learn the root	Noncompliance

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		cause so that it can be addressed. A review of the Injury Trend Reports for the past year indicated that reports of injuries, particularly non-serious injuries have been declining for the past year. The Trend report noted that any individual with three or more injuries in 30 days was reported to the IDT for review. While the downward trend and the practice of reviewing injuries appeared to be important steps toward protecting individuals from harm, the number of injuries still required a concerted effort to discover what caused patterns to emerge and whether such a significant number of injuries suggested possible abuse or neglect. The Facility indicated that the IMC had contacted other facilities in April and May of 2012 to review their processes for trending injuries and conducting audits, but that the process for CCSSLC was still under development. The Action Plan for this provision projected regular monthly audits to commence by September 2012. This was a revision from the previous projection of March 2012 for the completion of these audits. The Monitoring Team will evaluate this process when it is complete. The Monitoring Team's finding of noncompliance was consistent with the Facility's finding that it was not in substantial compliance with this provision.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and	According to Section DD.1 of the CCSSLC Policy and Procedure Manual, all staff responsible for 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.	Substantial Compliance

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	who are not within the direct line of supervision of the alleged perpetrator.	The Monitoring Team previously reviewed the curricula for the Facility and the DFPS investigators, and generally determined it was adequate. In response to a document request, a list of seven DFPS investigators with their hire dates and courses completed, their training transcripts, and a crosswalk to the titles of courses, which had changed over time, were provided. The training records for these investigators were reviewed with the following results: ▪ Seven of the seven (100%) DFPS investigators whose names were provided had completed the requirements for investigations training. ▪ Seven of the seven (100%) DFPS investigators whose names were provided had completed the requirements for training regarding individuals with developmental disabilities. ▪ A review of the Sample #D1 revealed that all (100%) investigations in the sample were completed by trained investigators. CCSSLC staff with responsibilities for conducting Facility investigations included the Incident Management Coordinator, who oversaw the investigations at the Facility, three full-time investigators, and four Campus Administrators, 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 eight staff. A review of the investigators who conducted the investigations in Sample #D.2 indicated that all (100%) had been conducted by one of the investigators listed as trained. The training records for these investigators were reviewed with the following results: ▪ Seven out of seven Facility investigators (100%) had completed the requirements for investigations training. ▪ Seven out of seven Facility investigators (100%) had completed the requirements for training regarding individuals with developmental disabilities. ▪ The IMC had completed all required training. A review of the investigators who conducted the Facility Investigations that corresponded to the DFPS investigations in Sample #D.1 indicated that all had been conducted by one of the trained Facility Investigators. There were no nurses listed as investigators. In the two investigations in Sample #D.2 that involved deaths, the QA nurse was involved in gathering and reviewing records, but did not sign the investigation as the preliminary or the final investigator. This appeared to be a use of nurses as experts to review documents and provide opinions. However, if nurses are to act as investigators, they should be trained as investigators.	

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		The Facility's Self- Assessment indicated a finding of substantial compliance. Based on the Monitoring Team's findings, the Facility has been found to be in substantial compliance.	
	(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. 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. ▪ Review of the investigation files in Sample #D.1 showed that in 25 out of 25 investigations (100%), Facility staff cooperated with DFPS investigators. ▪ Review of the investigation files in Sample #D.2 showed that in four out of five (80%) investigations, there was minor or no involvement with outside entities and no indication in the files of any problems with cooperation. In the fifth, the case was investigated by DFPS and law enforcement was notified. There were no indications of lack of cooperation between the various entities. The Facility's IMC reviewed all investigations and found signs of cooperation in all of them. He noted that a meeting was held in January 2012 with outside investigating agencies and no concerns were raised related to cooperation. Based on these findings, the Facility is in substantial compliance. The Facility's finding for this provision was consistent with the Monitoring Team's finding.	Substantial Compliance
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	The Memorandum of Understanding, dated 5/28/10, provided for interagency cooperation in the investigation of abuse, neglect, and exploitation. This MOU superseded all other agreements. In the MOU, "the Parties agree to share expertise and assist each other when requested." The signatories to the MOU included the Health and Human Services Commission, the Department on Aging and Disability Services, the Department of State Health Services, the Department of Family and Protective Services, the Office of the Independent Ombudsman for State Supported Living Centers, and the Office of the Inspector General. DADS Policy #002.2 stipulated that, after reporting an incident to the appropriate law enforcement agency, the "Director or designee will abide by all instructions given by the law enforcement agency." Based on a review of the investigations completed by DFPS and the Facility, the following was found: ▪ Of the 25 investigation records from DFPS (Sample #D.1), 17 had been referred to	Substantial Compliance

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		law enforcement agencies. For 17 out of these (100%), adequate coordination appeared to have occurred to ensure that there was no interference with law enforcement's investigations. ▪ Of the five investigation records from the Facility (Sample #D.2), one had been referred to law enforcement agencies and there was no evidence of lack of coordination. Since they were no indications of lack of cooperation the Monitoring Team concurred with the Facility Self-Assessment that the Facility is in Substantial Compliance with this provision.	
	(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. 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. Based on a review of the investigations completed by DFPS (Sample #D.1) and the Facility (Sample #D.2), there was little need to secure and store evidence. ▪ In Sample #D.1 evidence that needed to be safeguarded was properly secured and safeguarded in 24 of the 25 (96%) DFPS investigations reviewed. One case involved the possible ingestion of a substance, believed to be hand sanitizer, by an individual. In that case (DFPS Case #42357694), the Coke can the individual had been drinking from was put in the trash before it was examined for hand sanitizer. However, the can was retrieved, examined and the substance was correctly identified. The individual did not suffer ill effects from this experience. However, Facility staff should have secured the can and held it for the investigator's examination before it was thrown away. ▪ Evidence that needed to be safeguarded was properly secured and safeguarded in 100% of the Facility investigations. 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 increasing 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. A	Substantial Compliance

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		review of the procedures of the video surveillance team and a review of the equipment used indicated a professional approach with attention to preserving evidence. A policy on handling evidence was in place, video surveillance footage was being properly identified and preserved, and staff were following the policy (with one exception noted.) The Monitoring found the Facility to be in substantial compliance. Similarly, the Facility's Self-Assessment showed it was in compliance with this provision.	
	(e) Require that each investigation of a serious incident commence within 24 hours or sooner, if necessary, of the incident being reported; be completed within 10 calendar days of the incident being reported unless, because of extraordinary circumstances, the Facility Superintendent or Adult Protective Services Supervisor, as applicable, grants a written extension; and result in a written report, including a summary of the investigation, findings and, as appropriate, recommendations for corrective action.	Based on Section DD.10 and DD.11 of the CCSSLC Policy and Procedure Manual, investigations of serious incidents: ▪ Were to commence within 24 hours or sooner, if necessary; ▪ Were to be completed within 10 calendar days of the incident; ▪ 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 ▪ Were to result in a written report that included a summary of the investigation findings, and, as appropriate, recommendations for corrective action. To determine compliance with this requirement of the Settlement Agreement, samples of investigations conducted by DFPS (Sample #D.1) and the Facility (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. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ Twenty-five out of 25 (100%) commenced within 24 hours or sooner, if necessary. This was determined by reviewing information included in the investigation reports 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. It was noted that Commencement Checklists accompanied most of the reports, but most were not completed. ▪ Twenty-five of the 25 (100%) cases were completed within 10 calendar days of the incident with one having been granted an extension, and one being one day late and attaching an explanation. ▪ Twenty-five of the 25 (100%) cases resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. ▪ In 13 of the investigations reviewed, recommendations were included, though often phrased as "concerns." In 12 of these investigations (92%), the	Noncompliance

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		recommendations were adequate to address the findings of the investigation. The following was an investigation for which the Monitoring Team had concerns with the adequacy of the recommendations: o Case #41186437 involved Individual #7 who ran from the two staff members assigned according to her level of support, broke a glass bottle and ingested some of the pieces. The staff were unable to stop her in part because there was a medical restriction on using a basket-hold restraint, limiting them to a hand-hold, which did not prevent her from ingesting the glass. The noted concerns included the inadequacy of the lighting in the area, the ineffective use of mittens that the individual could easily remove, and the Infirmary's refusal to open the door to the individual after she had swallowed the glass. While these were important concerns, another issue was the need for the Facility to review and clarify whether staff could or should have stopped the individual in the crisis situation with a restraint that, while medically contraindicated, might have prevented the ingestion of glass and resulting surgery, or what other crisis intervention techniques could be put in place to protect the individual in the future. ▪ An example of a case that included an appropriate recommendation: o In case #41197456 two staff were found to be asleep on duty while providing a two-to-one level of support to an individual known to ingest inedible objects with serious consequences. The investigator registered a concern that one of the staff had been on duty for 12 hours without a break according to the sign-in record, implying that the Facility needed to review its overtime practices. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations (Sample #D.2), four of which were Facility-only investigations and one of the five had a companion investigation by DFPS: ▪ Five of the five (100%) Facility–only investigations 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. ▪ Four out of five (80%) were completed within 10 business 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. There were no extensions evident in the documents presented. ▪ All five (100%) resulted in a written report that included a summary of the investigation findings. The quality of the summary and the adequacy of the basis	

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		for the investigation findings are discussed below with regard to Section D.3.f of the Settlement Agreement. ▪ In four of the five investigations reviewed, recommendations for corrective action were included. In one of the five no recommendations were needed. A review of the 23 Unusual Incident Reports that accompanied DFPS investigations was conducted. (Note that two reports were selected during the on site visit and the UIRs were not requested.) These reports cannot be concluded until DFPS has completed its investigation. The following summarizes those results: ▪ Fourteen of 23 (61%) were completed within ten days of the issuance of the DFPS report. Those that were not completed within the time frame were missing signatures or dates or were late in being signed by the supervisor and the Director. ▪ Twenty-three of 23 (100%) included summaries of the investigation findings. ▪ For 13 of the 13 cases where DFPS noted concerns (100%), the Unusual Incident report included recommendations, based on the DFPS findings and concerns. A finding of noncompliance has been made. The Facility's Self-Assessment included a finding of noncompliance. The main issue was the completion of Facility Unusual Incident Reports within the specified timeframes.	
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed,	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: ▪ The contents of the investigation report be sufficient to provide a clear basis for its conclusion; ▪ The report utilize a standardized format that set forth explicitly and separately: o Each serious incident or allegations of wrongdoing; o The name(s) of all witnesses; o The name(s) of all alleged victims and perpetrators; o The names of all persons interviewed during the investigation; o For each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o All documents reviewed during the investigation; o All sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o The investigator's findings; and o The investigator's reasons for his/her conclusions. The Facility investigations were recorded in an electronic system with screens to capture	Substantial Compliance

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	and a summary of material statements made; all documents reviewed during the investigation; all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; the investigator's findings; and the investigator's reasons for his/her conclusions.	the required format of the report. Some of the issues raised in the Monitoring Team's last report had been addressed including: a separate table was inserted to show the alleged perpetrators and whether they had been placed on TWR; and a table for entering recommendations and assignment of responsibilities was included. The resulting reports were adequate to capture the required information.
		
		The official files were organized according to a checklist. They were in binders, with separators between documents delineated on the checklist.
		
		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.
		
		<u>DFPS Investigations</u>
		The following summarizes the results of the review of DFPS investigations:
		▪ In 25 out of 25 investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion.
		▪ The report utilized a standardized format that set forth explicitly and separately:
		o In 25 (100%), each serious incident or allegations of wrongdoing;
		o In 25 (100%), the name(s) of all witnesses;
		o In 25 (100%), the name(s) of all alleged victims and perpetrators;
		o In 25 (100%), the names of all persons interviewed during the investigation;
		o In 25 (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made;
		o In 25 (100%), all documents reviewed during the investigation;
		o In 25 (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency.
		o In 25 (100%), the investigator's findings; and
		o In 2 (100%), the investigator's reasons for his/her conclusions.
		
		<u>Facility Investigations</u>
		The following summarizes the results of the review of Facility investigations:
		▪ In five out of five investigations reviewed (100%), the contents of the investigation report were sufficient to provide a clear basis for its conclusion.
		▪ The report utilized a standardized format that set forth explicitly and separately:
		o In five (100%), each serious incident or allegations of wrongdoing;
		o In five (100%), the name(s) of all witnesses;	

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		o In five (100%), the name(s) of all alleged victims and perpetrators; o In five (100%), the names of all persons interviewed during the investigation; o In five (100%), for each person interviewed, a summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a summary of material statements made; o In five (100%), all documents reviewed during the investigation; o In five (100%), all sources of evidence considered, including previous investigations of serious incidents involving the alleged victim(s) and perpetrator(s) known to the investigating agency; o In five (100%)), the investigator's findings; and o In five (100%), the investigator's reasons for his/her conclusions. Based on the Monitoring Team's review of investigations, the Facility remained in substantial compliance with this provision. The Facility's Self-Assessment also found substantial compliance.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff supervising investigations to ensure that the investigation is thorough and complete and that the report is accurate, complete and coherent. Any deficiencies or areas of further inquiry in the investigation and/or report shall be addressed promptly.	Based on review of CCSSLC Policy #002.2 and the associated procedure DD.11, it required 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 required that any further inquiries or deficiencies be addressed promptly. The reporting formats for the Facility unusual incidents investigation reports provided for a signature and comments by the supervisor. 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. <u>DFPS Investigations</u> The following summarizes the results of the review of DFPS investigations: ▪ In 23 of 25 investigation files reviewed (92%), the supervisor had signed the report indicating he/she had conducted a review of the investigation report. However, there was nothing in the record to provide detail on the nature of the supervision, or whether or not errors were corrected due to that supervision. When the Monitors met with DFPS in April 2012, they indicated they would submit a proposal to address this issue. ▪ In the two files where no signature was found, the allegations were handled as Administrative Referrals, meaning that the allegations were referred back to the Facility for action and no investigations were conducted. ▪ For the investigation noted in D.3.e for which the Monitoring Team identified	Noncompliance

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		issues with the lack of a recommendation and the need for a workable crisis intervention technique, neither the DFPS nor the Facility supervisory review appeared to address this deficiency. <u>Facility Investigations</u> The following summarizes the results of the review of Facility investigations: ▪ In five of five Unusual Incident Investigation files reviewed (100%) for Sample #D.2, there was an "Investigation Review/Approval Form" indicating review by the IMC. ▪ In 22 of 23 (96%) Unusual Incident investigation files which were companion files to the DFPS investigations in Sample #D.1, there was evidence that the CCSSLC supervisor had conducted a review of the investigation report. The Facility Action Plan indicated the adoption of an Investigation Review/Approval form was complete. The one file that did not contain the form was a case that occurred in January 2012, before the use of the approval form was in full operation. The completed forms contained brief, but important feedback about missing information, spelling, and questions remaining to be resolved or a notation of "good work," if the report reviewed was found to be satisfactory. The Facility had a process in place for review of investigations by the IMC as evidenced by the adoption of the form and its inclusion in all but one report. DFPS reports included a supervisor's signature, but no notes were provided related to issues identified and addressed with investigators. When the Monitors met with DFPS in April 2012, DFPS indicated it would submit a proposal to address this issue. Meanwhile, this provision remains in noncompliance.	
	(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 with regard to Section D.3.f above.	Substantial Compliance
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the	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. Facility Policy D.14, entitled Participating In and Completing Review Authority Team, 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 also included follow-up tracking of all recommendations made by the Team.	Noncompliance

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	corresponding outcomes.	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. CCSSLC's Action Plan for this provision specified five steps to accomplish the tracking and documentation. According to their Action Plan status, three steps had been completed: to evaluate concerns and recommendations in the reports, to add any recommendations from the Facility investigators, and to ensure that Review Authority Team recommendations were entered into the Recommendation Tracking Log. Two steps remained: to address any recommendations that were not completed, and to revise recommendations that were implemented but unsuccessful. The target dates for the remaining steps were 7/31/12 and 12/31/12, respectively. 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 four DFPS Investigations and two Unusual Incident Investigations as listed in the documents reviewed section. The following summarizes the results of this review: ▪ DFPS Investigation #41186437 involved an allegation of neglect of Individual #7 for failing to intervene in a timely and appropriate manner to prevent harm. The allegations, involving three staff members who had been unable to prevent Individual #7 from breaking a bottle and ingesting some of the broken glass, were determined to be unconfirmed. However, the DFPS investigator registered three concerns that: o Individual #7 could easily remove the mittens that were placed on her hands to prevent her from ingesting small objects, and that the mittens "appeared to be the most successful item" in preventing the individual from picking up inedible objects to ingest. o Poor lighting along the fence prevented staff from scanning areas beyond the immediate parameter; o The denial of access to the Infirmary of Individual #7 was a clinical issue that needed Facility resolution. The Unusual Incident Report noted that the Review Authority Team had reviewed the DFPS final report and recommended: o Discontinuation of the mittens, without explanation; o No lighting to be added; o Access to the Infirmary was addressed in administrative review. The Unusual Incident Report noted in the "Recommendations for Current/Future Action" that: "The DFPS concerns and recommendations will be addressed," and set a due date for 2/16/12.	

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		It was not clear from the Review Authority Team record or from the UIR, why the mittens were discontinued when the DFPS investigator had indicated they appeared to work; why no lighting would be provided; or whether the Infirmary access issue had been successfully addressed. A review of the Personal Support Plan Addendum for 2/6/12 indicated that a basket hold follow-down restraint had been approved for Individual #7 to prevent future efforts to search for inedible objects to ingest. This appeared appropriate since staff had been prohibited by a medical order from using that restraint to stop her when it became clear she would ingest broken glass. However it was not mentioned in the Review Authority Team or UIR tracking. The file contained a memorandum from the nurse to the Director indicating that the issue of access to the Infirmary had been reviewed and resolved, confirming what was included in the UIR tracking, although the tracking did not include the date it was resolved. There was nothing recorded to indicate why the lighting was not addressed. ▪ In DFPS investigation #41868913 neglect was confirmed when a staff member left papers where they could be reached and ingested by Individual #307. The Review Authority Team recorded that the staff member had been terminated and a letter advising the staff of her termination was on file. The UIR recorded the termination and noted that a clinical issue that arose during the investigation, involving an LPN (alleged failure to respond timely to individual's ingestion of paper) had been referred to the Chief Nurse Executive for resolution, but had not been addressed and listed a due date of 6/1/12 (the date the report was printed was 5/27/12). Since it was not clear that the issue with the LPN had been resolved, the actions taken were not adequate. ▪ In DFPS Investigation #41891452, Individual #117 had returned to the Infirmary from the hospital where a G-tube was placed. Staff were assigned to him as a standard practice. At some point, the individual sustained bruises and abrasions to his face, but extensive investigation did not produce sufficient evidence to sustain findings of abuse or neglect against three of the alleged perpetrators, and a disposition of unconfirmed was entered. Allegations against a fourth alleged perpetrator were determined to be inconclusive. The DFPS investigator listed concerns including: o No record of injuries was noted in the Integrated Progress Notes in the Infirmary, but the notes did show nursing care every two to three hours on the date of the injuries. o Although the individual had 24/7 staff support, no one seemed to have any knowledge of how he sustained his injuries. o Individual #117 sustained the injuries in the Infirmary and was not provided with medical attention (lack of documentation). o There did not appear to be any clear definition or understanding of the term "staff support."	

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		The Review Authority Team recorded the DFPS concerns and listed staff in-service on documentation and revisions to Policy M.17 to address staff support. However, M.17 addressed staff support to individuals in the hospital, not in the Infirmary. The UIR recorded the Review Authority Team's decision, to provide in-service training to staff on documentation and to make revisions to Policy M.17, but did not indicate that the actions had been taken. ▪ In DFPS investigation #42160077, it was alleged that two staff and the "system" were neglectful of Individual #117 when the individual was sent to an off-campus medical appointment with a staff member who had been pulled from another residence, was not familiar with the individual's PNMP, and was not in-serviced on his PNMP by Infirmary nurses as was required. As a result, the staff member attempted to assist the individual to use the rest room without a second staff to provide the two-person pivot transfer as required in the PNMP, resulting in a fall and injury to the individual. The DFPS investigator confirmed neglect against CCSSLC, but not the two staff members. DFPS declined to investigate the allegation of neglect involving the nurse, because they viewed it as outside their jurisdiction and referred the matter back to the Facility. The DFPS investigator indicated that all recommendations were being handled through the administrative referral to the Facility to deal with the failure of nursing staff to in-service the direct support professional on the requirements of the PNMP. The Review Authority Team indicated that the Chief Nurse Executive would address assistance given to direct support professionals by Nursing at the Infirmary, and required evidence of action taken by 6/15/12. The UIR recorded the decision by the Review Authority Team, and added that the Facility was to review Policies P.2 and M.2 for possible revisions on 6/22/12. The file contained a training roster with evidence that training was provided on the individual's two-person stand pivot transfer to 14 staff at the individual's residence. There was evidence of a reminder to staff about all those individuals needing a two-person stand pivot transfer, and an addition to the Appointment Memorandum to require the direct support professional to check the PNMP prior to sending an individual off-campus. A training roster indicated that 16 Infirmary nurses had received training on Policies M.2 and M.9. An employee development note addressed the individual circumstances of this investigation. A memorandum from the Chief Nurse Executive to the Director on 5/30/12 confirmed that the above steps were taken.	

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		In summary, steps were taken to follow-up on the recommendations in the investigation except for the recommendation to review two policies for possible revision. ▪ Facility Investigation #12-261 involved the death of Individual #96. Individual #96 was in the hospital for gall bladder surgery, and died the day of the surgery after being returned to her room. The preliminary cause of death was Cardiac Arrest, but the Facility was awaiting an autopsy for a final determination. In the course of the investigation, gaps were noted in the documentation of the direct support professional present during the individual's stay. The investigator noted that the assigned staff was not familiar with hospital procedures and did not document what was being done. The investigator noted that a sexual encounter that the individual had while on a home visit was not reported to the IMC as required and recommended that the IDT be re-in-serviced on Policy DD.5 Managing Unusual Incidents. The UIR contained further recommendations that the nursing staff be in-serviced on using Nursing Protocol Cards to guide documentation and that the case managers be in-serviced on Quarterly Assessments. There were no Review Authority Team notes in the file and no follow-up documentation in the UIR to indicate the recommendations had been carried out. There was no indication as to how the discovered failure to report an incident was addressed. While there had been progress in the Review Authority Team's documentation of their decisions and the UIR tracking of some aspects of the follow-up on recommendations, there was not a clear demonstration that the system for recording and monitoring follow-up was occurring. As a result that Monitoring Team has made a finding of noncompliance. This was consistent with the Facility's Self-Assessment that this provision was not in substantial compliance	
	(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. The Facility investigations were entered electronically into the Facility's computer system, allowing access to investigators without resorting to the paper file. DFPS files were maintained electronically to allow access to their authorized personnel. It	Substantial Compliance

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		appeared that their official reports were transmitted to CCSSLC in hard copy, which were filed. Based on the Monitoring Team's review, the Facility remained in compliance. The Facility's findings in its Self-Assessment were consistent with this finding.	
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: ▪ Type of incident; ▪ Individuals directly involved; ▪ Location of incident; ▪ Date and time of incident; ▪ Cause(s) of incident; and ▪ Outcome of investigation. The Facility had discontinued the practice of reporting the names of staff involved in allegations in its monthly Trend Reports, which circulated within the Facility, but retained the names in the electronic files. In this way, the names were available for review to selected staff that could analyze them. The Facility provided tracking reports for incidents and allegations for months from January 2012 through May 2012. Each report showed the number of incidents or allegations by month with analyses of the data for the month. While the reports displayed data by month for the last and the current years (e.g., in the May 2012 report, there were data from twelve months of 2011 and five months of 2012), the analysis was only for the most recent month. The charts and graphs did not include trend lines to show how allegations or incidents were changing over time, nor did they analyze how allegations or incidents regarding an individual or a home had changed over time. While the information in the report was useful, it did not provide complete trending of data as required by this provision. The Action Plan for this provision included revising current local policy regarding use of databases for trend reporting, production of a complete trend report to be shared with the IMRT on a monthly basis, and the implementation of corrective action plans to address issues identified in the Trend Reports. The policy should include sharing the report with the QA/QA Council as well. The Facility's Self-Assessment indicated that the Facility was not yet in compliance with this provision. This was consistent with the Monitoring Team's findings. Because the Facility's current trend reports did not include trending (i.e., analysis) of the specified data over time to allow the Facility to determine the need for corrective action, the Facility had	Noncompliance

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		not met the requirements of the Settlement Agreement.	
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. 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 25 staff. The information obtained about volunteers was discussed and confirmed with the Facility Director, and confirmed in a sample of five volunteers. 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 October 2011. Once the fingerprints were entered into the system, the Facility received a "rap-back" that provided any updated information. The registry checks were conducted annually by comparison of the employee database with that of the Registry. In addition, employees were mandated to self-report any arrests. Failure to do so was cause for disciplinary action, including termination. Examination of the self-reporting information documented that one person was terminated upon background check information showing a failure to self-report an arrest. In an interview with the Facility Director, his decisions regarding the employment of a sample of applicants with any criminal history were discussed on a case-by-case basis. In each instance, his decisions were based on the facts and were mindful of his responsibility to safeguard the individuals and staff of the Facility. Based on the Monitoring Team's review, the Facility remained in compliance with this provision. The Facility's Self-Assessment also indicated the Facility was in substantial compliance with this provision.	Substantial Compliance

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

1. When an incident is reported to IMU whether by DFPS or by someone else, the date and time should be recorded in the UIR. If it was reported to DFPS and to IMU, both should be recorded to help establish that staff are following the rule about reporting to both. (Section D.2.a)
2. 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)
3. DFPS investigative reports should include evidence of the content of the review by the supervisor. As DFPS had discussed with the Monitors, DFPS will propose a format for providing this information. (Section D.3.g)
4. The UIR should contain documentation of when any recommended actions were completed, and reference documentation in the file that demonstrates that completion. When recommendations involve physical changes to an individual's residence or specific retraining for staff, the Campus Administrator should confirm the changes or training during their rounds and produce their notes as evidence for the file. (Section D.3.i)
5. The Facility should finalize its tracking and trending system. (Section D.4)
6. The Facility should expand its efforts to conduct critical analysis of the trend data collected to determine if any actions should be taken, or corrective 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, etc.). (Section D.2.a)
2. In order to maintain the finding of compliance, 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)

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o CCSSLC Statewide Policies and Procedures: Policy #3.1 effective 1/26/12; o CCSSLC Procedures E.2, E.5, E.10, E.11 and E.12, implemented 5/24/12; o CCSSLC Facility Self-Assessment, dated 6/25/12; o Centers for Medicare and Medicaid Intermediate Care Facility for Persons with Developmental Disabilities reports of 5/14/12 and 6/27/12; o CCSSLC Action Plans, updated 6/25/12; o CCSSLC Provision Action Information, undated; o Presentation Book for Section E; o Summaries of Compliance findings and inter-rater reliability scores for Sections: C, I, J, K, O, P, R, S, and U, from Document Request Response IV.6; o Settlement Agreement Monitoring Tool for Section E, dated April 2012; o Data Collection at CCSSLC, dated 9/30/11; o CCSSLC Plan of Implementation (POI) Submissions – FY12, undated; o CCSSLC Quarterly Trending Report from 6/1/12 through 6/30/12 for Injuries, Unusual Incidents, and Abuse/Neglect/Exploitation; o Corrective Action Plan Tracking Log, undated (based on entries through May 2012); o Quality Assurance/Quality Improvement (QA/QI) Council Minutes, dated 1/5/12, 1/12/12, 1/26/12, 2/2/12, 2/9/12, 3/1/12, 4/5/12, 5/3/12, 6/14/12, and 7/5/12; o Quality Assurance/Quality Improvement agenda and meeting materials, for 7/12/12; and o Customer Satisfaction Survey Response Reports, dated January, February, March, and April 2012. ▪ **Interviews with**: o Mark Cazalas, Facility Director; o Bruce Boswell, Assistant Director of Programs; o Cynthia Velasquez, Director for Quality Assurance; o Program Compliance Monitors; o Twenty staff members from various residential locations; and o Ten individuals in various residential and day locations. ▪ **Observations of**: o Residences: 522A, B, C, and D; 524A, B, C, and D; and 514; o Day and Vocational Programs in Buildings 512, 513, and 517; o Incident Management Review Team Meeting, at 11 a.m. on 7/9/12; o Interdisciplinary Team meeting for Individual #341 on 7/11/12; and o QA/QI Council Meeting, on 7/12/12.
	Facility Self-Assessment: The Facility's Self-Assessment did not find the Facility to be in compliance with any of the five provisions of Section E of the Settlement Agreement. This was consistent with the Monitoring Team's findings.

	The Facility Self-Assessment addressed each provision of each section of the Settlement Agreement by listing: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating using the information cited in the section on results. In addition to the self-assessment, the Facility provided Action Plans for addressing improvements, and Provision Action Information to record activities undertaken to achieve compliance between monitoring visits. The Facility had a Monitoring Tool for Section E, dated April 2012. There was no indication of the frequency of use or persons responsible for completing it, nor were there separate guidelines for use of the tool. The Facility did not supply evidence of having conducted the Section E Monitoring Tool or provide a summary of the results. The Monitoring Tool results were not referenced in the Facility Self-Assessment under individual provisions. The following concerns were noted with regard to the Facility's Self-Assessment of Section E: ▪ The Quality Assurance Department was not using the monitoring tool to measure progress on its own performance and relying on the tool results, at least in part, to support its Self-Assessment analysis. ▪ In determining whether or not the Facility was in compliance with Section E.1, the Self-Assessment did not review the Facility's data collection efforts, its QA Plan matrix, the POI data reports, and/or other data collection and tracking activities. ▪ The Self-Assessment did not indicate how many Quality Assurance Reports had been completed and for which sections, or whether and how many Corrective Action Plans (CAPs) were developed as a result. ▪ There was no reference to policies that had been developed to clarify the data collection processes. ▪ There was no review of how various sections were using their QA data to improve services. The activities engaged in need to demonstrate the use of Monitoring Tools to inform the self-assessment. The monitoring tool should be a used as a mechanism to gather quantified data on which to base findings together with any other related information, such as the status of policy development. The Action Plan steps should include enough detail to allow understanding of the objective and the process for accomplishing that objective along with the evidence needed to show achievement, responsible person, and projected dates. If projected completion dates are months in the future and when dates have been modified from previous reports, they should have a status update.
	Summary of Monitor's Assessment: CCSSLC was in the process of amending its policies and procedures to align with the revised State Policy on Quality Assurance. There did not appear to be a current Quality Assurance Plan in place, although a plan had been provided and reviewed during the Monitoring Team's last review. Monitoring tools to measure quality had been adopted based on the tools the Monitoring Teams used, 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, meeting with discipline heads to share and compare results of monitoring, and developing ideas for improvements to the tools and guidelines, which should result in greater inter-rater reliability. Data and summary reports were available for some of the reviews, as was inter-rater reliability data. Data for some of the sections had been analyzed and reported to the section leads and the QA/QI Council. Continued work was needed with regard to inter-rater reliability, as well as the accuracy of the monitoring. Some sections of the Facility's Self-Assessment were using data gained from the monitoring tools as evidence of the Facility's compliance status. This should become a standard part of the assessment of each section of the Settlement Agreement. 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. However, issues were noted with regard to the report on restraints. It could not be produced for June due to changes in the statewide AVATAR data system. 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. However, while displaying the data each month over a year-long period was helpful, there was no longitudinal trending and analysis of the data to identify if individuals or units had concerning trends, or which residences or program location potentially had problems. As the Facility continued to capture and display data on its Trend Reports, QA monitoring reports and Plan of Improvement Reports, it had not begun to cross-analyze data from these reports to assist in determining where system weaknesses were emerging in order to focus preventive attention on those areas. The Quality Assurance/Quality Improvement Council had been organized to develop, revise, and implement quality assurance procedures. During previous visits, the Performance Implementation Team (PIT) and the Performance Enhancement Teams (PETs) were in evidence. During this visit, these teams appeared to be in suspension with no minutes or meeting dates. Instead there were three groups of section leads who were supposed to be meeting to work on compliance issues. These groups were to report to the QA/QI Council, but it was not clear whether they were meeting and reporting. Some work had been done on improving the quality of the data being entered into the State Office database through the adoption of procedures. It also appeared some additions had been made to the list of data. Some basic elements of a quality assurance system were in place, but it was not clear that there was a general understanding of how those elements worked together. The next steps should include completing the Corrective Action Plan process, using the data system to report on information the monitoring activities generate, 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; ▪ Identifying proactively homes, day programs, and/or departments that require improvement; and ▪ Identifying a wide array of potential systemic issues. 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. At the time of the review, the Facility did not have a complete system such as this in place. However it did have certain elements, including: ▪ A Quality Assurance Policy: the Facility had adopted the State Office policy, amended some related Facility procedures and had other procedures in draft. ▪ Quality Assurance Plan: the latest version of the plan was not presented for review. However, it was referenced in various reports and had been present at the last monitoring visit. ▪ Monthly, quarterly, and annual Trend Reports were available that showed unusual incidents; allegations, investigations, and results of investigations of abuse, neglect and exploitation, as well as injuries, and restraints. ▪ These reports were displayed by type, individuals involved, location, home, hour, shift, and day of week, and could be displayed by staff involved, though the Facility chose to redact that information from reports shared widely throughout the Facility. ▪ CCSSLC POI Submissions: These reports tracked data on areas of service, including: integrated protections and services, pharmacy services, physical nutritional management, psychological services, and others. Specifics on collection of information for these reports were found in Facility Procedures E.7 and E.8, which were in draft form. The POI did contain some of the elements of measurement of service outcomes (e.g., persons involved in on-campus day	Noncompliance

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		programs outside their home, persons in workshops on campus and off campus). With additional definition of terms used, data sources, identification of benchmarks and desired outcomes, and some additional specificity, this collection of data could be expanded upon to form the basis of set of key criteria to measure progress on service outcomes. ▪ Auditing tools were in place for Sections C, D, E, F, I, J, K, M (multiple tools), O, P, R, S, T (multiple tools), U and V. Sections without tools in place were L, N, and Q. ▪ QA auditing data resulting from use of the auditing tools was being collected and summarized for Sections C, I, O, P. Data was collected for Sections J, K, R, S, and U, but was not summarized. Data needs to be collected for all protections, supports and services, and areas of care, analyzed, summarized and reported to the Quality Assurance/Quality Review Council. Other auditing tools might have been it use, but it was not apparent that the resulting data had been summarized, analyzed, and submitted to the Quality Assurance Department for review. All databases were enumerated in a chart entitled: "Data Collection at CCSSLC," which was supplied in response to onsite Request #9. The date on the report was 9/30/11, but it was not clear if that was the date the report was written or the date the report shell was developed. Listings such as this, if widely disseminated, could help to prevent the multiplication of databases with the same information. It was important that the Facility had taken this first step of identifying the data it currently had available in databases. It will be important going forward to have a system for assuring the accuracy of the data in the system. Two issues discussed with the Director for Quality Assurance at the two previous monitoring reviews 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: ▪ 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. Not printing the names on the reports that circulate internally, but preserving them in the system for review by selected people as needed had resolved this issue. The Monitoring Team was able to obtain copies when requested. ▪ "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. This time the Action Plan (E.1.5) called for a review of the "Monthly POI Submission Report and the Quarterly Trend Reports to develop quality indicators (key indicators) to measure many	

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		areas of care and to be reviewed during QA/QI to develop corrective action plans." The Action Plan had specific time frames and the step was marked as completed on 6/1/12. It was not clear how the QA Director was going to accomplish this, who else would be involved, and whether there would be data from other sources included to present a comprehensive set of key performance indicators. From review and interview, it was not clear whether all the indicators on the POI list were considered "key indicators" or whether there was a plan to designate certain of those elements as "key" and add elements from other data lists to create a "key indicators" list. However, at the time of the review, the Facility had not yet developed a set of key indicators that were measurable, identified baseline data, and/or set goals to measure progress towards stated outcomes. Most of the monitoring tools had been in use for a year or longer. Four Program Compliance Monitors and one quality assurance nurse, who reported to the Director of Quality Assurance, were conducting audits. The four Program Auditors divided the Settlement Agreement sections according to their experiences, so that each Program Auditor had a specific set of tools and responsibilities. Each month, the QA Auditor drew a sample and discipline head or someone assigned by the discipline head applied the monitoring tools and recorded the results. The QA Auditor used the tool to monitor a subsample for purposes of determining inter-rater reliability. Upon interview, the Program Auditors (excluding the nurses who were not present for the interview) could identify where some tools were beginning to work (Section F in particular), and where some of the issues were still unresolved. In some cases such as Section K, the entire tool had been modified from the original. In others, guidelines or wording changes were made without major changes to the tools. Program Auditors were working with discipline heads to understand where there were differences in interpretation and to select the most appropriate solutions. There had been some combination of tools, and efforts were underway to streamline tools to avoid redundancy within tools and within groups of tools where multiple tools were in use for a single section. From the Monitoring Team's perspective, work was still needed to refine these tools and their implementation, including improving the guidelines or instructions associated with each tool and 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 QA Department had begun to work on the needed revisions with section leads, and reported the projected completion date of changes to the tools as 9/1/12.	

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		As indicated in the Facility's Self-Assessment, the Facility was not in substantial compliance with this subsection. However, there was sustained progress in the auditing of performance, summarizing and reporting on collected data in some sections, and modifying the auditing process. For progress to continue the Facility should reformulate its Action Plan for this section to clarify how it will identify key indicators as described above. In addition, the Facility should continue to enhance the monitoring tools and methodologies, and continue to work on auditing programs and addressing any resulting identified issues. Particular attention is needed in the medical sections to assure that their data is being analyzed and used.	
E2	Analyze data regularly and, whenever appropriate, require the development and implementation of corrective action plans to address problems identified through the quality assurance process. Such plans shall identify: the actions that need to be taken to remedy and/or prevent the recurrence of problems; the anticipated outcome of each action step; the person(s) responsible; and the time frame in which each action step must occur.	The Facility needed to demonstrate that the data in the QA matrix were summarized, graphed, and analyzed. The data needed to be trended by each discipline department with oversight and additional analysis provided as needed by the QA Department. The Facility had prepared graphs and reports analyzing the data obtained through application of the monitoring tools for some sections of the Settlement Agreement. Examples included section C, I, O and P. However, such analyses and reports were not available for all sections. The Facility was analyzing monthly data on restraints (except for June 2012), abuse/neglect/exploitation, unusual incidents, injuries, and risks, and producing trend reports. However the analyses were not longitudinal. Trends should be identified longitudinally across, among, within and/or regarding: ▪ Time (by month usually); ▪ Program area, living unit, work shifts; ▪ Protections, supports, and services; ▪ Areas of care; ▪ Staff involved; ▪ Individuals involved. The POI data was collected monthly and the numerical data was displayed in a chart covering nine months. This data was not analyzed. At the time of the Monitoring Team's last visit, CCSSLC had three teams involved in the review and analysis of data, and the production and review of the resulting corrective action plans. There had been modifications to the activities of these teams as follows: ▪ The Quality Assurance/Quality Improvement Council was responsible to develop, revise, and implement quality assurance procedures that enabled the Facility to comply fully with the Settlement Agreement, and detect problems in a timely manner in the provision of adequate protections, services, and supports to ensure that appropriate corrective steps were implemented.	Noncompliance

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		(CCSSLC Procedure #E.5, revised 5/24/12). A review of the minutes of the Council between January and June 2012 revealed: o Meetings were held at least once each month and sometimes more often; o Minutes included information about progress on achieving compliance with ICF/DD requirements, and policies and procedures were reviewed and approved; o Six Action Plans were tracked regarding topics such as the Mock Code Drill Policy, data procedures for entering peer-to-peer injuries, and the use of the Arjo Slings. Each plan listed actions to be taken, anticipated outcomes, persons responsible, and timeframe for completion. All were recorded as completed by the end of March, and one was reviewed in May by the Program Compliance Monitor to verify the results. o The CAPs were related to the quality of the system, but it was not clear from the QA/QI Council minutes how they were connected to data analyses being produced by the QA system. ▪ The Program Improvement Team (PIT) was responsible to conduct monthly review of the data by home and department in areas related to compliance with action steps outlined in the Settlement Agreement (CCSSLC Procedure #E.3), and to report its findings and recommendations to the QA/QI Council at its regular monthly meetings. Information supplied for this monitoring visit indicated that the PIT had been suspended. Facility Procedure E.10, revised 5/24/12, did not specify a role for PITs, and it appeared that their use had been ended. There were three subgroups of section leads that were supposed to be meeting to review and discuss progress toward compliance, but it was not clear how often they met or with what results, since no minutes of their meetings were presented. ▪ On a monthly basis, the Performance Evaluation Teams (PET) were responsible to review the Monitoring Team's assessment of status at the last visit, the Facility's Plan of Improvement (now Facility Self-Assessment), action plans, evidence of compliance, and data generated by the Monitoring Tools (CCSSLC Procedure #E.4). These teams had not met, and it appeared that their functions had been combined into the work of the three groups of section leads as described in relation to the PIT above. It did not appear that the section lead groups were analyzing or trending the data, since there was no documentation to support such activity. No Corrective Action Plans emerged from discussions as evidenced by the report of the Director of Quality Assurance in the Facility Self-Assessment. (However the information in the report appeared to be for the June through October 2011 time period.) There were six CAPs	

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		developed in January through March 2012 as evidenced by the Corrective Action Plan Tracking sheet and noted in the QA/QI minutes. Facility Procedure E.10, revised 6/17/12, called for the Quality Assurance Director to "present data from the monthly monitoring conducted to the respective section leads for review on a quarterly basis." If that data demonstrated the lack of sufficient progress towards substantial compliance on any Settlement Agreement provisions or need for compliance with other audits and safety codes, the Facility workgroups or department/discipline were instructed to develop CAPs for review and approval by the QA/QI Council. The Program Compliance Monitors were producing analyses of the monitoring tool data that was being collected on at least four Settlement Agreement sections, including: C, I, O, and P. These analyses were extensive and did contain information that could be used to stimulate CAP discussion and selection. However, with the Section Groups not regularly producing data analyses and corrective action plans, or endorsing the ones the Program Compliance Auditors developed, the QA/QI Council minutes did not reflect action on them. It was not clear whether the six CAPS that were tracked by the QA/QI Council had emerged from this process or were developed by the section leads independently. On 7/12/12, members of the Monitoring Team attended an abbreviated meeting of the QA/QI Council. The meeting centered on reminding staff about plans of correction that were due in response to a recent ICF/DD survey and assessments that were due for upcoming ISP meetings. A presentation about an upcoming event to have murals painted and recognition of staff accomplishments were the main topics for the meeting. There was no discussion of data reviews or CAPs. Minutes of the 7/5/12 meeting were distributed and those minutes indicated that section leads had presented their quarterly reviews at that meeting. No plans of correction were presented or ordered based on the data presentations at that meeting. The Facility was not using available data to identify individuals with concerns across multiple areas (e.g., injuries, incidents, hospitalizations or ER visits, restraints, etc.), and/or to make concerted efforts to address the needs of these individuals. There did not appear to have been any action in this area. An in-depth discussion of the issue was included in the Monitoring Team's last report. Based on the Monitoring Team's findings, the Facility remained out of compliance with this provision. This was also the Facility's assessment. If the Section Lead groups have replaced the PIT and PET, this should be formalized in procedures. The groups need to review, analyze and present data, and develop corrective action plans to address identified trends and issues. They QA/QI Council should approve plans and track them.	

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E3	Disseminate corrective action plans to all entities responsible for their implementation.	The Monitoring Team noted six corrective action plans in the CAP Tracking sheet and referenced in the QA/QI minutes. For example: ▪ 2/2/12: the issue was "errors on peer-to-peer injury database." The actions to be taken were training and correction of the errors (two separate CAPS). The IMC was designated as responsible and the actions were reported as completed on the tracking sheet. However, no copy of the plans was provided. The minutes of the February QA/QI Council recorded the need for the CAP, but with no other information or instructions. ▪ 3/1/12: the issue was the need to use some plastic parts with the Arjo Slings. Again, there were two plans: one for purchasing bags to hold the parts and one for training. Both were assigned to the Director of Habilitation Therapies and reported as completed. However, there was no CAP presented. Both of these issues needed to be addressed. However, they did not appear to have arisen from data and trend analysis. While the QA/QI Council might want to track actions such as those cited above, they might not have required cross-discipline discussion and plan development. The more challenging issues might include: an individual who has experienced a high level of repeated injuries, neglect allegations and infirmary admissions, or a residence that has a high level of chronic caller incidents to the DFPS or 911 lines and a high level of refusals to participate in day programs. To make the minutes useful as tracking and dissemination tools, they need to record the assignment of a CAP, the progress along the way, and explain any deviations from the schedule or decisions to abandon the plan. The minutes need to include a list of those who should receive a copy of the plan or verify that a dissemination list is included in the plan. Although the Monitoring Team identified a number of corrective action plans, it was not clear how the CAPs were disseminated. As a result, the Facility remains out of compliance with this provision. This was also the Facility's self-assessment.	Noncompliance
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.	The procedure for Developing, Implementing and Tracking Corrective Action Plans was set forth in a Draft Facility Procedure E.10, revised 5/15/12. According to the draft: ▪ The QA Director would present data from monthly monitoring to section leads on a quarterly basis. The draft did not indicate whether those quarterly data presentations were to include analysis or only data. ▪ Any lack of sufficient progress towards compliance with a number of internal or external audits could be reason for a CAP. ▪ Center Leads were to develop and present CAPs to the QA/QI Council for approval and the QA Director was to track and monitor progress and report progress to the QA/QI Council quarterly.	Noncompliance

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		Since this draft procedure had not been finalized or in operation, and there were so few CAPs available for review, this section will be reviewed during future monitoring visits.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	As with Section E.4 of the Settlement Agreement, 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 Settlement Agreement, 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 Facility's Action Plan should be revised to clarify how the Facility plans to develop a set of key indicators, which data sources will be involved, and how baseline data will be determined, goals or outcome measures set, and the data collected and tracked. (Section E.1)
4. The Facility should produce and implement a data management plan that assures the integrity of data used to produce quality assurance reports. (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. Decisions regarding the PIT and PET and their replacement by or relationship with Section Lead groups should be formalized. (Section E.2)
7. The Facility should strongly consider initiating Administration-level reviews, involving, for example, the Facility Director, Assistant Director of Programs, clinical discipline heads, etc. This would involve review of a select group of individuals who met set criteria, including a number of negative events. The goal would be to provide the individuals' teams with the benefit of review and the expertise of a more objective and experienced group. The group would make recommendations to the individuals' teams to address issues identified. Individuals would need to be followed until positive outcomes were realized. (Section E.2)
8. As the Facility moves forward in developing its self-assessment processes, the Facility should include additional 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 Facility Self-Assessment including the Quality Assurance Section. (Facility Self-Assessment).

SECTION F: Integrated Protections, Services, Treatments, and Supports	
Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section F; o CCSSLC Self-Assessment for Section F, updated 6/25/12; o Action Plan for Section F, revised 3/23/12; o CCSSLC Provision Action Information for Section F, undated; o Draft Individual Support Plan (ISP) Meeting Guide and Integrated Risk Rating Form (IRRF) for Individual #341; o Instructions for ISP meeting Guide, undated; o CCSSLC Individual Support Plan Meeting/Documentation monitoring Checklist, dated 6/12; o For last three months, trending reports for Section F; o Q Construction: Facilitating for Success – Qualified Mental Retardation Professional (QMRP) Facilitation Skills Performance Tool, with instructions, dated 6/7/11; o A list of Qualified Developmental Disability Professionals (QDDPs) who have been deemed competent in meeting facilitation; o CCSSLC QDDP Listing with current caseload totals, undated; o Settlement Agreement Cross Referenced with Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) Standards Section F: Integrated Protections, Services, Treatments and Supports, revised August 2010; o Corpus Christi State Supported Living Center Personal Support Plan Meeting/Documentation Monitoring Checklist, dated 9/1/10; o CCSSLC Integrated Protections, Services, Treatments and Supports policies revised since last review, including: ▪ F.15 - Individual Support Planning, implemented 3/22/12; and ▪ F.21 – Submitting Assessments, implemented 3/22/12; o Last 10 monitoring tools completed by the QDDP Coordinator, various dates; o Last 10 monitoring tools completed by the Quality Assurance Department Staff, various dates; o For the last year, total number of ISPs completed, total not held within 365 days of previous meeting, and number not filed within 30 days of meeting; o For the last three months, the ISP Tracking Sheet; o For training provided for Section F, number of staff requiring training and number of staff who have been trained; o List of individuals with most recent ISP date, previous date, and date of implementation, dated 6/5/12; o In response to request for: "Based on monitoring/audit data, or other reviews or data that the Facility has collected in relation to integrated protections, services, treatment, and supports, reports showing analysis of such data, as well as descriptions of actions taken or

	corrective action plans developed," the response: "No Evidence;" o ISPs for Individual #244, Individual #172, Individual #88, and Individual #118; o Individual Support Plans, Sign-in Sheets, Assessments, Individual Support Plan Addenda, (ISPAs), Personal Focus Assessments (PFAs)/Preferences and Strengths Inventory (PSI), Rights Assessments, Community Living Options Information Process (CLOIP) worksheet or most recent Permanency Plan, skill acquisition and teaching programs, the last three monthly, and the last two quarterly reviews, individual's daily schedule, Special Considerations list, and third quarterly meeting documentation for the following: Individual #290, Individual #363, Individual #184, Individual #268, Individual #282, Individual #336, Individual #26, Individual #250, Individual #124, Individual #155, Individual #174, Individual #226, Individual #160, Individual #287, and Individual #7; and o ISP, assessments, sign-in sheet, Integrated Risk Rating Form (IRRF), PSI, and Integrated Health Care Plans for the following: Individual #228 and Individual #63. ▪ **Interviews with**: o Rachel Martinez, QDDP Coordinator; o Kimberly Benedict, Director of Active Treatment; o Iva Benson, State Consultant; and o Sally Schultz, State Consultant. ▪ **Observations of**: o ISP meeting for Individual #341.
	Facility Self-Assessment: Based on a review of the Facility's Self-Assessment with regard to Section F of the Settlement Agreement, the Facility found that it was out of compliance with all of the subsections. This was consistent with the Monitoring Team's findings. Since the Monitoring Team's previous review, the Facility had made notable improvement in the justification it offered for its findings. In its Self-Assessment, the Facility identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating using the information cited in the section on results. Although a number of concerns continued to exist with the Facility's self assessment process, over time, this format should be helpful in substantiating the Facility's findings with regard to compliance. The following concerns were noted: ▪ The Facility's Self-Assessment did not consistently define how the samples were selected, or who collected the data used in the report (i.e., the QA Department, the QDDP Department, or a combination of the two). Some, but not all sections identified the sample selection process and the staff that completed the review. ▪ For the various monitoring/audit tools, inter-rater reliability needed to be established with the QA and programmatic staff (e.g., QDDP Coordinator) responsible for conducting audits. ▪ As discussed during the last review, the need still existed 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). Based on interview, the QDDP Coordinator and assigned Program Monitor had begun to work on

	developing instructions. ▪ The Self-Assessment did not consistently show an evaluation of quality, as opposed to the mere presence or absence of an item. For example, with regard to Section F.1.a, some of the indicators assessed whether or not preferences were discussed at the ISP meeting, or action plans were developed. It was unclear whether or not the quality and comprehensiveness of such activities were evaluated, or simply whether any related discussion had occurred. Similarly, for Section F.1.e, it was unclear what the indicators measured in relation to discussion about community options, discussion about overcoming obstacles, and assessment information related to living in the most integrated setting. More specifically, it was not clear if the quality of these discussions and assessments were evaluated or just their occurrence/existence. These are just a few examples of where this distinction was not clear. ▪ In some instances, it would have been helpful to break the data out more in order to ensure that if problems were noted, the specific issues could be identified. For example, for Section F.2.a.3, a number of issues were evaluated together (i.e., methods for implementation, timeframes for completion, and staff responsible). The Facility calculated a 100% compliance rate. However, as noted in the Monitoring Team's assessment, problems continued to exist particularly with regard to the adequacy of methodologies, and to a certain extent timeframes and identification of staff responsible. If these were broken out, and the standards for acceptable practice established against which to monitor (i.e., in instructions), accurate assessment of this subsection would be more attainable. This would be similar for Sections F.2.a.5, F.2.a.6, and F.2.f. ▪ For Section F.2.c, the Facility had only looked at accessibility of ISPs to staff responsible for their implementation, not comprehensibility. Similarly, the review for Section F.2.d, related to monthly assessments, only assessed some portions of the requirement. ▪ The data presented clearly identified areas of need. However, the Facility Self-Assessment did not yet provide any analysis of the information, identifying, for example, potential causes for the issues, or connecting the findings to portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings. Since the last review, the Facility made some specific improvements to its Self-Assessment in response to recommendations from the Monitoring Team. These efforts were appreciated. Specifically: ▪ In its report, the Monitoring Team noted that not all requirements of the Settlement Agreement had been reviewed. More specifically, within a sub-section, the Settlement Agreement might have numerous requirements, but only some were included in the Facility's Self-Assessment (e.g., Section F.2.a.1, or F.2.e). The Facility had taken steps to correct this issue. As noted above, in some sub-sections this continued to be a problem, but in others it had been corrected. ▪ Similarly, the Monitoring Team recommended that the Facility cite the rate of compliance (versus noncompliance). The Facility had made this change as well, which made interpretation of the results easier. Overall, in its Self-Assessment, the Facility had demonstrated some good use of the data it had collected to make compliance determinations. However, based on documents submitted and interviews, the Facility was not yet using this data to determine where its best practices were and/or when problems were

	identified, conducting further analysis to target its corrective action plans. Efforts to ensure the validity and reliability of the data will be important next steps, as will using the data to identify areas in which focused attention is needed. 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: In May 2012, the State Office provided additional training on a revised ISP format and process to CCSSLC's QDDPs and other team members. A revised ISP Meeting Guide (Preparation/Facilitation/Documentation Tool) was introduced to assist the QDDPs in preparing for the meetings and in organizing the meetings to ensure teams covered relevant topics. In addition, according to the new procedures, more pre-planning was to begin 90 days prior to the ISP meeting. In addition to the team using a new tool to identify the individual's preferences, strengths, and priorities, at the ISP Preparation Meeting, the team also was to review the previous ISP to determine the status of action plans. If plans had not been completed and/or successful, then the team was to decide what action to take. The team also was to make decisions regarding the team members that should attend the annual meeting, and assessments that needed to be completed prior to the meeting. At the time of the Monitoring Team's review, two teams had been selected to pilot the new process, including the new at-risk process. Two ISPs had been fully completed using the new process. Although the new process showed some improvements, as would be anticipated with a new process, more work was needed to continue to make necessary changes and refine the team meetings as well as the ISP documents. As has been discussed in previous reports, comprehensive, thorough, and adequate assessments are the cornerstone of ISPs that adequately address individuals' strengths, preferences, and needs. At CCSSLC, teams continued to be at a disadvantage, because they did not yet have adequate assessments from which to develop individuals' ISPs. In addition to problems with the quality of the assessments, teams were not consistently identifying the need for and/or receiving all of the necessary assessments. Although some improvement was being realized, a number of assessments continued to be submitted late, making it more challenging for QDDPs and others to complete preparation activities prior to the annual meetings. The Facility and State Office were taking some actions to address these concerns. Specifically, using a database in which information related to the timeliness of assessments was tracked, CCSSLC had begun reviewing this information as part of its QA/QI Council activities, and discussing potential barriers and solutions. In addition to working on new formats for assessments, the State Office was developing a set of quality indicators, and it was anticipated CCSSLC's discipline heads would use these to evaluate the quality of the assessments. With regard to individuals' ISPs, although teams were identifying some preferences and strengths of individuals, these remained limited. In addition, teams were not yet effectively incorporating individuals' preferences and strengths into action plans, or using them creatively to expand individuals' opportunities or address their needs. Prioritization of individuals' needs was not evident in the ISPs reviewed. As is discussed in the subsections below, individuals' needs were not comprehensively addressed in action plans. More individuals had action plans that addressed community skill acquisition plans, but these varied in quality.

	Some progress had been made in the expansion of the scope of measurable objectives, and efforts clearly were being made to improve the measurability and individualization of objectives and action steps. However, as the Facility recognized, these remained areas in which significant work was needed. Given the limited implementation of the new ISP process, it remained to be seen if the revised ISP Meeting Guide and process would result would result in ISPs that more comprehensively addressed the individual's array of needs. Based on the review of the two plans that used the revised process, some progress was seen with regard to the integration of a more comprehensive set of "protections, services and supports, treatment plans, clinical care plans, and other interventions." However, many supports were still missing or were inadequately defined. Teams will need continued training and coaching to implement the revised process fully. The Facility continued to develop its quality assurance system related to the ISP process. The QA Department continued to monitor ISP meetings, as well as ISP documents and implementation. The QDDP Coordinator also conducted monitoring. 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 QDDP 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 was in the process of revising Policy #004.1: Individual Support Plan Process, and had provided the Monitoring Teams with a draft copy, dated 5/10/12. The three Monitoring Teams were in the process of reviewing the policy, and any comments will be provided jointly. The Monitoring Team's previous reports had identified the need for CCSSLC to tailor its policies to not only meet the requirements of the State policy, but also to describe in further detail some of the procedures or expectations that were specific to the Facility. During the most recent review, Facility staff requested further clarification about this recommendation. The Monitoring Team provided some examples, including memorializing in policy or procedures the process the Facility had in place for determining the competency of QDDPs with regard to meeting facilitation. Similarly, the Facility had developed some specific tools and procedures for conducting quality assurance checks of ISP meetings and documents. Whereas the State policy discussed in general terms the need for competency-based training of staff as well as quality assurance procedures for ISPs, it would be important for CCSSLC to spell out its expectations for these processes in greater detail in its local policies and procedures. Although the Facility had begun to do this in some of its Section F policies, further detail	

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		was needed in some areas, and once the State Office policy is finalized, review and revision of the Facility policies might be necessary. In order to review this section of the Settlement Agreement, a sample of ISPs was requested, along with sign-in sheets, assessments, ISPAs, PFAs/PSIs, Rights Assessments, Integrated Risk Rating Forms (IRRFs), integrated health care plans, CLOIP worksheet or most recent Permanency Plan, skill acquisition and teaching programs, the last three monthly, and the last two quarterly reviews, individual's daily schedule, Special Considerations list, and third quarterly meeting documentation as available. A sample was requested of the most recently developed ISPs, 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 QDDPs and interdisciplinary teams (IDTs) had been responsible for the development of the plans. This sample included plans for: Individual #290, Individual #363, Individual #184, Individual #268, Individual #282, Individual #336, Individual #26, Individual #250, Individual #228, Individual #63, Individual #124, Individual #155, Individual #174, Individual #226, Individual #160, Individual #287, and Individual #7.	
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 ISPs 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: ▪ DADS Draft Policy #004.1 in both the definition section and in Section II.F.1.b indicated that the QDDP would assist the individual and LAR, as appropriate, in leading the team in an interdisciplinary discussion. The Facility's Policy F.15: Personal Support Planning, implemented 3/22/12, further defined the role of the QDDP, including activities before, during, and after the ISP meeting. Since the last review, this policy had been modified. These revisions defined the QDDP's role in notifying team members required to attend the meeting of the date and time, ensuring that necessary assessments were submitted, and if assessments were missing, taking action to obtain them. ▪ The QDDP Coordinator confirmed that QDDPs facilitated the teams, including team meetings. Observations of team meetings and reviews of ISPs also illustrated that the QDDP was the team leader and responsible for ensuring team participation. In the meeting for Individual #341, the individual played a role in raising topics and ensuring certain items were discussed. His QDDP assisted him in ensuring the team addressed his concerns and topics. ▪ With regard to staffing, in addition to the QDDP Coordinator and two Lead QDDPs, since the last review, a QDDP Educator had been hired. The current QDDP Educator recently had accepted another job at the Facility, but a	Noncompliance

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		replacement had been hired, and that person was expected to start in the QDDP Educator role soon. A total of 14 QDDP positions resulted in a QDDPs being assigned an average caseload of 19 individuals, with a range of 11 to 22. At the time of the review, two of the QDDPs also had accepted other jobs, including one QDDP that would fill the QDDP Educator position. Applications already had been submitted and screened, and interviews were being scheduled for the two vacant QDDP positions. ▪ In May 2012, the State Office provided additional training on a revised ISP format and process to QDDPs and other team members. A revised ISP Meeting Guide (Preparation/Facilitation/Documentation Tool) was introduced to assist the QDDP in preparing for the meeting and in organizing the meetings to ensure teams covered relevant topics. Using assessment and other information, the QDDP used this template to draft portions of the ISP prior to the meeting. Copies of the draft were then provided to team members at the beginning of the meeting, and changes were made as appropriate. In addition, more pre-planning began 90 days prior to the ISP meeting. For example, prior to the 90-day ISP Preparation meeting, QDDPs were expected to work with team members who knew the individual best to complete a new Preferences and Skills Inventory. The intention of this document was to identify the individual's preferences and skills, as well as priorities so all team members responsible for completing assessments could utilize this information in the assessment process, as well as in developing the ISP. This document would become a living document that would be updated and revised over time. At the ISP Preparation Meeting, the team also was to review the previous ISP to determine the status of action plans. If plans had not been completed and/or successful, then the team was to decide what action to take. ▪ At the time of the review, two teams had been selected to pilot the new process, including the new at-risk process. Two ISPs had been fully completed using the new process. These ISPs were reviewed as part of the Monitoring Team's sample. They included the ISPs for Individual #228 and Individual #63. As is discussed in more detail in the sections that follow, the new process showed some improvements, but as would be anticipated with a new process, more work was needed to continue to make necessary changes and refine the processes. ▪ The QDDP Coordinator had continued to use the Q Construction: Facilitating for Success - QDDP Facilitation Skills Performance Tool to assess QDDPs' competence in the meeting facilitation process. At the time of the review, only the outgoing QDDP Educator had been deemed competent. However, the process being used appeared to be helpful in identifying areas in which QDDPs continued to require guidance, coaching, or mentoring. In addition, the Facility was having two staff, including the QDDP Coordinator and a Lead QDDP	

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		complete the tools, and when results from both showed the QDDP was competent, then the QDDP was considered competent. This procedure helped to verify that the QDDP was able to demonstrate competence across meetings and reviewers. ▪ During the week of the review, the Monitoring Team observed two team meetings. Progress had continued to occur with regard to the facilitation of meetings. Based on these limited observations and review of ISPs, some of the areas in which progress had continued or begun included: o At annual ISP meetings, an agenda was clearly set forth, along with ground rules. o Paper hung on the walls or white boards were used to track key components of the ISP process, such as the agenda, the individuals' preferences, and action plans that needed to be developed. In addition, a note-taker was present to allow the QDDP to run the meeting without needing to maintain detailed notes. o The QDDPs made efforts to elicit information from all team members. Team members' participation varied. Some team members participated fully, and offered ideas on a variety of topics, even those outside of their specific areas of expertise. In the ISP meeting for Individual #341, it was positive to see that a number of team members participated in many aspects of the discussion, and respectfully questioned the need to add or revise treatment strategies. However, not all team members participated to the extent they should have. Even at times when clinical expertise would have been helpful to inform the team's decision-making, some team members did not participate, and the QDDP and/or other team members did not seek their opinions. o Based on observations on site, as well as review of ISP documents, QDDPs and teams were using more data to make decisions in relation to individuals' risk areas. A number of gaps continued to exist, for example with regard to teams' discussions about data related to skill acquisition programs, PBSPs, and measurable objectives related to risk plans. However, the teams were discussing more objective clinical data in a number of areas. o Based on the observations of the two ISP meetings, although problems still existed with the detail included in action plans, teams were observed discussing action plans in more detail, particularly some of the strategies that were in place or would be put in place to address risks. Again, although more work was needed, this work was beginning to be seen in the written documents as well. Areas in which improvements should be made in order to achieve compliance, included:	

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		▪ As noted above, the Q Construction: Facilitating for Success training included a competency-based component. At the time of the review, only the QDDP Educator had been deemed competent. None of the 14 QDDPs had yet reached this level of competency. Review of a few of the completed tools showed that some important aspects of the facilitation process had been identified as areas in which QDDPs needed to work. ▪ Based on review of ISPs as well as during observations of meetings held the week of the onsite review, facilitation of team meetings was continuing to improve, but for none of the plans reviewed (0%) 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: o The team, including the QDDP, did not consistently identify issues requiring concerted efforts on the team's part to resolve. For example, at one of the ISPs the Monitoring Team observed as well as in one of the written plans reviewed, individuals had body mass indexes of 40 or above, placing them in the morbidly obese range, but their teams did not develop action plans with the level of clinical intensity that would be expected to address a health risk of this magnitude. For example, neither team set measurable objectives for weight loss to determine if the strategies put in place were working. The strategies identified included exercise and diet related activities, but without a process to measure if these were having the desired effect (e.g., weight loss of so many pounds per month), and changing them if they did not, the team had not developed an adequate action plan. In addition, neither the team meeting nor the ISP for these individuals showed adequate integration of services to determine the potential cause and or solutions to the individuals' weight issues (e.g., psychiatry, medical, nursing, psychology, dietary, residential, and vocational). o As is discussed in further detail below, other areas in which QDDPs will need to obtain full team participation and facilitate meaningful discussion included, but was not limited to: ▪ Expanding the list of individual preferences to include preferences related to work, relationships, past experiences, etc. and using the preferences to offer the individual new experiences. ▪ Similarly, identifying a comprehensive list of the individual's strengths, and using them to build upon the individual's current independence, relationships, vocational experiences, etc. ▪ Making sure decisions the team makes are data-based to the	

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		extent possible. ▪ Developing measurable objectives. As the QDDP Coordinator indicated during interview, teams continued to struggle to define measurable, functional objectives during team meetings, and, as a result, they often were not included in ISPs. This factored into the overall process of developing adequate action plans, including appropriate methodologies. ▪ Articulating meaningful outcomes for individuals. Often the outcome was expressed as a process (e.g., Individual #63 will attend cooking class), rather than as a change in the individual's life (e.g., Individual #63 will cook a main dish or plan a menu for a high fiber, low fat meal). o Although the length of the meetings was somewhat decreased, the majority of the time at the ISP meetings the Monitoring Team observed was spent on the risk rating process. Although this was an essential activity in which teams needed to engage, it resulted in little time being spent, for example, on the team defining the measurable outcomes to determine the efficacy of the interventions the team discussed to address the risks, or other important topics, such as the individual's vocational ambitions and plans to achieve them, his/her plans to increase skills leading to greater independence, ways in which greater integration into the community could occur, etc. In addition to establishing estimated time boundaries for each topic at the outset, additional preparation by the QDDPs as well as other team members before the meetings also was an area for improvement. For example, if all team members had familiarized themselves with the information included in the draft IRRF, the team would not have had to review it all in detail, but rather could have discussed any questions and then made decisions. As during past reviews, during the Monitoring Team's discussions with the QDDP Coordinator, she correctly identified areas in which additional work was needed. Some of these already are mentioned, and others are mentioned in the sections that follow. It was important that the Facility staff had this insight, and were working with State Office staff on some specific areas in which they knew improvements were needed, Progress had been made, but the Facility remained out of compliance with this provision. Additional training and tools had been provided to QDDPs to assist them in facilitating meetings. Based on the pilot teams, although much work was needed, QDDPs were working with teams to apply some of the new processes. These were beginning to result in more data-based and meaningful discussions occurring about individuals' risks and	

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		some of the strategies necessary to overcome them. More of the individuals' strengths and preferences were being brought to the table. In order to meet the requirements of the Settlement Agreement, QDDPs will need to play a key role in facilitating a number of additional discussions to ensure that adequate action plans are being developed, including individualized and measurable goals; individuals' preferences and strengths are evident throughout the plan; and integration occurs to ensure that individuals' needs are adequately addressed.	
F1b	Consist of the individual, the LAR, the Qualified Mental Retardation Professional, other professionals dictated by the individual's strengths, preferences, and needs, and staff who regularly and directly provide services and supports to the individual. Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs.	DADS Draft Policy #004.1 described the interdisciplinary team (IDT) as including the individual, the Legally Authorized Representative (LAR), if any, the QDDP, direct support professionals, and persons identified as providing services and supports to the individual, as appropriate, including professionals dictated by the individual's preferences, strengths, and needs and who are professionally qualified and/or certified or licensed with special training and experience in the diagnosis, management and treatment of individuals with intellectual disabilities. Since the last review, the Facility had added procedures to its Policy F.15 on Individual Support Planning requiring QDDPs to send an ISP Meeting Attendance Memo 30 days prior to the scheduled ISP meeting to notify the team members that they were required to attend the ISP meeting. Attendance requirements were determined at the meeting 90 days prior to the annual meeting. Even with the recent revisions to the State policy, the QDDP Coordinator indicated that this process seemed to be beneficial in ensuring that team members attended ISP meetings, so these 30-day reminders might continue to be sent. As noted in the previous report, a database had been set up to track attendance at ISP meetings, and was being populated with information related to team members' attendance at meetings. With the new process for ISPs, at the ISP Preparation Meeting 90 days prior to the ISP, the team was to make a determination regarding whether a team member's attendance was required or not. Moving forward, this information would be included in the database. However, the documentation reviewed for the two individuals for whom the new process had been used did not provide explanations for the exclusion of team members that appeared should have attended based on the individuals' needs (i.e., Based on the Individual #63's needs, the following team members were missing: psychiatrist, dietician, and pharmacy. His PSI did not identify these team members as needing to be present. However, no justification was provided. For example, he was prescribed six psychotropic medications, so it was unclear why psychiatry and pharmacy would not be present. His BMI was 43, so dietary not being present also was not easily explainable. For Individual #228, the PSI did not identify a member of the dental staff as needing to be present, but she had a fair oral hygiene rating, and required sedation for dental appointments. She also was resistive to staff	Noncompliance

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		assisting her with routine dental care.). The checklist included at the end of the PSI did not include a rationale for the teams' decisions, so the justification for their decisions could not be determined. It would be helpful if the team provided an explanation of its decisions, particularly when an individual has a need in a specific area, and the team decides that the attendance of the team member with that area of expertise is not required. Given that the Settlement Agreement requires that: "Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs" as the Monitoring Team reviews individuals' ISPs, as well as the related assessments, if needs are identified for which the presence of a team member was warranted, but the requisite team member was not in attendance and no justification was provided, then the conclusion is drawn that a duly constituted team was not present. Based on the sample of 17 ISPs the Monitoring Team reviewed, for none (0%) did it appear that a duly constituted team participated in the annual meetings. Often, the individual presented issues requiring the attendance of specific team members, but these team members were not in 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.	Since the last review, the Facility had improved its tracking of the timeliness of assessments. A database was being populated with the date of the ISP, the date the assessments were due (i.e., 10 days prior to the ISP meeting), and for each assessment, the date it was completed. Based on interviews with staff, this data was being reviewed each Thursday at the QA/QI Council meeting. This was a forum in which the management team discussed challenges with as well as potential solutions for issues related to the timeliness of assessments. Based on a review of the ISP Tracking Sheet for ISPs scheduled to occur between 4/26/12 and 7/25/12, certain trends were evident. Assessments that frequently were missing included medical and nutritional assessments. Improvement was noted over the three months with the submission of other assessments, such as psychological assessments, OT/PT assessments, and Functional Skills Assessments. However according to this data, many assessments were submitted late. This was consistent with the findings based on the Monitoring Team's reviews of a sample of ISPs. The Facility as well as State Office recognized that the quality of assessments was still having a negative impact on the quality of team discussions and the resulting ISPs. CCSSLC had added a column in its database for the quality of ISPs. Discipline coordinators would be the ones responsible for reviewing the quality of the assessments.	Noncompliance

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		Staff reported that the State Office was developing a list of quality indicators for each of the discipline-specific assessments. Based on a review of 17 ISP files: ▪ For one individual (6%), it appeared that all the various types of assessments necessary to address the individuals' strengths, needs, and preferences had been completed (i.e., Individual#228). Part of the new ISP Preparation Meeting process, which was similar to the previous Personal Focus Assessment (PFA) process, was for the team to define the assessments needed for the ISP. Unfortunately, many PFAs did not identify which assessments should have been completed, and even those that did, did not provide adequate justification for the inclusion or exclusion of specific assessments. Often the narrative sections of individuals' ISPs identified issues of concerns for which assessments were not found, and the team had not provided a justification for excluding these assessments. Specifically in reviewing the PSIs and ISP Preparation Meeting information for the individuals for whom the new process had been used, Individual #228's team had identified all of the relevant assessments, and although some were submitted late, all were available at the time of the review. However, for Individual #63, despite his being on six psychotropic medications, a psychiatric evaluation had not been completed. As part of his ISP Preparation meeting, his team did not require psychiatric or pharmacy assessments, or a Structured Functional Behavior Assessment (SFBA) despite what appeared to be a significant need for all three. His team had not provided a justification for its decisions not to require these assessments. 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. The ISP Preparation Meeting documentation should include space for a justification, which teams should complete, particularly when they are not requiring completion of an assessment for which the individual has specific needs. ▪ For none of the individuals (0%), the quality of the assessments was adequate, including clear identification of the individuals' strengths, needs, and preferences. According to the revised State Office policy and process, at the 90-day meeting prior to the annual ISP meeting, the team, using the PSI, was to identify preferences and strengths, as well as the major goals towards which the	

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		individual wanted to progress. Assessments then should reflect these preferences and strengths, and, as appropriate, identify any additional ones. The assessments should then incorporate these as appropriate into recommendations, proposed action plans, etc. As the Facility had identified, assessments did not consistently and concisely list individuals' strengths, needs, and preferences. Some assessments did this better than others, such as the newer vocational assessments that had sections within the reports delineating strengths, needs, and preferences. However, with most assessments, this information was integrated throughout the report, and no analysis or listing of the information was provided. In other instances, assessments clearly did not provide the team with the information it needed to develop adequate plans for the individual. 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 detail throughout this report with regard to the sections of the Settlement Agreement that address 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' ISPs, it is essential that adequate assessments be completed that identify individuals' preferences, strengths, and needs. Of note, although as discussed with regard to Section J, the quality of psychiatric assessments had improved with the completion of Comprehensive Psychiatric Evaluations and the addition of some new tools for use during the quarterly psychiatric assessment process, this was not evident in the ISPs reviewed. For example, individuals that clearly needed psychiatric assessment for the adequate development of their ISPs did not have them (e.g., Individual #63, Individual #184, Individual #268, and Individual #26). As discussed with regard to Section J, little evidence was found of psychiatric supports in the ISPs, which likely was at least in part due to the assessments not being made available to teams. ▪ Assessments also frequently did not include adequate recommendations. Some of the issues noted included: o Some assessments typically included no or limited specific recommendations. For example, psychological assessments had a section for recommendations, but these often consisted of a summary of the individual's strengths and weaknesses, as opposed to recommendations. Medical and nursing assessments included few recommendations. Other assessments included an incomplete list of	

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		recommendations. o Recommendations frequently were not oriented to the development of action plans. For example, although therapy assessments often included recommendations, the therapists had not recommended functional or measurable goals. For the individuals for whom the newer ISP process was used, these issues continued to exist. For example, for Individual #228, many of the assessments included limited or no recommendations (e.g., psychology, nursing, education and training, and the FSA,) and in other cases, recommendations appeared inadequate to address identified needs (e.g., the nutrition assessment for this individual that had lost weight when not on a weight loss program, or dental for this individual with a fair rating). Similarly, for Individual #63, many of the assessments included few, if any recommendations. This individual was newly admitted to the Facility and came to the Facility with a number of significant issues that the team should have addressed. For example, given his traumatic past and its potential impact on his current behaviors, one would have expected some assessments to include recommendations to address his related diagnosis (e.g., potentially counseling). However, the assessments were not helpful in this regard. ▪ There were no cases (0%) in which all assessments had been completed in a timely manner (i.e., at least 10 working days prior to the ISP meeting). For assessments not submitted in a timely manner, 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. Although staff reported that these procedures had resulted in increased compliance with timely submission of assessments, based on the review of records, concerns still existed. This was no different for the two ISPs using the newer process and format. For example, for Individual #63, the following assessments were late: physical, OT/PT, Nutrition, and psychological. For Individual #228, the nutrition and medical assessment were late. ▪ As stated in the Monitoring Team's previous report, some further direction had been provided to staff responsible for assessments, including that each assessment should include a statement regarding whether or not an individual could transition to the community, as well as the supports needed. If not, the assessor needed to identify the reasons. Based on the review of sample plans, this was occurring more consistently. The Facility had added a component to its Policy #F.21 – Submitting Assessments. The addition provided a definition of a clarifying a "life changing event," and indicated that the team would need to complete an ISPA meeting at which time assessments would be	

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		reviewed to determine if they needed to be revised/updated. This helped to address the Settlement Agreement requirement that assessments be completed when the individual experienced "significant changes." Of course, other changes in status might require more limited review and revision of assessments. In the past, the Monitoring Team had recommended an annual review of incidents, and abuse, neglect, and exploitation allegations. This type of assessment had begun to be included in the ISPs. However, this often appeared to involve a cursory review of the incidents and allegations. It was not clear that the goal had been met of individuals' teams ensuring that all of the protections, supports, and services necessary to reduce to the extent possible such incidents were in place and appropriately incorporated into the ISP. Some examples of where thorough reviews did not appear to have been completed included Individual #363, Individual #268, and Individual #26. These individuals had numerous incidents and injuries, and in some cases, allegations. However, the teams did not adequately analyze the information and/or identify areas in which changes might be made to attempt to reduce the frequency of such occurrences. Overall, assessments were either not present or inadequate to guide teams properly in developing adequate ISPs. This is an area that will require the concerted efforts of all team members to resolve. The Facility remained out of compliance with this provision.	
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 ISP process had been specifically designed to be more interactive and staff were trained not to read their assessments at the meetings, teams continued to need to incorporate thoroughly the results of assessments in the ISPs. The following summarizes concerns related to the incorporation of assessments into ISPs: ▪ In none of the 17 plans (0%) were all recommendations resulting from assessments addressed in the ISPs either by incorporation, or evidence that the team had considered the recommendation and justified not incorporating it. Although a section of the report format the Facility had begun to use in December 2011 (prior to the most recent revision) included a section in which the team was to review recommendations not discussed previously, it often consisted of a listing of recommendations with little discussion, and often no justification for not implementing a recommendation and/or no related action plan to ensure the recommendation was addressed (e.g., Individual #290, Individual #268, Individual #282, and Individual #336). ▪ Two major factors negatively impacted the Facility's ability to ensure that assessment results were used to develop, implement, and revise, as necessary, a ISP that outlined the protections, services and supports provided to the individual were: 1) based on observations and review of documentation in ISPs, although some improvement was beginning to be seen, there was a lack of	Noncompliance

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		consistent interdisciplinary discussion and coordination in the development of ISPs. 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, 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. To illustrate the issues discussed above, Individual #63, who had a new format ISP, is discussed here specifically with regard to some of the concerns related to his assessments and the interdisciplinary discussion documented in his ISP in relation to the assessments. One of Individual #63's high risks was his weight. He had a BMI that placed him in the morbidly obese range. His nursing assessment did not adequately address this issue. For example, although the BMI was listed in the assessment section, it was not identified in the nursing problems/diagnosis section. In the nursing summary section, it was mentioned, but not identified as a significant problem. The only related "plan" in the medical assessment was to "Encourage exercise and low calorie diet to promote weight loss." In addition, the nutrition assessment offered few recommendations (i.e., reduced calorie/low fat/low cholesterol diet with addition of a piece of fresh fruit for snacks, and "continue with all other dietary arrangements"). Despite the fact that his mother reported that he snuck food at night and that she believed his psychotropic medication was negatively impacting his weight, the team did not address either of these concerns through action plans. The psychologist did not address the weight issue, and other than skill acquisition programs to encourage healthy eating, no strategies were discussed for how to encourage exercise, a goal for how much exercise would be helpful, whether or not incentive programs or support groups would be helpful to address his weight issue, etc. As noted previously, the team did not require psychiatric or pharmacy assessments, or Structured Functional Assessment of this individual, and none of these were provided as part of the package of assessments. Therefore, the team did not have information to further discuss the mother's assertion that his psychotropic medication was affecting his weight. An action plan indicated that the psychiatrist would see him as previously scheduled, but no action step to address the mother's concern about the weight issue was included. Although the Facility had not conducted a psychiatric assessment, this individual carried a diagnosis of Post Traumatic Stress Disorder. Without a psychiatric assessment, the team's discussion of this diagnosis appeared to be nonexistent. Although the psychological assessment mentioned it, no recommendations were made in relation to it. In fact, the psychologist made no discernable recommendations, except in relation to community placement. Although the	

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		medical assessment included information about a restriction against him having contact with his father, the team had developed an action plan to initiate contact with his father. The ISP provided no reconciliation of this contradictory information, nor did it appear that the team had discussed the potential impact that this contact might have on his behavior and/or psychological wellbeing. Similarly, without a psychiatric assessment, the ISP did not address the six psychotropic medications he was prescribed, and the team incorrectly identified him as being in the low risk category for polypharmacy. For none of these issues did his ISP show adequate collaboration or integration between disciplines. As has been recommended in the past, the State and the Facility should 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 and incorporate such discussions into comprehensive ISPs, 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).	Based on information the Facility provided, the following activities had occurred to provide additional education to QDDPs regarding community living options: ▪ On 5/18/12, the QDDPs were trained on the new rules regarding inclusion of the Designated Local Authority (LA) during living options meetings. More specifically, the rules had been modified to allow a referral to be made without the LA present. The rules also set forth the parameters for ensuring LA representatives were invited to meetings, notifications of the Admissions/Placement Coordinator of referrals made during meetings, informing the LA of referrals made in their absence, and holding an additional meeting should the LA have any questions or concerns about the referral. It was positive that LA representative's inability to attend a meeting would not delay a potential referral. 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. A subset of 10 plans were reviewed including those for: Individual #290, Individual #363, Individual #184, Individual #268, Individual #282, Individual #336, Individual #26, Individual #250, Individual #228, and Individual #63. To highlight some of the issues of concern: ▪ Teams were not consistently providing independent assessments of individuals' ability to transition to a more integrated setting. In order for the State Office requirement to be met, each discipline's assessment needed to include an opinion/recommendation. In addition, at the ISP meeting, the team needed to	Noncompliance

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		make a recommendation to the individual/guardian. Based on the review of records: o As noted above in the discussion regarding the quality of the assessments, some assessments included the required statements/recommendation, and others did not. However, this was an area in which improvement was seen. Of the 10 ISPs reviewed, all of the assessments for one individual (10%) (i.e., Individual #228) included the applicable statement/recommendation. For four of individuals most of the assessments included such a statement (i.e., Individual #63, Individual #250, Individual #336, and Individual #290). o Of the 10 ISPs reviewed, one individual (i.e., Individual #26) had been referred for transition to the community a few months previously, and the team agreed to continue the referral. For the remaining nine individuals, two individuals' ISPs (22%) included an independent recommendation from the professionals on the team to the individual and LAR (i.e., Individual #184, and Individual #282). The following problems were noted for the other individuals: ▪ For two individuals (22%), the assessments and/or ISP narrative included statements showing disagreement amongst the team regarding the individual's appropriateness for community transition (i.e., Individual #290, and Individual #63). For both of these individuals, the team recommendation was that the individual remain at the Facility. However, it was not clear how the team disagreement about this had been resolved. ▪ For one individual (11%) (i.e., Individual #228), all team members had included statements in their assessments indicating the individual could be supported in a less restrictive setting. In the ISP narrative, the team indicated: "All the disciplines who work with [Individual #228] agreed in their assessments that community placement would be appropriate if the proper supports were in place to meet her special needs. She is in good health and adapts well to new situations." Individual #228 did not have a guardian or active family involvement. In other portions of the ISP, the team concluded that she required a guardian for all aspects of decision-making. However, the team "determined that [the Individual] would not benefit from moving to a less restrictive environment at this time." The reason given was that: "She needs additional education about community living options." The team did not	

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		provide adequate justification for its conclusion. In addition to the fact that the team indicated the individual could not make her own decisions, she also had been on two community tours the previous year, and appeared to be "alert, looking around with interest, and smiling." Moreover, her PSI indicated in response to the question about where she would want to live: "She is nonverbal and therefore, unable to give us this information." It was unclear if the team did not have enough information about community options (given that in lieu of a guardian, the team was responsible for this decision), or if the team believed there was another barrier that they did not identify. ▪ For four individuals (44%), based on the assessments and sometimes the narratives in the ISPs, the team members stated that the individual could be supported in a less restrictive setting. However, a specific recommendation to the individual and/or LAR was not made (i.e., Individual #363, Individual #268, Individual #336, and Individual #250). ▪ 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 obstacles. In summary, the Facility remained at the initial stages of complying with this component of the Settlement Agreement. Although team members were including more statements in their assessments with regard to individuals' appropriateness for community transition, they were not consistently making independent recommendations to the individuals and/or LARs; when disagreements were noted, their resolution was not consistently explained; and the identification of and plans to overcome obstacles to transition were not yet adequately addressed. The Facility remained out of compliance with this provision.	
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		

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	years, an ISP shall be developed and implemented for each individual that:		
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	This provision of the Settlement Agreement addresses a number of specific requirements, including identification and use of individuals' preferences and strengths, prioritization of needs and explanation for any need or barrier not addressed, and identification of supports needed to encourage community integration. Each of these is addressed separately below. DADS Draft Policy #004.1 at II.F.4 indicated that action plans should be based on the individual's preferences, strengths, and needs. The policy further indicated: "The IDT must have a comprehensive, integrated discussion with input from each team member on how he or she will formally or informally support the prioritized action plans." The revised policy included considerable detail regarding the types of action plans teams should develop (i.e., skill acquisition plans, participation objectives, service objectives, and specific objectives to address individual risk factors); the content of action plans; topics that action plans should cover. It also required teams to "consider every opportunity for community integration," as well as ensure that "Outcomes and objectives are expressed in terms that provide measurable indices of performance…" As noted previously, the Facility had reiterated the previous DADS policy in its Facility policies. CCSSLC Policy F.5: Action Plans, implemented 11/1/11, might need to be reviewed and revised based on some of the changes to State Office policy. <u>Identification and Use of Individuals' Preferences and Strengths</u> As noted in the last report, teams were making efforts to identify individuals' preferences. The 17 ISPs reviewed all included some information regarding the individual's preferences. However, the following concerns were noted with regard to the identification and incorporation of preferences and strengths into ISPs: ▪ All 17 of the ISPs reviewed included a listing of individuals' preferences. Some plans included an objective or two that, for example related to a preferred activity of the individual (e.g., Individual #63). For four out of 17 (24%), the team had more effectively incorporated their preferences into related action plans. For example, Individual #26 was able to state many of her own preferences, and the team incorporated a number into her action plans. For example, action plans were developed to address her desire to learn how to use the bus to go to the bingo hall (a preferred activity), as well as explore Foster Care. She also wanted to learn more about her health conditions, and the team incorporated this into an action plan. Individual #184's ISP showed more integration of the individual's preferences. ISPs for Individual #226 and Individual #174 were additional examples of where teams had identified placement preferences and sought to incorporate appropriate actions. For	Noncompliance

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		example, an objective was included to investigate potential vocational opportunities that would address his preferences. Some leisure activities, such as purchasing a magazine, as well as finding decorations that would correspond with his preferences also were included. However, in most cases, the teams had not used these preferences in creative ways to address individuals' needs (e.g., building in incentives for individuals who refused to attend vocational or day programs, or needed to lose weight) or to expand individuals' horizons. Even when work was a preference, teams did not capitalize on this by expanding the individuals' vocational opportunities. Individuals with weight issues were noted as liking the outdoors or specific sports, but teams did not utilize this preference to build in regular outdoor exercise or participation in specific sports or activities. These are just a few examples of many missed opportunities. Specifically with regard to the two newer ISPs, Individual #228 had a new PSI. In response to many questions, the following was stated: "She is nonverbal and therefore, unable to give us this information." For other questions, responses were provided. It was unclear why the team relied on information from others for some questions and not for others. In general, her action plans did not specifically incorporate her preferences, and her strengths were not used to further expand her independence. For Individual #63, some limited integration occurred of his preferences (e.g., learning to cook, bicycling, etc.). ▪ As the Monitoring Team's previous reports have noted, 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. ▪ Little, if any, information about individuals' specific strengths was discussed in ISP documents. Strengths were not regularly built upon to address other need areas. As noted while on site, for the ISPs the Monitoring Team's observed, although lists of strengths were identified, they were limited. In addition, teams did not effectively discuss them, or use them in the development of action plans. <u>Prioritization of Needs and Explanation for Any Need or Barrier Not Addressed</u> None of the plans reviewed (0%), including the plans completed using the new format, included a list of priority needs. In none of the plans was an explanation provided of how the team had determined which supports or training needed to be prioritized over other needs. For example, no rationale was provided regarding why one of the individual's	

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		specific needs (e.g., one daily living skill as opposed to another, or a particular medical need) took precedence. In addition, although anecdotally, teams were concerned about lack of staffing or transportation to address individuals' needs, careful delineation of barriers to addressing needs was generally not found. Moreover, teams often cited individuals' behaviors or attitudes as preventing them from participating in activities (e.g., work), but teams had not clearly defined such issues as barriers, and/or implemented plans to address them. More specifically, in none of the 17 PSPs reviewed (0%) were barriers identified and addressed. <u>Identification of Supports Needed to Encourage Community Integration</u> In reviewing objectives related to individuals' involvement in the community, they continued to be limited. Sixteen of the 17 ISPs reviewed (94%) (i.e., those that did not include such objectives were: Individual #268) included specific skill acquisition action plans for implementation in the community. However, the following problems were noted: ▪ The skill acquisition programs generally involved implementation once a week or once a month (e.g. Individual #290, and Individual #63). ▪ Even in the limited plans reviewed, objectives were identical for three individuals (i.e., while on community outing, the individual was to respond to sensory inputs). ▪ Most of the community-related objectives were not written in a manner to actually encourage the integration of individuals with nondisabled peers and/or the expansion of individuals' experiences in the community. ▪ Some individuals had objectives for general community involvement activities, but they often were not measurable. For example, "DSPs to support [individual] with opportunities to participate in community activities that address his interests and preferences" did not set forth an action step that could be measured to ensure the individual was actively involved in the community in activities that he preferred. The timeframe for this activity was "ongoing." ▪ Specifically with regard to the two plans using the newest format, for Individual #228, although some community involvement action steps were included in the ISP, they were not measurable (i.e., no frequency of community outings was stated), nor were they individualized to support further integration into the community. For example, the action plan read: "will participate in community outings with peers" with action steps for staff to schedule outings, the individual to participate in them, and staff to document her reactions. Her skill acquisition goal for the community was to respond to sensory inputs while in the community. It was not clear how this assisted her to be more integrated in her community or to practice functional community skills. On the other hand, for	

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		Individual #63, the team identified an objective for him to learn to use the bus. This should provide him with functional community skills. The goal was scheduled for implementation just once a week. His other community-related action step read: "[Individual] will gain exposure to different community locations through participation in off-campus activities." No frequency was stated, making this objective difficult to measure. Although CCSSLC had made some progress, the Facility remained out of compliance with this provision. Although teams were identifying some preferences and strengths of individuals, these remained limited. In addition, teams were not yet effectively incorporating individuals' preferences and strengths into action plans, or using them creatively to expand individuals' opportunities or address their needs. Prioritization of individuals needs was not evident in the ISPs reviewed. As is discussed in the subsections below, individuals' needs were not comprehensively addressed in action plans. More individuals had action plans that addressed community skill acquisition, but these varied in quality.	
	2. Specifies individualized, observable and/or measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports to: attain identified outcomes related to each preference; meet needs; and overcome identified barriers to living in the most integrated setting appropriate to his/her needs;	Although some limited progress was seen in this area, this continued to be an area in which substantial effort was needed in order for CCSSLC to comply with the Settlement Agreement. The action plan section of the ISP was where measurable goals/objectives, the treatments or strategies to be employed, and the necessary supports were to be detailed 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. As during the Monitoring Team's previous reviews, Facility staff recognized that action plans were not adequate. The Monitoring Team agrees with this assessment. The following summarizes the concerns related to action plans: ▪ As noted in the last monitoring report, ISPs generally included some individualized and measurable goals/objectives, treatments or strategies, and supports. Since the last review, at CCSSLC, the scope of these goals and objectives had begun to increase. This was a positive development. The Monitoring Team recognizes that the Facility was in the process of revising the ISPs in accordance with recent training from the State Office. However, of note, for many of the individuals in the sample, risk action plans continued to be seen as separate from the ISP (i.e., they were submitted as part of the assessment package, as opposed to being attached to the ISPs). It will be important moving forward for teams to include all action plans within the ISP document. Action plans continued to include skill acquisition plans. At times, PBSP objectives were included, but often only a reference was made to implementation of the PBSP. As is discussed in further detail with regard to Section I, the action plans teams had developed for individuals' at-risk issues did	Noncompliance

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		not adequately address their needs, and did not include measurable objectives necessary to determine: a) if the supports outlined were provided as required; or b) whether or not the supports and strategies were having the desired outcome (i.e., were they effective in improving the individual's health, or maintaining his/her current status). ▪ None of the 17 plans reviewed (0%) included a full complement of measurable goals or objectives and/or strategies 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: o In the past, CCSSLC ISPs generally included the objectives related to skill acquisition programs, and often these were stated in measurable terms. Now, this varied. Sometimes the measurable objectives were included. In other instances, reference to a skill acquisition program was made in general terms, or the skill acquisition objectives did not include a description of the specific skill the individual would learn. For example, the following was fairly meaningless without the full skill acquisition program: "[individual] will improve his independence in a community setting of his choice by demonstrating task analysis steps 1-4 (implemented at step 1), 3 out of four trials per month for 3 consecutive months." o In addition, the great majority of other objectives included in action plans were not specific or measurable. Just a few examples included the following: "Nutrition: Follow and monitor," "will learn how to gain attention from positive behavior, " "will participate in Bingo at off campus Bingo hall" with no frequency defined, "encourage to walk or engage in low impact activities," or "will demonstrate fewer episodes of disruptive behaviors next quarter." o Necessary objectives, supports, and services often simply were not included in action plans. For example, limited to no objectives were seen in relation to the implementation of medical and/or psychiatric care plans, and, although some plans included objectives to implement PNMPs, nursing care plans, or PBSPs, they often were incomplete, and/or were not measurable. 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, or that the individual's psychiatric symptoms are documented should be specified in measurable ways in individuals' ISPs. o Objectives were not seen in any of the plans in relation to staff training	

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		requirements. o Although monitoring of supports was sometimes defined (e.g., PNMP implementation), this was not consistent. o Rights restrictions were another area in which very limited action plans were identified to assist in potentially reducing the need for the restriction. Although some money management programs were included, most restrictions had no associated plan identified. o More frequently, action plans referenced the implementation of physical and nutritional support plans (PNMPs). However, therapy plans, including walking programs, use of adaptive equipment, as well as integration of alternative or augmentative communication (AAC) devices were infrequently in the plans reviewed. Moreover, functional, measurable objectives and/or skill acquisition goals related to therapeutic interventions infrequently were included in ISPs. o ISPs should include measurable, observable objectives to determine the efficacy of the various action plans. In other words, objectives should be designed to allow the team to determine if the individual is doing better or worse, or remaining stable. In reviewing the action plans that had been developed to address individuals' risk areas, work had been done to improve the objectives, including individualizing them. However, often, it was not clear how the team would measure these outcomes, because they were separate statements, and not directly connected to an action step(s). Using the two newest plans, a couple of examples are provided: For Individual #228, in relation to choking, aspiration, and respiratory compromise, that had a goal to "maintain adequate gas exchange AEB [as evidenced by] sats [saturation rates] of 95% or better." Although this technically could be measured, the team had not included any action steps to actually measure her oxygen saturation rates. The team had not, for example, defined the frequency of such assessments, who would be responsible, and/or what would happen if they fell below a certain level. This is discussed in further detail with regard to Section I of the Settlement Agreement. Similarly, Individual #63's action plan for infections, skin integrity, and urinary tract infections had two overall goals, including: "will demonstrate adequate immune status by remaining afebrile, maintaining skin integrity, and by keeping hydrated and well nourished," and "will demonstrate appropriate hygiene practices (bathing, proper cutting of toenails, toothbrushing)." Although some of these could be measured based on the related action plans (e.g., nursing was to conduct skin integrity assessments quarterly, and labs would be completed to determine if he was receiving adequate nutrition and hydration), it remained unclear	

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		the specific parameters the team expected would be maintained (e.g., Braden score or specific lab results), and for other components it was unclear how the team would measure the individual's status. For example, an action step was included for direct support professionals to "encourage daily hygiene," with a monitoring frequency of "daily." Observation notes were to be maintained. However, it was unclear specifically what hygiene skills were to be monitored, and/or what direct support professionals were to document. ▪ In general, with regard to the two plans developed using the newest process, the plans included a mix of measurable and non-measurable goals, but many were not measurable, or individualized. The following specific comments are provided. For Individual #63, many of the goals and/or action steps were not measurable. For example, he was approximately 100 pounds above his Ideal Body Weight Range (IBWR). However, the overall goal stated: "will demonstrate weight control by gradually progressing towards target weight of 140-175." The team had not defined "gradually progressing, and no interim objectives were articulated to assist the team in determining if their action plan to decrease his calorie intake, continue his bike riding skill acquisition program, enroll him in a culinary class, implement a healthy choices SAP, and weigh him monthly was working. Other examples of action steps that were not measurable included: "Will have the opportunity to tour local group homes" with no frequency stated, or "encourage daily hygiene and activity." For Individual #228, generally, the objectives were not measurable. For example, one action plan included the objective: "[Individual] will participate in community outings with her peers." The action steps included such actions as "schedule the outings," "[Individual] will participate in the outings," etc. These did not identify any criteria with which to measure the individual's progress or lack thereof, or whether or not staff were providing the individual the supports she required. However, some objectives were measurable, such as: "Increase [individual's] ambulation program to 4 times per week for 15-20 minutes per session." It was positive to see that this therapeutic intervention was set forth in and ISP action plan. ▪ 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 initial stages of complying with this component of the Settlement Agreement. Some progress had been made in the expansion of the scope of measurable objectives, and efforts clearly were being made to improve the measurability and individualization of objectives and action steps. However, as the Facility recognized, these remained areas in which significant work was needed. The Facility remained out of compliance with this	

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		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 ISPs. ISPs appeared to integrate some, but not all protections, services and supports that individuals required, as this provision of the Settlement Agreement clearly requires. However, some action had been taken to improve the comprehensiveness of ISPs. Specifically, after Staff Office consultants provided training, two teams at CCSSLC had begun piloting a new ISP Meeting Guide (Preparation/Facilitation/Documentation Tool), as well as the new at-risk process. The meeting guide tool, along with a new process for completing the IRRF and developing integrated health care plans, was designed to assist teams in more comprehensively planning for, discussing, and developing ISPs that addressed individuals' array of needs for protections, supports and services, while approaching this in a person-centered manner and incorporating their preferences and strengths. At the time of the review, only two ISPs had been completed using the new process (although several had used the new shell for the ISP document). In addition, during the week of the review, two ISP meetings were held for individuals for whom teams were using the new process. Given this limited implementation, it remained to be seen if the revised ISP Meeting Guide and process would result in improved ISPs. Based on the review of the two plans that used the revised process, some limited progress was seen with regard to the integration of a more comprehensive set of "protections, services and supports, treatment plans, clinical care plans, and other interventions." However, teams will need continued training and coaching to implement the revised process fully. As noted above, as the Monitoring Team's observations of two ISP meetings on site indicated, the majority of the time was spent on the risk rating process. Although this was an essential activity in which teams needed to engage, it resulted in little time being spent, for example, on the team defining the measurable outcomes to determine the efficacy of the interventions the team discussed to address the risks, or other important topics, such as the individual's vocational ambitions and plans to achieve them, his/her plans to increase skills leading to greater independence, ways in which greater integration into the community could occur, etc. Additional preparation by the QDDPs as well as other team members before the meetings was an area for improvement. For example, if all team members had familiarized themselves with the information included in the draft IRRF, the team would not have had to review it all in detail, but rather could have discussed any questions and then made decisions. With regard to the two plans developed using the new process, the following comments are offered with regard to the integration of a comprehensive set of protections, services,	Noncompliance

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		and supports: ▪ For Individual #228, adequate discussion and inclusion of action plans related to protections, supports, and services were missing in a number of areas. For example, with regard to day/vocational supports, the ISP indicated she attended out of home day services two hours a day. No justification was provided for this limited schedule, and the ISP offered minimal definition of the supports she would receive in this setting. With regard to health risk plans, although the ISP indicated they were attached, it was unclear if they were. They were requested separately and submitted with the assessments. Some improvement was seen in these health risk plans over previous ones (e.g., definition of parameters for contacting physician; more proactive interventions, such as fluid intake and development by Habilitation Therapies of walking program to address issues related to constipation). However, a number of missing pieces were still missing. For example, with regard to weight, she had lost eight pounds. This was noted in the medical assessment, and the PCP identified a goal for her to gain weight. This goal and/or the plan for achieving it were not included in the integrated health care plan. The ISP and IRRF indicated that the behavioral services staff said she was not a candidate for desensitization "because of her spasticity." However, the description of her resistance at dental appointments did not appear to have anything to do with spasticity. The IRFF stated: "During appointments she exhibits anxious (sic), has excessive movement and is resistive to exams, she bends at the waist as avoidance and grabs hands." She also was resistive to staff assisting her with brushing her teeth, but no proactive strategies to address this were included in her integrated health care plans. On a positive note, it appeared the team discussed the need to expand the individual's opportunities to walk, and stand with the assistance of adaptive equipment and staff. The team developed action plans that described both the PNMP Coordinator's role, as well as the direct support professionals' role. ▪ With regard to Individual #63, in the narrative that addresses Section F.1.d, a number of examples are provided of supports that were missing from his plan. Additionally, with regard to his vocational supports, he was only scheduled to work from 1 p.m. to 4 p.m. each day. The ISP did not provide a reason for the limited schedule, and no plan was put in place to increase this amount of time. There was no apparent reason why he could not work full-time. Although he was going back to school in the fall, the ISP did not address how he would spend the rest of his day during the summer, and/or whether or not during the school year, he would work part-time. Job exploration also was included as a goal, but was defined in an action step that read: “will complete job introduction for off-campus janitorial work in DPS and Parks and Wildlife.” Although this was positive, the completion date appeared to be a year after the ISP, and it was unclear what the expectations were for the interim.	

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		Based on the sample of plans the Monitoring Team reviewed, none of the 17 plans (0%) integrated all of the protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual. For example: ▪ The medical, psychiatric, counseling, habilitation therapy, PBSPs, and nursing care plans frequently still were separate plans that were not integrated in any measurable way into the ISP, through, for example, measurable objectives, and did not show an integration of various disciplines and team members. Even the two plans using the new format did not successfully integrate or include all of these various components. For example, Individual #63's psychiatric treatment plan appeared as if it would be an important part of his treatment, but it was not integrated into his plan. In fact, at the point his initial annual ISP was developed, he had not yet seen the psychiatrist. His PBSP was identified as requiring implementation, but no specific goals or objectives were included in the ISP action plans. No counseling plan was included (i.e., only reference to participation in a "men's group"). As noted above, for Individual #228, it was positive that a therapy plan was included, but other plans were missing, such as full identification of medical supports. Although some nursing actions were included for both individuals, these did not represent full nursing care plans. ▪ Action plans often did not recognize the multiple staff and disciplines that needed to be involved in the training of staff, implementation of the programs/plans, monitoring of the implementation, and updating/maintenance of the plans and/or related equipment. Frequently action plans simply stated what would happen without detailing all of the steps and the staff who needed to work in an integrated fashion to achieve the stated outcome. For example: o The action step stating: "psychiatric medications will be reviewed in psychiatric clinic," or "continue PNMP" did not detail all of the various roles of staff who needed to work in an integrated fashion to accomplish the ultimate objectives for these individuals of maintaining good health. Often the persons responsible for these broad outcomes were "nursing," or "the PNMP Coordinator and QDDP." Again, this did not recognize the need for such supports to be integrated with the roles of many disciplines, including direct support professionals. Some of these roles had begun to be better defined in some of the integrated health care plans for the two newer ISPs. However, continued work was needed, particularly because the "IDT" often was identified as having responsibility, and without defining which team member(s), it remained unclear who was responsible. o Although references to the need to implement PBSPs were included in	

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		the ISPs, which was positive, often the action plans did not include the specific objectives. No detailed action steps were included related to staff training, monitoring of the plans, sharing of information with the psychiatrist, etc. In addition, evidence generally was not found that PBSPs were integrated with other supports, such as communication supports, or health related supports (e.g., weight reduction, medication administration, etc.). A number of ISPs identified issues in which psychology should have been involved, but was not. As noted above, the two newer plans also illustrated concerns in this area. It was positive that for Individual #268, the psychologist was assisting with the issue of work refusals. However, it appeared the SLP also should have been involved. o Although ISPs had begun to include objectives to implement the PNMPs, PNMPs lacked measurable outcomes, and, as a result, these were not included in ISPs. In addition, generally no detail was provided in relation to all of the various roles of team members necessary to ensure full implementation, including, for example, integration with nursing and dental plans. The two newer plans also illustrated concerns in this area. o In general, individuals' work and day activities were inadequately defined. Although at times an objective was identified for implementation at the day or vocational program, this was not consistent. In addition, the objectives that were included did not adequately define the team's expectations with regard to the program or training that the staff would offer the individual, or the outcomes that would be expected. Little information was provided with regard to rationales for the many individuals that had less than full-time schedules in off-home programs. In addition, minimal planning for the future was completed to identify next steps in the individuals' vocational paths. As noted above, the two newer plans also illustrated concerns in this area. o Individual's staffing needs generally were inadequately defined. For example, even when an individual's ISP indicated that one-to-one supervision was necessary, the role of this staff member and/or the supports the staff would provide were defined inadequately. The two newer plans did not specifically describe staffing supports. o As is discussed with regard to Section U, for individuals for whom the teams identified the potential need for a guardian or other assistance in making decisions, action plans had not been developed to address this need. ▪ Examples of issues related to the lack of integration continued to be found	

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		between nursing, dental, and physical and nutritional supports to incorporate PNMPs with medication administration and dental work, and dental/medical and psychology to develop and implement desensitization plans. The Facility remained out of compliance with this provision. Although the Facility had begun to implement the revised ISP template and process, it was in its initial stages of implementation. Some limited improvements were seen. However, as noted above, teams will need additional coaching and mentoring to fully implement the process and develop ISPs that meet this requirement of the Settlement Agreement.	
	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, for the two ISPs using the newer format, the timeframes often were confusing, because: 1) teams had completed the "implemented by (Date) column" and the "Completion date" column, but often for items that should not have taken a year (e.g., completing a job introduction, seeing the psychiatrist, etc., the beginning date was the month of the ISP meeting, and the end date was a year later, giving the impression that the team had a year to complete these activities; 2) particularly because the action steps themselves did not define the frequency with which actions should occur (e.g., use of dining plan, documentation of emesis) and the monitoring column was not designed to address implementation, the use of the term "ongoing" in the completion column for some action steps did not appear to be appropriate, when activities should have occurred, for example, "daily," "at every meal," etc.; and 3) the ISPs frequently did not distinguish between timeframes for implementation of action steps, and monitoring or oversight of implementation, although this issue appeared to be resolved in the newest integrated health care management plans. They included a column to indicate "monitoring frequency and location of documentation." An issue related to the identification of staff responsible noted in the one of the ISPs that used the new format (i.e., Individual #63) was the use of the term "IDT" as opposed to a specific member(s) of the ISP. Particularly, when it comes to monthly monitoring of programs/supports, it will be important for one person to be identified. In addition, by using this broad description everyone was responsible, but no one was responsible, reducing the level of accountability. Generally, direct support professionals were identified more frequently in the action plans. Since the last review, this was an improvement. It will be important, though, as discussed elsewhere to ensure that their roles are clearly defined, as well as the methodologies they should use to implement action steps. Methods for implementation were not always adequate or present. In other words, the "how" was not provided. In none of the 17 plans reviewed (0%) was the methodology	Noncompliance

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		sufficiently described for the action plans included. For example, for plans using the older format, as well as the two plans using the new format and process: ▪ When a team agreed that a desensitization plan would be developed to address an individual's dental needs, a number of steps should have been set forth in the action plan, including the development of the plan, training of staff on the plan, and implementation of the plan. Each of these should have had a separate timeframe attached to it. Instead, such action plans often read: "Implement desensitization plan" with the end date of a year. ▪ Similar to other plans, for Individual #63, it was unclear how staff would "encourage fluid intake and adequate nutrition" (it also was unclear how this would be measured). Similarly, the integrated health care plans included many objectives to monitor labs, obtain weights, or measure blood pressure readings. However, it was unclear what would happen once these were obtained. No criteria for action were provided. ▪ For Individual #228, more of the methodology was set forth in the integrated health care plans. For example, specific tracking of certain health indicators, such as Bowel Movements, were identified with the actions to be taken should stated criteria were met. However, at times, no methodology was stated. For example, the individual was to "maintain adequate gas exchange AED [as evidenced by] O2 [oxygen] sats [saturations] of 95% or better." However, the methodology for determining this was not stated (e.g., when saturation rates would be measured). Similarly, maintaining or improving her oral care rating was a goal. However, despite a description that she was resistant to staff assistance with tooth brushing and that she could not brush her teeth herself, it was unclear what methodology the team would use to achieve the stated goal. In addition, as is discussed with regard to Section I, action plans for individuals identified as being at risk frequently did not include adequate methodologies to reduce the at-risk factors to the extent possible. The plans included in individuals' risk action plans often indicated plans already in place would be implemented, or set forth plans that were not sufficiently aggressive to either further evaluate and/or address individuals' high and medium risk levels. When an individual is identified as being at risk, teams should develop plans with clinical intensity that corresponds with the level of risk identified. The new format ISP for Individual #63 was an example of a plan that should have included a more assertive plan for addressing his high risk for weight. As discussed elsewhere in this section, for an individual under the age of 20 with a BMI of 43 (i.e., approximately 100 pounds over weight, and in the morbidly obese range), the clinical plan the team developed to address this was inadequate. The Facility remained out of compliance with this provision. In addition to better defining the methodologies in action plans, clear timeframes should be established and	

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		specific team members should be identified as responsible.	
	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 17 plans reviewed (0%) effectively addressed the individual's full array of needs for services and supports. 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. In addition, as noted in previous reports, 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. Only three of the 17 plans reviewed included a goal related to cooking, and this appeared to occur in a classroom setting. None of the plans reviewed included goals related to housekeeping or yard work, which would be typical activities for independent adults. 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. In addition, many individuals at the Facility had part-time schedules for work or day activities, and teams did not appear to view timeliness and attendance issues as priorities to be resolved (i.e., in an integrated fashion with assistance from psychology staff, when appropriate). Similarly, lengthy lunch breaks during which individuals went back to their residences did not allow opportunities for individuals to learn to either bring lunch and eat at their work sites or in the vicinity of their activity or vocational setting. These low expectations failed to provide individuals with functional skills to allow successful transition to a community setting, where regular participation in a day program or job would be expected. 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 person(s) responsible for the	Consistent with the previous reviews, for the goals and objectives included in ISPs, generally, the ISPs specified data to be collected and/or documentation to be maintained, and specified a frequency for data collection. It was not always clear who was responsible for reviewing the data, and what that review meant in terms of making changes when there was little or no progress. However, in the two plans using the revised format, this was becoming clearer. More specifically, for Individual #228, the "Persons Responsible for Implementation/Documentation," "Person Responsible for Plan Development," and "Person Responsible for Reviewing for Progress	Noncompliance

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	data collection, and the person(s) responsible for the data review.	and Effectiveness" were identified. However, for Individual #63, although his ISP used the new format, which included columns for both data collection and data review, often the person responsible was listed as "IDT." This did not make any one member(s) of the IDT responsible. The overarching concern was that many goals and objectives were not specified in individuals' ISPs, or other treatment plans that should have been integrated into the ISP (e.g., objectives related to health management plans, PNMPs, psychiatric treatment plans, etc.). As a result, appropriate data was not being collected to assist teams in decision-making. None of the 17 ISPs reviewed appeared to be driven by a review of data, and the presence or lack of progress on measurable objectives and outcomes. Since the last review, improvement was seen with regard to data being used to inform some of the at-risk discussions. Data that should have been included, but was not, related to skill acquisition goal data, data related to the implementation of other plans (e.g., PNMPs, PBSPs, psychiatric treatment plans, etc.), and details regarding individuals' successes or failures, etc. This was true for the two new plans as well. As is discussed below with regard to Sections K and S of the Settlement Agreement processes were not yet in place to determine the reliability of the data, but efforts were beginning in this regard. However, there continued to be some indications that the data being collected was not reliable.	
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 ISPs, 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. As noted above with regard to Section F.1.a, some improvements were being seen with the interdisciplinary discussions that occurred during ISP meetings. However, more work was needed to ensure adequate collaboration and coordination between team members.	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	At the time of the review, the ISP 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 skill acquisition programs were located on the unit and accessible to staff, usually in Individual Notebooks.	Noncompliance

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	responsible for implementing it.	Improvements were seen in the manner in which plans were written to facilitate direct support professionals' understanding. However, one was rather difficult to understand. It appeared this was due to the writing style (i.e., Individual #282). Another issue related to comprehensibility of the 17 ISPs 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 ISPs as written and determine what his/her responsibilities were for the individual during the course of the 24-hour day. Although as noted above, the role of direct support professionals was becoming better defined, this in large part was due to the fact that the ISPs 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 ISP. This is necessary to provide one document that clearly identifies all of the protections, supports, and services that need to be provided to the individual, and clearly identifies the responsibilities of various team members. In addition, without clear methodologies, it will continue to be difficult for direct support professionals to consistently implement programs and supports (e.g., "encourage" and other similar terms would be difficult to implement).	
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 being completed more consistently. However, they only included the QDDPs' review of skill acquisition programs. The Facility recognized that this review would need to be expanded to include various team members' review of "each program or support included in the ISP." The QDDP Coordinator was working with the State Office discipline lead to develop an appropriate format and process. This was confirmed through document review. Based on the sample of 15 records reviewed (excluding the ISPs for Individual #228 and Individual #63), six (40%) had monthly reviews each month for the previous three months (i.e., Individual #184, Individual #363, Individual #26, Individual #250, Individual #124, and Individual #155). Moreover, examples are provided in various sections of this report of individuals 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 medical and nursing care, as well as physical and nutritional management supports.	Noncompliance
F2e	No later than 18 months from the	Previous reports have described the training that CCSSLC staff underwent, including	Noncompliance

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	Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter. Staff responsible for implementing ISPs shall receive competency-based training on the implementation of the individuals' plans for which they are responsible and staff shall receive updated competency- based training when the plans are revised.	Supporting Visions: Personal Support Planning. The QDDP Coordinator and one Lead QDDP had been certified as trainers for the Q Construction: Facilitating for Success training. As indicated above, since the last review, staff at CCSSLC had participated in additional training. This included: ▪ The Q Construction: Facilitating for Success training was routinely provided to new QDDPs. 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 QDDP Coordinator has completed checklists on the QDDPs. Based on interview with the QDDP Coordinator, only the QDDP Educator had been deemed competent on the facilitation of ISP meetings. However, the tool generally provided a good format for reviewing a number of planning and facilitation skills, and it appeared the QDDP Coordinator had critically reviewed the skills that the QDDPs demonstrated. As indicated in the previous report, 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 was providing some valuable information to assist QDDPs in refining their skills. ▪ As noted with regard to Section F.1.a, in May 2012, the State Office provided additional training on a revised ISP format and process to QDDPs and other team members. A revised ISP Meeting Guide (Preparation/Facilitation/ Documentation Tool) was introduced to assist the QDDP in preparing for the meeting and in organizing the meetings to ensure teams covered relevant topics. In addition, the new process on which the QDDPs were trained included more pre-planning that began 90 days prior to the ISP meeting. As part of this, QDDPs were trained on the implementation of a new tool/assessment entitled the Preferences and Skills Inventory, as well as the new ISP Preparation Meeting process. Written instructions for the ISP meeting guide also were provided to QDDPs. These instructions provided some helpful hints and direction to QDDPs. ▪ The QDDP Coordinator also continued to provide training to QDDPs as CCSSLC policies were changed, or procedures, such as the rules about LA's involvement in Living Options meetings, changed. Areas in which additional work was needed to reach compliance with the Settlement Agreement included: ▪ As indicated in previous reports, QDDPs should be required to demonstrate competency in meeting facilitation and the development of an appropriate ISP 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 QDDP Coordinator recognized, this would be an ongoing process until each QDDP demonstrated competency in this area. Only the QDDP Educator had achieved	

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		competence, but none of the 14 QDDPs. Competency measures had not been developed or implemented with regard to the ISP document. ▪ Competency measures for other team members also should be identified and used to evaluate whether additional training is needed. ▪ 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 individual's strengths and 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 the individual's interests, priorities and vision for his/her living arrangements, while reconciling these with the individuals' medical and safety needs. ▪ Reportedly, the State consultants as well as the QDDP Coordinator were conducting some hands-on technical assistance at team meetings. These efforts should continue, because technical assistance will be a key component of enhancing and refining the skills of QDDPs, as well as other IDT members.	
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.	Based on summary data the Facility provided with regard to individuals' most recent and previous ISP dates, within the last year 259 ISP meetings had been held, and to-date 251 documents had been completed. Of the 259 meetings held, all (100%) were held within 365 days of the previous meeting. The Facility tracked the dates that ISPs were completed and filed. For the last one-year period, of the 251 completed plans, 139 (55%) plans were completed and filed within 30 days of the ISP date. As is noted in other sections of this report, IDTs did not consistently meet to make changes to ISPs 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 the ISPs are developed and	Progress had been sustained with regard to the implementation of quality assurance processes that identify and remediate problems to ensure that ISPs are developed consistent with this section of the Settlement Agreement. Positive aspects of the process included: ▪ DADS Draft Policy #004.1 at V continued to address quality assurance processes to ensure ISPs were developed and implemented consistent with the provisions of the Settlement Agreement. ▪ CCSSLC was conducting reviews/audits of ISPs, including audits using:	Noncompliance

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	implemented consistent with the provisions of this section.	o The Personal Support Plan Meeting/Documentation Monitoring Checklist. The Facility recently had updated this form, which was now called the Individual Support Plan Meeting/Documentation Monitoring Checklist, dated 6/12. The modifications to the form were made to correspond with the revised ISP process, and to focus on pre-meeting activities, the ISP meeting, the ISP document, and QDDP activities after implementation begins. Based on a review of the document, it included many important questions/probes that should be helpful in identifying areas of best practice, as well as areas requiring improvement. The only caution would be that those implementing the form consistently look for quality. This will be important for some of the questions that are worded: "Did the team… (e.g., discuss action plans or integrated health plans, or review and approve the psychiatric treatment plan). It would be possible to answer these questions "yes" or "no" without evaluating the quality of the discussion or reviews, which would result in limited valuable information. The Facility intended to begin use of this form in July 2012; and o The Settlement Agreement Cross Referenced with ICF/MR Standards Section F: Integrated Protections, Services, Treatments and Supports audit tool. A Program Compliance Monitor from the QA Department, as well as the QDDP Coordinator were conducting the reviews. Based on the documents provided, QA Department and QDDP Coordinator were using both of the audit tools listed above. Facility staff responsible for these audits appeared to be making efforts to conduct thorough and critical reviews, and provide justification for both negative and positive findings. Areas in which improvements should continue to be made in order to achieve compliance, included: ▪ The Facility's policy F.10 was entitled Quality Assurance for ISP Process, and had an implementation date of 11/1/11. 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. ▪ For the various monitoring/audit tools, inter-rater reliability needed to be established with the QA and programmatic staff (i.e., QDDP 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, and efforts were being made to improve the validity and reliability of the findings. Some of these activities included attending the same meetings and comparing findings, meeting monthly to discuss monitoring results, and beginning the	

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		process of developing detailed instructions for the tools. The addition of instructions/guidelines will be essential to improve the accuracy of the monitoring results (validity), as well as the congruence between various auditors (reliability). ▪ In response to a request for reports showing analysis of monitoring/audit data, as well as descriptions of actions taken or corrective action plans developed, the Facility submitted the following statement: "No Evidence." 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 action plans that were submitted for Section F appeared to be based largely on recommendations from the Monitoring Team's reports. Although this is a positive first step, over time, the Facility's data should be used to identify areas in which change is needed. In its self-assessment the Facility recognized that it remained out of compliance with this provision, which was consistent with the Monitoring Team's findings.	

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

1. As appropriate, the Facility should refine facility-specific policies and procedures to assist in ensuring full and consistent implementation of the State policy on the Individual Support Plan process. (Section F.1)
2. As necessary and appropriate, as the QDDP Coordinator completes competency checks for all QDDPs, QDDPs should be provided with additional technical assistance or training on group facilitation, particularly as is relates to the interdisciplinary team process. (Section F.1.a)
3. As teams move forward with the implementation of the new ISP Preparation meetings, teams should provide an explanation of their decisions related to team member attendance at the annual ISP meetings, particularly when an individual has a need in a specific area, and the team decides that the attendance of the team member with that area of expertise is not required. Such decisions should take into consideration the Settlement Agreement requirement that: "Other persons who participate in IDT meetings shall be dictated by the individual's preferences and needs." Although this is an issue that should be carefully coordinated with the State Office, now that risk levels are being established for individuals, this might be one mechanism that teams could use to determine which team members should attend an individual's annual planning meeting. (Section F.1.b)
4. Assessments should include a full set of recommendations that are designed to assist the teams in developing action plans that describe the array of protections, supports and services that the individual requires. As appropriate, assessments should recommend specific areas of focus for skill acquisition programs, as well as detail data that needs to be collected and roles and responsibilities of various staff. (Section F.1.c)
5. Now that the ISP process includes an annual review of incidents, and A/N/E allegations, teams should adequately consider how to address whatever themes might be revealed, as an addition to reviewing new allegations or incidents as they arise. (Section F.1.c)
6. 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' ISPs. This should include ensuring that assessments consistently and concisely identify individuals' strengths, needs, and preferences. (Section F.1.c)
7. 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)

8. The ISP Preparation Meeting documentation should include space for a justification, which teams should complete, particularly when they are not requiring completion of an assessment for which the individual has specific needs. (Section F.1.c)
9. 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 ISPs, 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)
10. IDTs should integrate the recommendations from assessments into ISPs, not just reference them, and make the health care, therapeutic, and behavior support plans a part of the ISP, rather than stand-alone documents. The IDT should review and approve all related plans, and the specific plan that has been approved should be referenced in the ISP, including the title and date of the plan. The team should approve any modifications of the approved plans through an ISPA. IDTs also should include a set of objectives in the ISP related to each of the plans, including, but not limited to the expected outcomes for the plans, any related skill acquisition plans, as well as defining what supports need to be implemented, who is responsible, how success will be measured, who is responsible for data collection, as well as who is responsible for monitoring and/or data review. (Sections F.1.d, F.2.a.2, and F.2.a.3)
11. 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)
12. 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' ISPs should identify these clearly, if they are barriers to providing the individual with adequate supports and services. (Section F.2.a.1)
13. IDTs 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)
14. 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)
15. ISPs should delineate clearly: 1) persons responsible for data collection; and b) persons responsible for data review. (Section F.2.a.6)
16. Given the responsibilities that direct support professionals have in implementing the plans, efforts need to be made to ensure that ISPs and all of their various components are comprehensible, while still containing the necessary clinical requirements, and that they clearly delineate the roles of direct support professionals. (Section F.2.c)
17. As the Facility finalizes its monthly review process, it should ensure that the following basic requirements are met:
    a. It includes a process for each team member to conduct monthly reviews of the programs which he/she is responsible that results in easy access for all team members to the information;
    b. Monthly reviews should incorporate data, as appropriate, to allow the QDDP and the team to assess the efficacy of the plans and programs in place, and determine if changes are needed, staff need to be retrained, more monitoring needs to occur, etc.; and
    c. QDDPs should document clearly follow-up activity and/or changes that are made to ISPs as a result of these reviews. (Section F.2.d)
18. As the facilitation skills performance tool evolves:
    a. The criteria used to make decisions regarding whether to rate an indicator "yes," "needs work," or "N/A" should be clarified.
    b. Guidelines should be provided as necessary to support reviewers' understanding of the indicators.

c. Two areas related to quality that should be added to the checklist include the QDDP's ability to: solicit discussion of the individual's comprehensive set of strengths, preferences, needs, and supports; and facilitate the adequate integration of the various disciplines to problem-solve, where appropriate. (Section F.2.e)

19. QDDPs should be required to demonstrate competence in both meeting facilitation, and the development of an appropriate ISP 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)
20. Ongoing training and technical assistance should be provided to address gaps in knowledge regarding the new ISP process, as well as to enhance the various team members' skills. (Section F.2.e)
21. Consideration should be given to adding examples of ISPs that are well done, while protecting the identity of the individual, to the training manual to assist in teaching QDDPs and teams what is expected. (Section F.2.e)
22. With regard to the process of determining whether or not QDDPs are competent with regard to meeting facilitation skills, Facility policy and/or procedure should set forth the parameters with regard to actions that will be taken to assist QDDPs who do not originally meet the competency requirements, as well as other steps that would need to be taken if competency could not be achieved. (Section F.2.e)
23. The Facility's QA processes with regard to ISPs 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 QDDP Coordinator, and the QA/QI Council), analyzing data, and developing and implementing corrective action plans, as appropriate. (Facility Self-Assessment and Section F.2.g)

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section G, including: Integrated Clinical Services Meeting – Attendance summary for January 2012 through May 2012; Section G Monitoring Tools; Completion of Assessments by Discipline (January 2012 through May 2012); Rosters: annual medical assessments/dental/nursing/psychology in Client's Information Record (CIR) by deadline January 2012 through June 2012; consult review tracking March to May 2012; hospital discharge ISPAs/ Infirmary ISPAs tracking February to June 2012; ISP Attendance – All meeting types 3/1/12 to 4/12/12, 4/1/12 to 4/30/12, 5/1/12 to 5/25/12, 5/29/12 to 6/14/12; Skin integrity meeting attendance; Integrated Clinical Services Report as of 6/28/12; Integrated Clinical Services G.5: Diagnostics, Appointments and Consults Tracking draft, revision 1/27/12; Diagnostics Review Tracking March to May 2012; and Chart Audit Report and Trend Analysis for 3/12, and 4/12; o For hospitalizations in prior six months, copies of follow-up ISPAs: Individual #186 on 2/29/12; Individual #126 on 3/15/12, 4/18/12, and 5/17/12; Individual #223 on 1/2/12; Individual #244 on 3/26/12, 3/28/12, and 4/5/12; Individual #137 on 4/20/12, and 4/24/12; Individual #167 on 1/20/12, 5/9/12; Individual #213 on 2/21/12; Individual #275 on 3/27/12; Individual #273 on 4/11/12, 5/7/12; Individual #21 on 4/18/12; Individual #89 on 1/9/12, 1/23/12; Individual #176 on 4/19/12 (edited 4/25/12); Individual #304 on 4/24/12; Individual #174 on 2/27/12; Individual #124 on 3/30/12; Individual #326 on 1/18/12; Individual #268 on 3/15/12; Individual #224 on 5/8/12, and 5/17/12; Individual #150 on 1/10/12, and 1/17/12; Individual #282 on 3/26/12; Individual #270 on 4/17/12, and 4/23/12; Individual #239 on 2/15/12, and 2/22/12; Individual #175 on 3/22/12, 4/25/12; Individual #367 on 4/3/12; Individual #130 on 4/6/12; Individual #163 on 2/16/12; Individual #87 on 3/26/12; Individual #181 on 4/23/12; Individual #293 on 2/24/12, 2/27/12, and 2/29/12; Individual #166 on 4/9/12; Individual #308 on 2/10/12; Individual #316 on 2/17/12, 2/21/12, and 3/16/12; Individual #195 on 3/26/12, 4/12/12; and Individual #156 on 5/15/12; o For one individual from each residence, since the Monitoring Team's last review, copies of all consultant reports (medicine and surgery, inclusive of subspecialties), and all integrated progress notes commenting on consultant reports (medicine and surgery, inclusive of subspecialties) (agreeing or reason not agreeing), and any ISP addendum related to the consultant report: for Individual #58, neurology consult 12/10/11, ophthalmology consult 12/9/11, neurology consult 2/4/12, radiology report 3/21/12, and pulmonary consult 4/3/12; for Individual #325, urology consult 3/22/12; for Individual #298, radiology report 3/20/12; for Individual #213, nephrology consult 2/24/12, urology consult 3/28/12, urology consult 4/23/12, and neurology consult 4/22/12; for Individual #355, cardiology consult 3/22/12, neurology consult 3/31/12,

	podiatry consult 4/3/12, diagnostic report 4/24/12, diagnostic report 4/28/12, and diagnostic report 3/22/12; for Individual #326, ophthalmology consult 2/15/12, pulmonary consult 2/21/12, and radiology report 4/2/12; for Individual #53, ophthalmology consult 2/27/12; for Individual #269, neurology consult 2/4/12, cardiology consult 2/22/12, ophthalmology consult 4/6/12, and pulmonary consult 4/24/12; for Individual #291, ophthalmology consult 1/13/12, cardiology consult 4/17/17, and radiology report 4/23/12; for Individual #240, gastroenterology report 4/24/112; for Individual #187, endocrinology consult 3/6/12, nephrology consult 3/20/12, and cardiology consult 4/24/12; and for Individual #69, Ear Nose Throat (ENT) consult 1/31/12, and ophthalmology consult 3/22/12. ▪ **Interviews with**: o Eugenio Hernandez, MD; o Sandra Rodrigues, MD; and o Althea Pat Stewart, RN, Medical Compliance Nurse.
	Facility Self-Assessment: According to CCSSLC's Self-Assessment, the Facility began to measure integration of clinical services, including collection of data. For example, attendance signature sheets were obtained and reviewed to determine which clinical departments attended the Integrated Clinical Services Meeting. Post hospital ISPAs were reviewed, and found incomplete, not focusing on the reason for the hospitalization. The Facility assessed whether or not health concerns were resolved by the morning clinical meeting's assigned deadlines. A number of other audits were conducted to determine whether appropriate disciplines reviewed the Monitoring of Side Effect Scale (MOSES)/ Dyskinesia Identification System: Condensed User Scale (DISCUS), Quarterly Drug Regimen Reviews (QDRRs), and Do Not Resuscitate Orders (DNRs). The active record was reviewed to determine if diagnoses and allergies were consistently documented across documents and assessments. The Facility also assessed whether disciplines were completing assessments for ISPs by 10 days prior to the ISP. These were all appropriate measures to assist the Facility in determining whether or not integrated clinical services were occurring at CCSSLC. However, the Facility's Self-Assessment should include a description of the samples selected (e.g., how many ISPA were reviewed in comparison with how many had been completed, from what time period, etc.), who conducted the reviews (e.g., department staff, QI staff), and other data sources used (e.g., database or review methodology used to determine timeliness of assessments). For Section G.2, the Facility used the Section G Monitoring Tools and reviewed five percent of the consultations/appointments that occurred each month to determine whether or not follow-up had occurred of non-facility clinician recommendations, whether the primary care practitioner (PCP) processed consults within five business days, and if the IDTs were reviewing these documents. The Facility's review also included other data concerning consult review from the external peer review and internal medical provider audits. These were also appropriate areas to review for Section G.2, and would seem to have the potential to provide a practical impact. Overall, although the areas being monitored were appropriate, the Facility should expand the scope of information monitored to include all the departments listed in Section G.1, and not focus simply on the

	Medical Department. Compliance with integrated clinical services requires monitoring of all clinical services. The role of the QA Department should be significant in monitoring the many other departments included in Section G.1, but at the time of the review, it did not appear that this had begun to occur. As the quality and oversight of the ISPA process was of concern with regard to individuals' healthcare, the Facility should review methods of measurement to track the quality of the ISPA process. This is also closely connected to the development of the at-risk process as discussed with regard to Section I. Based on these data sets, the Facility determined it was not compliant with this section. This was consistent with the Monitoring Team's findings. However, it was unclear if this information had been shared with the Acting Medical Director, or the other departments.
	Summary of Monitor's Assessment: As noted above, the Facility had begun assessing itself in areas such as attendance, quality of ISPAs related to medical issues, and consult review. These were important areas. It remained unclear how this valuable information was shared with the Medical Department staff or other departments. The role of the Medical Director is important in providing guidance in this medical administrative area, and the continued lack of a Medical Director was problematic. Medical department staff meetings should be formalized. Periodic/quarterly meetings would be appropriate forums to discuss topics and in-service information specific to medical staff. For topics that generalize to other departments, the Integrated Clinical Services Meeting might be appropriate. The Facility had a number of forums in which integrated services could be facilitated, including, for example, the daily Integrated Clinical Services Meeting, ISP and ISPA meetings, and cross-discipline committees. However, many of these lacked the full participation of members, or did not result in adequate follow-through to develop integrated, interdisciplinary plans to address individuals' needs on either an individual or systemic level. Improvements had been made in PCPs reviewing consultation reports in a timely manner. Although more work was needed, PCPs also were more often documenting their agreement or not with recommendations. However, where additional work remained was in ensuring that IDTs met and developed ISPAs, as appropriate.

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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	The Morning Medical Meeting was renamed as the Integrated Clinical Services Meeting. Attendance was tracked to determine the degree of representation from clinical departments. The Medical Department submitted a table entitled "Attendance Summary for January 2012 through May 2012." Attendance was documented through a signature sheet for each morning meeting. Attendance was tracked for dental, habilitation therapy, nursing, medical, pharmacy, psychiatry, and psychology. From February through May 2012, the Dental Department was represented 90 to 100% of the time. During this same time period, for Habilitation Therapy, attendance was 43 to 70%. For the most recent	Noncompliance

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	therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	month of May 2012, attendance was 50%. For nursing, from February through May 2012, attendance was 95 to 100%. For the Medical Department, attendance from February through May 2012, attendance was 100%. For the Pharmacy Department, attendance from February through May 2012 was 73 to 86%. For the most recent month of May 2012, attendance was 73%. For psychiatry, attendance from February through May 2012 varied from one to 25%. For the most recent month of May 2012, attendance was one percent. For the Psychology Department, attendance from February through May 2012 varied from 45 to 60%. For the most recent month of May 2012, attendance was 45%. It is recommended that analysis of departmental attendance continue, and be distributed quarterly. Additionally, attendance by other clinical departments is recommended, such as regular attendance from the Physical and Nutritional Management Team (PNMT). Some departments should be represented periodically, such as dietary, and data should also reflect their participation. The quality of the activities of the Integrated Clinical Services Meetings is discussed with regard to Section L.1. Integrated clinical services also were reflected in IDT discussions, ISPAs, and changes in risk plans. This was measured by the Medical Department through the Section H Tool. For those individuals hospitalized or placed in the Infirmary, the Medical Department tracked the completion of an ISPA. Based on the Facility's data, this occurred 100% of the time. However, according to the Facility's Self-Assessment, the ISPAs did not adequately address ways to prevent a recurrence. This would appear to indicate several health concerns were not tracked to completion. If an ISPA did not address the concern, or did not include steps to prevent a recurrence, then it would appear that the health concerns identified during the morning medical meeting were not tracked to completion of the concern, but rather to receipt of an ISPA without regard for the quality of the ISPA. An important focus of an ISPA for a health concern is identification of preventive steps that are clearly defined in the action plan, and clearly answer the concern raised in the morning medical meeting. The available data did not reflect in summary form (similar to the Integrated Clinical Services Committee Meeting), those who attended the IDT meeting to develop the ISPA. ISPAs were reviewed for individuals returned from hospitalizations in the prior six months. In most ISPAs, no evidence was found that the IDT discussed or developed clear action plans to attempt to prevent another hospitalization, Emergency Room (ER) visit, or Infirmary admission, nor was there evidence of discussion of precipitating events (i.e., a review of preceding events, signs, and symptoms might be important). Examples of inadequate ISPAs included the ISPA for: Individual #186 hospitalized on 2/29/12 for pneumonia; Individual #126 hospitalized on 5/17/12 for dehydration (for which post hospital orders were changed) and pneumonia; Individual #223 hospitalized on 1/2/12 for pneumonia; Individual #275 hospitalized on 3/27/12 for colitis and fecal impaction; Individual #273 hospitalized on 5/7/12 and 4/11/12 for pneumonia; Individual #176	

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		hospitalized on 4/19/12 for pneumonia and sepsis; Individual #270 hospitalized on 4/23/12 for pneumonia; Individual #239 hospitalized on 2/15/12 for pneumonia; and Individual #87 placed in Infirmary on 3/26/12 for pneumonia. These findings are similar to the data by Medical Department collected showing that the ISPAs generally were not addressing prevention of acute illness. Although it was positive that the Medical Department was monitoring the ISPAs that resulted from recommendations at the morning medical meeting, others needed to be involved in the process. There is an urgent need for the QA Department and QDDP Department to review the quality of the ISPA process to ensure concerns from the medical morning meeting are addressed, and preventive steps are considered for those hospitalized or those that had an ER visit/Infirmary admission. Although the new at-risk process might assist with this process, especially in relation to health status changes, at present, the ISPAs were not addressing the needs of the individual in several instances. It also did not appear the morning medical team critically reviewed all post-hospital ISPAs for content of action steps concerning prevention, as many ISPAs without prevention steps were not returned to the IDT for further discussion and plan implementation. There was limited information concerning ISP attendance, which included "all meeting types." Time periods submitted overlapped and included 3/1/12 to 4/12/12, 4/1/12 to 4/30/12, 5/1/12 to 5/25/12, and 5/29/12 to 6/14/12. Based on the data the Facility submitted, attendance appeared to be 100% at required meetings for most departments. However, no data was attached to verify the many departments that attended 100% of all required meetings. It also was not clear the attendance requirements for various types of IDT meetings. In addition, this also was not consistent with the Monitoring Team's findings in relation to Section F, which addresses the ISP process specifically. For verification of data, it would be important to separate the ISP attendance from the "all meeting types," and especially focus on the ISPAs generated as a response to hospitalizations, Infirmary admissions, and requests for follow-up from the morning medical team meeting. The Medical Department also tracked whether the Morning Medical Team Meeting/Integrated Clinical Services Meeting reviewed the ISPA once completed. Whether an ISPA was created was tracked, as well as whether the Morning Medical Team reviewed the ISPA. Based on this data the Facility submitted, the IDTs' compliance with ISPA creation was 75% in January 2012, 100% in February 2012, 92% in March 2012, and 93% in April 2012. According to the data, review of the ISPA in the morning medical team review was 100% for all months from February through April 2012. Similar data was collected for the ISPA creation following an Infirmary admission, and the Morning Medical Team's follow-up review. Based on the Facility's data, the IDTs' compliance with ISPA creation was 83% in January 2012, 100% in February 2012, 100% in March 2012, 96% in April 2012, and 80% in May 2012. According to the data, the morning medical	

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		team's review was 100% in all months from January through May 2012. Again, as noted above, it did not appear the Integrated Clinical Services Meeting members' review of the quality of the ISPAs was adequate. The Section G Monitoring Tool also tracked interdisciplinary involvement in the use of clinical tools and clinical decisions. These included documentation of review by nursing staff, the PCP, neurologist, and psychiatry of the MOSES/DISCUS instruments, as appropriate; review of DNRs for rationale with updating from the PCP and IDT; medical/psychiatric diagnoses with a focus on consistency across disciplines; and the consistency of designated allergies throughout the active record and across departmental assessments. For March 2012, compliance in this area was 60%, and in April 2012 was 61%. Use of this overall compliance score was fairly meaningless. Without further information, the data did not assist the Facility in identifying which, if any, of these various activities had been implemented as it should have been and which required attention. In addition, inter-rater reliability for Section G.1 Monitoring Tool was 0% (only one record was reviewed). TAs noted previously, there also was a need for the QA Department's greater participation in this process. There were a number of interdisciplinary clinical committees for which integrated clinical collaboration would be essential. A Skin Integrity Meeting attendance roster was submitted for meetings in January 2012 and April 2012. Attendance included representation of key departments in January 2012, but not in April 2012. In April, habilitation services, medical services, and food services were not represented. Also as discussed with regard to Section H.1, timely completion of departmental annual assessments for the ISP process was tracked, with summary information available from January through May 2012. Based on the data the Facility submitted, for the Dental Department, compliance was 94 to 100%. For the Nursing Department, compliance varied from 50% (in February 2012) to 93% (in May 2012). For the Medical Department, compliance ranged from 93% in April 2012 to 7% in May 2012. For the Psychiatry Department, compliance ranged from 33% (January 2012) to 100% (in March 2012). For the Psychology Department, compliance ranged from 31% in February 2012 to 78% in May 2012. As background, the data submitted included lists of completed assessment dates. These documents were entitled: "Annual Medical Assessments in CIR (Client's Information Record) by Deadline January 2012 through June 2012," "Dental Assessments in CIR by Deadline January 2012 through June 2012," "Nursing Assessment in CIR by Deadline January 2012 through June 2012," "Psychiatry Assessments in CIR by Deadline January 2012 through June 2012," and "Psychology Annual Assessments in CIR by Deadline January 2012 through June 2012." As is discussed in further detail with regard to Section F, the lack of timeliness of many assessments, as well as issues related to their quality continued to interfere with teams' ability to develop adequate annual	

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		ISPs for individuals. The Facility submitted an un-named series of tables, dated weekly, beginning 6/7/12, that included the dates of the various departmental annual assessments in preparation for the ISP of a number of meetings scheduled for 6/18/12 to 7/18/12. In the future, the assessments for which other clinical departments are responsible should be tracked similar those currently being monitored. For assessments that might be due at less frequent intervals than yearly (such as audiology), this information also should be taken into consideration in computing timeliness of the departmental assessments. This data provided a different perspective of when assessments were completed, in that it recorded if they were received in a timely manner by the ISP due date. It might have reflected delays in data input as well as delays in completion of assessments. However, the different databases indicated a need for a thorough QA review of how the information is generated, and should include an interpretation of the quality of the data generated. In summary, although the Facility was engaging in some activities that facilitated the integration of care and had begun to collect data in this regarding, all clinical departments are essential in providing integrated clinical care, and each clinical department should provide evidence of their participation in and impact on integrated care. This should include development of measurable indicators for each department that reflect the integration of care across the campus. The role of the IDT is essential, and measuring the quality of the ISP document and the discussion at the IDT meetings would provide evidence related to the quality of integrated services. Also, there is considerable potential to demonstrate integrated clinical care in the risk rating process, including the quality of the Integrated Risk Discussion Results, the Risk action plans, the implementation steps taken, and the outcomes. This could be tracked for stable conditions as well as changes in health status. At the time of the Monitoring Team's visit, no data was available to measure many of these components that demonstrate integrated clinical care.	
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	The Facility submitted consultant reports for one individual from each residence, as well as any Integrated Progress Notes (IPNs) commenting on the consultant reports. Consultations for 12 individuals were submitted, with a range of one to six consultations per individual. A total of 34 consultant reports were submitted. These are listed above in the documents reviewed section. Review of these documents revealed the following: ▪ Of the 34 reviewed, 33 (97%) included the PCP initials, indicating review by the PCP. ▪ Of the 34 reviewed, 33 (97%) included the date on which the PCP conducted the review, indicating timeliness of review.	Noncompliance

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	refer the recommendations to the IDT for integration with existing supports and services.	▪ To determine whether there was agreement or not concerning consultant recommendations, follow-up IPNs and ISPAs were requested. When submitted, these were reviewed. Of the 34 reviewed, there were five for which an agreement or non-agreement was not indicated (an informational report). This left 29 consultations for which agreement or non-agreement was indicated. o A total of 23 out of 29 (79%) consults included documentation of agreement or not with the consultant recommendations. ▪ Of the total of 34 reviewed, 24 (71%) included PCP IPN entries. ▪ Of these 34, there were two consultant reports for which an ISPA was not indicated. For the 32 consultant reports for which an ISPA was indicated, one out of 32 (3%) ISPAs documented the discussion of the contents of the consultant reports, and the PCP's recommendation. The IDT submitted a roster of signatures indicating an IDT review of the consultant report in six out of 34 (18%). However, for these, it could not be determined specifically what the IDT discussed and/or decided. There were a number of other ISPAs submitted, but the contents concerned issues unrelated to the consult and the IDT follow-up of the consult, and the reason for submitting ISPAs that did not address the specific consults was unclear. Additionally, there were several measurement probes in the Section G Monitoring Tool, which focused on Section G.2. One of the probes was whether the "appropriate clinician reviews and dates recommendations from non-facility consultants" within five business days. For both March and April of 2012, compliance was 100%. However, the IDT reviewed only 25% of these consult reports. The Medical Department conducted a more thorough review of PCP review of non-facility consultant reports through review of detailed tracking data. For January 2012, there was a listing of one page. For February 2012, there was a listing of five pages. For March 2012, there was a listing of six pages of consultant reports. For April, the listing was eight pages. For May 2012, the listing was five pages. The analysis indicated that in January 2012 the PCPs reviewed 87.5% of consult reports within five days of receipt, 82% in February 2012, 70% in March 2012, 89.7% in April 2012, and 98.5% in May 2012. The IDT reviewed 0.07% of the consult reports in March 2012, 43.1% in April 2012, and 46.2% in May 2012. There was no data for January 2012 or February 2012 for the IDT review of consult reports. This was valuable for guiding the Medical Department and the IDTs, but it was not clear if this was shared in a timely manner. To assist the PCP in acknowledging review of consult reports, a stamp was entered on each consult report received. It included the date of review by the PCP, the signature/initials of the PCP, whether there was agreement or not, verification of a PCP	

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		IPN completed, or whether the PCP was out of the office. Separately, information was available from the Medical Provider Quality Assurance Audit – External Audits for Round #5. From question #27 ("Are medical and/or surgical consultant recommendations addressed in the integrated progress notes within five business days after the consultation recommendations are received?"), results indicated 82% compliance. An "Internal Audit for Round #5" documented 86% compliance for the same indicator. There were other questions probed in the Section G.2 Monitoring Tool, including: "clinician documents in IPN decision whether or not to adopt recommendations," "clinician writes orders for adopted recommendations," "IDT informed of clinician's decision whether or not to adopt recommendations as evidenced by signed Consultant Recommendations Review," " signed consultant recommendations placed behind original consult in AR (Active Record)," and "adopted recommendations are integrated into new ISP/ISPA as indicated." Based on the Facility's data, for March 2012, compliance with these G.2 probes was 55%, and for April 2012 compliance was 61%. Inter-rater reliability was 50% (one record reviewed). There were policy updates as part of the systemic changes to improve integration of clinical care and documentation of this process. On 1/27/12, the Integrated Clinical Services Policy G.5: Diagnostics, Appointments, and Consults Tracking was revised. Some of the areas of change included pulling the active record for PCP review in the Clinic as soon as a report was received, new diagnoses were to result in a nursing care plan or health maintenance plan to address the diagnosis, an expedited process to update the DG 1 through the Medical Department, and an additional column in the log database for PCP review and date of review for lab and diagnostic test results. If this policy were to be consistently carried out, it would provide evidence to support compliance with several areas of the Settlement Agreement, including Sections G.2, H.2, L.1, L.3, as well as aspects of Sections I and M. Based on the Monitoring Team's review, improvements had been made in PCPs reviewing consultation reports in a timely manner. Although more work was needed, PCPs also were more often documenting their agreement or not with recommendations. However, where additional work remained was in ensuring that IDTs met and developed ISPAs, as appropriate. The Facility remained out of compliance with this provision.	

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

1. The analysis of departmental attendance at Integrated Clinical Services Meetings should be distributed quarterly to Facility Administration and

the departments being tracked, and used, as appropriate, to make needed changes. Additionally, attendance by other clinical departments and/or those not regularly attending is recommended and encouraged, such as PNMT or Habilitation Services and Dietary. (Section G.1)

2. An important focus of the ISPA for a health concern should be a determination of preventive steps that are clearly defined in the action plan. (Section G.1)
3. A system should be developed to review the quality of the ISPA to ensure it answers the concerns identified at the Integrated Clinical Services Meetings, and provides a preventive plan for hospitalizations, ER visits, etc. (Section G.1)
4. For ISPAs that focus on health and safety, departmental attendance at the ISPA meeting should be tracked and analyzed. This should be tracked separately than for other meetings, such as ISPs or ISPAs for other reasons. (Section G.1)
5. The QA Department should increase its monitoring role for Section G. (Section G.1)
6. Timely completion of annual assessments or periodic assessments (if less frequent than annual) should be tracked for all clinical departments. (Section G.1)
7. The Integrated Clinical Services Report should be completed quarterly for distribution and discussion at a medical staff meeting, as well as forwarded to the QA Department and Facility Administration for review and action, as appropriate. (Section G.2)
8. The Facility's Self-Assessment should include a description of the samples selected (e.g., how many ISPA were reviewed in comparison with how many had been completed, from what time period, etc.), who conducted the reviews (e.g., department staff, QI staff), and other data sources used (e.g., database or review methodology used to determine timeliness of assessments). (Facility Self-Assessment)
9. The Facility should expand the scope of information monitored to include all the departments listed in Section G.1, and not focus simply on the Medical Department. (Facility Self-Assessment)

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section H: Texas ICD-10 Site Visit Agenda; Common Diagnosis Medicare Coding Guide, revised 4/1/03; Clinical Indicator Guide for at-risk categories; hospital documents listing January to March 2012; ER documents Jan to April 2012; Section H Monitoring Tool; Completion of Assessments by Discipline January 2012 to April 2012; annual assessments in CIR by deadline January to June 2012: medical, nursing, psychiatry, psychology; Quality Assurance Questionnaire: ER visits/hospitalizations; Hospitalization QA December 2011 to May 2012; constipation tracking, diets, reason/criteria for DNR, Down's syndrome tracking, mammogram tracking, osteoporosis tracking, tracheostomy tracking, seizure tracking, consult review tracking, diagnostics review tracking; QA/QI Quarterly Section review of Settlement Agreement Progress - Section H, 3/21/12, 6/28/12; and Integrated Clinical Services Report as of 6/28/12; o For two individuals from each PCP's caseload, four diagnoses with criteria for justification from active record, including: Individual #255, Individual #137, Individual #55, Individual #93, Individual #250, Individual #357, Individual #187, and Individual #156; and o "Individuals with ISPs scheduled between 5/1/12 and 6/30/12 - Assessment Compliance." ▪ **Interviews with**: o Norma Brown, MD; o Sandra Rodrigues, MD; and o Althea Pat Stewart, Medical Compliance Nurse.
	Facility Self-Assessment: In its Self-Assessment, the Facility had identified a number of appropriate activities to monitor its compliance with Section H. For example, for Section H.1, the Facility reviewed routine assessments of clinical departments to determine if these were completed in a timely manner (annual). Dental, nursing, medical and psychiatry departments were reviewed. The sample included one active record from each of the PCPs' caseloads each month. Also, the Facility reviewed the quarterly data related to MOSES/DISCUS, QDRRs, as well as DNRs, and quarterly reviews by the medical, nursing, and psychiatry departments. Data related to the review of the MOSES/DISCUS, DNRs, and QDRRs were summarized as one value, despite the different departments involved in these documents, and the potentially different indicators that would need to be measured for each of these processes (e.g., timeliness of completion, timeliness of review by clinical staff, quality of review and documentation, etc.). No data was provided concerning the quarterly assessments the clinical departments completed. Although it was positive that the Facility had identified additional self-assessment activities for Section H and many of these had merit, the process required further refinement. For example, for Section H.2, the Facility assessed for training on diagnostic codes, and concluded that the training had not occurred. It had not yet conducted record reviews as the Monitoring Team was doing to determine if adequate justification

	existed for the diagnoses of record. The Monitoring Team found compliance for Section H.2, but the Facility did not. In other instances, it was unclear what criteria reviewers were using to determine compliance. For example, when determining whether treatments were "clinically appropriate," it was unclear if the clinical guidelines State Office had issued were used. In still other instances, it did not appear that what the Facility was measuring related directly to the requirements of the Settlement Agreement. For example, for Section H.4, which requires that: "clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner," none of the indicators appeared to relate to clinical indicators (i.e., measurable objectives). The Facility identified that it was not in substantial compliance with any of the subsections of Section H. However, more work was needed to refine the Facility's Self-Assessment processes. The Quality Assurance Department should work with Department staff to finalize monitoring tools as well as key indicator measures, and to establish reliable and valid data collection methodologies.
	Summary of Monitor's Assessment: Although CCSSLC was putting some systems in place to ensure that assessments and evaluations were completed timely, the systems continued to be in the development stage. In addition, the various databases collecting this information differed somewhat in the results related to timeliness of assessments. This might be due to the fact that the databases were being used for different purposes (e.g., annual ISP assessments as opposed to comparison to the date of the previous assessment). Change of status also was an area the Facility was trying to better define. With regard to accurate diagnoses, reviews the Monitoring Team completed of both medical diagnoses and psychiatric diagnoses found adequate justification for 100% and 95%, respectively. As a result, the Facility was found in compliance with this provision. Teams were not consistently identifying clinical indicators to measure the efficacy of treatment interventions for individuals at risk. Problems with the indicators included, at times, a lack of measurability. The quality of the indicators also was problematic in terms of telling the individuals' teams whether or not the individuals were doing better or worse, or remaining the same. Finally, individuals' teams often did not develop measurable indicators to address all of the individuals' areas of risk. Although the Facility had developed some At Risk Clinical Indicators Guidelines, these were not yet fully in use. The Facility still did not have an adequate system to effectively monitor the health status of individuals. As one example, as discussed with regard to Section M, although quarterly nursing assessments were being completed, they were inadequate. In addition, day-to-day nursing assessments were not adequate to ensure that changes in individuals' status were promptly identified and reported to the PCPs.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	The Medical Department monitored the completion of routine assessments to determine timeliness of completion. Five departments were reviewed: dental, nursing, medical, psychiatry, and psychology. Review involved determining the number of assessments due per month. Data from January through April 2012 were provided. Based on the Facility's data, the Dental Department was consistently compliant from January 2012 through April 2012, with a compliance rate of timely submission of assessments in 94 to 100% of cases. According to the data, the Nursing Department improved over the four months in submission of completed annual assessments. In January 2012, nursing had completed 67% of annual assessments in a timely manner, which dropped to 50% in February 2012, increased to 86% in March 2012, and increased further to 91% in April 2012. Based on the Facility's data, the Medical Department had a similar compliance curve as nursing. In January 2012, 67% of annual medical assessments were completed in a timely manner, which dropped to 56% in February 2012, increased to 84% in March 2012, and increased further to 93% in April 2012. Psychiatry was 33% compliant with timely completion of annual assessments in January 2012. This increased to 75% in February 2012, and 100% in March 2012, but decreased to 81% in April 2012. Psychology was 42% compliant with timely completion of annual assessments in January 2012, 31% compliant in February 2012, 45% compliant in March 2012, and 44% compliant in April 2012. The Monitoring Team did not confirm this data. However, as discussed below, although for different time periods, some of this data did not show similar improvements. A computerized list was submitted separate from the Medical Department review. Information requested included dates of ISPs for the past two months, along with dates of the assessments by the various departments. A chart was submitted entitled "Individuals with ISPs scheduled between 5/1/12 and 6/3/12 – Assessment Compliance." It was noted that for two departments, there were significant documents not received, or at least not noted in the database as being received. There were 52 annual ISP meetings scheduled. For the Medical Department, there was a record of only six updated assessments (12%) being received. For dietary, only nine (17%) assessments had been received. It is recommended that the list of annual assessments being tracked be expanded to include other clinical departments such as dietary and habilitation therapy. Separately, Question #17 of the Medical Provider Quality Assurance Audit provided another approach to review the appropriateness of assessments and evaluations: "Are medically appropriate diagnostic tests and/or therapeutic procedures ordered?" From the Internal Audit of Round 5, there was 100% compliance with this aspect of care in the charts reviewed.	Noncompliance

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		The Medical Department also developed databases for various diagnoses. These reflected preventive testing done at regular intervals, as well as treatments (e.g., diet, medication) to prevent adverse events (e.g., choking, acute constipation, etc.). The Medical Department submitted the following charts as examples of these: Constipation track (individuals with routine medication to prevent constipation), individuals requiring diets with special textures or fluid thickening, individuals with DNR status (date of last review, reason for DNR status), Down's syndrome track (individuals and date of last thyroid testing), mammogram track (individuals and date of last mammogram with reasons if not completed), osteoporosis tracking (individuals with osteoporosis/osteopenia, date of last DEXA scan, T score, treatment), individuals with tracheostomy, seizure track (individuals with seizure type and medications prescribed), hospital history and physical and hospital discharge summaries received and located in the active record, and discharge orders from the ER located in the active record. These many databases were of mixed completeness. The data on mammograms, seizures, and tracheostomies appeared to be complete and up-to-date. The data on osteoporosis had significantly improved in completeness of data, but still lacked complete information concerning parenteral bisphosphonate use. As a result, not all databases were adequate in guiding the PCPs and Medical Department. It was not clear when these databases were reviewed, and the mode of communication used to disseminate any analysis of the data, such as quarterly reports, medical staff meetings, etc. Section H.1 includes all elements of clinical care. As is discussed in the various sections of this report, issues remained with both the timeliness, and particularly the quality of assessments and evaluations. The QA Department should ensure each clinical department measures progress in the timely completion of required monthly, quarterly or annual assessments and forms. Attendance should be tracked at interdisciplinary meetings. Other clinical indicators of integrated care of these common elements should be developed. The clinical guidelines might assist in developing a blueprint for evaluation. For example, for a given diagnosis, there should be evidence that the needed disciplines provided assessments, that the team discussed these evaluations, and that the essential elements for care for that diagnosis were included in a corrective action plan. The corrective action plan should be monitored until closure. As indicated, this should include psychology, psychiatry, medical, dental, nursing, habilitation therapies, dietary, and pharmacy. Although CCSSLC was putting some systems in place to ensure that assessments and evaluations were completed timely, the systems continued to be in the development stage. In addition, the various databases collecting this information differed somewhat in the results related to timeliness of assessments. This might be due to the fact that the	

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		databases were being used for different purposes (e.g., annual ISP assessments as opposed to comparison to the date of the previous assessment). Change of status also was an area the Facility was trying to better define. In addition to reconciling the data, the Facility should use the data that was being produced to identify areas of concern in relation to assessments. The Facility remained out of compliance with this provision of the Settlement Agreement.	
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.	A sample of diagnoses listed in individual's active problem lists was submitted. The sample was derived from two active records from each PCP's caseload, for individuals for whom annual medical assessments were most recently completed. The PCPs were asked to provide the criteria or evidence used to show the diagnoses clinically fit the information in the corresponding assessments or evaluations for four diagnoses from each active record. Evidence was provided through various sources (e.g., consultant reports, test reports, etc.). For 32 of 32 diagnoses submitted with supportive documentation (100%), the criteria listed were consistent with the diagnosis listed. As discussed in detail with regard to Sections J.2 and J.6, based on the sample reviewed for Section J, there was adequate clinical justification for the diagnosis of record for 19 of the 20 individuals (95%). With the completion of Comprehensive Psychiatric Evaluations according to the requirements of the Settlement Agreement and ongoing quarterly updates for everyone prescribed psychotropic medication, the Facility had significantly improved in its diagnostic practices related to psychiatric disorders. An 11-page list of common diagnoses utilized at CCSSLC was submitted along with the current ICD-9 codes, which was used to assist the PCPs in determining the most accurate and detailed diagnosis reflected in the IDC-9 codes. However, according to the PCPs, when reviewing the ICD-9 options and selecting the most appropriate and detailed terminology, when this terminology and code was submitted for updating the DG 1, the software program utilized in the State Office system at times converted it to a terminology which was less specific or less accurate. It appeared the software converted the specific diagnosis provided by the PCPs to more general diagnostic categories, which potentially would lead to less accurate lists of diagnoses in the DG 1 database. Although this does not directly relate to compliance, it is recommended that the systems analyst communicate with the counterparts at the State Office to determine if the more specific diagnoses can be entered on the computerized DG 1. The systems analyst also should review the new software for the upcoming ICD 10 coding system to determine if the same problem will occur, or if the codes will maintain specificity and detail in categorizing the diagnosis.	Substantial Compliance
H3	Commencing within six months of the Effective Date hereof and with	The Facility had begun to review its performance with regard to timely and appropriate treatment and interventions. It chose acute and emergent care presumably because such	Noncompliance

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	full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	situations required high levels of performance to protect individuals from harm. In order to analyze various aspects of acute and emergent care, the Medical Department used "Acute Care/Emergent Care Monitoring Tool," revised 3/5/12. Subsections of this tool included: "Responding to acute illness/ injury," and "Hospitalization, Transfers, Readmissions" to measure acute care. "Responding to Acute Illness/Injury" included measurable steps from the direct support professional reporting an illness/injury to the nurse, to the nurse notifying the PCP, referral to the Clinic, documentation requirements in the IPN and in the Active Problem list, and updating Risk Action Plans. Sixteen measurable steps were identified. For March 2012, one active record from each PCP caseload was chosen. For two out of four (50%), it was noted that the nurse documented in the IPN in SOAP format and notified the PCP and IDT. The PCP updated the Active Problem List in one of three. The Risk Action Plan was not found in any of the four records. For the April 2012 review, the nurse notified the PCP within one hour of readmission to CCSSLC in three of four cases, the Active Problem List was updated in three of four cases, and the Risk Action Plan was updated in one of four cases. The "Hospitalization, Transfers, Readmissions" section included 17 measureable steps, such as specific updated documents in the transfer packet, the PCP or nurse telephoning the receiving facility, a nursing assessment completed upon return to CCSSLC, a PCP summary of hospitalization, and hospitalization information received once the individual was discharged. One record was reviewed from the caseload of each PCP. Based on the Facility's review, the transfer packet appeared to be generally updated and complete. Areas of concern included the hospital discharge summary not being placed in the active record, the ISPAs not describing steps to prevent a recurrence, and Integrated Risk Rating Form and Risk Action Plan not being updated. For April 2012, there was documentation that the PCP and/or nurse telephoned the receiving facility in only two out of four cases (50%). The same post hospital concerns as found in March 2012 continued to persist in April 2012 The Medical Department submitted data used in the monitoring process to determine whether the information packet sent to the receiving facility was complete. A list of all hospitalizations indicated whether there was compliance with the hospital packet. The hospital liaison nurse, while visiting the hospital, reviewed the packet of information that had been sent with the individual at the time of transport to the ER, and completed a form "ER visits/hospitalizations: QA questionnaire." Seven questions were included, such as whether the facility received a history and physical completed within the past year, whether the facility received pertinent progress notes, whether there was an active problem list, whether there was a list of current medications, diet, and treatments, etc. Compliance with the quality of the information packet sent to the hospital was broken down by month. For December 2011, compliance was 96%. For January 2012, compliance was 94%. For February 2012, compliance was 80%. For April 2012,	

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		compliance was 84%. For May 2012, compliance was 78%. For each of the seven questions, the involved departments should review if one particular document was commonly lacking in the packet, or whether most packets were complete at the hospital. However, the data reflected that packets did not arrive with all individuals. A review would assist the departments in improving and maintaining quality transfer of information. ISPAs were expected to be developed post hospital and post Infirmary visit. The purpose in part was to identify the cause, early warning signs, and steps to be taken to prevent a repeat admission. The Medical Department reviewed sample of active records monthly for each PCP. The results of the internal medical QA indicated that in 100% of hospitalizations/Infirmary admissions, ISPAs were written in March 2012 and April 2012. However, in 0% was there identification of steps taken to prevent a recurrence. The Medical Department used "Routine/Preventive Care Monitoring Tool," revised 3/5/12 to monitor this aspect of care. Subsections of this tool included: "Expectations" which reviewed quarterly assessments as well as post hospital and Infirmary assessments, "Physical Exam and Screening," as well as an extensive list of clinical categories which were reviewed if applicable to the individual. These included: "Management of Aspiration," "Management of anticoagulation therapy, "Management of Coronary Artery Disease/ Hyperlipidemia," "Management of Constipation," Management of Diabetes," "Management of Down's Syndrome," "Management of Fluid Imbalance," "Management of GERD." " Management of Hypothermia," "Management of Osteoporosis," "Management of Weight Gain/Loss," "Management of Psychiatric and Psychological Illnesses," " Antiepileptic Medication used as Psychotropic Medication," "Protocol Labs for Atypical Antipsychotics," "Protocol labs for Antipsychotics," "Management of Seizures," and " Protocol labs for Antiepileptic Medication." One active record from each PCP caseload was chosen per month for review. For March 2012, it was noted that none of the charts reviewed had quarterly medical reviews. One of three had vitamin D levels completed every six months. Overall evaluation of this area indicated compliance of 82%. For April 2012, compliance for this area of health care was 77.5%. However, it will be important to concentrate on specific results and questions rather than overall compliance scores in order to begin to use the information for systems improvement. Separately, Question #20 of the Medical Provider Quality Assurance Audit, Internal Audit for Round #5 addressed this concern as part of a larger medical quality audit: "Are abnormal diagnostic tests that needed interventions addressed by the provider with appropriate follow up documented in the integrated progress note?" The internal Medical Department audit indicated 100% compliance with this question. The question in the audit tool was broad and as an internal peer review appeared to provide evidence	

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		that the practice patterns of the PCPs were similar at CCSSLC. However, it did not provide specifics for any test or diagnosis, and could not be used for any comparison with a national guideline or specific standard. The Medical Management audit was diagnosis specific and began to review specific tests for measuring health and wellness. However, additional tools independent of the Management Audit should be developed. It is recommended that the medical staff meet to agree upon standards (e.g., derived from the State Office clinical protocols, national professional society recommendations, etc.). This would provide an opportunity for the PCPs to be involved in developing the system to be used in monitoring their practice patterns, and to guide those monitoring compliance with quality medical care.	
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 Medical Department measured processes of clinical care completion, including whether tests were reviewed by the PCP within 24 hours of receipt, the Risk Action Plans included measurable outcomes and specific clinical indicators, and the Risk Action Plans were reviewed quarterly and used clinical indicators to evaluate effectiveness. Based on the Facility's data, the PCP review of diagnostic tests within 24 hours of receipt was compliant in 513 out of 882 (58%) of records reviewed for March 2012. PCP review of diagnostic tests within 24 hours of receipt was compliant in 649 out of 728 (89%) in April 2012. PCP compliance with review of diagnostic tests within 24 hours of receipt was 535 out of 596 (90%) in May 2012. However, based on the Facility's data, Risk Action Plans were not written with measurable outcomes and were not reviewed quarterly/were not using clinical indicators to evaluate effectiveness in 75% of cases. As discussed in greater detail with regard to Sections I and F, this was a much higher rate of compliance than what the Monitoring Team found with regard to both the measurability of clinical indicators as well as their appropriateness. One of the challenges had been the identification of clinical indicators that could be readily measured. Recommendations include meeting with the medical staff, so they can assist in influencing the indicators by which their practices will be measured. The State Office might also assist, in part through the clinical guidelines. Review of recommendations from national professional organizations might also allow for adaptation of some of these recommendations to be reflected as clinical indicators for specific diagnoses. According to the QA/QI Quarterly Section Review of Settlement Agreement Progress Section H, dated 3/21/12, an At Risk Clinical Indicators Guidelines draft had been completed, and finalized. The Facility submitted a number of risks for which clinical indicators and/or alarm indicators were listed. Risks for which clinical indicators had been developed included: Blood thinner risk, cardiac disease risk (hypertension and	Noncompliance

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		hyperlipidemia), challenging behavior risks, circulatory disease risks, choking risk, enteral feeding risk, falls risk, fluid imbalance risk, hypothermia risk, GERD risk, fracture risk, infection risk, osteoporosis risk, poly-pharmacy risk, pneumonia risk, seizure risk, and skin integrity risk. However, a new process for Section I - At Risk, had been developed and was being piloted, which took priority over the campus-wide implementation of the At Risk Clinical Indicators Guidelines. The 6/28/12 QA/QI Quarterly Section Review of Settlement Agreement Progress for Section H also indicated there were challenges related to monitoring, including that diagnoses in each individual's assessments were not consistent across clinical disciplines, and allergies were not consistent throughout the active record. It is recommended that the discrepancies in assessments be resolved as a priority. It will be a challenge for any department to begin to track risks, if the risks are not clear in the documents that are the basis for action. As discussed in greater detail with regard to Section I.3, teams were not consistently identifying clinical indicators to measure the efficacy of treatment interventions for individuals at risk. Problems with the indicators included, at times, a lack of measurability. The quality of the indicators also was problematic in terms of telling the individuals' teams whether or not the individual was doing better or worse, or remaining the same. Finally, individuals' teams often did not develop measurable indicators address all of the individuals' areas of risk. Although the Facility had developed some At Risk Clinical Indicators Guidelines, these were not yet fully in use. As the Facility's self-assessment activities showed, the Monitoring Team found that the Facility remained out of compliance with this provision.	
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	The Facility had begun to develop a detailed system to follow health status change through the morning medical meeting. The group reviewed reports daily as a clinical interdisciplinary team, including the PCP on-call concerns, those admitted to the Infirmary, and those hospitalized. All of these major changes in health status appeared to be documented and discussed. A tracking system also was in place to monitor this health status change until resolution or stabilization. Concerns that required follow-up were assigned to the appropriate discipline, and were brought back to the committee for further discussion. When resolution occurred, this was documented as a brief entry in the minutes, along with the date of resolution. However, as discussed in greater detail with regard to Section L.1, the group continued to need to focus on what concerns needed to be followed and documented until closure, as well as the quality of the review process to closure, but the process was in place and appeared to be having significant practical impact in providing integrated quality care that monitored health status changes in all individuals.	Noncompliance

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		However, the Facility still did not have an adequate system to effectively monitor the health status of individuals. For example: ▪ Based on the Monitoring Team's review of medical record as described in detail with regard to Section L.1, two of 19 (11%) active medical records included any medical quarterly notes. None included more than one quarterly medical review for the entire year. ▪ As discussed with regard to Section I, the Facility remained in the process of developing an effective system to address the health status of individuals at risk in various categories. ▪ As discussed with regard to Section M, although quarterly nursing assessments were being completed, they were inadequate. In addition, day-to-day nursing assessments were not adequate to ensure that changes in individuals' status was promptly identified and reported to the PCPs. The Medical Department developed a Section H Monitoring Tool, which included monitoring of health status on an ongoing basis. Several of the measurements included specific parameters of timeliness, which could be reviewed to ensure health status was being monitored. Areas in the monitoring tool included: "Diagnostic tests are reviewed by the PCP within 24 hours of receipt," "risk action plans are reviewed at least quarterly and using designated clinical indicators evaluate effectiveness of plans," "The active problem list was updated as new diagnoses were made and when problems were resolved, and reviewed quarterly," "the medication list, diet, protocol labs is updated as new orders are written, to include orders to discontinue," and "the preventive care flow sheet will be completed annually and at the time of the annual medical assessment." Although it was positive that the Facility was beginning to monitor these types of indicators, the impact on individuals' healthcare was not yet evident. It will be important for the Facility to use the data collected to effectively make systemic changes. The Facility remained out of compliance with this provision.	
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 will require demonstration of a functional system that is both integrated and provides the full spectrum of all elements of clinical care. The various protocols developed by the State Office represent an initial framework for this section, but there needs to be evidence that these are put into action, and that treatment reflects ongoing interventions and changes in interventions based on identified clinical criteria/clinical indicators that are appropriate for the individual. Evidence for this is anticipated to occur based on reviews of the morning medical meeting minutes, as well as the internal and external audit reviews of clinical care. Discussions at the morning meetings should include reviewing the changes (deterioration) in health status reported. This should lead to a review of current treatment interventions, and discussion of potential modifications guided by the clinical guidelines (and other national professional recommendations, as	Noncompliance

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		appropriate). Use of related clinical indicators would be helpful in tracking progress. With the clinical medical management reviews being added to the internal and external audit processes, measurement also will begin regarding whether or not the Facility is responding to changes in health status (for the condition reviewed). This process also will assist in measuring improvements the Facility makes over time. Although as described below, the Facility had begun to develop a monitoring system to review the system as a whole, work was needed to ensure that this impacted the treatment the Facility was providing to individuals. The Medical Department developed a set of clinical indicators to determine whether treatments and interventions were modified in response to clinical indicators. One aspect of this was documenting that a change of health status occurred, and as a result, the orders had been written for medications, diet, labs, etc. The Medical Department had begun to monitor the review process of consult reports, and measured each step of the process, and determined clinical indicators/standards of acceptable care. Once consult reports and lab data are received and reviewed, the PCPs may add/change treatments. As s measure of quality care, this needed to occur within a window of time. The Medical Department tracked timeliness of PCP review of lab and consult reports. For consult reports, the measure was whether the consults reports were reviewed within five days of receipt. Additionally, whether the IDT reviewed the consults after PCP review was tracked. Based on the Facility's data, for March 2012, 70% of consult reports were reviewed by the PCPs within five days. The IDT subsequently reviewed 0.07% of the consults. For April 2012, 89.7% of consult reports were reviewed within five days of receipt, and 43.1% of these consult reports were subsequently reviewed by the IDT. For May 2012, 98.5% of consult reports were reviewed within five days of receipt, and 46.2% of these consult reports were subsequently reviewed by the IDT. In March 2012, 513/882 (95%) of lab results were reviewed within 24 hours by the PCP. For April 2012, 649/728 (89%) of lab results were reviewed within 24 hours by the PCP. For May 2012, 535/596 (90%) of lab results were reviewed within 24 hours by the PCP. Although the internal medical QI program had not chosen criteria to measure whether the lab results were processed according to clinical indicators/guidelines/national standards, it did indicate the foundational steps of ensuring timely review of new information. As mentioned with regard to Section L.3, the Medical Department will need to determine the clinical indicators on which compliance will be monitored. These should include measurement of evaluation and treatment, and should be agreed upon by the Medical Department and based on the State Office clinical protocols/guidelines and/or recommendations of national professional societies/associations. Additionally, it is recommended that the lab and consult reports be tracked to ensure they are obtained in a timely manner, and data should be generated to determine the number of consults or labs not received in a timely manner as defined	

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		by the Medical Department. Additionally, Section G Monitoring Tools included measurement probes to ensure the PCP reviewed the recommendations of non-facility consultants and responded to the recommendations. Six questions from Section G Monitoring Tool addressed this area. Compliance with this section was 55% in March 2012 and 61% in April 2012. However, as the Monitoring Team has repeatedly stated, overall compliance scores have little, if any meaning.	
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 Action Plan included development of a post ER visit/hospitalization policy that clearly defined actions/responsibilities and time frames for an individual returning from the ER or returning after a hospitalization. However, this had not been developed and a draft was not available for review. The Facility revised a policy: Minimum Common Elements of Clinical Care H.1: Clinical Operations, revised 1/13/12, approved 1/26/12, implemented 2/1/12. Changes included case manager responsibilities of taking all consults reviewed by the PCP on a daily basis and distributing them among the IDT members at the morning meeting for review and signature, as well as returning the completed signature sheet to the Clinic RN. Exhibit C of the policy was entitled "Consultant Recommendation Review" and recorded the signature and date of review of the consultant report. In attempting to create a system of policies to guide CCSSLC in creating a quality care system, it is recommended that the various policies related to this section that have been discussed in this and previous reports be mapped to determine areas of overlap, and areas of care that remain without guidance, or have no oversight. The policies developed for integrated care and elements of clinical care 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 (e.g., morning medical meeting, clinic operations, etc.) 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 all important information is tracked until closure. It is also recommended this same mapping process be completed with committees and other oversight bodies, to ensure all clinical areas have an ongoing monitoring process in place. The QA Department also should develop a monitoring tool measuring effectiveness of these various committees to ensure they are efficient and effective, and provide quality oversight of the clinical areas assigned to them.	Noncompliance

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

1. For a given diagnosis, evidence should be available that the needed disciplines provided assessments, that the team discussed these evaluations, and that all essential elements for care of that diagnosis have been included in an integrated action plan. (Section H.1)
2. All clinical areas, including nursing, psychology, psychiatry, habilitation therapy, etc., should provide evidence that routine quality assessments are completed in a timely manner, as well as evidence of timely response to changes in health status of the individual. (Section H.1)
3. The implementation of the risk action plans of the individuals should be tracked by the Facility to determine the involvement of each clinical department that might have impact on that risk, as a method to provide/ensure that individuals have adequate access to the minimum common elements of clinical care. (Section H.1)
4. To ensure appropriate identification of clinical indicators in the Risk Action Plans/ISP addendums, it is recommended that medical staff attend the meeting and provide information concerning choice of indicators of practical significance that can be measured. (Section H.4)
5. Changes in health status of the individuals should be tracked by the Facility to ensure all appropriate clinical departments participate in resolving the health concern identified. (Section H.5)
6. The various CCSSLC policies should be mapped to determine areas of overlap, and areas of care that remain without guidance or have no oversight. (Section H.7)
7. The various CCSSLC committees and oversight bodies should be mapped to ensure all clinical areas have an ongoing monitoring process in place. (Section H.7)
8. The QA Department should take a more active role in monitoring Section H. (Facility Self-Assessment)

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

1. The systems analyst should communicate with the counterparts at the State Office to determine if the more specific diagnoses associated with the ICD 9 codes can be entered on the computerized DG1. The systems analyst also should review the new software for the upcoming ICD 10 coding system to determine if the same problem will occur, or if the codes will maintain specificity and detail in categorizing the diagnosis. (Section H.2)

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS SSLC revised "Risk Guidelines" laminated record, dated 4/17/12; o CCSSLC's Self-Assessment; o CCSSLC's Provision Action Information; o CCSSLC At-Risk Individuals list; o Draft of revised At-Risk Individuals Policy, 006.3; o Section I Analysis reports for April and May 2012; o Section I monitoring tool and instructions; o CCSSLC training rosters; o The following documents: Integrated Risk Rating Forms, Action Plans for Risk Assessments, ISPs and/or ISP Addendums, Comprehensive Nursing Assessments, and Health Management Plans for the following individuals: Individual #144, Individual #183, Individual #278, Individual #9, Individual #282, Individual #378, Individual #213, Individual #327, Individual #91, Individual #221, Individual #34, Individual #210, Individual #153, Individual #211, Individual #38, Individual #182, Individual #8, Individual #44, Individual #224, Individual #276, Individual #10, Individual #138, Individual #297, Individual #350, Individual #268, Individual #26, and Individual #95; o Section I Presentation Book, including: draft SSLC Statewide Policy and Procedures #006.3: At Risk Individuals, dated 5/24/12; flow diagram SSLC at-risk process, dated 2/10/12; Instructions – Risk Guidelines; SSLC Risk Guidelines, dated 4/17/12; Instructions: draft Aspiration Nutrition/Enteral Nutrition Data Sheet (APEN), dated 5/24/12, and instructions, dated 6/13/12; instructions for IRRF, dated 5/24/12; draft blank IRRF, dated 5/25/12; instructions Integrated Health Care Plan (IHCP) process and form, draft dated 5/24/12; Annual Integrated Health Care Plan – Risk Group 1, dated 5/24/12, and Risk Group 2, dated 7 5/25/12; direct Support Professionals Instructions Risk groups 1 through 7; Instructions: Trigger Data Sheet, dated 4/16/12, and Trigger Data Sheet for each risk category, dated 5/25/12; Change of Status IRRF draft blank form, dated 5/24/12; draft Change of Status Integrated Health Care Plan, dated 5/24/12; Risk category: at risk criteria/alarm indicators/clinical indicators; CCSSLC Integrated Risk Ratings – Trend Report FY 2011, 2012; Compliance and Integrated Risk Rating Quarterly Charts – Section I; and Section I Analysis – April 2012, and May 2012; o For the following individuals, selected documents from their active records, including: DG-1, most current annual medical assessment and physical exam, preventive care flow sheet, most current nursing assessment, past one year of IPNs, past one year of lab results, x-rays, scans, Magnetic Resonance Imaging (MRIs), ultrasound reports, hospital discharge summaries for past year, ER report for past year, consults and procedure reports for the last year, DNR forms if applicable, physician orders for the past year, most recent PSP/ISP and subsequent addendums, most recent BSP, past three medical quarterly reviews, integrated risk rating form for past year, risk action plan(s) for past year for the following individuals: Individual #215, Individual #31, Individual #244, Individual #213, Individual #144, Individual #251, Individual #103, Individual #65, Individual #294, Individual #210, Individual #86, Individual #158, Individual #299, Individual #356, Individual #181, Individual #253, Individual

	#42, Individual #156, and Individual #72; and o Annual Integrated Risk Rating Form, and ISP for Individual #156. ▪ **Interviews with**: o Colleen M. Gonzales, BSHS, Chief Nurse Executive; o Angela Roberts, Au.D., Director of Habilitation Therapies; o Althea P. Stewart, RN, Medical Services; o Bruce Boswell, Assistant Director of Programming; o Mark Cazalas, Facility Director; o Iva Benson, State Office Consultant; o Dana Verhey, Quality Assurance Program Compliance Monitor; o Jennifer Urban, RN, BSN, Nursing Operations Officer; o Araceli Aguilar, RN; o Patricia Glass, RN, Case Manager Supervisor; o Connie Horton, State Office Consultant, Family Nurse Practitioner; o Linda Fisher, State Office Consultant, Family Nurse Practitioner; and o Sally Schultz, State Consultant. ▪ **Observations of**: o ISP Meeting for Individual #341, on 7/11/12; and o ISP Meeting for Individual #156, on 7/12/12.
	Facility Self-Assessment: Since the Monitoring Team's last review, the Facility had implemented a promising monitoring tool with instructions for Section I, and had completed eight tools. From discussions with the staff lead for Section I, she and the Quality Assurance Program Compliance Monitor had established inter-rater reliability for the monitoring tool above 85%. However, from discussions with the PCM, she reported she was not a clinician and scored the items based on completion, and not on the quality. For example, she reported that she reviewed assessments to ensure that they were completed within five days of the identification of a high or medium risk. However, she reported that she did not review the clinical appropriateness and adequacy of the assessments when determining compliance. As noted during several past reviews and in previous Monitoring Team's reports, the quality and adequacy of the assessments conducted by a number of disciplines regarding the at-risk individuals were consistently found to be significantly inadequate. Unfortunately, the Facility's current process of monitoring Section I did not capture this essential issue. The Facility should evaluate who would be best to audit this highly clinical area in order to generate accurate information regarding clinical issues related to the individuals at risk. The Facility's Self-Assessment indicated that four of four (100%) monitoring tools that were completed for Section I were analyzed, trended, and aggregated. However, no findings were presented in the Facility's Self-Assessment indicating the trends, analysis, or compliance status of the items contained on the monitoring tools. A review of the Presentation Book for Section I found two reports entitled: Section I Analysis April 2012, and Section I Analysis May 2012. These reports provided a narrative description of the number of the reviewed ISP samples that were in compliance with specific items on the tool. However, "combined" compliance scores for the overall tools were reported by individual and collectively, which provided no interpretable information for analysis. Consideration should be given to standardizing the presentation of data across the Facility for consistency in interpretation using, for example, tables to report monitoring findings rather than a narrative format that is more appropriate for presenting the analysis of the

	data. With that being said, the Monitoring Team noted that the Analysis Reports did not contain any analysis of the findings or what actions were being taking to address the problematic trends identified. Also, the Facility Self-Assessment indicated that there were no data available regarding the review of three of the Integrated Health Care Plans that had been piloted on 524A to determine if interventions were consistently implemented. The reason given was that the pilot was implemented June 1, 2012, and data would not be available until July 9, 2012. The Facility indicated that a review of three Integrated Risk Rating Forms currently piloted on 524A found that none (0%) contained the following required components: a) data; b) current supports; c) baseline information; d) discussion and analysis/need for new supports; e) rationale/risk rating; f) triggers; and g) criteria for IDT Review. However, no indication was provided regarding how these problematic issues were to be addressed. The Facility's Self-Assessment indicated that based on its findings from its self-assessment, this provision was not in compliance since the enhanced risk process was still in the pilot phase, and had not yet been implemented across the Facility. Although the Monitoring Team's findings supported the Facility in finding that it was not in substantial compliance with the Settlement Agreement requirements for Section I, this finding was based on a review of the current documentation for individuals that were identified as being at risk by their teams, and not based on the fact that the Facility had only recently implemented the pilot system. The implementation of new system changes were necessary to improve the system, but did not supersede the needs of the individuals regarding the provision and documentation of clinical care as required by the Settlement Agreement.
	Summary of Monitor's Assessment: Since the last review, the State Office had made revisions to the At-Risk Individuals policy (in draft form at the time of the review). Some of the changes included regrouping the Risk Guidelines so that the risk factors that were clinically inter-related regarding outcomes or provision of services and supports were listed together, and linking each risk factor with specific clinical indicators. In addition, the Integrated Risk Rating Form was revised to follow the same grouping sequence as the Risk Guidelines. Some additional revisions included replacing the Risk Action Plans for the identified high and medium risk indicators with Integrated Health Care Plans designed to provide a comprehensive plan that will be completed annually; different forms regarding IRRF and the IHCP were developed addressing changes in status; the Aspiration Pneumonia Enteral Nutrition was revised as a data collection tool; and Trigger Data Sheets were developed to include observable and measurable clinical signs and symptoms that alert the staff to possible changes in status. In May 2012, two teams at CCSSLC had been trained on the new policy and processes, and had begun to pilot them. It was important that the new system was being piloted with two teams to determine any additional implementation steps/changes that needed to be made, or any additional training that would be beneficial before broadening its scope to the entire campus. The many changes that had occurred with regard to the At-Risk system were reflected in the different ISP documents, and the varying quality of the IRRF indicated some confusion amongst the teams with the previous process. Developing a successful program on a small scale that can then be implemented across campus should reduce such issues. Staff from the pilot systems in two residences also could act as mentors to the other teams, another important step in providing consistency across campus and improving the quality of the process. Until now, the quality

	of the risk reviews and implementation process varied depending on the understanding and expertise of the various IDTs. Hopefully, the process will become more standardized, which should benefit the individuals residing at CCSSLC. From review of the ISP and addendum documentation, individuals' teams were having discussions of the individuals' status, and more pertinent clinical information was being included in the Integrated Risk Rating Forms than previously. However, the overall lack of clear documentation included in the ISPs, the Risk Action Plans, and the associated disciplines' assessments regarding what actions were taken in response to pertinent events or health issues, and the lack of dates and supporting documentation addressing actions and completion of action plans made the Monitoring Team's review of the At-Risk system difficult, and the lack of progress noted was troubling at this juncture of the compliance process.

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I1	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, each Facility shall implement a regular risk screening, assessment and management system to identify individuals whose health or well-being is at risk.	Since the last review, interviews with the Facility staff, CCSSLC's Self-Assessment, and Provision Action Information documents indicated that the following steps had been implemented, and assessments conducted regarding the At-Risk process: ▪ Since the last review, the State Office had made revisions to the At-Risk Individuals policy (in draft form at the time of the review). Some of the changes included regrouping the Risk Guidelines so that the risk factors that were clinically inter-related regarding outcomes or provision of services and supports were listed together, and linking each risk factor with specific clinical indicators. In addition, the Integrated Risk Rating Form was revised to follow the same grouping sequence as the Risk Guidelines. Seven groupings of risk categories were identified. The template of the draft Integrated Risk Rating Form included bulleted items to be addressed for each risk factor, including: data, supports, baseline, discussion and analysis/need for new supports, rationale/risk rating, triggers (trigger sheet indicated/not indicated), and criteria for IDT review. This draft was dated 5/25/12. Some additional revisions included replacing the Risk Action Plans for the identified high and medium risk indicators with Integrated Health Care Plans designed to provide a comprehensive plan that will be completed annually; different forms regarding IRRF and the IHCP were developed addressing changes in status; the Aspiration Pneumonia Enteral Nutrition was revised as a data collection tool; and Trigger Data Sheets were developed to include observable and measurable clinical signs and symptoms that alert the staff to possible changes in status. When there was a change of status (according to the definition provided in the instructions), a change of status integrated risk rating form was to be completed. A draft template, dated 5/24/12, of this form was submitted. ▪ In May 2012, two teams from CCSSLC were trained on the "Enhanced Risk Process" described above which was implemented at 524A and Porpoise in June 2012. Since the system had only been recently implemented at the time of the	Noncompliance

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		review, the Monitoring Team was not able to adequately assess any progress made from the system revisions. ▪ In May 2012, the Facility reported that it hosted the Statewide Nurse Educator Meeting where competency-based training was provided regarding medication administration, and Nursing Care Plans. Although training rosters were included in the Presentation Book for Section I, no curriculum was included for the Monitoring Team to evaluate the quality of the competency-based training, and there was no indication from the training rosters as to how many staff were required to attend (N), and how many actually attended and passed the training (n) to accurately determine a compliance percentage for training. From the significantly problematic findings noted below for Section I, the numerous changes to the At-Risk system had resulted in fragmented documentation that made it difficult, if not impossible to sequentially follow the assessment and action plan processes for a sample of 27 individuals in Sections I.2, and I.3, who the Facility determined to be at high risk regarding health and/or mental health issues. From review of the ISP and addendum documentation, individuals' teams were having discussions of the individuals' status, and more pertinent clinical information was being included in the Integrated Risk Rating Forms than previously. However, the overall lack of clear documentation included in the ISPs, the Risk Action Plans, and the associated disciplines' assessments regarding what actions were taken in response to pertinent events or health issues, and the lack of dates and supporting documentation addressing actions and completion of action plans made the Monitoring Team's review of the At-Risk system difficult, and the lack of progress noted was troubling at this juncture of the compliance process. To assess the Facility's revised risk screening process, members of the Monitoring Team observed two individuals' ISPs meetings (i.e., Individual #341, and Individual #156) while on site. Although there were other ISPs conducted during the week of the Monitoring Team's review, the two ISPs observed were reflective of the new ISP format and process, and thus were chosen for that reason. Specifically, the observations of the ISP meetings indicated that: ▪ All appropriate disciplines were present at both (100%) of the observed ISPs. ▪ The staff present at the ISPs meetings were the actual staff that worked with the individual, and not substitute staff sitting in for other staff members for all (100%) of the ISPs. ▪ The individual was present at both (100%) of the ISPs meetings observed. Although Individual #156 was in the Infirmary at the time of the ISP, the staff was able to have her available by conference call during the meeting. However, it was not clear why the team could not hold the meeting at the Infirmary. ▪ The IDT consistently used the Risk Level Guidelines when determining risk	

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		levels at one (50%) of the ISP meetings. The IDT for Individual #341 did not appear to consistently use the Risk Level Guidelines to determine risk levels since some of the risk levels assigned were not in alignment with the Guidelines without justification provided by the team. ▪ The IDT consistently used supporting clinical data when determining risks levels for both of the ISPs observed (100%). The Monitoring Team noted that there had been consistent improvement for this indicator since the last review. ▪ Overall, the risk levels the IDT designated were appropriate for each category for none of the ISPs observed (0%) from information and data provided by the IDTs. The individuals' IDTs that did not consistently designate appropriate risk levels for each risk category included Individual #341 and Individual #156. ▪ There was adequate and appropriate clinical discussion among appropriate team members in decisions regarding risk levels in both (100%) of the ISPs meetings observed. ▪ Team disagreements regarding risk levels were noted in neither of the ISP meetings for Individual #341, and Individual #156, and thus, the Monitoring Team did not observe the process of resolving issues. In evaluating this indicator, when team disagreements are observed the Monitoring Team evaluates the process of resolution based on the use of specific clinical data, the use of the Risk Guidelines, appropriate clinical judgment, and the use of a person-centered focus to determine compliance. ▪ Based on both ISPs observed by the Monitoring Team, the ISP facilitator kept the team focused in all (100%) of the ISPs meetings observed. Areas for continued focus included time management since both of the ISPs observed were exceptionally lengthy, presenting justification for risks levels in alignment with the Risk Guidelines and individual-specific clinical information, and continuing to increase team discussions of risk indicators. In addition, other positive observations from the Monitoring Team included: ▪ At the ISP meeting for Individual #341, many of the disciplines were actively involved in the discussions about risk, and offered comments, suggestions, and opinions in areas outside of their direct purview. These discussions were noted to be respectful, and the different viewpoints and recommendations were appropriately incorporated into the resulting action plans. However, this remained an area that needed continued growth. From the observations of the Monitoring Team, there were some disciplines that did not participate meaningfully in the discussions, even when their expertise potentially would have been helpful; ▪ The Active Treatment team member for Individual #341 consistently looked for ways to incorporate skill acquisition programs into the ISP, including during risk-related discussions. Although concerns were noted with regard to the use	

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		of data from last year's plans or the Functional Skills Assessment, as well as a lack of some disciplines providing needed input, it was positive that the team discussed more skill acquisition programs throughout the various team discussions; ▪ The guardians for Individual #156 were able to take part in the ISP and were kept engaged and well informed by the Nurse Practitioner who did an exceptional job of discussing a number of complicated medical issues and diagnoses during the meeting. In addition, since the individual was in the Infirmary at the time of the ISP meeting, she and her direct support professional were able to participate in the meeting via conference call; ▪ During some of the team's discussions for Individual #156, a number of the team members remained cognizant of allowing the individual to maintain as much independence as possible; ▪ Generally, facilitators for Individual #341 and Individual #156 promoted team participation and kept the meetings appropriately focused; and ▪ There continued to be a noted increase in the use of specific clinical data to support risk ratings. Problematic areas needing focus or improvement included: ▪ There was a lack of integrated supports noted in some instances at the ISP for Individual #341. For example, the individual had a PNMP that addressed the need for staff supervision during mealtimes due to his fast pace while eating. The individual stated that he ate fast because previously people had taken food from him. However, no psychology or active treatment involvement was noted with regard to, for example, a skill acquisition program to help him slow his eating pace. ▪ Overall, although the team discussed action plans related to risk for Individual #341, some critical pieces were missing. For example, although the team identified weight as a high-risk area, and one that impacted many of the individuals' other risk factors, the related action plan lacked the clinical intensity to correspond with the level of risk. He had a Body Mass Index (BMI) of 41, placing him in the severely obese range. His weight had increased over the previous year. Other than modifying his salary cap from $40 to $25 per week to potentially decrease the amount of food he could buy outside of his prescribed diet, having staff remind him to exercise, developing two skill acquisition programs to help him identify healthy choices, and educating his family about health options, the team did not develop a plan to aggressively address this high-risk indicator. It was unclear, for example, how much exercise he currently was getting and if this could be increased. It also was unclear if the team had considered typical methods that his nondisabled peers would have used to assist with weight loss, such as support groups or specific diet programs. Similarly, the	

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		team did not discuss incorporating incentives for weight loss into his program, and/or using some of his lengthy list of preferences as further incentive for reducing his weight. Although the team discussed the potential impact of his psychotropic medications on his weight, it was also not clear if the team had a plan to address this issue. As with all of the other risk action plans discussed, for weight, no measurable objective was discussed to assist the team in determining if the plans in place were having the desired effect, or if changes were needed. ▪ Team discussions for Individual #156 indicated that she had several missing teeth, had moderate periodontitis, exhibited anxiety and sensitivity during exams and required pre-sedation and anesthesia for dental work to be completed. Although her dental risk had been rated as high in the past and the dentist had recommended a dental desensitization program, the team reported that she was deemed as not being a candidate for desensitization without explanation. The discussion of the team indicated that staff would "monitor" her tooth brushing. However, there was no discussion regarding what criteria/clinical indicators would be used to determine if she was effectively brushing her teeth. In addition, there was no discussion addressing the original problem regarding her anxiety during dental procedures. ▪ While the team discussed the need for Trigger Sheets to be implemented for each of the Risk Factors for Individual #156 to collect data regarding specific symptoms, the team appeared to have little understanding that the collection of data was only the first step in the monitoring of a particular health indicator. There was no discussions observed indicating who would be regularly reviewing this information; how often it would be reviewed; who, how, and how often this information would be presented to the team; and what the criteria were to indicate the team needed to take additional actions. ▪ Although it was positive that the family members for Individual #156 were present for the ISP, it was obvious that there had not been regular communication between the team and the family based on the activities the family thought were in place compared to what the team reported during the meeting. For example, the family believed that the individual had a hospital bed from a discussion of needs at her previous ISP. However, once it was verified that she did not have this type of bed, no one from the team could provide the family with a rationale for why she was not provided a hospital bed. ▪ Overall, the IDT for Individual #156 had limited and incomplete discussions of action plans related to the high and medium risk ratings. In several cases, the objectives were not functional and/or measurable, and adequate preventative measures were not discussed. ▪ Overall, any action plans that were developed in the ISP meetings were weak, in that the objectives were not discussed by the IDTs in order to establish a measure of success or failure of the action plans developed, and the	

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		interventions did not reflect the clinically intensity in alignment with the level of risk designated by the teams. In addition, a sample of 19 records (13 randomly selected and six chosen according to high risk categories, including those for Individual #215, Individual #31, Individual #244, Individual #213, Individual #144, Individual #251, Individual #103, Individual #65, Individual #294, Individual #210, Individual #86, Individual #158, Individual #299, Individual #356, Individual #181, Individual #253, Individual #42, Individual #156, and Individual #72) was reviewed with regard to the integrated risk rating process. For the 19 individuals, the active record was reviewed along with the integrated risk rating form. The attendance sheet for the ISP was also utilized in making the following findings: ▪ For seven out of 19 (37%) active records, the appropriate disciplines were present at the ISP. ▪ For 14 out of 19 (74%) active records, the individual was present at the ISP. ▪ For 13 out of 19 (68%) active records, the IDT used the Risk Level Guidelines when determining risk levels. ▪ For 14 out of 19 (74%) active records, the IDT used supporting clinical data when determining risk levels. ▪ For 12 out of 19 (63%) active records, the designated risk levels were appropriate for each category (i.e., the team provided adequate justification). From the Monitoring Team's observations and record reviews, there had been some positive steps made regarding the structure and format of the ISPs, specifically the increased use and team discussions of supporting clinical data when assessing risk levels. However, there needs to be significantly more efforts made to ensure that the risks level is accurate, that the action plans that reflect the needed clinical intensity in alignment with the appropriate designated risk levels, that objectives included are functional and/or measurable, that adequate preventative measures are discussed and are included in the action plans, and teams clearly document this process. In addition, the Facility should implement a system addressing the reassessment of risk factors for individuals experiencing significant changes in status. It should be inclusive of acute changes in status for at-risk individuals, and not only activated in response to hospital admissions. CCSSLC should continue to provide training and mentoring for the IDTs regarding the At-Risk process.	
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	Based on a review of records for 27 individuals determined to be at risk (i.e., Individual #144, Individual #183, Individual #278, Individual #9, Individual #282, Individual #378, Individual #213, Individual #327, Individual #91, Individual #221, Individual #34, Individual #210, Individual #153, Individual #211, Individual #38, Individual #182, Individual #8, Individual #44, Individual #224, Individual #276, Individual #10, Individual #138, Individual #297, Individual #350, Individual #268, Individual #26, and	Noncompliance

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	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.	Individual #95), there was documentation that the IDT 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. Problematic issues that resulted in noncompliance included: ▪ Integrated Risk Rating forms did not consistently include specific clinical data, such as the number of bowel medications and supplemental laxatives/stool softeners regarding constipation risks, or dates and the types of injuries/fractures when addressing falls, to support the risk ratings for the health indicators. As a result, it was unclear whether further assessment was needed; ▪ There were inconsistencies found between the risk levels found on the individuals' Integrated Risk Rating forms, Comprehensive Nursing Assessments, ISPs, and the CCSSLC's At-Risk Individuals list. Reconciliation of these differences was not found; ▪ Due to the lack of documented dates on the various forms, the Monitoring Team was unable to consistently determine what new information was added to a revised Integrated Risk Rating form, and what additional assessments were needed and/or conducted in response to the revised information or possible change of status; and ▪ When recommendations for further assessment were found on the Risk Action Plans, the date of completion was frequently left blank, or the dates that were listed on the Action Plans did not correspond to dates on the Integrated Risk Rating forms, ISPs, or ISP addendums. Thus, it was impossible to determine what precipitated the recommended assessment, and if it was timely completed. <u>Nursing Assessments</u> Based on a review of 27 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 #144, Individual #183, Individual #278, Individual #9, Individual #282, Individual #378, Individual #213, Individual #327, Individual #91, Individual #221, Individual #34, Individual #210, Individual #153, Individual #211, Individual #38, Individual #182, Individual #8, Individual #44, Individual #224, Individual #276, Individual #10, Individual #138, Individual #297, Individual #350, Individual #268, Individual #26, and Individual #95. As noted based on the past previous five reviews, the Facility continued to use the last quarterly or annual Comprehensive Nursing Assessment to meet the nursing assessment requirement. In addition, a review of the most current quarterly or annual Comprehensive Nursing Assessments for the above 27 Individuals found that none of them (0%) contained an	

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		adequate assessments of the specific high-risk health indicators or provided any type of analysis of the high-risk health indicators in the Summary Section of the Comprehensive Nursing Assessment form. In fact, the Comprehensive Nursing Assessments the Monitoring Team reviewed were noted overall to be worse than the previous review in that some of the nursing assessments did not reflect the correct risk rating, and some nursing assessments did not even include the particular health risk in the Summary Section, especially regarding high-risk ratings for dental issues. As noted based on the previous five reviews, nursing had no specific procedure in place addressing the process regarding the nursing assessments and the analysis of the identified risk indicators. From some of the problematic issues noted above regarding missing or inaccurate risk ratings, it was clear that some of the Case Managers completing the Comprehensive Nursing Assessments were using past quarterly or annual information without providing any type of update and analysis regarding the current status of the health risk indicators. As noted based on past reviews, the nursing assessments for the At-Risk individuals were not adequate in addressing the health risks of the individuals reviewed. In addition, regarding the Integrated Risk Rating forms, although overall more specific clinical information was contained on the forms, some of the areas that nursing was responsible for assessing and/or providing information, such as for constipation and dates of injuries/fractures, a decrease in this individual-specific information was noted from the previous review. When reviewing some the Integrated Risk Rating forms that included dates of revisions, the areas that contained deficits in individual-specific information remained unchanged. As previously recommended, the Facility, in conjunction with the State, should specifically define the nursing assessment and documentation process regarding at-risk individuals. <u>Medical Assessments</u> At risk criteria and alarm indicators had been developed to assist the IDTs in identifying an individual's at-risk categories and when there was a change in status. These at-risk criteria, alarm indicators, and clinical indicators were created for each of the major risk areas (i.e., choking, aspiration, enteral feeding, pneumonia, dental, GERD, constipation, cardiac disease, circulatory disease, blood thinner, fluid imbalance, weight, diabetes mellitus, osteoporosis, falls, fracture, infection, urinary tract infections, skin integrity, seizures, polypharmacy, challenging behavior, and hypothermia risk). These were discussed with regard to Section H, and were being piloted at two homes before full implementation campus wide. A sample of 19 individuals' records (i.e., Individual #215, Individual #31, Individual #244, Individual #213, Individual #144, Individual #251, Individual #103, Individual #65, Individual #294, Individual #210, Individual #86, Individual #158, Individual #299, Individual #356, Individual #181, Individual #253, Individual #42, Individual #156, and	

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		Individual #72) was reviewed. Based on a review of these 19 records, there was documentation that the IDT started the assessment process as soon as possible but within five working days of the individual being identified as at risk for none of the individuals (0%). There was little information in the system to provide documentation to show the assessment process began within five working days. Even if the team had started an assessment process during that time, the documents did not reflect that, and it appeared there was no standard system approach to this documentation. It did appear that most plans did not have direct statements that further assessments were needed. Based on a review of two individuals' records in response to changes in an at-risk individual's condition (i.e., Individual #213, and Individual #158), there was documentation that the IDT started the assessment process as soon as possible but within five working days of the individual changes in an at-risk condition for none of the individuals (0%). Similarly, there did not appear to be a system by which to identify requests for assessments, or provide a tracking mechanism with dates to ensure this aspect of the Settlement Agreement was met. Based on a review of 19 individual records for whom assessments had been completed to address the individuals' at risk conditions, 10 (53%) included an adequate medical assessment to assist the team in developing an appropriate plan. However, this review included a narrow focus of only medical assessments. Other clinical areas such as nursing, OT/PT/SLP, psychiatry, and psychology were not part of the focused review of medical assessments. The Facility indicated that it was not in compliance with the requirements of the Settlement Agreement for this area. This was consistent with the findings of the Monitoring Team.	
I3	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall establish and implement a plan within fourteen days of the plan's finalization, for each individual, as appropriate, to meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take	The Enhanced Risk Process included a replacement of the Risk Action Plans with Integrated Health Care Plans. Components included goals, needed services and supports, the date of implementation, the person responsible for the implementation and documentation, the data to be collected, the determination of how often the data was to be collected, the person responsible for the plan, the person responsible for the plan's effectiveness, completion date, follow-up to any identified needs, and outcome. An Integrated Health Care Plan was to be created for any medium or high-risk category. According to submitted instructions for this process, the Integrated Health Care Plan was to be developed during the IDT/ISP meeting and finalized by the nurse case manager for the individual. A template for the Annual Integrated Health Care Plan for Risk Group 1, dated 5/24/12, and for Risk Groups 2 through 7, dated 5/25/12, were submitted. This process was initiated on 5/18/12. As part of the Integrated Health Care Plan, a template	Noncompliance

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	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.	was submitted for "Direct Support Professionals Instructions," with signature of the home manager/charge and each of the direct support professionals reviewing the instructions. There was a separate form for each of the seven Risk Groups. There did not appear to be a designated area for the date when the instructions were to be implemented. Similarly, a template, dated 5/25/12, for the trigger sheets for each of the Risk Groups was also submitted. The shift nurse was to review the direct support professional documentation on the Trigger Sheet at the end of each shift, and initial as evidence of review. The SSLC At-Risk Process, dated 2/10/12, was illustrated through a flow diagram, which was an aid for understanding the several steps in the enhanced risk assessment process. At the same time, a process/pathway was created to ensure a change in health or behavioral status would be part of the enhanced risk process, and would be reflected in the IDT/Risk process and the Integrated Health Care Plan. As part of the annual ISP process, a trigger data sheet was to be implemented. This sheet was to list clinical indicators, and measurable observations that would guide staff in early recognition of health status change. Trigger data sheets were to be developed for all high-risk categories by the IDT. Based on a review of 27 records for individuals determined to be at risk (i.e., Individual #144, Individual #183, Individual #278, Individual #9, Individual #282, Individual #378, Individual #213, Individual #327, Individual #91, Individual #221, Individual #34, Individual #210, Individual #153, Individual #211, Individual #38, Individual #182, Individual #8, Individual #44, Individual #224, Individual #276, Individual #10, Individual #138, Individual #297, Individual #350, Individual #268, Individual #26, and Individual #95), there was documentation that the Facility: ▪ Established an appropriate plan within fourteen days of the plan's finalization, for each individual, as appropriate, in none of the cases (0%) reviewed. ▪ Implemented a plan within fourteen days of the plan's finalization for each individual, as appropriate in none (0%) of the cases reviewed. Although the Action Plans reviewed usually included a date of implementation, there was no supporting documentation verifying that the action steps contained in the plan had in fact, been implemented. In addition, a number of the action steps were so nonspecific and generically written, their implementation essentially would be impossible to verify. ▪ Implemented a plan that met the needs identified by the IDT assessment in none of these cases (0%). ▪ Included preventative interventions in the plan to minimize the condition of risk in none of the cases (0%). Although some generic interventions were found in some ISPs addressing the need for exercise or fluids that would have led to a	

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		preventative intervention, because these interventions were not written in measurable terms to allow implementation and tracking, they were found not to be in compliance with this indicator. ▪ When the risk to the individual warranted, took immediate action in none of the cases (0%). ▪ Integrated the plans into the ISPs in three of the cases reviewed (11%). Individuals who had not had their Risk Action Plans integrated into their ISPs included: Individual #183, Individual #278, Individual #9, Individual #282, Individual #378, Individual #213, Individual #327, Individual #221, Individual #34, Individual #210, Individual #153, Individual #38, Individual #182, Individual #8, Individual #44, Individual #224, Individual #276, Individual #10, Individual #138, Individual #297, Individual #350, Individual #268, Individual #26, and Individual #95. ▪ None (0%) of the plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. ▪ None of the plans (0%) had appropriate, functional, and measurable objectives incorporated into the ISP to allow the team to measure the efficacy of the plan. ▪ None of the plans (0%) included the specific clinical indicators to be monitored. ▪ The frequency of monitoring was included in the plans for none of the individuals (0%). Although the Action Plans contained a heading addressing "Monitoring Frequency," the frequency was noted generally as daily or weekly without the specific shift or day included to ensure accountability. The significant problematic issues that resulted in noncompliance with the above compliance indicators included: ▪ There appeared to be no format in place to indicate when Action Plans contained in the ISPs were related to a high or medium risk designation to easily identify the individuals' interventions addressing their significant health/behavioral risks; ▪ Many of the Risk Action Plans included in the ISPs only included a portion of the interventions contained on the separate Risk Action Plans generated from the previous independent risk meetings held by the teams to determine the level of risk; ▪ When additional dates added to the Integrated Risk Rating Forms indicated revisions were made, the Monitoring Team was unable to determine what information on the form was actually revised, which in turn, made it impossible to determine if there had been appropriate and timely associated changes made to the Risk Action Plans; ▪ Since many of the dates on the Risk Action Plans did not coordinate with any of the revision dates on the Integrated Risk Rating forms, the ISP date, or an ISP	

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		addendum date, it was impossible to determine exactly when and in response to what event the Action Plan was developed; ▪ Risk Action Plans were generic, and non-specific in addressing the health risks of the individual; ▪ Specific and measurable preventative interventions were not included in the Risk Action Plans; ▪ Interventions listed on the Risk Action Plans did not include specific clinical indicators to be monitored or the specific frequency included; and ▪ Basically all of the interventions on the Risk Action Plans reviewed were not in alignment with the designated risk rating of high or medium risks. The Monitoring Team had a few additional general observations for Section I that would assist in guiding the IDTs and in interpretation of the documents by all reviewers. ▪ There needed to be a system to document timeliness of steps outlined in the Settlement Agreement (i.e. beginning the assessment process within five days, proof of implementation within 14 days, etc.). ▪ For several individuals, there were numerous revisions of the IRRF and risk action plans in the past year. It is important to differentiate new information (with date that paragraph or statement was updated) from prior information. It was difficult to determine what had changed from one version to the next version. ▪ Teams needed to clearly define the assessments being requested to create a final risk action plan. For most IRRF documents, it was difficult to determine if additional assessments were being requested, and when the request was made, which is especially important for the five-day time period to begin the assessment process. ▪ It would be helpful to have a chart at the end of the document listing the assessments with columns to indicate when it was requested, when it was completed, when it was received by the IDT, and when it was discussed at an IDT meeting, and the date of the ISPA at which it was discussed and acted upon. ▪ The IRRF and risk action plan were inconsistent about including monthly/quarterly updates in the documents. There should be consistency across the campus about whether to include these in the reports or not. ▪ The ISP did not capture interdisciplinary discussion for most risks defined for the individual, but simply copied the risk from the IRRF. For many entries, the focus was on a contribution of a department to the ISP (i.e., medical, nursing, etc.), as opposed to a focus on the risk and how each department could contribute to preventing or minimizing the risk. ▪ The ISPs did not appear to reflect the process for health status change, or the questions raised at the morning medical meeting that resulted in an IDT meeting	

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		followed by an ISPA. Documentation of the health status change and the effectiveness of any steps taken as a result of implementation of the ISPA would be expected to be part of an amended or future ISP for that particular risk. For each hospitalization/ER visit, the goal would be to have a discussion of preventing a recurrence, with action steps that can be measured. ▪ The purpose of including transition information (especially dental) in the IRRF was not clear. Transition information might need to be placed in a different document or in a category of risk for transitions. However, when there were no immediate well-defined plans that were underway for a transition for the individual, it was unclear why it would be included in the IRRF. At the time of the review, the Facility indicated it was not in compliance with the requirements of the Settlement Agreement for this area. This finding was consistent with the findings of the Monitoring Team. However, the increase in the inconsistent and fragmented documentation regarding the At-Risk individuals was of significant concern. This made determining the chronological clinical sequence of events confusing and complicated in the midst of the ever-changing At-Risk system. CCSSLC should continue to focus its efforts on the process of developing specific and clinically appropriate risk action plans for each individual by the next review. These Risk Action Plans should meet the individuals' needs, contain functional, and measurable objectives, include clinical indicators to be monitored and the specific frequency of that monitoring, include preventative interventions, and be fully integrated into the ISPs.	

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

1. In prioritizing involvement in the ISP/at-risk process, PCPs should be expected to attend the at-risk discussion to ensure teams arrive at clinically appropriate conclusions. (Section I.1)
2. The PCP should provide background information concerning the diagnostic tests already completed, the dates of completion, with a brief entry concerning results. The IDTs 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 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)
4. Additional training on the at-risk process should be provided to the IDTs. 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)
5. 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)

6. Each IDT member should obtain all relevant information ahead of the meeting, especially information on which the team will base a risk rating. (Section I.1)
7. There should be evidence to confirm the team's rationale for each category of risk reviewed. (Section I.1)
8. When there is a change in health status, the IDT 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 IDT should meet promptly address any changes in health and functional status. (Sections I.1, I.2, and I.3)
9. It is important to create a standardized approach to differentiate the original plan/information from updates and other information that is entered into the plan, with dates of each additional entry. (Sections I.1, I.2, and I.3)
10. 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)
11. The Facility should create a tracking system listing dates of action that follow the identification of individuals at risk, including the assessment process and the development and implementation of risk action plans. (Sections I.2 and I.3)
12. The areas that the At-Risk Individuals policy designates that nursing is to assess should be reviewed to determine which discipline is the most appropriate to conduct those assessments. (Section I.2)
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 IDTs, at times, do not realize when more assessment is indicated, department heads should review IDT findings relevant to their department to ensure appropriate guidance is provided to the teams in determining needed assessments. (Sections I.1, and I.2)
15. A summary list of the assessment(s) being requested as a result of the IRRF or ISPA should be created to assist in tracking the completion of the assessment. To use this as a tracking tool, it would be helpful if it included the date of request, date completed, date received by the IDT, date discussed at an IDT meeting, and date of ISPA at which it was discussed and acted upon, if applicable. (Section I.2)
16. The Facility should decide upon a system for quarterly/monthly updates, including whether these should be maintained in the documents themselves, or in a separate document. (Section I.3)
17. The ISP and related action plans should capture the interdisciplinary discussion about the risks defined for the individual. (Section I.3)
18. 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)
19. The Facility should monitor the ISPs to ensure the risk ratings and action plans are integrated into individuals' ISPs. (Sections I.1, I.2, and I.3)
20. Regarding the Facility's self-assessment system addressing Section I, the Facility should evaluate who would be best to audit this highly clinical area in order to generate accurate information regarding clinical issues related to the individuals at risk. (Facility Self-Assessment)
21. Consideration should be given to standardizing the presentation of data across the Facility for consistency in interpretation, using, for example, tables to report monitoring findings rather than a narrative format that is more appropriately used to summarize the analysis of the data. (Facility Self-Assessment)
22. As the Facility's self-assessment processes evolve, additional data should be analyzed, addressed, and included in the Self-Assessment 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	
Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Policies related to the use of pre-treatment sedation medication; o 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; o Job Descriptions of Psychiatrists; o List of individuals whose psychiatric diagnoses have been revised, along with the Psychiatrist's rationale for the new diagnosis; o List of individuals prescribed intra-class polypharmacy, with total number of medications prescribed; o List of all meetings and rounds that the Psychiatrist typically attends, including other professional disciplines that usually attend those meetings; o List of support services for Psychiatry Department; o Minutes of Polypharmacy Meetings Review, for the last six months; o In response to Monitoring Team's request for documentation pertaining to complaints about the psychiatric and medical care at CCSSLC, document indicating no complaints; o Lists of individuals with tardive dyskinesia, and individuals being monitored for tardive dyskinesia; o List of all individuals prescribed psychotropic medication, including diagnosis, name of medication, and dosage; o List of all individuals prescribed anticonvulsant medication as a psychotropic medication; o List of individuals who were psychiatrically hospitalized within the prior six months; o List of Individual Support Plan Meetings attended by members of the Psychiatry Department within the prior six months; o Consent database for psychotropic medication; o Examples of the medication side effects monographs for five psychotropic medications; o Psychiatric symptoms tracking scale definitions, updated 6/29/12; o Reiss Scoring Sheets with results for every sixth individual listed on the Reiss Status Spreadsheet produced on 7/10/12; o Chemical restraint trending data for the last six months, and the chemical restraint administration documentation for the last six months; o Comprehensive Psychiatric Evaluation (CPE) completion status spreadsheet and ten examples of recently completed CPEs, which included Individual #186, Individual #169, Individual #183, Individual #326; Individual #46, Individual #20, Individual #88, Individual #34, Individual #332, and Individual #12; o Spreadsheet listing the dates of the Neurology Consultations and the corresponding Psychiatric Clinic Review for the last six months; o Neurology Clinic notes and the corresponding Quarterly Psychiatric Clinic notes for the

	following individuals: Individual #285, Individual #78, Individual #55, Individual #7, Individual #243, Individual #198, Individual #363, and Individual #213; o Spreadsheet of Reiss Screen Examinations for all CCSSLC individuals; o List of individuals receiving anticholinergic medication; o List of individuals prescribed benzodiazepines; o The following sections from the active record: Face Sheet; Social History; Rights Assessment; Consents for Psychotropic Medication; Consents for Pre-Treatment Sedation Medication; Human Rights Committee (HRC) section and Referral Form, as well as Addendums related to Psychotropic Medication; the Psychology section, including the PBSP and any addendums as well as the Functional Assessment; the Individual Support Plan and Addendums; Hospital section; Psychiatry section; Side Effect section; Pharmacy section; and the Neurology Consultation section for: ▪ The following individuals who were recently admitted to the Facility: Individual #97, Individual #63, Individual #61, Individual #40, and Individual #5; ▪ The following individuals who the Facility selected for the pre-review document request: Individual #231, Individual #359, Individual #237, Individual #13, Individual #112, Individual #279, Individual #158, Individual #298, Individual #295, and Individual #145; ▪ The following individuals who were selected based on the acuity of their psychiatric presentation: Individual #147, Individual #348, Individual #71, Individual #318, Individual #253, and Individual #145; 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 last six months; o List of individuals receiving Reglan as of 7/10/12 with notation as to which individuals are also followed in the Psychiatric Clinics; o Curriculum Vitae (CV) and Contracts for the locum tenens Psychiatrist, Dr. Jason Kirkpatrick; and the Consulting Psychiatrist, Dr. Michael Hernandez; o List of individuals who are prescribed Reglan and who are not followed in the Psychiatry Clinic, as well as the list of individuals who are prescribed Reglan and are followed in the Psychiatry Clinic as of July 2012; o MOSES and DISCUS side effect rating scores for the last year for the following individuals receiving Reglan who were not also receiving a psychotropic medication: Individual #43, Individual #205, Individual #252, Individual #113, and Individual #239; 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; o Chemical restraint documentation related to the administration of the following five incidents of chemical restraint: Individual #147 on 7/14/12, Individual #147 on 7/6/12, Individual #147 on 7/6/12, Individual #147 on 7/8/12, and Individual #237 on 7/7/12; o Documentation from the 7/11/12 Human Rights Committee Meeting;

	○ The material presented at the 7/10/12 Polypharmacy Committee Meeting; ○ The clinical information discussed at the 7/11/12 and 7/12/12 morning Medical Meetings; ○ The material that was presented and discussed at the 7/9/12 Pharmacy and Therapeutics Committee Meeting; and ○ The minutes of the Informed Consent Committee Meetings of 4/10/12 and 6/25/12. ▪ **Interviews with**: ○ Glynn Bogard, Psychiatric Assistant; Michelle P. Lora-Arteaga, R.N., Psychiatric Nurse; Brinda Fuller, R.N., Psychiatric Nurse; and Joseph Ward, Psychiatric Assistant, on 7/9/12 and 7/12/12; ○ Michael Hernandez, M.D., Consulting Psychiatrist, on 7/10/12; ○ Judy Sutton, MS, BCBA, Director of Behavioral Services; and Robert Cramer, Psy.D., Clinical Psychologist, on 7/9/12; ○ Donald Kocian, R.Ph., and Kenda Pittman, RPh, on 7/10/12; ○ Sandra Rodriguez, M.D., on 7/10/12; ○ Enrique Venegas, D.D.S.; and Kathy Roach, Dental Hygienist, on 7/10/12; ○ Karen Forrester, Human Rights Officer, on 7/11/12; ○ Glynn Bogard, Psychiatric Assistant; Brenda Fuller, R.N., Psychiatric Nurse; and Joseph Ward, Psychiatric Assistant, on 7/11/12; ○ Glynn Bogard, Psychiatric Assistant, to review Facility Self-Assessment, on 7/12/12; ○ Araceli Matehuala, Program Compliance Monitor for Psychiatry, on 7/12/12; ○ Mark Cazalas, Facility Director, on 7/10/12. ▪ **Observations of**: ○ HRC Meeting, on 7/11/12; ○ Polypharmacy Committee Meeting, on 7/10/12; ○ Individual transactions at the Reinforcement Token Economy Store, Kingfish Living Unit, on 7/11/12; ○ Medical Morning Meetings, on 7/11/12 and 7/12/12; ○ Pharmacy and Therapeutics Committee Meeting, on 7/9/12; and ○ The following individuals were observed during the onsite review of the Living Units and program sites: Individual #30, Individual #368, Individual #267, Individual #34, Individual #29, Individual #13, Individual #118, Individual #61, Individual #242, Individual #166, Individual #318, Individual #255, Individual #243, Individual #94, Individual #40, Individual #94, Individual #44, Individual #78, Individual #218, Individual #169, Individual #329, Individual #359, Individual #323, Individual #332, Individual #177, Individual #72, Individual #95, Individual #246, Individual #158, Individual #97, Individual #151, Individual #12, Individual #172, Individual #208, Individual #186, Individual #106, Individual #184, Individual #237, Individual #268, Individual #162, Individual #246, Individual #296, Individual #90, Individual #273, Individual #336, Individual #19, Individual #295, Individual #47, Individual #109, Individual #279, Individual #300, Individual #339, and Individual #11.

	Facility Self-Assessment: A member of the Monitoring Team reviewed the Facility Self-Assessment with the member of the Psychiatry Department who was the primary author of the document, and also had compiled the statistical information from which the results of the self-assessment were derived. The methodology that the Psychiatry Department utilized involved both a data-based approach, as well as case sampling methodology. The Facility maintained detailed databases related to specific documents, such as the CPEs and the new diagnostic checklists that were used to establish the psychiatric diagnosis (Sections J.2, J.6, and J.13), the polypharmacy statistics (Section J.11), the MOSES/DISCUS monitoring (Section J.12), and the Reiss Screening evaluations (Section J.7). They were able to utilize this information to document completion rates for the entire population of individuals receiving psychotropic medication. The sampling methodology for the individual cases consisted of selecting three individuals per month for the time period of December through May 2012. This produced a total of 18 individuals, which formed the basis for the analysis. Members of the Psychiatry Department then scored the records in relation to the 15 provisions of the Settlement Agreement. For example, for Section J.10, team members reviewed Progress Notes for individuals who had started using a new psychotropic medication within this timeframe. These notes were then analyzed to determine discipline representation in the process of determining whether or not the potential harmful effects of the mental health condition outweighed the potential risks of the medication. The presence and quality of the risk analysis also was assessed. The presence of the Guardian Consent was tracked via a separate spreadsheet with regard to Section J.14. The internal review for Section J.14 also included an assessment of the quality of the "consent form packets for psychotropic medication." These packets included the risk-benefit analysis, the rationale for the medication, the potential side effects of the medication, and the actual signed consent form. Where appropriate, both methodologies were employed. For example, for Section J.12, the Facility maintained and reviewed a detailed database of the MOSES and DISCUS status for all individuals who required those assessments, and they also reviewed the records of 25 individuals to determine if these assessments could then be located in the individuals' records. The self-assessment followed the format of the Settlement Agreement and the prior monitoring reviews. More specifically, each section was broken down into its key components and then the presence or absence, as well as the quality of those items were assessed. For example, for Section J.6 the team determined whether the CPE followed the prescribed outline in the Settlement Agreement and occurred within the annual timeframe. The team also assessed if a qualified Psychiatrist had completed it. The same general process was applied to the assessment of the Monthly and Quarterly Reviews for Section J.13. The Facility's self-ratings for the individual provisions paralleled those of the Monitoring Team, with only a few exceptions. This likely related to the similarity in the combination of a database and sampling approach. At the time of the previous Monitoring Review, the Facility's Self-Assessment of substantial compliance was similar to the Monitoring Team's assessment, with only one exception. The ratings for the current review were somewhat more divergent. Specifically, while the Facility and Monitoring Team's independent ratings were congruent for 12 of the 15 provisions, they were divergent for Sections J.3, J.6, and J.13.

	▪ With regard to Section J.3, the Facility's Self-Assessment of substantial compliance did not factor in the assessment of the chemical restraint data, which was deficient and, thus, led to the Monitoring Team to make a finding of noncompliance. Given that the quality of the documentation related to the use of chemical restraint relates directly to the components of Section J.3, the Facility might want to consider adding an analysis of these documents to their self-assessment process. ▪ The discrepancy between the Facility's ratings for Section J.13 of Substantial Compliance and the Monitoring Team's finding of noncompliance was primarily due to fact that a member of the Psychiatry team did not routinely attend the ISP Meetings and the efficacy of many of the prescribed medications could not be substantiated. ▪ With regard to Section J.6, the Monitoring Team's finding of substantial compliance was different from the Facility's, because the Facility focused on the lack of a completed CPE for the three individuals most recently admitted to CCSSLC from the community. The Monitoring Team noted that these individuals all had been admitted within six weeks prior to the onsite review, and even taking these three individuals into account, the Facility's overall percentage rate for CPE completion was still 98 percent. The representative of the Psychiatry Department indicated that they did not enlist the assistance of the Quality Assurance Department in carrying out their self-assessment for this monitoring review cycle. The rationale was that the Quality Assurance component had only been consistently present since March 2012. However, the interview with the member of the Quality Assurance Department who will be working with Psychiatry, as well as the review of the Quality Assurance monitoring data from March through the present time suggested that the collaboration between the Psychiatry team and the Quality Assurance Department should enhance the Facility Self-Assessment process.
	Summary of Monitor's Assessment: The Psychiatry Department had continued to make progress in a number of the 15 provisions of Section J of the Settlement Agreement. Perhaps the most notable of these was the completion of current Comprehensive Psychiatric Evaluations for all of the individuals receiving psychotropic medication prior to the April 2012 departure of the locum tenens Psychiatrist. The locum tenens psychiatrist had two prolonged stays at the Facility that were devoted solely to the completion of the initial CPEs, as well as the annual updates. Three of the individuals who had been admitted to the Facility within the six-week period preceding the onsite review did not have completed CPEs, although they had been seen and evaluated in the Psychiatry clinic and received initial side effect monitoring. This resulted in an overall completion rate of 98 percent. It was anticipated that the locum tenens Psychiatrist would return in the fall, prepare annual updates for the current CPEs, and complete initial CPEs for any individuals newly admitted. The CPEs, in conjunction with the Quarterly Psychiatry Review documentation directly applied to 10 of the 15 provisions of the Settlement Agreement. The Consulting Psychiatrist recently had decreased his consulting time from 12 to eight hours per week, and it remained to be seen if this would have a negative impact on the Facility's efforts to meet the requirements of the Settlement Agreement, or if the four members of the psychiatric support team would be able to compensate for this. The Facility was continuing to actively recruit full-time Psychiatrists for the two open Psychiatrist positions that were available.

	The psychiatry team had developed and implemented a psychiatric symptom tracking scale that defined 21 symptoms of the Major Axis I psychiatric diagnostic categories. This scale was designed to allow the treatment team to better document the symptoms that supported the psychiatric diagnosis and also track the frequency and intensity of these symptoms over time. This newly developed tool augmented the DSM-IV Diagnostic Checklists, which the Department previously had implemented fully. The full implementation of these initiatives, coupled with the Psychology Department's inclusion of a new section in their documentation entitled "Psychiatric Information" made it possible to differentiate the symptoms of the psychiatric disorder for which the psychotropic medication was prescribed from the challenging behaviors that were related to environmental or interpersonal factors. The separation of the consent for the psychiatric medications from the Behavioral Support Plans had been fully implemented. The consents were now obtained for each prescribed medication, which represented an improvement over the prior practice of pursuing consents for as many as four or five medications as a single package. As part of this development, a nurse obtained the consent for the medication, where previously the Associate Psychologist had been responsible for this task. At the time of the onsite review, the Psychiatry staff were just beginning an initiative to both attend the Individual Support Plan meetings for the individuals they followed, and also directly compose and place their material into the ISP documentation. This was another important development, because the language of the Settlement Agreement specifies that a number of discussions, such as the risk discussion related to the psychotropic medications and whether they represent the least intrusive intervention, should occur in the context of the ISP and then be documented there as well. This initiative was not apparent in the current review of the records of individuals who were receiving psychotropic medication, but it should be present in the next review cycle. The effort to develop pre-treatment desensitization plans had progressed, but would still be classified as in the early stages of implementation. There was an effort to develop these plans for medical interventions as well. This was important in light of the fact that the orders for pre-treatment sedation for medical procedures outnumbered those for dental procedures by a significant margin. The selection of the best medication to use for pre-treatment sedation for a specific individual occurred annually in the context of the Psychiatric Clinics, which members of the Pharmacy and Dental Departments also attended so that they could discuss these issues with the entire treatment team. The rate of polypharmacy with psychotropic medications was down to 50 percent from 56 percent in 2010. However, progress was incremental despite a monthly review in the Polypharmacy Committee Meetings, which was quite thorough. A primary recommendation of this report is that the Psychiatry Department increases its efforts to develop objective evidence to support the continued utilization of multiple medications for those individuals for whom they believe this is essential. CCSSLC continued to experience new admissions at the rate of approximately one individual every other month. To date, these had all been individuals who had not been able to be maintained in the community

	due to behavioral reasons and, thus, were admitted on multiple psychiatric medications. The range of psychiatric medications these individuals had been receiving on admission ranged from three to seven, with an average of 4.8 per person. At the time of the onsite review, the range for the number of medications for these same individuals was three to four, with an average of 3.4 per person, so the team had made considerable progress in reducing the polypharmacy for these complex individuals. The Quality Assurance Department was now actively involved with the Psychiatry team and had developed a thorough monitoring tool and format. The collaboration between the Quality Assurance Department and the Psychiatry Department should be a significant addition to the Department's ongoing self-assessment efforts. Thus, in summary, the Department continued to make progress in a number of areas. This progress is both recognized and documented in this report. As noted above, the Facility should focus on the matter of polypharmacy (Section J.11). These issues also impact the risk-versus-benefit process (Sections J.9 and J.10), the informed consent process (Section J.14), and the determination that the medications are effective (Section J.13).

#	Provision	Assessment of Status	Compliance
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 interview, which took place on 7/10/12, 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. Dr. Hernandez estimated that he had engaged in providing psychiatric services to individuals with ID/DD for over five years. He had been a psychiatric consultant to CCSSLC for approximately five 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. During the time periods both before and following the last review, the Facility had contracted with Dr. Jason Kirkpatrick through a locum tenens physicians' agency. Most recently, on 12/16/11, Dr. Kirkpatrick had returned to CCSSLC, and continued to work at the Facility until his departure on 4/6/12. 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 Comprehensive Psychiatric Evaluations for the individuals receiving psychotropic	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		medication. 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. Dr. Kirkpatrick was working on-site at the time of the prior onsite review of the Facility, and thus, it was possible to interview him on 1/2/12. During this interview, he indicated that he did not have any extensive clinical experience in working with individuals who have both intellectual deficits and mental illness. However, the format for the CPEs was familiar to him, both from his psychiatric training at the Institute of Living in Hartford, CT, as well as his subsequent psychiatric practice. In addition, 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-Spiritual Formulations that he had developed for the individuals that he reviewed. The status of the progress in completing the CPEs will be discussed below with regard to Section J.2. As noted above, Dr. Kirkpatrick had departed prior to the current Monitoring Review and, thus, it was not possible to interview him again, during the current review. The Facility was found to be in substantial compliance with this provision based on the observation that Dr. Hernandez was certified in Adult Psychiatry by the American Board of Psychiatry and Neurology, and Dr. Kirkpatrick was Board Eligible, having completed a psychiatric residency at a fully accredited training program. In addition, Dr. Hernandez had significant clinical experience with this specific population. While Dr. Kirkpatrick did not have this clinical experience, the review of the CPEs that he had completed indicated that he had a solid grasp of the clinical issues presented by individuals who have both mental illness and ID/DD.	
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.	As noted above, at the time of the review, the primary Psychiatrist who diagnosed and treated the individuals who resided at CCSSLC was Board Certified in Adult Psychiatry by the American Board of Psychiatry and Neurology. This Psychiatrist also had extensive prior experience in the diagnosis and treatment of psychiatric disorders in individuals with ID/DD. The locum tenens Consulting Psychiatrist, whose sole function was to complete the CPEs, was Board Eligible in Adult Psychiatry, having completed a residency in Adult Psychiatry at an accredited Psychiatry Residency Program. The background with regard to the two Psychiatrists is discussed in more detail with regard to Section J.1. Although the psychiatric diagnoses appeared in a number of sections of the individuals' records, the clinical justification that supported the validity of the diagnosis primarily appeared in the related sections of the CPEs and the Quarterly Psychiatry Reviews. The	Substantial Compliance

#	Provision	Assessment of Status	Compliance
		Quarterly Psychiatry Review process and documentation is discussed in detail with regard to Section J.13, because it is more pertinent to that section. As noted in the prior reviews, the Facility had begun an initiative to complete a thorough CPE that would comply with the terms of the Settlement Agreement for all of the individuals who were receiving psychotropic medication. The Facility's status with regard to the CPEs is discussed in detail in Section J.6. The discussion here primarily relates to the results obtained by the comprehensive review of records of 16 percent (n=20) of the 128 individuals who were receiving psychotropic medication at the time of the onsite review. The sample is described in more detail above in the section of this report that details the documents that were reviewed. The sub-sections of the individual records that were reviewed are also specified. The review of the clinical record of these 20 individuals indicated that there was adequate clinical justification for the diagnosis of record for 19 of the 20 individuals (95%). This documentation could be found in the sections of the CPE that specifically were devoted to the psychiatric diagnosis and the related section that discussed the "Bio-Psycho-Social-Spiritual Formulation." The material in the Quarterly Psychiatric Review documentation that specifically addressed this were the diagnostic sections, which included a listing of the overt symptoms of the disorder that the individual presented with, as well as the "DSM-IV Diagnostic Checklist." The checklists reproduced the diagnostic criteria for that individual's diagnosis as listed in the DSM-IV criteria, and then the specific symptoms manifested by the individual were checked off so that it was easy to determine if the DSM-IV criteria for that diagnosis had been met. In addition, CCSSLC had developed psychiatric symptom tracking scales. These scales provided operational definitions of 21 symptoms that are common to many of the most prevalent Axis I psychiatric disorders. The IDT, members of which routinely attended the Psychiatric Clinics, working in conjunction with the Consulting Psychiatrist and the broader psychiatry team tailored the specific symptoms that were monitored for each individual. The revised policy related to the psychiatric review, which was updated on 4/27/12, discussed these checklists under the sub-heading: "Ensuring Clinically Justified Psychiatric Diagnosis." The Presentation Book for Section J also contained information related to the training that was provided to the nurses regarding how to utilize this instrument, including the roster for the initial 4/20/12 training. The Unit Nurses monitored the frequency and intensity of these symptoms and the results were presented at the Quarterly Psychiatric Clinics, which direct support professionals also attended. They also would be able to comment on the frequency and intensity of these symptoms in that format. The raw data for this information was not included in the individual's record, but was commented on in the narrative portion of the quarterly psychiatry documentation, which was prepared by the Consulting Psychiatrist. The Psychiatry Department might want to consider developing a method to include a	

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		summary of the raw data in the record and/or incorporate a synopsis of this information into the Quarterly Psychiatric documentation in a manner that would compliment the behavioral data that the Psychology Department contributes. The record of the individual that did not contain adequate documentation to support the psychiatric diagnosis was that of Individual #295. The record of Individual #295 contained a different psychiatric diagnosis in the CPE and the Quarterly Psychiatric Clinic documentation. Specifically, the diagnostic and related "Bio-Psycho-Social-Spiritual" section of the CPE listed a diagnosis of "Adjustment Disorder with mixed disturbances of emotions and conduct." The formulation explained how the individual's behavioral status had improved following an environmental intervention and, in light of that, questioned whether the prior diagnosis of a Bipolar Disorder was accurate, and instead proposed the Adjustment Disorder. The Quarterly Psychiatric Clinic documentation continued to carry forward the Bipolar Disorder diagnosis. This was an unusual occurrence, because the policy of the locum tenens Psychiatrist was to discuss any discrepancies between his diagnosis and that of the Consulting Psychiatrist in a joint meeting between the two of them. This practice had resulted in concordance in the other records contained in the sample, except for Individual #97, who had been admitted so recently that a CPE had not yet been performed. CCSSLC also maintained data on the number of psychiatric diagnoses that had been modified or changed over the last six months, and this data indicated that there had been 16 diagnostic changes. This material also contained a description of the rationale for those changes, all of which appeared to be reasonable. The review of this information, as well as the clinical material in the sample of 20 individuals indicated that the Psychiatry Department at CCSSLC did not utilize "NOS" (Not Otherwise Specified) diagnosis, nor did they use "R/O" (Rule Out) qualifiers unless they were indicated for a brief period of time for a newly admitted individual. The review of the spreadsheet that listed the names, psychiatric medications, and psychiatric diagnosis for all of the individuals who were receiving psychotropic medication also confirmed these observations. An issue that had been identified in the Monitoring Team's previous reports with regard to psychiatric diagnoses related to the observation that the identified target behaviors of the psychiatric medications were frequently described in the Psychology section of the record as stemming from learned behavioral and/or an environmental issue. The current review found that this problem had been rectified and did not occur in 19 (95%) of the individual records reviewed. The one exception was that of Individual #295, because the Psychology section of the record had maintained the Bipolar Disorder as a psychiatric diagnosis, which was consistent with the Quarterly Psychiatric Clinic documentation, but was different from the CPE. The explanation that was contained in	

#	Provision	Assessment of Status	Compliance
		the CPE was compelling with regard to the rationale for the Adjustment Disorder diagnosis. The Facility's improvement in this regard was primarily due to two systematic changes that the Psychiatry Department and Psychology Department had implemented in their respective documentation. These changes were also directly responsive to recommendations that had been made in the Monitoring Team's previous reports. As mentioned above, the Psychiatry Department now identified the symptoms of the psychiatric diagnosis for which the medication was prescribed, and to determine the efficacy of the medication, it was the frequency and intensity of those symptoms that was primarily measured. The link between the symptoms of the psychiatric disorder and the monitored behaviors also was clarified in both the CPE and the Psychiatric Quarterly Review documentation. The Psychology Department had added a section to their documentation entitled: "Psychiatric Information," which included the psychiatric diagnosis as well as the impact of that psychiatric disorder on the individual's challenging behaviors. Thus, it was possible from these sources to ascertain which behaviors the team judged to be related to the symptoms of the psychiatric disorder, as opposed to being present on a purely behavioral basis, or influenced by both biological and behavioral factors. The finding of substantial compliance was based on the consistency with which these assessments were carried out, the thoroughness of the clinical documentation, and the concordance between the diagnostic material that was contained in the Quarterly Psychiatric documentation, the CPEs, and the Psychology section of the individual records. An important component of maintaining substantial compliance with this provision is the regular updating of the CPEs. Due to the fact that the first round of the completion of CPEs recently had been completed, this requirement had only been partially tested. However, during upcoming reviews, annual updates to CPEs will be necessary for substantial compliance to be maintained.	
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	The individual interviews with the Psychiatry Department, as well as the review of the records of 20 individuals who were receiving psychotropic medication, did not reveal any evidence that psychotropic medication was being overtly used for the convenience of the staff, or as a form of punishment. No Psychiatric Clinics were scheduled during the current onsite review and, thus, it was not possible to make direct observations of the procedures. However, these Clinics had been observed on numerous occasions during previous reviews. Those prior observations indicated that the individual's Psychologist was an essential member of the interdisciplinary team present at the Psychiatric Clinics.	Noncompliance

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	of staff, and effective immediately, psychotropic medications shall not be used as punishment.	During the onsite review, a member of the Monitoring Team directly observed approximately 49 percent of the 128 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 routinely used for the convenience of the staff. The presence of an appropriate psychiatric diagnosis that would warrant the use of psychotropic medication is discussed with regard to Sections J.2, J.6, and J.13. In addition, the review of the spreadsheet listing all of the individuals prescribed psychotropic medications indicated that each of these individuals had a psychiatric diagnosis of record. The 20 records that were reviewed indicated that an active Positive Behavior Support Plan (PBSP) was in place for each individual who was prescribed psychotropic medication. The adequacy of the PBSPs is discussed in detail with regard to Section K.9. However, the Monitoring Team's previous reports had noted a significant concern in that behaviors identified as the "target behaviors" of the psychotropic medication also were identified in the Functional Analysis and related PBSP as being present on a behavioral basis and/or related to environmental factors. This observation suggested that for these individuals, the prescribed psychotropic medication could have been utilized to suppress behaviors that were not directly derived from a psychiatric diagnosis, which would not be consistent with the terms of this provision of the Settlement Agreement. In other words, they potentially were being used in the absence of adequate behavioral treatments or interventions. However, the Psychiatry Department, working in conjunction with the Psychology Department had now effectively addressed this problem through the development of collaborative, systemic methods. These methods are described in detail with regard to Section J.2 and summarized in relation to Sections J.8, J.9, and J.13. The use of chemical restraint could be construed as punishment, because it frequently involved the intramuscular (IM) injection of a psychotropic medication against an individual's will. Thus, the description of the circumstances surrounding the involuntary administration of intramuscular antipsychotic and/or anxiolytic medication was extremely important in differentiating between the necessary utilization of these interventions to prevent physical harm to the individual and/or others, as opposed to being used to punish an individual for aggressive behavior, or for the convenience of staff in responding to a difficult situation. In order to further assess the circumstances surrounding the use of chemical restraint at	

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		CCSSLC, the related documentation was requested for the most recent five incidents that involved the use of chemical restraint, as summarized below:	

INDIVIDUAL	DATE	TIME	MEDICATION
Individual #147	7/4/12	11:10 p.m.	Ativan 2 milligrams (mg) IM
Individual #147	7/6/12	11:15 a.m.	Zyprexa 5mg IM
Individual #147	7/6/12	3:00 p.m.	Ativan 2mg IM
Individual #147	7/8/12	1:00 p.m.	Ativan 2mg IM
Individual #237	7/7/12	8:23 p.m.	Zyprexa 10mg IM *

*****The Restraint Form did not contain this information, as the section was blank. This information was obtained from the Physician's Orders, dated 7/7/12 at 19:55 hours (7:55 p.m.).

The individual restraint data was reviewed for the presence and quality of the five components of the documentation that the Facility utilized to record the events preceding, during, and following the administration of chemical restraint. These sections and the results of this review were as follows:

1. The information contained in the section of the form following the prompt: "Description of behaviors prior to restraint" was reviewed. This section of the documentation had been completed for all five of these individuals. However, the documentation for these individuals only described the overt behavior that necessitated the restraint, and not the "events" that precipitated this behavior.

   For example, the information contained in this section for the 7/6/12 (3:00 p.m.) chemical restraint for Individual #147 was as follows: "SIB, pulling hair, hitting self on face and chest. Hitting and scratching self." This description (which was similar to the others in this sample) could be considered to be responsive to the prompt that appeared in bold type to the left of the section, which stated: "Description of behaviors prior to restraint." However, within the response area (but in a smaller font) the following, more precise directions appeared: "Describe the individual's environment, actions and interactions with others in the time before you began taking steps to avoid the use of restraint."

   The nature of the responses found in this sample, which were similar to those found during previous reviews, suggested that the staff were responding to the primary prompt, which appeared in bold type, and not the more specific directions presented in a smaller font. A response to the more specific directions is essential to provide the information necessary to determine if these very intrusive interventions are being appropriately utilized. This information also would be of use to the individual's Psychologist in determining if

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		programmatic strategies could be developed to prevent or minimize the need for chemical restraints in the future. Based on the current available documentation, it was impossible to determine if the aggressive behavior was provoked by an unnecessary demand, or another environmental precipitant that might have been avoided. The Psychology Department should further investigate this observation to ascertain if changes in the format of the documentation and/or additional training are needed. 2. The section that followed the prompt to describe: "Interventions attempted to avoid restraint" was completed for all five of these individuals. This information was collected with a checklist. Although this list contained a number of options, it did not provide the specificity that would be provided by a narrative report. The checklist menu included a total of 16 different items and without some internal auditing method, it would be impossible to determine the accuracy with which these were completed. In addition, the presence of the checklist appeared to contribute to the narrative section following the checklist either not being completed or containing little useful information. 3. The portion of the documentation in which the physiological post-restraint monitoring was recorded was appropriately completed for all of the individuals in this sample, with the exception of Individual #237. This section of the documentation was blank for Individual #237. The monitoring of the individual's physical status after the administration of the Chemical Restraint is necessary to ensure the safety of the individual, and thus, is an essential component of the process. 4. The face-to-face post-restraint debriefing also was present for all of these individuals. 5. The Chemical Restraint Clinical Review Form, which contained sections for the Pharmacy and Psychiatrist to comment on the appropriateness of the chemical restraint and any information that might be used to prevent further episodes was completed for four of these five individuals (80%), with the exception of Individual #237, for whom the documentation was absent. Documentation had been completed within 48 hours for three of the four individuals for whom it was present (75%). This documentation primary addressed the pharmacological aspects of the Chemical Restraint, such as whether the medication utilized was appropriate in light of the individual's history and their overall pharmacological profile. It did not address whether or not the reviewer felt that the specific circumstances warranted the use of Chemical Restraint and/or if its use could have been avoided. The episode for which there was a delay of greater than 48 hours in completing this information was the 7/6/12 (3:00 p.m.) chemical restraint for Individual	

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		#147. The psychiatric section of this report was completed for this individual on 7/10/12, and the Pharmacy information was completed on 7/11/12. One of the Psychiatric Nurses completed the psychiatric section, and this was clearly indicated on the form, which required the signature of the Pharmacist and Psychiatrist. However, during the onsite interview, the Clinical Pharmacist indicated that these forms were now circulated via e-mail, and he completed the form electronically, hence there was no written signature. The lack of data related to the 7/7/12 chemical restraint for Individual #237 is worthy of further discussion. In light of the missing data regarding the medication utilized and the lack of physiological monitoring, it appeared that this might have been the documentation for a physical restraint, although it was produced in response to the document request for a sample of the most recent chemical restraints. In addition, a Physician's Order was found for the administration of Zyprexa 10mg IM on 7/7/12 at 19:55 hours (7:55 p.m.), which would constitute a chemical restraint. This would appear to be temporally related to the 8:23 p.m. restraint information on the same date, because there is usually a delay of several minutes between when the order is given and the medication is administered, due to the time required for the nurse to prepare the syringe and the related documentation, and to assemble the staff necessary to ensure the physical stability of the individual while the nurse administers the injection. This more detailed information is discussed here so that the Psychology Department can determine if there was a significant breakdown of the documentation for this episode of chemical restraint, or if these omissions represent a clerical error. Thus, these essential elements of the documentation needed to verify the appropriate utilization of the involuntary administration of intramuscular medications were fully completed in a timely manner for only three of the five individuals in this sample (60%). In addition, the important section of this documentation that was intended to describe antecedents to the use of chemical restraint, while completed, did not contain information that was directly responsive to the question, as discussed above. Although no instances were found in which the documentation showed chemical restraint was definitively used as punishment, the documentation should be improved to allow Facility staff as well as external reviewers to determine that it was not used as punishment or for the convenience of staff. As detailed above, the Facility had made progress with regard to the differentiation of psychiatric symptoms and behaviors that were present on a behavior basis or in relation to environmental factors. Progress also had been made in ensuring individuals had accurate psychiatric diagnoses that justified the use of psychotropic medication.	

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		However, the rating of noncompliance is based on the finding that the chemical restraint documentation was deficient, and without this it was not possible to conclude that chemical restraint was not being inappropriately used for punishment or for the convenience of staff.	
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.	At the time of the Monitoring Team's previous review, a new initiative related to this provision of the Settlement Agreement had been developed and implemented. It involved the establishment of an inter-disciplinary process to ensure the appropriateness and safety of medications 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, the Psychologist, the Clinical Pharmacist, and the Dentist. These reviews were scheduled to occur at the beginning of the Psychiatric Clinics, because all of the disciplines identified above routinely participated in these meetings, with the exception of the Clinical Pharmacist and the Dentist. The scheduling of the reviews at the beginning of the meetings allowed the Pharmacist and the Dentist to participate in an efficient manner. The spreadsheet tracking the occurrence of these meetings indicated they had been completed for the current year for all of the individuals that required these interventions (100%). In addition, the Quarterly Psychiatric Review documentation for each of the 20 individuals in the review sample (100%) contained a reference to this meeting and the date on which it occurred. Specific concerns related to the quality of the current Desensitization Plans are discussed with regard to Section C.4 of the Settlement Agreement. At the time of the prior review, the Facility had developed a methodology for determining who would likely benefit from a Desensitization Plan to reduce the need for pre-treatment sedation. The Facility's plan involved identifying individuals whom they believed were not candidates for a Desensitization Plan, because they had neurological conditions, such as Cerebral Palsy, and required a benzodiazepine medication prior to a dental visit, primarily for the muscle relaxant properties. The other group, which the new decision-tree screened out, consisted of individuals who were thought to have an innate, organically driven, motor restlessness that would make them poor candidates for a Desensitization Plan. The criteria that the Psychology Department utilized to define the population that would not potentially would benefit from a desensitization plan included the inability to sit still for more than three minutes either due to motor spasticity or what was conceptualized as an organically driven state. The list of individuals identified using this filter was contained in a spreadsheet, undated, produced in response to an onsite document request. This spreadsheet contained the names of 57 individuals. The reasons identified for an individual not being a candidate for dental desensitization included "Physiological spasticity" (N=34); "Edentulous" (N=2); and "No Sedation	Noncompliance

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		Required" or "No problems at Dental (N=21). Based on the Monitoring Team's review of ISPs, the validity of this screening process was questionable. For example, for Individual #228, the ISP and IRRF indicated that the behavioral services staff said she was not a candidate for desensitization "because of her spasticity." However, the description of her resistance to dental appointments did not appear to have anything to do with spasticity. The IRFF stated: "During appointments she exhibits anxious (sic), has excessive movement and is resistive to exams, she bends at the waist as avoidance and grabs hands." Based on this example, it was unclear if the criterion related to an individual's diagnosis was being used without regard for other behavioral considerations that would be important in defining which individuals should have a desensitization plan developed. Further complicating the interpretation of this data, a spreadsheet, dated 6/11/12, which was entitled: "Deemed Inappropriate for Desensitization Plans" was included in the Presentation Book for this provision. That document listed the names of 45 individuals, 32 of which were deemed not to be candidates for a desensitization plan because of either "Physiological" or "Physiological-Spasticity." The other individuals were considered to not be candidates because either they were edentulous or did not require pre-treatment sedation. The reason for these discrepancies was not clear. Another onsite document requested produced a spreadsheet that was labeled "CCSSLC: Individuals with Desensitization Baselines." This spreadsheet contained an alphabetical listing of 182 individuals, that included: 1) their residential unit; 2) whether or not their decision-tree and baseline had been completed for a Desensitization Plan for dental and/or medical procedures; and 3) where applicable, the status of each plan. On this list, there were some individuals for whom "NA" was indicated, but when their names were cross-referenced with the list of individuals who were not candidates for Desensitization Plans, they were not included on that list. Presumably, this meant that the process had not begun. This spreadsheet was not dated, but the most recent date that appeared in any column was 2/21/12. Therefore, either it had not been updated since that time, or there had been no substantial progress since that time. A more recent spreadsheet, which was included in the Presentation Book for this provision. This document was labeled: "Individuals with Desensitization Plans," dated 6/11/12, and contained an alphabetical listing of 116 individuals including their residential unit, the date their initial plan was developed, as well as the date of any subsequent updates to that plan. All of these individuals were identified as having such a plan for Dental procedures. This information further indicated that 51 of these individuals also had a desensitization plan for medical procedures. These numbers are consistent with those the Director of Behavioral Services supplied during the onsite interview on 7/9/12. The data regarding the completion and current status of the desensitization plans would be more useful and comprehensible if it were consolidated into a master spreadsheet that was continuously updated.	

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		The purpose of the Desensitization Plans or other strategies was 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 medication to the extent possible. Accordingly, the Facility should track information specifically that identifies those individuals for whom the implementation of a behavioral Desensitization Plan or other strategies had resulted in their no longer requiring pharmacological pre-treatment sedation for dental and medical procedures, or resulted in a reduction in the use of pre-treatment sedation. This was not occurring at the time of the review. The Dental Services Department had been maintaining data on the frequency with which intravenous (IV) sedation and pre-treatment oral sedation were required to accomplish successful dental appointments. At the time of the Monitoring Team's previous review, this data indicated that approximately 90 percent of the total monthly dental appointments were accomplished without either pre-treatment sedation or IV anesthesia. During the onsite meeting with the Facility Dentist and the Dental Assistant, they noted that these percentages continued to be approximately within the same range. The review of the Facility orders for pre-treatment sedation for both dental and medical procedures from 1/20/12 through 6/30/12 confirmed that during that time period the orders were primarily for Ativan (a benzodiazepine), in a range from 1mg to 3mg, and/or Atarax (an antihistamine with sedative properties) in a range of 50mg to 100mg. The Director of Dental Services indicated that if standard, conservative dosages of sedative medications were not effective, the Psychiatry staff and/or the Pharmacy would be consulted for additional recommendations and, as noted above, the Facility had developed a procedure for the multidisciplinary review of individuals' pre-treatment sedation in the context of the Quarterly Psychiatric Reviews. The IV anesthesia monitoring was very detailed. The Consultant who actually administered the anesthesia also performed the monitoring. The monitoring for the physiological effects of the oral pre-treatment sedation was initiated on the residential units, as the medication itself was administered on the residential unit 60 to 90 minutes prior to the appointment in the Dental Clinic. Thus, the pre-administration monitoring of the individual's physiological status was performed at the residence and then transitioned to the Dental Clinic at the time of the appointment. After the work in the Dental Clinic was completed, when the Dental staff felt it was appropriate to release them, the individual returned to their residential unit. The topic of the physiological monitoring related to the use of pre-treatment sedation for dental appointments is discussed in more detail with regard to Section Q of this report.	

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		As noted above, the Facility had devoted a great deal of attention to determining which individuals required plans to minimize the use of pre-treatment sedation and monitoring the use of pre-treatment sedation for dental procedures. However, the documentation that detailed the utilization of pre-treatment sedation from 1/1/12 to 6/30/12 indicated that the majority of pre-treatment sedation at CCSSLC was utilized for medical appointments. For example, a limited review of the data of the first 20 individuals listed in this database indicated that the frequency of orders for dental procedures was 13, as compared to 27 orders for pre-treatment sedation for medical appointments or procedures. The total number of these orders exceeded 20, as there were multiple orders for some of the individuals during this time period. Close examination and inspection of the entire spreadsheet indicated that this ratio varied considerably over time, but the observation was consistent that the frequency of pre-treatment sedation orders for medical procedures greatly exceeded the number for dental procedures. As with the orders for pre-treatment sedation for dental procedures, the majority of the orders for medical procedures were for Ativan, in a range of one to 3mg and/or Atarax, in a range of 50mg to 100mg. Overall, the medications utilized appeared to be appropriate and were prescribed in moderate dosages. As indicated above, the Psychology Department had begun to develop Desensitization Plans for medical procedures, but this process was not as developed as that for dental procedures. The Facility had an adequate process in place for coordinating pre-treatment sedation for dental procedures with other medications, supports and services including as appropriate psychiatric, pharmacy and medical services. However, there did not appear to be a well-developed monitoring system for the use of pre-treatment sedation for medical procedures. The finding of noncompliance for this provision was primarily based on the observation that fully effective operational Desensitization Plans or other strategies to reduce the need for pre-treatment sedation for medical and/or dental procedures had not yet been fully developed and/or fully implemented.	
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	The Monitoring Team's previous 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 residing at the Facility, because many of these individuals presented with complex psychiatric disorders. The current utilization rates of multiple psychotropic agents for numerous individuals would suggest that this is a reasonable estimate. During the 7/9/12 interview with the professional support staff of the Psychiatry Department, a specific inquiry was made as to whether the above determination was	Noncompliance

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	this section of the Agreement.	supported by any empirical analysis of the time that would be required to fully meet all of the provisions of the Settlement Agreement, including participation in the ISP process. The Psychiatry team responded that both the locum tenens Psychiatrist and the regular Consulting Psychiatrist had commented on this issue and they were both in agreement that two full-time Psychiatrists or equivalents would be adequate. However, these opinions were not based on an empirical time allocation analysis, but rather were primarily subjective in nature. The Facility should consider performing a more detailed empirical analysis of the amount of psychiatry time that would be required to meet the requirements of the Settlement Agreement. This analysis also should take into account the functions that are performed by the Psychiatry Department support staff, such as attendance at the ISP meetings. The Facility was relying on one part-time Consulting Psychiatrist to provide the day-to-day psychiatric care to all of the 128 individuals receiving psychotropic medication. His weekly allotment of time recently had been decreased from twelve to eight hours (two four-hour blocks per week). This equated to 20 percent of one full-time equivalent Psychiatrist. As noted above with regard to Section J.1, the Consulting Psychiatrist was Board Certified in Adult Psychiatry. An additional locum tenens Psychiatrist had been on site on a full-time basis for six weeks following the January 2011 review. His time was devoted to completing the CPEs for the individuals prescribed psychotropic medication. The same Psychiatrist returned to CCSSLC on 12/16/11, and was still present at the time of the January 2012 site visit. He departed the Facility on 4/6/12, at which time current CPEs had been completed for all of the individuals receiving psychotropic medication. (This process is described in more detail with regard to Section J.6.) He estimated that it required eight to 10 hours to complete a CPE. As noted above, with regard to Section J.1, the locum tenens Psychiatrist was eligible to take the Psychiatry Board Examinations, but had not done so. 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 provided, made it possible to maximally utilize the limited amount of psychiatry time that was available. However, psychiatric staffing remained inadequate to meet the psychiatric needs of the individuals CCSSLC supported. During the interview with the Facility's Director, he described the efforts that CCSSLC had undertaken to recruit additional Psychiatrists. Thus, the Facility's administration had been making an active, sustained effort to address this deficiency, but had not yet been successful and, thus, the finding of noncompliance was carried forward from the prior review.	

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J6	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement procedures for psychiatric assessment, diagnosis, and case formulation, consistent with current, generally accepted professional standards of care, as described in Appendix B.	As indicated in the Monitoring Team's previous reports, CCSSLC had developed an initiative to complete a thorough CPE for each individual receiving psychotropic medication, which they believed would meet the requirements set forth in the Settlement Agreement. The review of the active records of 20 individuals receiving psychotropic medication identified a recently completed CPE for 17 of the 20 individuals in the sample (85%). However, the three individuals who did not have completed CPEs had been admitted to the Facility within the six-week period prior to the onsite review, and it is reasonable to conclude that this timeframe would not have provided sufficient time to collect the necessary historical information and make the clinical observations necessary to complete these comprehensive assessments. It should be noted that these individuals did have initial Psychiatric evaluations as documented in the Psychiatric Clinic notes, and also had baseline side effect evaluations. The CPEs average approximately 10 single spaced pages and in order to fulfill the criteria specified in the Settlement Agreement must contain a great deal of historical information. As will be discussed below, in addition to the record review, the Psychiatrist who is completing the evaluation also interviews both direct support professionals and other professional members of the team as well as family members, if possible. These activities all require a certain amount of time to both schedule and complete. In addition, for those individuals for whom the Psychiatric Diagnosis is ambiguous and/or there are multiple possible psychiatric diagnoses that must be ruled out, this determination can consume an extended amount of time in order to be able to establish the most appropriate diagnosis. This process naturally varies depending on the complexity of the individual's presentation, but it could well take somewhat longer than six weeks to complete. The locum tenens Psychiatrist (who had left the Facility in April of 2012) had completed all of the CPEs, with the exception of Individual #40 and Individual #5, who had been admitted to the Facility during the January through April timeframe. The Consulting Psychiatrist had completed these CPEs. The review of the spreadsheet that the Facility maintained to track the completed and annual updating of the CPEs indicated that a current CPE had been complete for all of the 128 individuals prescribed psychotropic medication, with the exception of the three individuals mentioned above. These individuals were included in the current sample of individual records, because they had been admitted to the Facility within the six weeks prior to the onsite review. Thus, at the time of the onsite review, a CPE had been completed for 125 of the current 128 individuals receiving psychotropic medication (98%). In order to further assess the integrity of the spreadsheet, an additional sample of ten individuals was selected from the spreadsheet to augment the 20 individuals in the sample. This brought the total number of CPEs reviewed to 27 of the 128 individuals	Substantial Compliance

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		(21%) receiving psychotropic medication. The CPEs of the additional ten individuals were those of Individual #186, Individual #169, Individual #183, Individual #326, Individual #12, Individual #20, Individual #46, Individual #88, Individual #34, and Individual #332. The format and content of these documents also met the criteria specified in the Settlement Agreement, and had been completed and/or updated by the locum tenens Psychiatrist within the prior year. The CPEs included the components set forth in Appendix B of the Settlement Agreement. They began with a description of the documents reviewed, and the people interviewed in the process of gathering the information necessary to complete the CPE. This section of the CPEs indicated that, in addition to the extensive document reviews, the Psychiatrist interviewed both direct support professionals and other members of the staff, including clinicians. Family members also were contacted, if possible, and the individual was interviewed. However, if the individual was incapable of verbal interaction, there was a period of direct observation. The diagnostic sections of the records provided a thorough description of the symptoms that supported the psychiatric diagnosis, and the Bio-Psycho-Social-Spiritual formulation section presented a cohesive description of the rationale for the individuals' diagnosis and the impact that this psychiatric disorder had on his/her functional status. The quality of the individuals' psychiatric diagnosis is also discussed with regard to Section J.2. In summary, the review of the sample of 20 individual records indicated that the psychiatric diagnosis for 19 of the individuals 20 (95%) receiving psychotropic medication contained adequate documentation to justify the individuals' psychiatric diagnosis. As further noted with regard to Section J.2, the review of Individual #295, for whom there was a discrepancy between the diagnosis contained in the CPE and the Quarterly Psychiatric Clinic documentation indicated that the discussion contained in the CPE was more comprehensive and compelling than that contained in the Quarterly Psychiatric Clinic documentation. In summary, the finding of substantial compliance for this provision was based on the quality of the CPEs, which met the requirements set forth in the Settlement Agreement, and, in addition, these documents all had been completed and updated within the last year for all of the individuals prescribed psychotropic medication, with the exception of the three individuals who had been admitted to the Facility within the six weeks prior to the onsite review. The overall completion rate at the time of the onsite review was 98 percent.	
J7	Commencing within six months of the Effective Date hereof and with	A spreadsheet, updated on 6/5/12, listed the individuals that had been administered the Reiss Screen for Maladaptive Behavior in April of 2012. The Facility's policy was to	Substantial Compliance

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	full implementation within two years, as part of the comprehensive functional assessment process, each Facility shall use the Reiss Screen for Maladaptive Behavior to screen each individual upon admission, and each individual residing at the Facility on the Effective Date hereof, for possible psychiatric disorders, except that individuals who have a current psychiatric assessment need not be screened. The Facility shall ensure that identified individuals, including all individuals admitted with a psychiatric diagnosis or prescribed psychotropic medication, receive a comprehensive psychiatric assessment and diagnosis (if a psychiatric diagnosis is warranted) in a clinically justifiable manner.	repeat the Reiss Screen for all of the individuals who were not receiving psychotropic medication each year. The spreadsheet contained the Reiss administration dates (in 2012) for the 132 individuals to whom the Reiss had been administered. The Facility census at the time of the July onsite review was 259, at which time 128 individuals were receiving psychotropic medication. The minor discrepancy in the total number of individuals (i.e., one) was likely related to changes in the census between the time when the Reiss Screen was administered in April 2012 and the onsite review. Each of the Monitoring Team's initial three reports included the results of an analysis of a distinct 20 percent sample of individuals who had been administered the Reiss Screening instrument. This methodology verified the accuracy of the data by comparing the information contained in the spreadsheet to a copy of the actual Reiss scoring sheet for each individual in the sample. Each of these prior reviews confirmed that the information in the spreadsheet was 100 percent accurate. The current review focused on those individuals for whom the Reiss Screen had been administered since the previous monitoring review. Since the last review, the Reiss Screen was not administered to individuals admitted to CCSSLC who were receiving psychotropic medication, because they were evaluated with a psychiatric evaluation instead of a Reiss Screen for Maladaptive Behavior. All of the individuals admitted since the last review were receiving psychotropic medication at the time of their admission. A request for the names of the individuals whose score on the Reiss (CCSSLC utilized the commercially available computer scoring for the Reiss) was above the cut-off score that prompted further clinical assessment indicated that this year there were no scores above the clinical cut-off score that would have precipitated a CPE. In order to further evaluate the Facility's diligence in following up on elevated Reiss scores, a sample of Reiss scoring sheets was requested during the onsite review. Specifically, the actual Reiss scoring sheets were requested for every sixth individual on the Reiss Spreadsheet, beginning with number six. This request produced the raw data for 21 individuals of the total of 132 (16%). The range of these scores was from zero to five, well below the clinical cut-off score of nine. Therefore, none met the criterion for a referral to Psychiatry for a CPE. This analysis again verified the integrity of the spreadsheet with regard to the dates the Reiss Screenings were administered, and also indicated that for this random sample of 21 individuals, the scores were below the clinical cut off. At the time of the prior review, the Reiss Screenings for April (2011) had produced five individuals whose scores were above the clinical cut off, and they were referred for a CPE and Psychiatric/psychological follow-up as required. Although the status of these five individuals was not specifically investigated at the time of this review, it is possible that the prior yearly screenings had identified individuals who had experienced a change in their psychological status, which	

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		then had been clinically addressed. The yearly screenings with the Reiss instrument essentially functioned as an annual screening of all of the individuals not followed in the Psychiatric Clinics. The finding of substantial compliance is carried over from the previous review, because the annual screening of all individuals not receiving psychotropic medication provides a mechanism for assessing if such individuals have experienced a change in their status that would benefit from a psychiatric assessment.	
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 integration between Psychiatry and Psychology Services was apparent in the interviews with the Director of Psychological Services, the Consulting Psychiatrist, and the other members of the Psychiatry Department. During this review, Psychiatry Clinics did not take place while the Monitoring Team was on site. However, during the Monitoring Team's previous reviews, it had been possible to observe multiple Psychiatric Clinics. These observations indicated that the Psychologist played an important role in both the conduct of the meeting, and the analysis of the behavioral data upon which key decisions related to changes in the psychotropic medications were based. In terms of case formulation, the Monitoring Team's previous reports revealed a persistent deficit in this collaboration. Specifically, this was the co-identification of the same behaviors as being both a "target behavior" of the prescribed psychotropic medication, and as also being present on a learned or behavioral basis in the Functional Analysis and the PBSP. As indicated in previous reports, it is entirely possible that a given behavior could be co-determined by both biological and behavioral factors, but the rationale for this determination should be delineated clearly. The Psychiatry Department, working in conjunction with the Psychology Department, had developed a system, which was responsive to recommendations in Monitoring Team's previous reports, to integrate pharmacological treatments with behavioral and other interventions through combined assessment and case formulation. This subject is also relevant to Sections J.2 and J.9 of the Settlement Agreement, where it is discussed in further detail. In summary, these innovations clarified the symptoms of the psychiatric disorder for which the psychotropic medication was prescribed. The related PBSPs, developed by the Psychology Department, included a section entitled: "Psychiatric Information" and described how the psychiatric disorder would affect the individual's behavioral presentation for those individuals for whom this was relevant. This coordinated, complimentary documentation was evidence of collaboration between the Psychiatry and Psychology Departments, with regard to combined case formulation. The accuracy and integration of the behavioral data into the Psychiatry Clinics and	Noncompliance

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		documentation is discussed in detail with regard to Section J.13. The Psychiatry Department's utilization of objective measurement tools is discussed in Sections J.2 and J.13. The primary disciplines that attended the Monthly and Quarterly Psychiatry Clinics were Nursing, Psychiatry, Psychology, Medicine, a direct support professional, and a Qualified Developmental Disabilities Professional. However, disciplines such as Occupational Therapy and Physical Therapy were not able to attend the individual Psychiatry Clinic reviews, due to time constraints. These disciplines often did attend the individual ISP meetings. The ISP meeting documentation was reviewed for the 20 individuals in this sample. This review indicated that a member of the Psychiatry Department attended a recent individual ISP meeting for the following three individuals (15%): Individual #318, Individual #63, and Individual #5. A request for a list of individual ISP meetings that a member of the Psychiatry Department had attended within the last six months indicated that a member of the Psychiatry Department had attended the ISP meeting for the following eight individuals and (date of ISP): Individual #5 (2/15/12), Individual #318 (6/12/12), Individual #118 (5/3/12), Individual #191 (2/22/12), Individual #234 (7/6/12), Individual #63 (6/19/12), Individual #275 (3/27/12), and Individual #97 (4/20/12). The documentation from the ISP meetings that were reviewed in this sample did not fully reflect the psychiatric aspects of the individuals' treatment in any of the individual records reviewed. There was a discussion of the psychological treatment plan and reference to the individuals' psychotropic medication, but no detailed information was included to reflect the psychiatric aspects of their presentation. In addition, the ISPs did not include action plans related to the implementation of the psychiatric treatment plans, including, for example, collection of the objective data necessary to determine the efficacy of the medications. As a result, the integration of psychiatric supports with other supports was not evident in the individuals' ISP documentation. The rating of noncompliance for this provision of the Settlement Agreement is due to the lack of overall integration of psychiatric services into an individual's ISP. The Psychiatry Department had begun an initiative to have a member of the Department (either a Psychiatric Nurse or a Psychiatry Assistant) attend the ISP of each individual receiving psychotropic medication. The Department also intended to prepare the documentation representing the individual's psychiatric treatment, and then ensure that this information was placed directly into the ISP documentation, which should ensure the consistency of the documentation.	
J9	Commencing within six months of	As noted above with regard to Section J.8 of the Settlement Agreement, the integration of	Noncompliance

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	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.	psychiatric and psychological behavioral services was evident in the conduct of the Psychiatric Clinics, as well as the documentation that was found in the sample of 20 records of individuals receiving psychotropic medication. The Monitoring Team's previous reports revealed a significant deficiency in this process related to the degree to which behaviors that were identified as being targets of a psychotropic medication also were identified in the Functional Analysis and the PBSP as being present on a learned/behavioral basis and/or as being related to environmental factors. It is entirely feasible that a given behavior could be co-determined by both biological and behavioral factors. However, the dual description of the behavior as both a target of the psychotropic medication, and as being present on a purely behavioral basis suggested that the medications were being used to suppress environmentally-determined behaviors, and/or that the Psychiatric Treatment Plans and the Psychological Behavioral Treatment Plans were developed through parallel processes that were not fully integrated. The Facility had addressed this problem with strategies that are described with regard to Sections J.2 and J.8. The review of the sample of 20 records of individuals receiving psychotropic medication identified one (5%) for whom the dual classification of behaviors described above was present. A detailed description of the circumstances that resulted in this finding for Individual #295 is provided with regard to Section J.2. However, the records of 19 individuals (95%) contained an adequate differentiation of the behaviors that were present due to biological factors, as opposed to behavioral determinants. The differentiation of the maladaptive behaviors with which the individual presented is directly related to the concluding requirement of this provision, specifically: "the need to minimize the need for psychotropic medication to the degree possible." As was identified in prior reviews, the misidentification of behaviors that in reality were related to behavioral/environmental factors as being linked to a psychiatric disorder would increase the risk that the individual could be prescribed unnecessary psychotropic medication. In addition, the individual would not receive the behavioral supports appropriate to address the problem. The changes in the Psychiatry and Psychology Departments' documentation addressing this issue are described with regard to Section J.2, and summarized with regard to Section J.8. In its efforts to address the issues related to the misidentification of behaviors, the Psychiatry Department had modified the format for the Quarterly Psychiatric Reviews so that it would contain more explicit information concerning the linkage between the symptoms of the individual's psychiatric disorder and his/her other monitored maladaptive behaviors. The newly formatted Quarterly Review documents now had been incorporated into the records of all of the individuals who received psychotropic medication. The CPEs meeting the quality standards of the Settlement Agreement also	

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		provided discussions addressing this differentiation. These discussions primarily appeared in the Bio-Psycho-Social-Spiritual Formulations section of the CPEs, and the discussions of the differential psychiatric diagnoses, as well as the Quarterly Review documentation discussed above. In addition, the Psychology Department had added a section to their documentation entitled: "Psychiatric Information," which also addressed this problem. All of these methods are described in more detail in Section J.2. This provision also stipulates that this documentation should be discussed in the ISP meeting and be included in the documentation of the ISP meeting as well. As noted with regard to Section J.8, a member of the Psychiatry Department had only been able to attend ISPs for three of the 20 individuals (15%) in the sample of individuals receiving psychotropic medication: Individual #318, Individual #63, and Individual #5. None of the ISPs reviewed in this sample contained adequate documentation to address the stipulations contained in this provision. A member of the Psychiatry Department had attended the ISP for eight individuals over the prior six months, as described with regard to Section J.8. The Psychiatry Department recently had begun an initiative to have either a Psychiatric Nurse or a Psychiatry Assistant attend the ISP meetings of the individuals they serve, and then to both compose and directly place their documentation into the ISP file. In order to fulfill the requirements of this provision, this documentation should explicitly describe the deliberations leading to the decision that the use of psychotropic medication represented the least intrusive and most positive intervention to treat the psychiatric disorder. The team must also determine whether the individual will best be served primarily through behavioral, pharmacological, or other interventions. In addition, the documentation in the ISP should specify non-pharmacological treatment, interventions, or supports to address signs and symptoms of the disorder in order to minimize the need for psychotropic medication to the lowest degree possible. Although the existing documentation in the: a) Behavioral Support Plans; b) Quarterly documentation; and c) CPEs (as discussed in detail with regard to Sections J.2, J.6, J.8, and J.13) contributed to the fulfillment of these requirements, it would be helpful to explicitly refer to these three factors in both the Psychology and Psychiatry sections of the individual record as well as the ISP documentation, in order to directly address this provision of the Settlement Agreement and thus avoid any confusion. Also, as noted above, the deliberations and supporting evidence that led the team to these conclusions should be explicitly stated, rather than a simple opinion that these criteria had been met. The finding of noncompliance for this provision was primarily based on the lack of attendance by a member of the Psychiatry Department at the ISP meetings, as well as the inadequacies in the deliberations of the interdisciplinary teams in relation to the use of behavioral, pharmacology, or other interventions, in combination or alone, and the	

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		related documentation in the ISPs or other document (e.g., ISPA).	
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 of the Settlement Agreement addresses the risk-versus-benefit considerations related to the use of psychotropic medications for a specific individual. The Monitoring Team's previous reports indicated that these discussions primarily appeared in the HRC section of the record, as well as the Positive Behavior Support Plan, and usually concluded that the benefits of the proposed medications outweighed the risks presented by their side effects. The descriptions of the benefits were formulaic in nature, and the benefits were uniformly described as a reduction in the behaviors that were identified as the targets of the psychotropic medication. At the time of the most recent review, the Facility had responded to the recommendations contained in the Monitoring Team's previous reports. The Facility was providing more information related to the risk-versus-benefit equation for the psychotropic medications in the Quarterly Psychiatric Reviews and the CPEs. The current review found an improved discussion of the risk-versus-benefit analysis in 11 of the 20 individual records reviewed (55%) in the Quarterly Psychiatric Reviews and/or CPEs. The specific records that contained this information were those of Individual #147, Individual #71, Individual #253, Individual #5, Individual #231, Individual #359, Individual #237, Individual #13, Individual #112, Individual #145, and Individual #279. These discussions included more information regarding the potential and realized side effects, as well as the potential and/or realized therapeutic benefits of the medication, including the rationale for those determinations. However, even these improved discussions did not provide a comprehensive comparison of these risk benefit assessments to those that would be presented by reasonable alternative strategies. Not surprisingly, the list of individuals for whom these improved risk-benefit determinations could be identified paralleled the list of individuals for whom it was possible to discern that the prescribed psychotropic medications had been effective. They also tended to be individuals who were prescribed fewer psychotropic medications. Thus, this finding is similar to the determination of efficacy discussion related to Section J.13. The following nine individual records (45%) did not contain the sufficiently detailed information that was included in the records identified above: Individual #348, Individual #318, Individual #63, Individual #97, Individual #61, Individual #40, Individual #5, Individual #158, and Individual 298. These individuals tended to be prescribed more psychotropic medications. However, five of these individuals had been admitted to the Facility within the last six months, and this affected the Facility's ability to fully sort out the risk-versus-benefit factors related to the medications they were prescribed in the community. In addition, the Facility was still actively reducing the number of prescribed medication for these individuals.	Noncompliance

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		The Facility had developed a tool to be utilized in the review of the psychotropic medications at the HRC Meetings. This tool included specific prompts to facilitate the review of the major considerations that both clinicians, and the members of the Human Rights Committee should take into account when assessing the risk-versus-benefit of prescribed medications. On 7/11/12, a member of the Monitoring Team attended the HRC meeting. The reviews that occurred at this meeting were thorough, detailed and comprehensive. The observations of the deliberations of the HRC meetings during prior onsite reviews were also consistent with these findings. At the time of the Monitoring Team's previous review, it was noted that the thoroughness of these discussions was not always reflected in the actual documentation subsequently found in the record reviews. The Facility had responded to these recommendations by changing the format of the minutes of the Human Rights Committee Meetings so they covered more of the salient aspects of the discussions in a succinct manner. Since the last review, the Facility had made progress. However, the continued finding of noncompliance for this provision was due to the continued deficiencies in the risk-versus-benefit discussions that occurred in 45 percent of the sample of records reviewed. As noted above, a number of the individuals whose records did not contain adequate risk-versus-benefit discussion were prescribed multiple psychotropic medications. This factor also adversely effected the determination of efficacy for these medications, as eluded to above and discussed with regard to Section J.13.	
J11	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that	CCSSLC had continued its policy of reviewing individuals whose psychotropic medication regimens met the criteria for polypharmacy on a monthly basis. The "Monthly Psychiatry Polypharmacy Reduction Meeting Notes" for the prior six months were reviewed. The Consulting Psychiatrist, Director of Pharmacy Services, an Attending Physician, a member of the Psychology Staff, a Nurse from the Quality Assurance Department, and a Psychiatry Assistant attended these meetings. The meeting notes indicated that the group engaged in detailed case-centered discussions of individuals whose medication regimens met the criteria for polypharmacy. This discussion focused on the feasibility and current status of the attempts to reduce polypharmacy for specific individuals. Documentation from the 7/10/12 meeting provided a summary of the Facility's progress toward minimizing polypharmacy as of 6/30/12. As per recommendations that were made in the Monitoring Team's prior reports, the Facility tracked the status of the individuals who were admitted from the community within the last year in a separate database and those numbers are discussed later in this section. The data for the remaining 121 individuals indicated that 23 of the 121 individuals prescribed	Noncompliance

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>medications that are not clinically justified are eliminated.</td><td>psychotropic medication (19%) were receiving two or more medications from the same class; and 59 individuals (49%) were receiving three or more medications, regardless of class. The total number of individuals who met the criteria for polypharmacy was 61, as 21 of the 23 individuals who were receiving intra-class polypharmacy also qualified for the three or greater designation. The specific information regarding the number of individuals receiving multiple medications was as follows:
▪ Two medications = 34 individuals;
▪ Three medications = 32 individuals
▪ Four medications = 21 individuals
▪ Five medications = five individuals; and
▪ Six medications = one individual.

Historical data from several years ago was not available for comparison. However, monthly comparative data was available going back to November 2010. Tabular representation of that data is as follows:

<table>
<tr><th>DEFINITIONS OF POLYPHARMACY</th><th>October 2010</th><th>June 2012*</th></tr>
<tr><td>Number of individuals receiving two or more medications from the same class</td><td>37</td><td>23</td></tr>
<tr><td>Number of individuals receiving three or more medications regardless of class or indication</td><td>81</td><td>59</td></tr>
<tr><td>Total number of individuals on polypharmacy</td><td>81</td><td>61</td></tr>
<tr><td>Total number of individuals receiving psychotropic medication</td><td>145</td><td>121*</td></tr>
<tr><td>Percentage patient population receiving psychotropic medication whose medications met the criteria for polypharmacy</td><td>56%</td><td>50%</td></tr>
</table>
*These numbers did not reflect the seven individuals who were admitted since August 2011 and were receiving multiple psychotropic medications, because they were tracked in a separate database.

This provision of the Settlement Agreement also stated that it was necessary “to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.” Thus, this provision also related to the documentation that all prescribed medications could be empirically demonstrated to be effective. The discussions with the Psychiatry Department regarding the individuals whose psychotropic medication regimens continued to meet the criteria for polypharmacy indicated that the psychiatric team believed that many of these medications were essential for the individuals’ stability. This belief also was reflected in the observations of the monthly Psychiatry Polypharmacy Reduction Committee Meeting that took place during the onsite review. During that meeting, it was evident that the question of</td><td></td></tr>
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		whether all of the individuals' medications were necessary was discussed during each individual's review, and it often was concluded that the Facility continued to believe that this was true for many individuals. However, the Committee had not made a formal distinction between these individuals and those for whom they believed further reductions might be possible. As noted above, the Facility tracked, as a separate category, those individuals admitted from the community that were receiving multiple psychotropic medications. At the time of the onsite review, that number currently equaled seven. Five of these individuals were admitted to CCSSLC within the last six months. The range of the number of psychotropic medications these individuals were receiving at the time of admission was three to seven, with an average of 4.8 per person. The current range of psychotropic medication for these individuals was from three to four, with an average of 3.4 per person. Within this group, a decrease in intra-class polypharmacy from two to zero also had occurred. Thus, the Psychiatry Department had been able to implement significant and timely reductions in the amount of polypharmacy to which these individuals were exposed. The necessity of documenting the efficacy of those medication regimens meeting the criteria for polypharmacy was discussed with the Psychiatry Department during the onsite review. This evidence does not need to consist of a mathematical proof of efficacy, but should provide more documentation than a simple opinion that the medications continue to be necessary. There was an extensive discussion of this subject with the members of the psychiatry support staff during the onsite review. An example of information that would represent sufficient documentation a given medication was effective could include documentation that the individual experienced a significant deterioration in their psychiatric status following a decrease or discontinuation of the medication, and then benefited from restoration of that medication. Another scenario would be the ability to demonstrate that the symptoms and behavioral manifestations of an individual's psychiatric disorder significantly improved following the institution of treatment with a specific medication. As noted above, the Psychiatry Department had made only modest progress in reducing the use of polypharmacy with psychotropic medication for the individuals who resided at CCSSLC. The current finding of noncompliance for this provision primarily related to this finding, which is reflected in the continued relatively high rate of polypharmacy at CCSSLC, and the lack of a process to empirically justify the continued use of polypharmacy, as appropriate.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system,	This provision of the Settlement Agreement mandates systemic, quarterly monitoring for the emergence of motor side effects related to the utilization of antipsychotic medication with the Dyskinesia Identification System: Condensed User Scale, and the monitoring of	Substantial Compliance

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	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.	more general systemic side effects related to psychotropic medication with the Monitoring of Side Effects Scale every six months. An important component of this side effect monitoring also includes the latency between the time that the nurse completed the exam and the documentation was reviewed and signed by the prescribing physician. The review of the sample of the records of 20 individuals prescribed psychotropic medication indicated that the documentation that the MOSES evaluation was current (completed within the last six months) and had been performed at least every six months, was present for all of the individuals in this sample (100%). The records of the 20 individuals in the sample contained documentation that the prescribing physician had reviewed the MOSES evaluation in a timely manner for 18 of the 20 individuals (90%). The two individuals for whom the documentation of the review was inadequate were Individual #40 (missing second page with physician signature for 4/12/12 evaluation), and Individual #359 (missing second page with physician signature for 3/26/12). Thus, there was insufficient documentation to confirm that the MOSES evaluations were reviewed in a timely manner for these two individuals. The purpose of the DISCUS was to detect the emergence of motor side effects related to the use of antipsychotic medication. The review of the records of the sample of 20 individuals indicated that the DISCUS had been completed as specified for all of these individuals (100%). Those individuals whose records showed a significant delay between the date the nurse completed the DISCUS evaluation, and the prescribing physician reviewed and signed it were as follows: Individual #279 (5/11/11), no physician's signature); and Individual #359 (3/26/12), also missing physician's signature. Thus, these evaluations had been reviewed and signed in a timely manner for the remaining 18 individuals (90%). These results indicated significant progress, as compared to prior reviews. The date the MOSES and DISCUS evaluations were performed was recorded in the Psychiatric Quarterly Review documentation, including the results for each administration and whether or not any additional action was required. The presence of any significant side effects, as well as any action required, would be discussed in the section of this document that represented the Psychiatrist's narrative summary. Each Quarterly Review document contained the historical information for the prior year and was continuously updated. The DISCUS and MOSES also are necessary to monitor for the side effects of Reglan, which although prescribed for gastroesophageal reflux disease (GERD), has pharmacological properties that are similar to those of antipsychotic agents. One of the Psychiatric Nurses performed the DISCUS for those individuals who were receiving	

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		antipsychotic medication. Thus, a Psychiatric Nurse would monitor an individual for side effects if they were receiving Reglan, as well as an antipsychotic medication. Accordingly, a list was obtained from the Pharmacy of all individuals receiving Reglan to develop the sample for this analysis. This list was then cross-referenced with the Facility-wide list of individuals receiving psychotropic medication in an effort to generate a list of individuals receiving Reglan, but not also prescribed psychotropic medication. The rationale for this distinction was that the nurses on the individuals' residential units administer the evaluations for these individuals, rather than the Psychiatric Nurses. This process indicated that, as of 7/10/12, 14 individuals were receiving Reglan, but were not prescribed medication for a psychiatric disorder. The following sample of five individuals (36%) who fit the above criteria was selected, including: Individual #43, Individual #205, Individual #252, Individual #113, and Individual #239. The review of the records related to the MOSES evaluations indicated that the examination had been performed every six months as required for all of the individuals in this sample (100%). All of these MOSES evaluations had been reviewed and signed by the prescribing physician in a timely manner. The same sample of individuals receiving Reglan was used to evaluate the completion of the DISCUS. The results of this review indicated that the DISCUS evaluations were completed every three months as required for all of the five individuals (100%). The documentation indicated that the prescribing physician had reviewed four of the five evaluations in a timely manner (80%). The results for Individual #239 indicated that the 3/7/12 DISCUS had not been reviewed and signed by the prescribing physician until 3/20/12. During the onsite review, a member of the Monitoring Team also inquired about the degree of training that the Unit Nurses receive with regard to performing the DISCUS evaluation. The Psychiatry Team indicated that all of the nurses receive both initial training, as well as annual updates. This training was quite extensive and included both the review of a videotape, as well as a required post-training competency test to assess for skill acquisition. The Facility's Psychiatry Nurses were the instructors for the training. In order to verify that the training was taking place, the attendance for the prior year was reviewed. The Psychiatric Nurses also supplied the results of post-training test and the DISCUS evaluations the Nurses conducted after viewing the videotapes to illustrate they were able to utilize the correct methods for performing the evaluations. The content of the training materials, the documentation of attendance, and the production of the testing materials/results indicated that the Unit Nurses were receiving adequate training on how to competently complete the DISCUS evaluations for those individuals prescribed Reglan.	

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		The MOSES evaluation material had detailed instructions on how to conduct the evaluation embedded into the actual testing material. This evaluation was designed to be completed by individuals with a nursing degree. The finding of substantial compliance for this provision is based on the continued high rates of completion of the MOSES and DISCUS evaluations, and the substantial improvements in the prescribing physicians' timely review of these evaluations.	
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 processes that are essential for the appropriate use of psychotropic medication for individuals with ID/DD. The first of these relates to the integrity of the psychiatric diagnosis, as indicated by the following terminology: "the Treatment Plan for the psychotropic medication identifies a clinically justified diagnosis or a specific behavioral-pharmacological hypothesis." The review of the records of a sample of 20 individuals (15% of the total receiving psychotropic medication) indicated that a description of the specific symptoms that would support the psychiatric diagnosis of record could be identified for 19 individuals (95%). The only individual for whom this documentation was not found was Individual #295. The psychiatric diagnosis for Individual #295 that was included in the Quarterly Psychiatry Reviews differed from that which was included in the CPE, and the justification for the diagnosis contained in the CPE was more compelling than the one accompanying the diagnosis in the Quarterly Psychiatric Review. This issue is discussed in further detail with regard to Section J.2. The narrative related to Section J.2 also contains a detailed review of the updated process and documentation related to establishing a psychiatric diagnosis at CCSSLC. The current CPEs contained sections that discussed the diagnosis, and the Quarterly Psychiatric Reviews included the DSM-IV Diagnostic Checklists, which verified that the diagnosis of record for that individual met the specific diagnostic criteria for each Axis I and/or Axis II diagnosis applied to that individual. These checklists had been developed and implemented at the time of the prior review. In addition, in the Monitoring Team's previous report, a discussion had been included of the utility of developing a method that would more specifically track the symptoms of the individual psychiatric disorder, as well as the identified "target behavior." The Psychiatry team had responded to this by developing a psychiatric symptoms tracking scale. It defined 21 symptoms that related to the Major Axis I psychiatric diagnosis. As discussed with regard to Section J.2, these instruments were now fully implemented. The Unit Nurses completed these ratings for the symptoms that were specific to the individual, as determined by the Consulting Psychiatrist and the other members of the multidisciplinary Psychiatric Clinic teams. The results of these were ratings were also reviewed and discussed in the context of the Monthly and Quarterly Psychiatric review meetings that took place on the living units and were attended by members of multiple professional disciplines as described	Noncompliance

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		elsewhere in this section. This allowed for both the review of the material as well as the inclusion of comments and observations from other members of the IDT. This data provided a measure of the frequency and intensity of these symptoms, which the Psychiatrist referenced in the narrative section of the Monthly and Quarterly Psychiatry Notes. The two-page Quarterly Review documentation included 18 specific domains of clinically relevant information, which collectively covered the broad categories of psychiatric diagnosis and current status. The prescribed psychiatric medications, including side effect and behavioral considerations, the medical diagnosis as well as the status of any neurological involvement followed, and recommendations for future interventions and monitoring. This information was presented in a logical format that made it relatively easy to absorb the content, despite the amount of information that was presented. As discussed with regard to Sections J.8 and J.9, it was not possible to observe a Psychiatric Clinic during the recent onsite review, but several Psychiatric Clinics had been observed during prior visits to the Facility. This provision of the Settlement Agreement also addressed the need to identify "the objective psychiatric symptoms or behavioral characteristics that will be monitored to assess the treatments' efficacy." These "symptoms or behavioral characteristics" were now effectively addressed through the methods described above and reviewed in detail with regard to Section J.2. As discussed with regard to Section J.2, the symptoms of the psychiatric disorder for which the psychotropic medication was prescribed were monitored to assess the efficacy of the medication. Scales the Facility developed provided operational definitions of 21 symptoms common to many of the most prevalent Axis I psychiatric disorders. The IDT, members of which routinely attended the Psychiatric Clinics, working in conjunction with the Consulting Psychiatrist and the broader psychiatry team tailored the specific symptoms that were monitored for each individual. As noted above, the living unit nurse completed these scales with input from the other members of the team. The Psychiatric Nurse working in conjunction with the Psychiatric Assistants, the consulting Psychiatrist and the other member of the IDT that routinely attended the psychiatric clinics completed the DSM IV Diagnostic checklists. The psychiatric diagnosis and the supporting symptoms were also specified in both the diagnostic section of the CPEs and the Bio-Psycho-Social-Spiritual Formulation section of those documents. In addition the relationship between the psychiatric disorder and the behaviors addressed by Psychology were clarified in the Bio-Psycho-Social-Spiritual formulation of the CPE, the Quarterly Psychiatric Notes documentation, and the Psychiatric Information section of the Positive Behavior Support Plan as detailed with regard to Section J.9. These measures were not described or addressed in the ISP as	

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		discussed with regard to Section J.8, and this will need to be remedied as the Psychiatry Department reorganizes its plans for both attendance at the individual ISPs and the information that is included in the related documentation. Another requirement of this provision of the Settlement Agreement related to the efficacy of the prescribed psychotropic medication. In 11 of the 20 records reviewed (55%), empirical evidence was found that the prescribed psychotropic medication had produced a significant diminution in the frequency of the monitored target behaviors. These records were those of the following individuals: Individual #147, Individual #71, Individual #253, Individual #5, Individual #231, Individual #359, Individual #237, Individual #13, Individual #145, Individual #112, and Individual #279. These tended to be individuals who were receiving fewer psychotropic medications. As noted in the discussion related to Section J.11, a number of individuals at CCSSLC continued to be prescribed multiple psychotropic medications. The determination of efficacy for each of these medications, naturally, becomes mathematically more complex, and this problem is then compounded when changes in those medications are made without sufficient time to establish a new baseline for an additional medication. In addition to the lack of sufficient chronological data, the major impediment to determining if an individual's medications were effective was the number of medications that the individual was receiving and the frequency of changes in those medications. The Quarterly Psychiatric Review documentation contained a section identifying the timelines by which the prescribed medication usually could be expected to begin to exert its therapeutic effects. Although this information was uniformly present for each medication the individual was prescribed, for most individuals this was no longer clinically relevant, because the medications already had been prescribed for several months or years. However, this information was important for assessing the efficacy of newly prescribed medications for which these timelines would be important to consider. CCSSLC Psychiatry and Psychology Progress Notes routinely carried forward chronological objective behavioral data, which presented the frequency of these behaviors over time in both a tabular and graphic format. Including a summary of the contemporaneous medication changes and/or changes in the Behavioral Plan as they corresponded with changes in the frequency of the monitored behavior would greatly enhance the utility of this information. This database would then provide additional historical data points with which to make comparisons with current frequencies. This would enable the Psychiatric Treatment Team to ascertain if a specific psychotropic medication could be determined to be effective from an empirical perspective. Although the Psychiatry Department had devised a method for monitoring the frequency	

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		and intensity of the symptoms of the psychiatric disorder, they were dependent on the individual Psychologists to report the frequency of the other behaviors presented in the Psychiatric Clinic notes. Direct support professionals collected the actual raw data for these behaviors under the direction of the psychologist assigned to the individual's living unit. Concerns with regard to the accuracy and reliability of this data are discussed in Section K.10. The final section of this provision related to the frequency with which the Psychiatrist reviewed individuals prescribed psychotropic medication. The current review of a sample of the medical records indicated that Quarterly Reviews were performed as specified in this provision for all of the 20 individuals (100%). The evidence that the Psychiatrist had evaluated the individual at the time of the Quarterly Review was contained in the detailed Mental Status section of these documents. The Psychiatry Department had made progress in relation to several of the requirements of this provision of the Settlement Agreement. Much of this progress was related to the completion of the CPEs and the Quarterly Review documentation for those individuals prescribed psychotropic medication. The finding of noncompliance for this provision directly related to the lack of documentation in those particular areas specified above. This included, the lack of empirical evidence that the prescribed psychotropic medication had produced a significant diminution in the frequency of the monitored target behaviors, as well as the lack of identification of individuals for whom medication tapering plans had been developed and the status of those plans.	
J14	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall obtain informed consent or proper legal authorization (except in the case of an emergency) prior to administering psychotropic medications or other restrictive procedures. The terms of the consent shall include any limitations on the use of the medications or restrictive procedures and shall identify associated risks.	The review of the Rights/Consents sections of the medical records for the sample of 20 individuals receiving psychotropic medication indicated that 10 individuals (50%) had a Guardian of the Person. Those individuals without a guardian relied on the Facility Director to review the material concerning risk-versus-benefit considerations related to the utilization of psychotropic medication, and then provide the necessary consent. The review of the individual records indicated that consents for the use of psychotropic medications had been obtained in a timely manner for 15 of the 20 individuals in the sample (75%). The specific individuals for whom consents for psychotropic medication could not be identified were Individual #253, Individual #97, Individual #40, Individual #13, and Individual #295. Of interest was the observation that all of these individuals had a Guardian of the Person, except Individual #13. CCSSLC recently had implemented a number of measures to improve the risk-benefit analysis, as well as the quality of the information provided to the guardian or Facility Director regarding the possible side effects of the proposed medication. Specifically, the	Noncompliance

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		more generic material referred to in the Monitoring Team's previous reports had been replaced with material from Micromedex, which is a nationally respected source of pharmacological information. In addition, the Facility was implementing an initiative to replace the practice of obtaining consents and Human Rights Committee approval for all of the individuals' psychotropic medication as a package with a process of obtaining consent for each medication as a separate entity. This change in the consent process was also mirrored in the Human Rights review process, in that the Human Rights review approval process now addressed each medication as a separate entity. However, as noted with regard to Section J.10, the current review found an improved discussion of the risk-versus-benefit analysis in 11 of the 20 individual records reviewed (55%) in the Quarterly Psychiatric Reviews and/or CPEs. For the remaining individuals, as noted in previous report, the deficits in the risk-versus-benefit discussions made it difficult, if not impossible, for a guardian or the Facility Director to render a truly informed consent regarding the use of psychotropic medication. An important component of the Facility's plan to address these issues also involved the transition from the practice of having the individuals' Psychologist obtain the consent from the guardian to a process of having the Living Unit Nurse secure the consent. The communication between the nurse and the guardian was primarily written, unless verbal consent was requested by the guardian and/or was required to implement the medication on an urgent basis. However the Psychiatrist and the other members of the Psychiatry Department including the Psychiatric Nurses and the Psychiatric Assistants all contributed to the information that was provided to the individual who was providing consent. The Consulting Psychiatrist did not have any direct, written, or verbal contact with the guardian unless it was required, or in the event that the guardian attended the Psychiatry Clinics, which was a relatively rare occurrence. The consents that were supplied by the Facility's Director for those individuals who did not have guardians were via written communication. The finding of noncompliance for this provision of the Settlement Agreement was related to the continuing deficits in the risk-versus-benefit discussions, although improvements were beginning to be seen in this area. In addition, this review found that signed consents for the psychotropic medication could not be located for 25% of the individuals in the sample. The reason for the decrease in this frequency, as compared to prior reviews, was not clear.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the	The Monitoring Team's initial reports identified deficiencies in the communication of relevant clinical information between the Psychiatrist and the Neurologist, related to individuals both disciplines followed. In response to these observations, the Psychiatry Department developed a system intended to enhance the communication between the	Substantial Compliance

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	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.	two disciplines. This system, which the Psychiatric Nurses and the Psychiatry Assistants facilitated, was designed to ensure that the Psychiatrist reviewed any recent neurological consultations and documented this review during the next Quarterly Psychiatric Clinic for that individual. Furthermore, the Neurologist also was 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 now been fully operational for three review cycles. In order to assess the efficacy of this process, the neurology section of the records for the 20 individuals in the review sample were requested. Review of this documentation indicated that the Consulting Neurologist had seen the following three individuals (15% of the sample) within the last 18 months: Individual #147, Individual #158, and Individual #145. Reference to the most recent Neurology Consult was located in the Psychiatric Clinic Notes for all of these individuals (100%). The most recent Neurology Notes also contained a reference to the psychiatric medications, as well as notation of any relevant changes in these medications for all of these individuals (100%). The extent of these discussions naturally varied according to the context of the individual's clinical status. For example, if there had been an increase in the frequency of the individual's seizures, the Neurology Consultation Note and the following Quarterly Psychiatric Review documentation would be more extensive than it would have been if the individual were stable from both a neurological and psychiatric standpoint. In order to increase the size of this sample to make the review more reliable, an additional sample was constructed by identifying nine individuals from the spreadsheet the Facility maintained to track the occurrence of Neurology Consults for the individuals also prescribed psychotropic medication. This spreadsheet listed the individuals who were followed in the Psychiatric Clinics and the Consulting Neurologist also had seen from 12/1/11 through 6/11/12. There were 37 distinct names listed in alphabetical order, although some individuals had more than one entry. Thus, the nine individuals represented 24 percent of the total. The Monitoring Team selected this sample without the input of the Psychiatry Department. The nine individuals selected, the date of the Neurology Consultation, and the following Psychiatric Review dates were as follows:	

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Individual	Date of Neurological Consultation	Date of Quarterly Psychiatric Review
Individual #285	2/4/12	2/7/12
Individual #78	2/4/12	2/8/12
Individual #55	3/31/12	4/10/12
Individual #7	2/4/12	2/21/12
Individual #243	2/4/12	2/21/12
Individual #198	3/31/12	4/10/12
Individual #363	4/28/12	5/15/12
Individual #213	4/28/12	5/8/12

The documentation contained in the second group of nine individuals also confirmed that the Neurology Consultation Notes contained the relevant information concerning the individual's psychiatric treatment and the following Quarterly Psychiatric Review Note discussed the salient aspects of the prior Neurological Consultation (100%).

The Facility had not carried out a formal assessment of the amount of Neurology Consultation time that would be needed to address the needs of CCSSLC. However, the Consulting Neurologist had the capacity to alter the frequency of his visits, if more clinical time was required. This did not appear to be a problem from the perspective of ensuring that adequate coordination occurred between the neurology and psychiatry consultants.

The finding of substantial compliance was carried forward from the Monitoring Team's previous review. This was based on the observation that the system the Facility had developed to ensure the necessary communication between the Neurology and Psychiatry Departments resulted in the clinical coordination required by this provision of the Settlement Agreement.

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

1. CCSSLC should ensure that all of the sections of their chemical restraint documentation are completed as specified. (Section J.3)
2. The staff members at Facility who complete the chemical restraint documentation should receive the instructions necessary for them to properly complete the section of this documentation that prompts a description of the events that precipitated the individual's behavior that then led to the need for chemical restraint. (Section J.3)
3. The Facility should consider adding an analysis of the chemical restraint data to its internal self-assessment process. (Section J.3 and Facility Self-Assessment)
4. 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)
5. Although the Facility had developed a decision-tree for determining which individuals would benefit from a Desensitization Plan, they still need

to develop and implement Desensitization Plans for individuals who they now consider being appropriate candidates for this intervention and will also need to expand this initiative to include desensitization plans for medical as well as dental procedures/appointments. (Section J.4)

6. The data related to the status of the Desensitization Plans for Dental and Medical procedures would be more comprehensible and useful if it was consolidated into a master spreadsheet, which was continuously updated. (Section J.4)
7. The Facility should specifically track information that identifies those individuals for whom the implementation of a behavioral Desensitization Plan or other strategies results in their no longer requiring pharmacological pre-treatment sedation for dental or medical procedures, or a decrease in the use of this medication. (Section J.4)
8. The Facility should ensure that the physiological monitoring related to the administration of pre-treatment sedation for medical procedures is complete. (Section J.4)
9. Psychiatry staffing should be increased to the two full-time equivalent positions currently determined to be necessary. The Facility should continue to advertise and make other efforts to fill its psychiatry positions. (Section J.5)
10. The Psychiatry Department should undertake an analysis of the actual time commitments of the Consulting Psychiatrist, and then determine how much additional time would be required to fulfill all of the requirements that are specified in the Settlement Agreement. This analysis also should take into account the functions that are performed by the Psychiatry Department support staff. (Section J.5)
11. The Facility should expand its initiative to have a member of the Psychiatry Department attend the ISP meetings for the individuals receiving psychotropic medication. (Sections J.8 and J.9)
12. Additional information concerning the psychiatric medication and the related Treatment Plan should be included in the individual's ISP or ISPA documentation. This documentation should state explicitly whether or not the use of psychotropic medication for the individual: a) represents the least intrusive and most positive intervention; b) whether the individual will be best served primarily through behavioral, pharmacological, or other interventions; and c) identify non-pharmacological treatments and supports that are being used to address the signs and symptoms of the disorder. The deliberations and evidence that led the team to these conclusions also should be stated explicitly, rather than a simple statement/opinion that these criteria have been met. In addition, the ISP action plans should include measurable objectives to ensure the collection of data necessary to evaluate any medication's efficacy. (Sections J.8, J.9, and J.10)
13. The risk-versus-benefit analysis contained in the documentation generated by the Psychiatry Department also should appear in other sections of the individual's record where applicable, including the PBSP, HRC, and ISP documentation. (Sections J.8, J.9, J.10 and J.14)
14. The Facility should continue and increase their attempts to decrease the utilization of polypharmacy with psychotropic medications. (Section J.11)
15. The Facility should consider reporting their progress toward reducing polypharmacy by organizing their data according to the following four categories: 1) continued monitoring of those individuals admitted to CCSSLC from the community on polypharmacy within the last year, with notation of the progress made since their admission in reducing the number of medications they receive; 2) delineation of those individuals the Psychiatry Department believes are receiving psychotropic medication regimens that meet the criteria for polypharmacy, but the continuation of these medications is necessary for the individual's continued stability. This information also should include the empirical evidence that supports these opinions; 3) identification of the individuals that continue to receive polypharmacy, but there is a plan in place to challenge those medications that might not be necessary. This information should include data on current and projected tapering schedules for specific medications that might not be necessary; and, 4) identification of those individuals (if any) that do not fit into one of the prior three categories. The compilation of the data in the categorical format described above should provide a more accurate representation of the Facility's progress in reducing polypharmacy. It also would provide the Facility with information it needs to determine if additional action is needed for specific individuals. (Section J.11)
16. The Facility should increase its efforts to provide adequate empirical data to support the efficacy of psychotropic medications that the individuals' teams have concluded are essential for the individuals' continued psychiatric stability. (Sections J.11 and J.13)
17. The Facility might want to consider adding a summary of the data related to the frequency and intensity of the monitored symptoms of the underlying psychiatric disorder to the Quarterly Review documentation in a manner that would compliment the behavioral data that the

Behavioral Services Department contributes. (Sections J.2 and J.13)

18. CCSSLC should investigate the possible causes for the decrease in the frequency with which signed consents for the psychotropic medications were found in the current sample individuals as compared to the Monitoring Team's previous reviews. (Section J.14)
19. The improvements being made in the risk-versus-benefit analysis, as related to the use of psychotropic medication, should be reflected in the informed consent documentation that is supplied to the guardian or individual designated to provide the consent. (Section J.14)
20. The internal review processes should be further refined to include quality parameters in addition to completion rates, where appropriate. (Facility Self-Assessment)
21. The Psychiatry Department should enlist the assistance of the Quality Assurance Department in developing larger samples for their self-assessment process. (Facility Self-Assessment)

SECTION K: Psychological Care and Services	
Each Facility shall provide psychological care and services consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of the Following Documents**: o Section K Presentation Book, developed by Judy Sutton, M.S., LPC, BCBA, Chief Psychologist; o Behavior Support Committee (BSC) meeting minutes, dated 12/1/11 through 6/29/12; o For Section K.4, Positive Behavior Support Plans, Safety Plans for Crisis Intervention (SPCIs) as appropriate, and PBSP Monthly Progress Notes, for the last three months, as available, for: Individual #167, Individual #263, Individual #307, Individual #218, Individual #7, Individual #353, Individual #226, Individual #72, Individual #225, and Individual #184; o For Section K.4, Safety Plans for Crisis Intervention and PBSP Monthly Progress Notes, for the last three months, as available, for: Individual #20, Individual #46, and Individual #300; o For Section K.5, Structural and Functional Behavior Assessment (SFBA), as provided for: Individual #186, Individual #368, and Individual #7; o For Section K.6, Psychological Evaluations and Inventory for Client and Agency Planning (ICAP), as available, for: Individual #38, Individual #184, Individual #186, Individual #58, Individual #263, Individual #218, Individual #167, Individual #275, Individual #159, Individual #153, Individual #20, Individual #254, Individual #225, Individual #46, Individual #307, Individual #226, Individual #300, Individual #7, Individual #368, Individual #353, Individual #315, and Individual #72; o For Section K.7, Psychological Evaluations, as available, for: Individual #5, Individual #40, Individual #61, Individual #63, and Individual #97; o For Section K.8, Counseling Treatment Plans, Weekly and Monthly Counseling Notes, and PBSP Monthly Progress Notes (for the last three months) as provided, for: Individual #140, Individual #325, Individual #7, and Individual #246; o CCSSLC list of individuals currently receiving counseling; o For Section K.9, Positive Behavior Support Plans for: Individual #7 and Individual #186; o For Section K.9, onsite chart review of consents related to PBSPs, as available for: Individual #38, Individual #218, Individual #159, Individual #153, Individual #307, Individual #225, Individual #368, and Individual #315; o For Section K.9, Crisis Intervention Plans and ISP Action Plans, as provided, for: Individual #61 and Individual #253; and o Section K.10, Positive Behavior Support Plans, Safety Plans for Crisis Intervention as appropriate, and PBSP Monthly Progress Notes, for the last three months, as available, for: Individual #167, Individual #263, Individual #307, Individual #218, Individual #7, Individual #353, Individual #226, Individual #72, Individual #225, and Individual #184. ▪ **Interviews and Meetings with**: o Section K review with Judy Sutton, M.S., LPC, BCBA, Chief Psychologist, on 7/9/12 and

	7/10/12; o Psychologists and Assistant Psychologists, including Daniel Rivera, Shesheia Neal, Tiffany Carranza, Melina Pineda, Lloyd Halliburton, Linda Cardwell, Robert Meza, Christina Mautinez, Edith Cahlik, Laurie Roberts, Robert Cramer, Gina Hawkins, Andy Spear, Samantha Mendoza, John Guerra, Gilda Montelegro, Everett Bush, Karen Hernandez, and Tabitha Anastasi, on 7/11/12; o Meeting with QA Department staff and Section K and S Monitors, including Judy Sutton, M.S., LPC, BCBA, Chief Psychologist; Araceli Matehala; Cynthia Velasquez, QA Director; Pearl Quintanilla, QA Administrative Assistant; Sharon Davis, QA Administrative Assistant; Karen Ryder, QA/Program Compliance Monitor; and Tabitha Anastasi, on 7/12/12; and, o Coordinators and Supervisors of Day Treatment, Habilitation, Vocational, and Educational Staff, including Janie Martinez, Denise Aguilar, Malinda Valdemar, Lucy Tigeria, David McKinney, Sofia Fores, Jose Soto, Brigette Escamilla, Patricia Zagorski, Mary Clauss, Erin Willis, and Kimberly Benedict, on 7/12/12. ▪ **Observations Conducted**: o Observation and discussion with staff members at the Skill Plan Review Committee meeting, on 7/10/12; o Observation and discussion with staff members and individuals at the "Top Chef o Competition," on 7/10/12; o Observation and discussion with staff members at the Restrictive Practices Committee, on 7/11/12; o Observation of Skill Plan Integrity checks at 524-A and 524-C on 7/11/12, as well as Sand Dollar and 514 on 7/12/12; o Onsite direct observations, including interaction with direct support professionals, and other staff and professionals, were conducted throughout the day and/or evening hours at the following residential and day programming, and habilitation sites: ▪ Apartment 522A (Kingfish 1), on 7/9/12; ▪ Apartment 522 C (Kingfish 3), on 7/9/12; ▪ Apartment 522D (Kingfish 4), on 7/9/12 and 7/11/12; ▪ Horizons/ALS Building, on 7/10/12; ▪ Apartment 524A (Ribbonfish 1), on 7/11/12; ▪ Apartment 524B (Ribbonfish 2), on 7/11/12; ▪ Apartment 518 (Porpoise), on 7/11/12; ▪ Gymnasium, on 7/11/12; ▪ Sand Dollar, on 7/12/12; ▪ Outer reef, on 7/12/12; ▪ Apartment 514 (Dolphin), on 7/12/12; and ▪ Angel Fish (Building 517) - Kaleidoscope Day Program and Comfort Zone, on 7/13/12.
	Facility Self-Assessment: As evidenced in the Monitoring Team's previous report, the Facility had developed a Self-Assessment with regard to Section K of the Settlement Agreement. According to the

	current Self-Assessment, the Facility found that it was in compliance with Section K.2, but out of compliance with all of the other subsections within Psychological Care and Services (i.e., Sections K.1, and K.3 to K13). This was consistent with the Monitoring Team's findings. The Self-Assessment identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating based on findings of the self-assessment. Compared with the previous assessment, the current Self-Assessment, dated 6/25/12, appeared to be a significant improvement. Most sections included objective data, the use of random sampling, specification regarding the items reviewed (i.e., numbers, dates, etc.), as well as the number of items examined within each section. Although this format appeared improved and certainly useful in monitoring the Facility's progress toward compliance, a number of concerns were noted: ▪ More specification regarding how the Facility measures certain items was needed. For example, for Section K.4: "results indicated progress toward treatment." It was unclear how "progress" was being measured. ▪ Although methods appeared to check for the inclusion of required components of various items, the quality of these critical elements was not necessarily judged. For example, for Section K.12, although the number of staff completing CBT was provided, data on their performance during or after training was not provided. That is, how effective was training? Are some staff better trainers? Are trainers competent to provide CBT? In addition, for K.11, it was reported that: "100% of PBSPs contained instructions to staff." It was unclear whether or not the quality of these instructions was examined. ▪ It was unclear what role the QA Department had in assisting or facilitating the current self-assessment. Indeed, it continued to be unclear whether or not the previous monitoring tool would be revised or replaced by the current Self-Assessment. ▪ Inter-rater reliability scores were not provided on measures used to assess compliance. Inter-rater reliability needs to be established across auditors to ensure the accuracy of the data, as well as the consistency across raters. ▪ In addition, consideration should be given to whether or not compliance indicators should be weighted. If so, consideration should be given to determining which items would be weighted more heavily. Overall, the Facility had improved the Self-Assessment and was collecting and examining data helpful in assessing progress toward compliance. Indeed, the amount of data was impressive. With the assistance of the Quality Assurance Department, the self-assessment process should continue to be improved and expanded, while ensuring validity and reliability of the data.
	Summary of Monitor's Assessment: Progress was noted in many areas of Section K of the Settlement Agreement. However, concerns remained throughout most areas. Many behavioral services staff continued to progress through the necessary coursework as well obtain necessary supervision toward the BCBA certification. Concerns regarding the difficulty in accessing and utilizing the education leave hours as well as difficulty in reliably accessing course content were noted.

	Slight progress was noted in the area of peer review. Although attendance improved for some clinicians and counselors, participation by other professionals and key staff remained inadequate. External peer review processes had just been initiated. Continued progress in the use of a standardized monthly progress note was evidenced. This included continued improvement in the area of data display and ongoing PBSP monitoring, including the initiation of inter-observer agreement checks on behavioral data. Progress was evident in the completion of standardized intellectual assessments to ensure that psychological assessments were updated at least every five years. However, progress in the completion of scales of adaptive behavior was not as conspicuous. In addition, a new format entitled the Comprehensive Psychological Evaluation was developed to integrate the psychological assessment and the structural functional behavioral assessment. Although concerns were noted, this new format appeared promising. Limited progress was noted in the timely completion of psychological assessments for newly admitted individuals, as well as the provision of counseling supports to individuals referred for counseling. Progress was noted in the area of PBSPs with the development of a new and improved format that was currently being piloted. Active efforts were noted with regard to writing PBSPs so that they could be understood and implemented by direct support professionals. Lastly, some progress was noted in competency-based training. However, the provision of adequate training across the Facility for all individuals remained inadequate and, as currently designed, the nature of training was significantly resource-dependent and likely not sustainable.

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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	Since the Monitoring Team's last visit, Psychologists in the Behavioral Services Department continued to make progress in obtaining necessary educational competencies and supervision needed to demonstrate competency within Applied Behavior Analysis. At the Monitoring Team's previous visit, nine out of 15 (60%) psychologists had completed at least one or more graduate course(s) necessary for certification. This number would have been higher at the current Monitoring visit, but reports indicated that three withdrew from Spring coursework. Currently, the number of psychologists who had completed at least one or more graduate course(s) remained at nine. At the last Monitoring visit, one psychologist had completed all of the required coursework. Currently, a total of four psychologists had now completed all of the required coursework. It was anticipated that all four would take the BCBA exam in the Spring of	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.	2013. Currently, based on documentation provided and verbal report, three staff were taking summer classes and, of the three that withdrew this past Spring, two were registered for Fall coursework. Consequently, according to documentation, there were only two psychologists who had not yet completed at least one required course, or were not yet registered for current or upcoming coursework. Verbal reports from the Director of Behavioral Services indicated that a remediation plan was put in place for one of these staff that included additional responsibilities in lieu of completing expected coursework. At the Monitoring Team's last review, it appeared that six of the eligible psychologists had started to receive the pre-requisite clinical supervision necessary for certification. Currently, it appeared that 11 had at least started receiving supervision (i.e., two staff withdrew from classes and stopped supervision). None of the current behavioral services staff have completed supervision. Verbal reports and documentation indicated that the same two contracted BCBA consultants continued to provide supervision. The Director of Behavioral Services and contracted supervisors should continue to ensure adequate adherence to the Behavior Analyst Certification Board supervision guidelines and policies, including the completion of supervisory signature forms. Current verbal reports indicated that tuition support as well as the availability of educational leave (i.e., up to four hours a week) continued to be highly valued. However, staff continued to voice serious concern about the difficulty in accessing and utilizing the education leave hours allocated each week. In addition, staff voiced difficulty in reliably accessing course content. According to verbal reports, this led to impaired performance with the courses, and, in some cases, withdrawal from coursework. These challenges appeared to require additional administrative support and immediate amelioration. This provision 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. Currently, only one member of the 14 Behavioral Service staff was a BCBA. Issues related to the quality of behavioral programming are discussed in further detail below 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	Judy Sutton, MA, LPC, BCBA was hired as the Director of Behavioral Services, and started within her current capacity on 8/15/11. Ms. Sutton had a Master's degree in Psychology, was a Licensed Professional Counselor in Texas, and had been a Board Certified Behavior Analyst since 2009. She had extensive experience supporting individuals with intellectual, mental, and physical disabilities, and had worked in the human services field since 1994.	Substantial Compliance

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	care throughout the Facility.	Current verbal reports continued to reflect support and confidence in the relatively new Director of Behavioral Services in establishing and maintaining a consistent level of psychological care throughout the Facility. Based on the current positive reports from executive leadership and Behavioral Services staff members, as well as on the continued progress noted in the provision of psychological services observed since the last visit, the Facility continued to be found in substantial compliance with this provision.	
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, some progress was noted in the area of internal and external peer review within Psychological and Behavioral Services. As previously described, peer review of psychological services was provided through the Behavior Support Committee. This committee was scheduled to meet twice a week, and previous reviews noted that the committee met for 61%, 100%, and 77% of the time for the time periods of June to December 2010, January to May 2011, and July to November 2011, respectively. Based on recent BSC meeting minutes, dated 12/1/11 to 6/29/12, it appeared that the BSC met approximately 41 (89%) out of 46 potential scheduled meetings. This percentage should be considered "approximate," because it was difficult for the Monitoring Team to accurately determine the expected number of BSC meetings. More specifically, it appeared that: 1) the committee changed from twice a week to once a week some time in March 2012; 2) apparently several extra meetings were held (e.g., 3/9/12 and 5/15/12); 3) meeting minutes were missing (for 2/23/12); 4) several meetings were held with only two or three professionals (i.e., on 3/9/12 and 3/13/12) and 5) several minutes noted "paper review done" (i.e., on 1/19/12 and 1/31/12). However, this estimate was consistent with that reported within Section K.3 of the Facility's Self-Assessment. As previously reported, CCSSLC policy recommended that the BSC have a diverse membership. A consistent finding over the Monitoring Team's last few reports, however, was a noted decline in the diversity of membership. This included decreasing representation from psychiatry, nursing, habilitation therapies, and administration. Previous improvement, however, was noted in the attendance of the contracted BCBAs, community-based counselors, as well as psychology assistants. Currently, the declining trend noted within psychiatry, nursing, habilitation therapies, and administration continued to be observed (less than 11%) in meeting attendance between December and June 2012. Comparatively higher attendance rates continued to be observed for contracted BCBAs (48%), community-based counselors (28%), and psychology assistants (65%). Lastly, the attendance of the Director of Behavioral Services improved from approximately 43% to 70% of the time. These estimates were consistent with those reported within Section K.3 of the Facility's Self-Assessment. As found in Monitoring Team's previous reports, the lack of adequate attendance of those	Noncompliance

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		who supervise the implementation of behavioral programming (e.g., Residence Coordinators, Unit Directors, or other administrative staff) continued to be concerning. As presented in previous reports, it is important to involve those who have direct administrative supervisory authority over the implementation of the plans, as well as anyone who was directly involved in the plans' design and/or training at the BSC meeting. As previously recommended, the Facility should identify those key stakeholders whose attendance is believed to be beneficial for the adequate review of PBSPs, as well as those who ensure their proper implementation and monitoring. It appeared that the Facility was responsive to the above concern by recently changing the schedule of BSC meetings from twice a week to once a week. This change occurred in March, and was based on the idea that reducing the number of meetings might improve attendance. Current documentation appeared to support this idea as the attendance of administrative and supervisory staff improved slightly following this change. It will remain to be determined if this improvement will continue and maintain over time. However, reducing the number of BSC meetings is likely to diminish capacity of BSC. That is, the BSC reviewed a substantial number of documents (e.g., psychological evaluations, SFBAs, PBSPs, and/or SPCIs), and also monitored referrals, delinquent reports, monthly progress notes, and counseling notes. Reducing the number of meetings by 50% might negatively impact this review process. Verbal reports from the Director of Behavioral Services indicated that increased self-monitoring by authors (using structured rubrics), as well as prior review by more senior Associate Psychologists was expected to facilitate more efficient reviews by the time documents were presented at BSC. According to current verbal reports, external peer review began in January 2012 and continued, somewhat inconsistently, through July 2012. This review initially started with the inclusion of professionals from one other Texas State facility (i.e., Abilene State Supported Living Center) and had grown over time to include other Facilities (i.e., Austin and Lubbock). However, documentation evidenced infrequent interaction between these external reviewers. This included permanent product review (evidenced by two emails) and one phone-conference meeting (i.e., meeting minutes dated May 11, 2012). Consequently, the status of the external peer review continued to appear inadequate. Lastly, once the ongoing evolution of the internal and external peer review process is established, the Facility will need to ensure that current procedures are reflected in policy. The Facility continued to be in noncompliance with this provision, because of the inadequate attendance of professionals demonstrably competent in applied behavior analysis, the absence of professionals external to CCSSLC currently participating in	

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		external peer review regularly, and the lack of guidelines regarding internal and external peer review in current policies.	
K4	Commencing within six months of the Effective Date hereof and with full implementation in three years, each Facility shall develop and implement standard procedures for data collection, including methods to monitor and review the progress of each individual in meeting the goals of the individual's PBSP. Data collected pursuant to these procedures shall be reviewed at least monthly by professionals described in Section K.1 to assess progress. The Facility shall ensure that outcomes of PBSPs are frequently monitored and that assessments and interventions are re-evaluated and revised promptly if target behaviors do not improve or have substantially changed.	Since the last review, progress continued to be evident in the area of data collection. This included methods to regularly monitor and review the progress of individuals meeting the goals of their PBSPs, as well as other psychological supports (e.g., desensitization, counseling, etc.). Although methods of review showed progress, concerns remained about the adequacy of data collection overall. In an attempt to examine the nature of data collection, a sample of 10 PBSPs was selected from individuals with PBSPs and ISPs held within the last six months. In addition, individuals were selected to ensure adequate sampling across residential programs. That is, only one individual from a residence was selected. However, not all residences were represented. This sample reflected approximately eight percent of the total PBSPs currently in place (based on the listing "CCSSLC Positive Behavior Support Plans," undated). In addition to the PBSPs, PBSP monthly notes from April, May and June 2012 also were reviewed. Of this sample, 10 (100%) PBSPs identified and operationally defined one or more target behaviors. Only one (10%) of the PBSPs (i.e., Individual #7), however, identified and operationally defined replacement behaviors. Although target behaviors were typically conspicuously identified and defined, measurable objectives were rarely detailed in the PBSPs. More specifically, measureable objectives for target behaviors were only found in two (20%) of the PBSPs reviewed (i.e., Individual #7 and Individual #225). The opposite appeared to be true for replacement behaviors. That is, although behavioral objectives were found for replacement behaviors in all the PBSPs reviewed, replacement behaviors were rarely operationally defined. This inadequacy was consistent with findings presented in the Monitoring Team's previous reports and is further discussed within the current report with regard to Section K.9. Data was displayed in nine (90%) of the PBSPs reviewed using tabular format, graphic format, or both. Graphing was used in the majority of plans (80%) and all of these graphs included one or more target behaviors. However, replacement behaviors were only graphed in four (50%) of these plans. In general, it appeared that graphic display was more predominate compared to previous reviews, because target and replacement behaviors, when displayed, were typically graphed. However, as discussed in greater detail with regard to Section K.10 of the Settlement Agreement, displayed data was often difficult to interpret, or the data display did not offer any meaningful information. It should be noted that the format of the PBSP had changed since the Monitoring Team's previous review. Indeed, the format of PBSPs had changed frequently over the course of	Noncompliance

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		the Monitoring Team's reviews as evidenced by the three different formats found within the current sample. This change (as described in greater detail with regard to Section K.9 of the Settlement Agreement) included the discontinuation of data display within PBSPs. That is, the most recent PBSP format (i.e., used for Individual #7 in the current sample) did not include any displayed data. This change was acceptable to the Monitoring Team as long as all of the necessary data was available within current monthly PBSP progress notes and that such data was effectively integrated and utilized to support data-based decisions with regard to behavioral programming. As consistent with findings within the Monitoring Team's previous reports, objective criteria for the revision or discontinuation of PBSPs was lacking in most of the plans reviewed. More specifically, objective criteria for discontinuation were found in only one (10%) of the plans reviewed (i.e., Individual #167); and objective criteria for revision were not found in any (0%) of the plans reviewed. Relatedly, none (0%) of the rationales found within the sampled PBSPs indicated that the plans were re-evaluated and/or revised due to the lack of progress or changes in maladaptive behavior as evidenced by collected data (i.e., reflecting data-based decision making). Most of the plans continued to offer a general statement regarding the need to address or manage target behaviors, or included a rationale describing the revision of the PBSP as concurrent with the ISP. Consequently, it was not evident from sampled PBSPs that any had been revised due to its ineffectiveness or change in the individual's functioning or his/her challenging behavior. Progress continued to be evident with regard to the Monthly PBSP Progress Note. As previously reported, the monthly note allowed ongoing evaluation of progress relative to identified behavioral objectives listed in the PBSP, SPCI, counseling treatment plans, and desensitization plans, if applicable. In addition, data on target and replacement behaviors, restraints, and/or medications was displayed in graphic form, and psychologists summarized progress and provided recommendations. Although the quality of the graphs continued to reflect improvement, concerns remained regarding graphing (this is discussed in detail with regard to Section K.10 of the Settlement Agreement). Currently, 10 (100%) of the individuals sampled had monthly notes completed (using the new format) for the requested time sample of April, May, and June 2012. Although progress was evident in the use of the PBSP monthly note, several concerns were noted, including: ▪ Although target behaviors were graphed in 100% of the monthly notes, many (50%) included data on "severity" which was not defined in any plans (e.g., Individual #167, and Individual #263); ▪ Correspondence between target behaviors identified and defined in PBSPs	

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		matched those graphed in the monthly notes in eight of the 10 (80%). The two for which this did not occur were Individual #218, and Individual #7; ▪ Correspondence between replacement behaviors identified and defined in PBSPs matched those graphed in seven of the monthly notes (70%). The three for which this was not the case were Individual #167, Individual #263, and Individual #225; ▪ Behavioral objectives for target behavior, albeit often inadequate, were found in all (100%) sampled monthly notes. The behavioral objectives for target behaviors identified in monthly notes were consistent with PBSPs of seven individuals (70%) and were inconsistent with PBSPs of three individuals (i.e., Individual #167, Individual #218, and Individual #226); ▪ Behavioral objectives for replacement behaviors were found in all (100%) sampled monthly notes. The behavioral objectives for replacement behavior identified in monthly notes were consistent with PBSPs of five individuals (50%) and were inconsistent with PBSPs of five individuals (i.e., Individual #167, Individual #263, Individual #307, Individual #7, and Individual #184); ▪ Although behavioral objectives for replacement behaviors were found in all (100%) of the notes sampled, several objectives did not appear to be measurable (e.g., Individual #353, and Individual #72) or realistically obtainable (e.g., Individual #307); ▪ The graphic display of medications often did not appear helpful, because no changes were displayed or because it would be more helpful to overlay medication changes against changes in behavioral functioning (e.g., Individual #255, Individual #184, and Individual #335); ▪ Review comments should be more descriptive, robust, and add relevant information beyond simply describing the data in a graph. In addition, comments should accurately reflect the data. For example, if trends of target behaviors are increasing and trends of replacement behaviors are decreasing, the description "…continues to do well behaviorally …" appears inaccurate and not helpful (i.e., June 2012 monthly note for Individual #226); and, ▪ Indicating that: "… suitable data is not available," but still including a graphic display of data (i.e., Individual #167) called into question the validity of the report. A sample of three individuals with Safety Plans for Crisis Intervention (SPCIs) and ISPs held within the last six months was identified. This sample reflected approximately 20% of the total SPCIs currently in place (based on a listing of individuals with SPCIs, dated 6/4/12). Of those sampled, two (67%) had SPCIs that were updated within the past year (i.e., the SPCI for Individual #46, dated 6/20/11, was outdated). Graphed data related to restraint was found in 100% of the SPCIs sampled. However, the data across graphs varied. That is, two (67%) included data on number of restraints, injuries, and average	

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		duration of restraint (i.e., Individual #20 and Individual #300). However, one graph only included data on the number of restraints (i.e., Individual #46). And, although 100% of the SPCIs included one or more objectives, as is discussed in more detail below, these objectives were only consistent with the monthly notes for one (33%) of the individuals sampled. In addition to the SPCIs, PBSP monthly notes from April, May, and June 2012 also were reviewed for the three individuals sampled. Of these, 100% had data related to restraint in each of the monthly notes reviewed. However, there were some concerns noted, including: ▪ The objectives listed in the SPCIs did not match those listed in the PBSP monthly progress notes for some of the individuals sampled (i.e., Individual #20 and Individual #300); ▪ The SPCIs were inconsistent in the variables tracked and data displayed. That is, some plans tracked number, duration and injuries of restraint (i.e., Individual #20 and Individual 300), while others did not track injuries (i.e., Individual #46). ▪ The SPCIs were inconsistent in the number of objectives listed. That is, some plans provided objectives for number of restraints (i.e., Individual #20), while others identified multiple objectives related to restraint (i.e., Individual #46). Indeed, the PBSPs progress notes for one individual did not list any objectives related to restraint (i.e., Individual #300). ▪ The amount of data included in the graph (i.e., seven behaviors as well as restraint data) in the SPCI for Individual #46 impaired the effective interpretation of the information. In addition, the SPCI identified an objective targeting restraint duration, but this data was not provided or displayed in the graph. ▪ The graphs related to restraint included in the PBSP progress notes for Individual #46 should modify the Y axis to include only real numbers ("-1" is meaningless) and "time in restraint" should identify a specific amount (seconds or minutes) time, and whether or not it is the total or average duration. ▪ The Facility should determine how to display restraint durations of less than one minute. For example, the May 2012 PBSP progress note for Individual #46 did not include the restraint duration in the data display or graph. Based on the text, the restraint duration was "… less than a minute." It was currently unclear why this data could not have been included in the data display. If this practice reflected a larger trend, meaningful data might be missing from documentation. ▪ Descriptions used to explain the restraint data appeared to be cut and pasted between monthly notes (i.e., May and June 2012 for Individual #300). ▪ Overall, the variables tracked typically included the number of restraints and information on time. However, more specification would be helpful regarding the amount of time (i.e., seconds or minutes). In addition, some data displays	

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		included data on "injury" and "emergency meds," but this was inconsistently found across the reviewed SPCIs. Review of the sampled PBSP monthly notes also evidenced the collection of inter-observer agreement (IOA) data. More specifically, IOA estimates were reported in the monthly notes of six (60%) of the individuals sampled. Reported estimates were all 100%. Although this was a promising finding, the data and information provided as well as the methodology utilized appeared inadequate. These findings are discussed in greater detail with regard to Section K.10 of the Settlement Agreement. Lastly, methodology as well as procedures involved in data collection, data display, and review had changed over time and will ultimately need to be included in the current policy. Indeed, documentation provided and verbal reports continued to evidence the evolution of data collection techniques, including the recent utilization of revised antecedent-behavior-consequence (ABC) data sheets, as well as time sampling procedures with select individuals. As recommended in the past, behavioral services staff should continue to evaluate which data collection systems provide the most relevant and accurate data given the individual and responses targeted. Ultimately, the Facility should consider reviewing and revising policies regarding data collection and monitoring. Overall, the PBSP monthly note demonstrated continued promise as an effective method of displaying and reviewing performance. The Facility, however, continued to be rated in noncompliance with this provision, because of the lack of adequate reliability estimates on tracked behavior, as well as continued limitations with data collection as described above.	
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 was observed in the completion of standardized tests of intelligence. In addition, the use of a new format, the 'Comprehensive Psychological Evaluation', was developed and initiated in an effort to integrate the traditional psychological assessment and the structural functional behavioral assessment. As presented with regard to Section K.6 of the Settlement Agreement, of the 22 sampled psychological assessments reviewed, 20 (91%) were updated within the last 12 months. In addition, psychological evaluations indicated that 13 (59%) of the sampled individuals had an ICAP evaluation completed within the last three years. However, available raw data indicated that the number of ICAPs completed in the last three months for those sampled was likely closer to 17 (77%). In addition, only 16 (73%) of the psychological assessments were completed prior to the ISP meeting. Closer examination revealed that 22 (100%) contained results of previously completed standardized tests of intelligence, and 16 (73%) of these were completed within the past five years, with 15 (68%) of these	Noncompliance

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		conducted within the past year. Tests of adaptive function (e.g., Vineland Adaptive Behavior Scales) were reported in 20 (91%) of the current psychological assessments, and seven (32%) of these tests were completed within the past five years, including six (27%) conducted within the past year. Consequently, evidence suggested that scales of adaptive behavior were not being updated as regularly as standardized tests of intelligence. Indeed, there was a substantial improvement in the number of intellectual assessment completed over the past year to ensure these were updated at least every five years. As observed during the Monitoring Team's previous reviews, in addition to the psychological assessment discussed above, 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. As described below with regard to Section K.6 of the Settlement Agreement, since the Monitoring Team's last review, a new "comprehensive psychological evaluation" format had been developed and implemented. According to documentation provided since the Monitoring Team's last review, 13 evaluations appeared to have been completed using this new format. To determine the quality of current functional assessments, comprehensive psychological evaluations developed using the new format for three individuals were examined (i.e., Individual #7, Individual #186, and Individual #368). Given that documentation indicated that 13 of these evaluations had been completed since the last review, this sample reflected approximately 23% of the total number of newly formatted comprehensive psychological evaluations. It should be noted that this figure (i.e., 13 evaluations completed since the Monitoring Team's last visit) might not be accurate, because the Monitoring Team received three different summary documents with different individuals and different totals of completed comprehensive psychological evaluations listed. Unfortunately, none of these summary documents were dated. The Monitoring Team also received at least four additional comprehensive psychological evaluations (i.e., Individual # 226, Individual #254, Individual #61, and Individual #63) that were not listed within any of the summary documentation. The Monitoring Team was concerned about this inconsistency and considerable disorganization and, consequently, questioned the accuracy of the data provided for review. The importance of this issue, as well as implications on the current review are discussed in greater detail below with regard to Section K.7 and within the	

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		Recommendations Section. Documentation also appeared to indicate that revised PBSP were developed and implemented prior to the completion of comprehensive psychological evaluations. That is, the development of revised PBSP (using the new format) appeared to have occurred prior to completion of the SFBA or comprehensive psychological evaluation for at least three individuals (Individual #7, Individual 363, and Individual #117). Although there may be an adequate rationale for this approach, it appeared to the Monitor to be illogical and potentially counter therapeutic (more details are presented below with regard to Section K.9 of the Settlement Agreement). The selected sample of three recently completed comprehensive psychological evaluations was reviewed. Based on the current review, the evaluations were very comprehensive and very detailed and included information necessary for a typical psychological evaluation as well as data required within a functional behavior assessment. In addition, the relevant psychosocial information was very informative and helpful in providing readers with descriptions of previous life events and other factors that likely could facilitate a better understanding of the individual and their current status. Information regarding standardized testing (e.g., intellectual and adaptive measures), medical and psychiatric conditions, communication, strengths, and preferences, as well as data derived from current and previous indirect and direct assessments all provided information valuable to effective programming. Overall, these evaluations appeared to be a significant improvement over previously completed SFBAs. However there were a few concerns noted, including: ▪ The reason for referral appeared to a boilerplate response and not very meaningful across all three individuals. It is hoped in the future that, when appropriate, the rationale would be more individualized and specific to the current functioning of each individual ▪ Sources of information were very detailed and lengthy, but did not appear to include more direct methods of assessment (e.g., direct observation). ▪ Information related to medical conditions and diagnoses were found in all of the current evaluations. However, the relationship between current medical conditions, including psychiatric diagnoses, and an individual's current status (e.g., emotional or behavioral responding) was not always evident. Indeed, many individuals had a substantial list of diagnoses and, for some individuals, many of these might not have any implications on their current functioning. The evaluation for Individual #368 was a good example of drawing implications from medical diagnosis and providing hints as to how conditions might influence responding. ▪ Some inconsistency was noted across evaluations. That is, the placement of the section on "current health and physiology" within the document was not	

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		consistent with the current format (i.e., Individual 7 and Individual #186). This minor difference was likely due to format revisions over time. Although not a significant concern, this difference might inhibit efficient peer review of the evaluation. ▪ Due to the often comprehensive review of previous and current assessment results, it was difficult in some cases to identify the date in which specific assessments were completed. For example, the date(s) in which standardized intelligence and adaptive tests were conducted was not conspicuous in the evaluation of Individual #7. ▪ Although there was a section on previous interventions and efficacy in each of the sampled evaluations, including data, descriptions of behavioral objectives, and overall summary of progress, identification of previous interventions and their related effectiveness (or not) was not found in two of the sampled evaluations (i.e., Individual #186 and Individual #386). ▪ Data obtained through interviews appeared rather inconsistent across sampled evaluations. That is, it did not appear that a standardized interview format was utilized. If so, it was not identified in the sampled evaluations. ▪ There appeared to be confusion regarding the terms "direct" versus "indirect" assessment. That is, a number of evaluations listed rating scales [e.g., Motivation Assessment Scale (MAS), Functional Analysis Screening Tool (FAST), Questions About Behavioral Function in Mental Illness] as a direct method. They are not. Direct observation is a direct assessment method. ▪ Although there was a section on adaptive skills within the evaluation, the inclusion of information on adaptive responding (i.e., current replacement behaviors or skills need to learn) was not conspicuously targeted within other areas of the report. For example, it was not apparent that staff members were interviewed about current or missing skills an individual would need to demonstrate to avoid challenging behavior. ▪ Sections of the evaluations appeared to contain too much specificity and the evaluations were too long. For example, the assessment for Individual #7 detailed every single restraint that occurred. This information could easily be summarized without losing meaningful data, and would potentially reduce the length of the assessment (currently 32 pages). ▪ A replacement behavior is just like a target behavior. It needs to be objective and measureable, and also needs to be defined. And yet, authors continued to view "replacement behavior" as some sort of process (e.g., description of replacement behavior in Individual # 368's evaluation), rather than a response that needs to be prompted and reinforced. Once again, although concerns were noted, this format appeared to reflect significant improvement over earlier SFBAs. These integrated assessments appear very promising	

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		and the Facility should continue to pursue their completion. However, a balance between the amount and detail of information provided and the usefulness of that data will need to be determined. Currently, it appeared that the assessments were too long and should be more concise. A rubric also was developed to facilitate review by psychologists as well as peer reviewers to ensure that comprehensive psychological assessments were completed as prescribed. This self-monitoring and peer review tool included 41 items and was scored using a 0-2 Likert scale. Documentation provided evidenced the use of this rubric to monitor and ensure the accurate completion of the evaluations. In summary, a significant improvement in sampled comprehensive psychological assessments was observed. Although this improvement was notable, the majority of psychological assessments (including current SFBAs) had not been completed within the current format. Concerns regarding the previous format(s) of SFBSs are provided in previous reports. As a result, the Facility remained 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.	Progress continued to be made in the area of psychological assessments. As described in the Monitoring Team's previous reports, the expectation that each individual residing at CCSSLC have a current psychological evaluation had remained unchanged. This required that a psychological assessment be completed, updated, and/or reviewed at least annually for each individual served. This expectation included reviewing results from the Inventory for Client and Agency Planning 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. 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 22 individuals was examined. This sample was primarily selected from those individuals that had had an ISP meeting over the past six months, although there were a few exceptions. Given the current census of 259 individuals at the time of the current visit, this sample reflected approximately eight percent of the total number of psychological assessments. Alternatively, documentation provided reported that 61 psychological evaluations had been completed since the Monitoring Team's last visit. Since 15 of the individuals sampled had psychological assessments updated within the last six months, the current sample more closely reflected approximately 25% of those completed since the Monitoring Team's last review.	Noncompliance

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		As presented with regard to Section K.5 of the Settlement Agreement, of the sampled psychological assessments reviewed, 20 (91%) were updated within the last 12 months. More specifically, psychological evaluations completed within the last year were not evident for Individual #353 (dated 6/30/11) and Individual #225 (document dated 3/12/12 was incomplete). Examination of overall delinquency rates of psychological evaluations was not completed due to the fact that, as currently reported by the Director of Behavioral Services, the previously developed Behavioral Services database contained inaccurate and likely falsified data. Information in the psychological evaluation indicated that 13 (59%) of the sampled individuals had an ICAP evaluation completed within the last three years. That is, dates provided in the psychological evaluations suggested that, at the time of the Monitoring Team's visit, nine individuals had outdated ICAP evaluations. However, documentation provided for four of these individuals revealed a recently completed ICAP that was not described in the current psychological evaluation (i.e., Individual # 38, Individual #263, Individual #167, and Individual #153). Consequently, there was evidence of current ICAP evaluations for 17 (77%) of those individuals sampled. This finding was consistent with findings from several of the Monitoring Team's previous visits. It remained unclear to the Monitoring Team why these ICAP evaluations were not completed and included in the psychological evaluation updates. One guess would be that these evaluations are completed primarily as a funding requirement and not to inform programming. In addition, it also remained unclear why psychological assessments were completed after the ISP meeting. That is, only 16 (73%) of the psychological assessments were completed prior to the ISP meeting. As a result, data, or the assessment, was not available to inform the ISP for six individuals (i.e., Individual #186, Individual #218, Individual #167, Individual #225, Individual #307, and Individual #368). Of the psychological assessments reviewed, 22 (100%) contained results of previously completed standardized tests of intelligence. These assessments generally included the use of the Wechsler, Slosson, Toni, and/or Peabody tests. Overall, 16 (73%) of these intelligence tests were completed within the past five years. More importantly, fifteen (68%) of these intelligence tests were conducted within the past year. However, three (14%) of these tests were completed over ten years ago (i.e., Individual #218, Individual #153, and Individual #353), and the dates of completion of intelligence tests were not conspicuous for two of the individuals sampled (i.e., Individual #225 and Individual #275). The much-improved progress in updating standardized tests of intelligence was evident in the current sample. However, the Facility should ensure that only qualified individuals are facilitating these evaluations. That is, it appeared that a Psychology Assistant completed at least one of the evaluations listed (i.e., Individual #307). It was currently unknown if this individual had the competency to conduct the standardized	

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		assessment. Tests of adaptive function (e.g., Vineland Adaptive Behavior Scales) were reported in 20 (91%) of the current psychological assessments. More specifically, scores from adaptive behavior scales were not found in two psychological evaluations (i.e., Individual #186 and Individual #218). Overall, seven (32%) of these tests of adaptive behavior were completed within the past five years, including six of these scales (27%) were conducted within the past year. However, nine (41%) of these tests were completed over ten years ago, and the date of completion for adaptive scales was not conspicuous for one of the individuals sampled (Individual #7). Documentation reviewed at the Monitoring Team's previous visit indicated that the Facility had provided training on the completion of the Vineland Adaptive Behavior Scales, and, at that time, the expectation was that the Vineland would be used in subsequent psychological evaluations. Review of sampled psychological evaluations that evidenced completion of standardized intelligence tests within the last six months suggested that this training was only minimally effective, because adaptive scales of behavior (e.g., Vineland) were only updated in four of the12 cases (33%) where standardized tests of intelligence were administered. Evidence suggested that scales of adaptive behavior were not being updated as regularly as standardized tests of intelligence. Indeed, there was a substantial improvement in the number of intellectual assessment completed over the past year, but this was not similarly observed with regard to scales of adaptive behavior. Overall, review of the sampled psychological evaluations reflected continued inconsistency in the template used for the evaluation. More specifically, it appeared that approximately three (14%), five (23%), and five (23%) of the psychological evaluations utilized the 12/15/10, 5/30/11, or 6/1/11 template, respectively. The template used in three (14%) of the psychological evaluations could not be determined. This continued diversity appeared to affect the consistency in which important content was included within psychological evaluations. For example, the inclusion and quality of behavioral data in psychological evaluations was inconsistently found across sampled plans. Inconsistency in the provision of data included the omission of all data (e.g., Individual #307), the inclusion of only target behavior data (e.g., Individual #38, Individual #184, and Individual #167), or appropriately, the inclusion of data on target and replacement behaviors as well as medication dosages (e.g., Individual #218 and Individual #226). In addition, the display format continued to reflect the use of tables (e.g., Individual #275 and Individual #20), and, in one case, the continued use of bar graphs (Individual #153). The diversity of formats will hopefully diminish over time as a qualitatively new format had been implemented since the Monitoring Team's last visit. This new format was utilized in six (27%) of the currently reviewed psychological evaluations and appeared to integrate the psychological evaluation and the SFBA into a single report. Overall, these more comprehensive reports appeared of higher quality that the other evaluations	

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		reviewed. The findings and implications associated with the use of this most recently revised format is discussed with regard to Section K.5. Due to the ongoing issues related to the inadequacy of psychological assessments, specifically a substantial number of evaluations with outdated scores from standardized intellectual assessments and assessments of adaptive functioning, the Facility remained 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 each individual residing at the Facility pursuant to the Facility's standard psychological assessment procedures.	Overall, some progress was noted in the provision of psychological assessments for all CCSSLC residents. However, limited progress was noted in the timely completion of psychological assessments for individuals newly admitted to CCSSLC. To determine whether or not psychological assessments were completed, updated or reviewed as often as needed, documentation provided on 22 sampled individuals was examined. As presented with regard to Section K.6 of the Settlement Agreement, of the 22 sampled psychological assessments reviewed, 20 (91%) were updated within the last 12 months. However, as previously presented, a number of these assessments were missing updated intellectual or adaptive functioning information. In addition, when this information was current, it often did not appear available to effectively inform the ISP process. Examination of overall delinquency rates of psychological evaluations was not currently completed (as done in the Monitoring Team's previous reports) due to the fact that, as reported by the Director of Behavioral Services, the Behavioral Services database contained inaccurate and likely falsified data. This issue was very serious, because the database was the primary electronic storage mechanism for data related to the provision of behavioral services, including, for example, dates of completion as well as approval/consents for assessments and behavioral interventions. As presented in the Monitoring Team's previous reports, the Behavioral Services Database 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. The Monitoring Team's previous report noted concerns with increasing delinquency rates for Psychological Evaluations and PBSPs, as well as a substantial number SFBAs that were not completed and/or updated on an annual basis. Unfortunately, due to the corruption of the database, delinquency rates could not be examined to determine whether or not these concerns had been ameliorated. Indeed, the Monitoring Team's ability to examine progress toward compliance with the Settlement Agreement was limited by the inaccessibility of accurate data.	Noncompliance

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		According to documentation provided, since the Monitoring Team's previous review, five new individuals were admitted to CCSSLC, including: Individual #5, Individual #40, Individual #61, Individual #63, and Individual #97. Of these five, only two (40%) appeared to have had psychological assessments that were completed within 30 days of admittance (i.e., Individual #5 and Individual #63). Although, it should be noted that this could not be confirmed, because the BSC approval date could not be verified. In addition, one of these evaluations did not include information on recently completed assessment of adaptive behavior. Of the other assessments, one was incomplete and not dated until after 30 days of admission (i.e., Individual #40), one was simply not adequate (i.e., Individual #97), and one was not dated (i.e., Individual #61). Overall, like many of the other psychological evaluations reviewed in the for the Monitoring Team's report, as discussed with regard to Section K.6, the format and content varied across the reports. However, none of the reports were signed or dated by the authors. As a result of issues related to the inadequacy of current standardized intellectual testing and assessment of adaptive functioning, timeliness of initial psychological assessments, and the stated inadequacy of the current Behavioral Services database, the Facility remained out of compliance with this provision.	
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.	No progress was noted with regard to the provision of services to individuals requiring psychological services other than PBSPs, including the way in which counseling treatment plans were developed and monitored. However, attendance at BSC by one of the two contracted counselors appeared to improve. Consistent with the Monitoring Team's previous review, two community-based counselors continued to provide weekly counseling supports both on and off campus. According to verbal report and provided documentation, greater participation in BSC meetings by the community-based therapist was evidenced in the last six months. More specifically, a community-based therapist was in attendance at BSC approximately 28% of the meetings since the Monitoring Team's last visit. This was compared to 23% of meetings identified in the Monitoring Team's previous report (as discussed with regard to Section K.3 of the Settlement Agreement). It appeared that one counselor (i.e., one of the two contracted counselors) was in attendance most of time. According to verbal reports and previous documentation, this was the same counselor that appeared more willing to develop counseling treatment plans as well as attempt to regularly monitor ongoing progress. Currently, according to documentation provided, 17 individuals were identified as receiving counseling services. Documentation indicated that, between 12/1/11 and 5/31/12, six individuals had been referred for counseling supports. Of these, according to verbal report from the Director of Behavioral Services and documentation provided, it	Noncompliance

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		appeared that two individuals were not yet placed with a counselor (i.e., Individual #264 and Individual #109). Reports indicated that the Facility had been attempting to contract with a third community-based therapist, but had not yet been successful. Currently, four individuals (out of the 17 individuals currently receiving counseling supports) were selected as a representative sample. This reflected approximately 24% of those individuals currently receiving counseling services. Documentation provided was reviewed, as available, including counseling treatment plans, counseling notes, and PBSP monthly progress notes. Of those sampled, only one appeared to have a "treatment plan" in place (i.e., Individual #140). That is, only one individual had a document that included information beyond that of an identified behavioral objective. This treatment plan, however, was inadequate. Three (75%) of the individuals sampled had a counseling objective identified. However, all of these objectives were incomplete or inconsistent compared to the objectives listed in the PBSP progress notes. In addition, review of sampled PBSP monthly progress notes for April, May, and June evidenced inadequate monitoring of progress for all individuals. More specifically, the same data displayed for April was displayed for May and June for Individual #140, the wrong data was displayed for Individual #325, no data was graphed for the two objectives for May and June for Individual #7, and the wrong data was graphed for Individual #246. Overall, the counseling documentation appeared inadequate and consistent with the documentation reviewed previously. The quality of the counseling plans as well as ongoing monitoring was inadequate. Because this finding was consistent with observations reported in the Monitoring Team's previous reports, all of the concerns are not repeated here, and the Facility is strongly encouraged to review the findings and recommendations stated within the Monitoring Team's previous reports. It should be noted that the current findings were similar to those reported in the recent CCSSLC Self-Assessment, dated 6/25/12. More specifically, the self-assessment reported that, based upon the Facility's review, several individuals receiving counseling services were missing related data, lacked identified behavioral objectives, and, perhaps most importantly, all of the objectives reviewed were not considered measurable. At the current time, it did not appear that any changes related to counseling supports were incorporated within the current policy. Consequently, the Facility is also encouraged to integrate expectations related to counseling supports within current policy. The Monitoring Team's previous reports had encouraged the Facility to examine evidence-based assessment practices that likely would facilitate the identification of functional skill areas as well as implement evidenced-based practices with regard to the specialized programming being developed for individuals with Autism or other	

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		developmental disabilities. Examples of these, including the Assessment of Basic Language and Learning Skills-Revised (ABLLS-R) and the Picture Exchange Communication System (PECS), were cited in previous reports. Recent observations within the Comfort Zone evidenced use of the PECS system within structured skill acquisition programs (SAPs) (e.g., Individual #147). This demonstrated some initial progress toward the utilization of this evidence-based practice. In addition, evidence was provided that the Facility recently had requisitioned an ABLLS-R assessment kit. Due to the continued inadequacy of counseling treatment plans, the Facility remained 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.	Some progress was noted in the area of PBSPs. A new and improved format had been developed and was currently being piloted with a small number of individuals. The Monitoring Team's previous report noted minimal progress with regard to PBSPs. Indeed, at that time, it was reported that 100% of the sampled plans were missing one or more critical components found in effective PBSPs, and that the formats of plans varied significantly. Overall, the adequacy of the content within most sections of the PBSPs was questioned, with the exception of improvements noted in graphic displays. Currently, in an effort to target the most up-to-date plans and avoid reviewing previously utilized formats, only those plans revised since the Monitoring Team's last visit as well as those completed using the newest PBSP revised format were reviewed. Consequently, the current review examined a small and selective sample of PBSPs. According to documentation provided, approximately 11 PBSPs appeared to have been approved and implemented since the Monitoring Team's last visit (i.e., since January 9, 2012). This is an approximate estimate, because verbal reports indicated that the Behavioral Services database was "corrupted" (more details are provided with regard to Section K.7), and up-to-date summary data was not provided. Nonetheless, available documentation indicated that the new PBSP format had been utilized for four individuals (i.e., Individual #7, Individual #117, Individual #186, and Individual #363). Of these four individuals, two were selected for the current sample (i.e., Individual #7 and Individual 186). This sample reflected approximately 50% of the current PBSPs written using the new format, and 18% of the plans written since the Monitoring Team's last visit. Currently, the new PBSP format was much more concise and user-friendly compared to previously reviewed documentation. That is, it appeared that a substantial amount of unnecessary and redundant information was removed. In addition, the format was structured to facilitate performance following competency-based training as well as ongoing integrity checks. Overall, the review evidenced an improvement in the quality of these plans. However, it should be noted that the sample was small and this new format	Noncompliance

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		was still in the "pilot" stage. Evidence suggested a better correspondence between functional behavioral assessment and the replacement behaviors and strategies included in the PBSP. In addition, evidence demonstrated improved awareness of critical elements (i.e., setting events, and immediate antecedents) within preventative interventions. Also, improved operational definitions as well as behavioral objectives were noted for one of the two PBSPs (i.e., Individual #186). Overall, the revised format appeared to be an improvement and appeared likely to facilitate more effective training and implementation integrity. In general, the new format had two main sections, including "Staff Instructions" and "Administrative Review." The staff instructions section included content areas of: 1) operational definitions of target and replacement behavior; 2) function of problem behavior; 3) prevention strategies; 4) consequence-based strategies; 5) data collection procedures; and 6) psychiatric medications and common side effects. The administrative review section included content areas of: 1) psychiatric diagnosis; 2) baseline or comparison data; 3) behavioral objectives; 4) prior intervention strategies and outcomes; 5) rationale for current interventions; 6) risk and risk analysis; and 7) signature of author. Although the reduced length and inclusion of many of these sections in the sampled PBSPs appeared to be an improvement over previous plans, there were some noted concerns, including the following: ▪ There were some differences in the format noted across the sampled PBSPs. For example, the PBSP for Individual #186 had information on "relevant medical conditions" and "outcomes" while the other plan did not (i.e., Individual #7). Although this inconsistency might have been due to the revision of the format over time, this appeared unlikely as both PBSPs were approved by BSC in the same month. In addition, the PBSP for Individual #186 had sections related to "prior interventions and efficacy" and "rationale," when compared to the other plan. To assist in monitoring whether or not the most up-to-date format was being utilized, a subheading with the revision date should be included within the PBSP format. ▪ Although most sections appeared to have been included in the revised plans, related content found within a few sections (within Administrative Review) were not included. That is, in several sections of the PBSP for Individual #7, the reader was directed to find the relevant information in another document (i.e., "See Comprehensive Psychological Assessment …"). This practice was not as evident in the other plan. That is, although the comprehensive psychological evaluation was cited, the information was briefly summarized within the PBSP (i.e., "Baseline or Comparison Data" section) for Individual #186. In addition, when a document was cited (i.e., "See attached Behavior Contract"), it was not necessarily attached (i.e., for Individual #7). ▪ Inconsistency in the quality of some necessary components was noted across	

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		PBSPs. For example, the operational definitions for target and replacement behaviors were inadequate as described in the PBSP for Individual #7. That is, although the definitions of self-injury and aggression included descriptions of the outcome of these responses, which is important, the topography of the typical response(s) was not included. After reading the definition for self-injury, for example, a new direct support professional might not appreciate the risk of eating a piece of glass versus a preference of staying in the sun too long. ▪ The separation of operational definitions from actual teaching strategies for replacement behaviors appeared to be an improvement (i.e., PBSP for Individual #186). The inclusion of teaching strategies with the definitions appeared to obscure the actual definitions (i.e., PBSP for Individual #7). ▪ Although the provision of reinforcement was noted with both PBSPs, their prescribed use was not always conspicuous. That is, although general staff instructions cited their use, further description (as described in behavioral contracts) was not provided to the Monitoring Team (i.e., for both sampled PBSPs). Consequently, it could not be determined if the use of reinforcers appeared robust and likely to support acquisition of new skills. ▪ Lastly, authors' signatures (and related dates) were not evident on plans reviewed. This was consistent with observations of the Monitoring Team, because record reviews evidenced PBSPs in records that were not signed or dated (e.g., Individual #7 and Individual #275) Overall, given the concerns noted above, the PBSPs appeared to reflect an improvement over previously reviewed plans. Trainings provided on the PBSP (e.g., targeting setting events, antecedents, and related interventions, dated 3/23/12, and rubric reviews, dated 2/2/12 and 2/7/12), as well as formal preference assessments, on 2/28/12 appeared to be helpful. In addition to the new format, a new CCSSLC PBSP Peer Review rubric, based on the new format, was developed to assist staff in reviewing PBSPs. This rubric, dated 2/1/12, appeared likely to offer staff the necessary structure to adequately review the quality of PBSPs. That is, examples provided revealed utilization of this rubric by peer reviewers since the Monitoring Team's last visit. At the Monitoring Team's previous visit, it was reported that a new PBSP peer review rubric, dated 6/1/11, had been developed and utilized to ensure the inclusion of critical components within all PBSPs. Indeed, past descriptions suggested that this rubric was designed to assist in the development of adequate PBSPs, staff training and ultimately, the improvement and measurement of treatment integrity. Currently, a revised PBSP peer review rubric, dated 2/1/12, had been in place since the last review, and evidence indicated that it has been used to estimate inter-rater reliability. That is, summary documentation (examples of inter-rater reliability scores for PBSPs and other documents) evidenced the use of this peer review rubric by various staff (i.e., the author	

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		of the document, peer reviewers, and QA/QI) in an effort to ensure the quality of the plan. In addition, because multiple reviewers were available, inter-rater reliability estimates were determined as well. According to verbal report, however, there was no summary data regarding the total number of reviews that had been completed using this rubric or associated scores. A listing was provided that displayed the names of 45 individuals for whom inter-reliability ratings had occurred as of 5/31/12. However, no additional data was available to indicate which documents were reviewed, or how many peer raters were involved in each review, and no summary data was provided to detail the overall findings. The use of peer review rubrics to evaluate the development of assessments and interventions appeared to be the first step toward ensuring adequate and consistent programming and, ultimately, improved treatment integrity by staff. That is, if robust efforts were directed at critically examining psychological products to ensure their adequacy and consistency, it appeared likely to support treatment integrity. It appeared that a hierarchical system had been implemented when using these rubrics. More specifically, psychologists initially used the rubrics as they developed or updated assessments or plans. Once completed, these rubrics were again used by more experienced Psychologist V mentors to review the product. Lastly, the rubrics were used by peers at BSC meeting, at times for training, but always by the Director of Behavioral Services or the Clinical Psychologist when the assessment or plan was finally approved. The data reflecting this process was very limited and the Facility should consider an efficient and meaningful data collection methodology to monitor progress on the use of this system and related progress in developing improved assessments and plans over time. To determine whether or not necessary approvals and consents were obtained prior to the implementation of the PBSPs, a subsample of plans were selected and related approvals (i.e., BSC approval, Guardian consent, and Director approval) were examined during the onsite visit. This sample of consents included eight individuals and, consequently, represented approximately seven percent of the total number of PBSPs currently implemented (N=121). Onsite documentation review revealed that only five (63%) of the individuals sampled had all of the necessary and current consents in their records, as well as corresponding dates recorded on the Behavioral Services database. Several of the dates listed within the database did not match the dates on the actual consent documents (i.e., wrong HRC date for Individual #218 and wrong BSC date for Individual #225). In addition, documentation could not be found for the BSC approval date for Individual #368. Most importantly, it appeared that the PBSP was implemented prior to the receipt of at least one of the necessary consents or approvals for three of the sampled individuals (38%). Although one of the individuals (i.e., Individual #225) appeared to have all of the necessary consents and approvals, the listed PBSP	

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		implementation date was over one year old. Consequently, it was unclear when this particular plan was formally implemented. Lastly, documentation provided indicated the discontinuation of the previous Safety Plans for Crisis Intervention (SPCI) format. That is, concurrent with changes in the current restraint policy (as discussed in more detail with regard to Section C of the Settlement Agreement), the SPCI format had been changed to reflect a new "Crisis Intervention Plan (CIP)" format. This new format appeared to contain information that was very similar to the content found in previous SPCIs. Indeed, reports from Psychologists indicated that, other than the requirements related to the ISP action plans, the two documents were not qualitatively different. Two individuals with CIPs were selected from all of those identified as having SPCIs or CIPs in place. This included a total of 15 in place according to documentation provided. Therefore, this sample reflected approximately 13% of those plans currently in place. The review of these two recently completed CIPs found that information necessary for the recognition for the need of restraint, as well as detail necessary for the appropriate use of restraint was adequately included (i.e., Individual #61 and Individual #253). More specifically, the CIPs provided: 1) objective description of responses that necessitated restraint; 2) detailed instructions on the type of prescribed restraints (in least-to-most intrusive order); 3) release criteria, including the maximum restraint duration; 4) instructions on when not to implement restraint and what not to do when restraint is utilized; and 5) detail on how to adequately document the use of restraint. It should be noted that the reviewed CPIs were not signed or dated by the authors. The Facility remained in noncompliance, because the adequacy of behavioral programming, although improved in some cases, was not fully adequate for the newest plans and had not been generalized to the majority of PBSPs. More specifically, the PBSP sampled continued to appear inadequate and the revised format had only been implemented with a small percentage of overall plans.	
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	Progress continued to be noted in area of data display and ongoing PBSP monitoring, including conducting inter-observer agreement checks on collected behavioral data. As previously discussed with regard to Section K.4 of the Settlement Agreement, progress continued to be evident in the use of monthly monitoring PBSP progress notes. More specifically, the monthly PBSP progress note appeared to be well integrated as 10 (100%) of the individuals sampled had monthly notes completed (using the new format) for the requested time sample of April, May, and June 2012. Although this was a positive finding, concerns were noted within current progress monitoring. That is, although target and replacement behaviors were graphed in 100% of the monthly notes, many included data on responses that were not identified or adequately defined in the PBSP.	Noncompliance

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	review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	Consequently, the accurate correspondence between important behaviors described in the PBSP were often not found in monthly review documentation or data displayed within progress notes was not adequately detailed in PBSPs. In an attempt to examine the nature of data collection and monitoring, a sample of 10 individuals was selected. This was the same sample as described above with regard to Section K.4 of the Settlement Agreement. This examination included the review of each individual's PBSPs as well as the PBSP monthly notes from April, May and June 2012. Closer examination of the graphic displays with PBSP monthly notes also evidenced progress over time. However, several concerns, many consistent with the Monitoring Team's previous reports, were noted. Therefore, the Facility is strongly encouraged to review findings and recommendations regarding graphing conventions in the Monitoring Team's previous reports. Currently, however, concerns were noted within the selected sample of monthly PBSP progress notes, including: ▪ The graphic display of medications often did not appear helpful, because no changes were displayed or because it would be more helpful to overlay medication changes against changes in behavioral functioning (e.g., Individual #255, Individual #184, and Individual #335); ▪ The graphic display of medications often did not appear helpful, because the necessary range of dosages made the interpretation of behavioral variation impossible (Individual #7); ▪ Multiple graphs displaying the same information were redundant and should be eliminated, when appropriate (e.g., Individual #225 and Individual #184); ▪ The utilization of phase change lines to highlight medication changes might be more helpful than inclusion of raw data or graphing the raw data (e.g., Individual #167); ▪ It is important to ensure that the axis labels are readable and meaningful (e.g., Individual #218, Individual #307, and Individual #46). For example, the Y axis for restraints for Individual #46 included "-1," and the label for duration indicated "time in restraints," which might be improved by indicating "seconds in restraint" or "minutes in restraint," as appropriate; ▪ Consideration should be given to graphing multiple data paths to facilitate comparison (co-variation of responding), as long as graphs remain interpretable (e.g., Individual #218); and ▪ Consideration should be given to simplifying graphs when too many data paths or the range of Y axis make the graph uninterpretable (i.e., Individual #353, Individual #218, and Individual #307). Consistent with previous recommendations, efforts should continue to thoughtfully display data and to eliminate redundancy. Graphs should not be displayed if they do not offer meaningful data or allow effective analysis. As noted during the previous review, it	

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		is unnecessary to display the raw data beneath a graph if the data can be reasonably and quickly estimated by viewing a conspicuous data path on a graph (or vice versa). As previously described with regard to Section K.4 of the Settlement Agreement, progress was noted in training staff to begin collecting inter-observer agreement data. According to verbal reports and documentation provided, psychologists and psychology assistants started collecting inter-observer agreement data in January 2012 as part of a pilot program that ultimately had expanded across campus. According to verbal reports from the Director of Behavioral Services, it was now expected that IOA data be reported in all monthly PBSP progress notes. As presented earlier, review of the sampled monthly PBSP notes, at this time, evidenced the collection of IOA data. More specifically, IOA estimates were reported in the monthly notes of six (60%) of the individuals sampled. This was an improvement over observations at the Monitoring Team's last visit, where no evidence of IOA data collection was provided. However, the information provided was rather general and did not specifically state the number of observations used to estimate IOA. According to verbal reports, the IOA session typically included a 10-minute observation using one-minute intervals. The data reviewed appeared to reflect 100% agreement on only the non-occurrence of a single selected target behavior. In the future, data should be collected on multiple target behaviors (perhaps all of the behaviors tracked) and include replacement behaviors as well. Data collectors should consider targeting high frequency behaviors in an attempt to examine agreement on the occurrence of these more probable responses. In addition, direct support professionals should ultimately be integrated into these observation sessions as well. Indeed, these are the staff where the demonstration of acceptable agreement estimates is most important. Although progress was noted in the areas of progress monitoring, the Facility remained out of compliance with this provision because of the continued inadequacy of IOA data collection as well as the limitations observed within the graphic display of behavioral data.	
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.	Some progress was evident with regard to writing PBSPs so that they could be understood and implemented by direct support professionals. As described above with regard to Section K.9 of the Settlement Agreement, a new PBSP format had been developed and was being piloted. This new format appeared highly likely to facilitate a more concise and user-friendly PBSP. Based on verbal report, this new format will be utilized following the completion of comprehensive psychological evaluations. The Monitoring Team looks forward to examining the continued use of this revised format as the Facility endeavors to improve the quality of PBSPs. One item on the current peer review PBSP rubric examined the estimated readability level of the document. That is, raters needed to review the readability level of the PBSP while	Noncompliance

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		conducting the peer review. The Facility had set a readability of 7th grade or lower. If a plan were to exceed that criterion, according to the Director of Behavioral Services, the plan would need to be revised. As discussed with regard to Section S.3.a of the Settlement Agreement, inconsistent findings with regard to staff knowledge of PBSPs and Skill Acquisition Plans continued to be observed during onsite visits. That is, a sample of staff members were interviewed about selected individuals and their programming in an effort to estimate staff knowledge about residents. Overall, although many staff appeared knowledgeable of plans and skill programs of randomly selected individuals, many staff still were unable to answer basic questions about behavioral or skill programming for some individuals. For example, a direct support professional was able to provide accurate information in response to questions about Individual #167, but was unable to locate the Individual Notebook to describe data collection. Staff correctly answered questions regarding target behaviors and prescribed consequence based interventions for Individual #58 and was able to generally describe the plan for Individual #22. However, when asked, staff needed to confirm whether or not some individuals had a PBSP (e.g., Individual #310). In some cases, staff reported that an individual (i.e., Individual #254) had a PBSP when that was not the case. In one case, staff described a target behavior of PICA and related preventative strategies that were not listed in Individual #315 PBSP. According to current verbal reports from the Director of Behavioral Services as well as reports in the Facility Self-Assessment, integrity checks were not currently being completed. Reports suggested that the new system designed to monitor the treatment integrity of individual plans was expected be initiated in January 2013. Although some progress was noted above, the Facility remained in noncompliance with this provision. This was due to the initial and limited implementation of the new PBSP format, inconsistency in staff's verbal report regarding knowledge of PBSPs, and the overall 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	Some progress was made with regard to competency-based training. The Monitoring Team's previous report noted that a pilot project had been initiated using a revised rubric that measured both staff knowledge and skills in implementing PBSPs. These rubrics included a didactic assessment that direct support professionals completed following training, and a second, much longer and more comprehensive rubric was utilized to assess actual direct support professionals' competency in demonstrating interventions as prescribed by the PBSPs. Both rubrics generated a total score and were individualized to specific individuals' PBSPs. Verbal reports as well as documentation	Noncompliance

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	are responsible and on the implementation of those plans.	provided at that time indicated that the pilot project had provided competency-based training and assessment for six individuals across two residential programs. Estimates suggested that to date, approximately 100 staff had been trained. Initial summary data indicated that staff performance was exceptionally high. Since the Monitoring Team's last visit, it appeared that the pilot program had continued and expanded. Verbal reports from the Director of Behavioral Services indicated that the pilot had expanded beyond the single residence into other residences across the entire Atlantic Unit. Indeed, verbal reports suggested that 22 PBSPs had been trained since the Monitoring Team's last visit using competency-based training. It was difficult for the Monitoring Team to estimate and confirm the amount of training, because summary information was provided for only two individuals (i.e., Individual #321 and Individual #7). In addition, verbal reports about how competency-based training was being implemented were very concerning. That is, staff described a direct service delivery model where the psychologist (trainer) spent approximately one to two hours with a single direct care staff member completing the training. This model is inappropriate and should not be the typical training model utilized. An indirect model must be employed where the psychologist (i.e., "expert") provides competency-based training to other trainers (e.g., psychology assistants, home team leaders, etc.) who share the responsibility in training the direct support professionals. The psychologist or one of these other competent trainers should train direct support professionals in small groups. That is, only individuals who have successfully demonstrated competence in what they are teaching (e.g., a particular PBSP) and also have demonstrated competence as a trainer (i.e., teacher) should conduct the training. The model the QDDPs utilized, where direct observation (by the Lead QDDP) during ISP meetings was used to ensure that QDDPs were facilitating the meetings as expected, could be similarly applied to psychologists and other trainers to ensure that they are utilizing best practice teaching methods when conducting competency-based training. Although some progress had been made, the provision of adequate competency-based training across the Facility for all individuals remained inadequate. As a result, the Facility remained in noncompliance with this provision.	
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	At the time of the most recent review, based on verbal report and documentation provided, there were 14 Associate Psychologists (i.e., four Associate Psychologist V and ten Associate Psychologist III positions), a Clinical Psychologist, and BCBA-certified Director of Behavioral Services. Only the Associate Psychologists carried a caseload. Currently, there were six Psychology Assistants and two open Psychology Assistant positions.	Noncompliance

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	assistant for every two such professionals.	As of the most recent onsite review, CCSSLC served 259 individuals. Based on this number and the understanding that the Clinical Psychologist and Director of Behavioral Services did not carry a caseload, an approximate average psychologist-to-individual ratio was estimated at 1:19. Given reports provided, there was less than one Psychology Assistants for every two Associate Psychologists employed. In addition, as noted with regard to Section K.1 of the Settlement Agreement, the Facility was rated as being in noncompliance with this provision, because the professionals in the Psychology Department were not yet demonstrably competent in applied behavior analysis as required by the Settlement Agreement. This was evidenced by the absence of professional certification, as well as by issues related to 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 develop, implement, and monitor a plan for each staff member who remains reluctant to take graduate coursework toward the BCBA. This should include working collaboratively to identify remaining obstacles and problem-solve regarding his or her 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, and that they do so according to supervision guidelines outlined by the Behavior Analysis Certification Board. (Section K.1)
3. Behavioral services staff should ensure that they are documenting on required BACB forms, and tracking their supervision over time, in accordance with supervision guidelines outlined by the Behavior Analysis Certification Board. (Section K.1)
4. CCSSLC should examine why eligible psychologists cannot access the allotted weekly educational leave and problem-solve to ensure that all of the psychologists enrolled in coursework can utilize the time prescribed. (Section K.1)
5. The Facility should attempt to identify and overcome barriers to attendance by BSC members to help ensure adequate peer review. (Section K.3)
6. The Facility should continue to pursue a robust external peer review though the inclusion of competent professionals with experience in ABA. In addition, the Facility should ensure adequate documentation of external peer review. (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 external peer review, as well as identification of the professionals who need to be in attendance to ensure adequate critical peer review. (Section K.3)
8. Emphasis should to be placed on examining how replacement behaviors are identified, defined, and monitored. This should include ensuring that operational definitions are conspicuously available and that all replacement behaviors are clearly labeled and graphed in monthly PBSP progress notes, as well as other documentation. (Section K.4).
9. More standardization of data collection methodology and expectations is needed. 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)
10. With regard to comprehensive psychological evaluations:
    a. Individualize when appropriate. That is, in regard to the identified rationale (reason for referral), provide specification if the evaluation is being updated or revised due to ongoing behavioral issues.
    b. Ensure that sources of information include description of direct methods of assessment, including direct observation. In addition,

consider summarizing these sources more concisely.

c. Very briefly highlight any known effects of underlying medical or psychiatric conditions/diagnoses. That is, concisely describe any medical or psychiatric conditions or changes that appear to contribute to an individual's functioning, especially the occurrence of maladaptive behaviors.
d. Utilize headers or sub-headers on documents to identify which format (by date) was utilized. Clearly identifying which format was utilized will likely assist peer reviewers to evaluate ongoing progress and adherence to expected procedures.
e. Ensure that date(s) are conspicuously identified. That is, for each assessment, ensure that the date on which it was conducted is clearly identified (near where the results are described).
f. Ensure that specific descriptions of effective and/or non-effective previous interventions, if known, are described in addition to summarizing behavioral progress and data review in the "previous intervention and efficacy" section.
g. Identify the specific standardized interview format, if utilized.
h. Direct methods of assessment (e.g., direct observation) typically provide the most helpful information. In addition to providing specific descriptions of direct observation sessions, authors of evaluations should attempt to summarize their observations.
i. Ensure that opportunities to discuss adaptive behavior (e.g., potential replacement behaviors currently within an individual's repertoire) are not overlooked in important assessment areas (e.g., staff interviews).
j. Ensure replacement behavior(s) are adequately defined, like target behaviors, including definitions that are objective, measureable, and complete, with examples and non-examples.
k. Examine ways to make the evaluation more concise, perhaps by eliminating much of the raw data. More specifically, this data could be summarized in the evaluation but stored for future use, if necessary. (Section K.5).

11. Ongoing training should be provided to psychologists to ensure adequate understanding of elements within the Comprehensive Psychological Evaluation. (Section K.5)
12. The Facility should ensure that psychologists understand the difference between direct and indirect methods of assessment, and why direct observation is critical to effective assessment and document their observations accordingly. When findings from assessment methods are unclear or inconsistent, additional indirect and/or direct assessments should be completed. In addition, emphasis should be placed on updating adaptive behavior assessments using appropriate scales. (Section K.5)
13. Specific policies regarding the required and ongoing utilization of standardized intellectual testing and assessment of adaptive behavior should be clarified in current policy, if not already in place. This should include ensuring that all components of the psychological evaluation are completed prior to the ISP. (Section K.6)
14. The Facility should consider tracking the number of assessments or plans that require revision prior to BSC approval. This might be an indicator of the quality of peer review and could inform the interpretation of the delinquency report. (Section K.7)
15. Counseling treatment plans should be developed, expanded, and/or refined to include measureable outcomes, and treatments should be evidenced-based. Recent changes within CCSSLC practices in this area should be included in revisions to current policy and/or procedures. (Section K.8)
16. 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, the utilization of 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.) should continue to be pursued, utilized, and evaluated to determine its effectiveness compared to alternative therapies. (Section K.8)
17. The use of evidenced-based interventions within PBSPs should be more conspicuous. The conspicuous use of accepted practice, such as differential reinforcement strategies (e.g., DRO, DRA, etc.) should be used as appropriate. (Section K.9)
18. 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 measurable objectives for target and replacement behaviors,

which would identify when team reviews or PBSP 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)

19. The pilot utilizing the revised PBSP should be expanded. The Facility should ensure that critical elements are adequately included or cited within the new PBSP format. Emphasis should be placed on operationally defining replacement behaviors, identifying preventative teaching strategies that target the acquisition and use of replacement behaviors, and regularly assessing reinforcers (through preference assessments), and ensuring they are individualized, robust, and clearly prescribed in both antecedent and consequence based approaches. (Section K.9)
20. The Facility should expand and move forward with the assessment and monitoring of inter-observer agreement for PBSP target and replacement behaviors. 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 and inter-rater agreement. (Sections K.4 and K.10)
21. 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)
22. In an effort to facilitate more efficient and effective visual analysis of graphs, psychologists should:
    a. Accurately label both axes and ensure that they are readable;
    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 and ensure that the units of measurement are meaningful; and
    e. Utilize phase/condition change lines to demarcate changes in treatment or other significant changes in functioning. (Section K.10)
23. 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)
24. The Facility should ensure that staff that are providing training are competent in providing competency-based training. This would include monitoring psychologists or other trainers as they provide trainings. In addition, data collection on the integrity of psychologists' completion of didactic and demonstrative competency-checks would be beneficial. (Section K.12).
25. The Facility should closely examine the model(s) being utilized to train direct care staff (i.e., beyond New Employee Orientation), and determine if it is appropriate. The Facility should consider using a more in-direct service delivery model where the psychologists train a few key "trainers" who will share the responsibility of completing competency-based training with all direct support professionals. (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, objectives, strategies, etc. Similarly, 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)
2. In providing documentation to the Monitoring Team, it should be dated and, when appropriate, signed by authors. This is important for the Monitoring Team's review, but also to ensure that the Facility has mechanisms for ensuring that documents are the most current and final/approved versions, and that historical information can easily be tracked. (Section K)
3. The "corrupted" Behavioral Sciences database was a significant problem, and inhibited the Monitoring Team's ability to determine the current status of psychological services, including providing an accurate review and valid estimates of compliance on the provisions of the Settlement Agreement. More importantly, the Facility needs an accurate and up-to-date mechanism to monitor the psychological services. (Section K).

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o List of all staff who work in the Medical Department, including names and titles; o Name and CV of Medical Director, if new since the last visit; o Name and degrees of all primary care providers that are new to Facility since last monitoring; o Number of individuals on each PCP's caseload; o Employees listed under Medical Department completing Cardiopulmonary resuscitation (CPR) training certification with dates of completion, and dates of expiration; o Copy of any in-service for PCP training on ICD and DSM diagnostic criteria in last six months; o Since the last on site review, copy of Continuing Medical Education (CME) for each primary care provider; list of CME credits according to topics reviewed; list per PCP of total CME credits during this time period (separate out/remove CME credits not earned since the last on site review); o Copy of any clinical guidelines developed and implemented since the Monitoring Team's last visit; o Minutes of infection control committee meetings during the prior six months; o Minutes of skin integrity committee meetings during the prior six months; o Most recent results/report of the medical quality improvement program, including identification of trends and descriptions of improvement actions taken. For each page of data, identify date of audit from which information was retrieved; o For any medical staff meetings (morning medical meetings, etc.) copy of all minutes, handouts, logs from Infirmary, hospitalizations, and 24-hour reports discussed, for 15 days prior to the Monitoring Team's visit; o Most recent results/report of the Facility-wide medical review system, including copy of any non-facility physician review reports or data since the Monitoring Team's last review. Separate reports/data of external medical peer review audits from internal medical peer review audits. For each page of data, identify date of audit and specific audit (# of audit round) from which information retrieved; o List of individuals who died since the Monitoring Team's last visit. For each individual, provide date of death, death certificate, whether autopsy was done (and if so, copy of autopsy report), medical problem list current at time of death, and for seven days prior to death or hospitalization, all clinical documentation including nursing and physician notes, and all diagnostic studies including radiologic and laboratory for: Individual #286, Individual #289, Individual #284, Individual #175, Individual #173, Individual #96, and Individual #316; o Mortality Reviews (clinical, administrative, and nursing reports) since last visit; o Corrective actions related to Mortality Reviews (include status reports on previous recommendations);

	o Notes and orders for any DNRs and rescinding of DNRs; o Current DNR list with reason/criteria for DNR; o List of death reports (clinical/administrative) that remain incomplete/outstanding; o Twenty most recent annual medical assessments and physical examinations and prior annual assessment and examination, including those for: Individual #182, Individual #343, Individual #244, Individual #372, Individual #30, Individual #160, Individual #114, Individual #287, Individual #24, Individual #56, Individual #305, Individual #214, Individual #28, Individual #250, Individual #299, Individual #324, Individual #293, Individual #291, Individual #231, and Individual #95; o Specialty clinic schedule per month for past six months; o List of all outside consultations for medical purposes for the past six months, categorized by specialty; o List of individuals (and a second updated list also provided week of Monitoring Team visit): ▪ With tracheostomies; ▪ With fractures, date of fracture, type of fracture (compound, simple, stress, etc.), bone fractured (location); ▪ With injuries requiring visit to ER or hospitalization since the last onsite review, and ▪ With pica or ingesting inedible object, date of ingestion, object ingested, whether taken to ER or hospitalized, since the last on site review; o Policies or procedures for medical screening and routine evaluations; 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; o For those women over 40, date of last mammogram and reason listed, if not up-to-date (guardian refusal, etc.); o List of all women age 40 or greater with date of birth; o List of all individuals age 50 or greater, with date of birth; o Current list of all those with diagnosis of osteopenia/osteoporosis with medications and dosage per person [include calcium, Vitamin D, intravenous (IV) bisphosphonate, etc.], date of last DEXA scan or state none completed, copy of most recent DEXA scan reports for each individual with diagnosis of osteopenia or osteoporosis; o For men with diagnosis of osteopenia/osteoporosis, copy of any lab work testing for secondary causes (from current active record), other information indicating cause (specific medications, etc.) of osteopenia/osteoporosis; o For women with diagnosis of osteopenia/osteoporosis, and premenopausal, copy of any lab work testing secondary causes (from current active record), other information indicating cause (specific medications, etc.) of osteopenia/osteoporosis; o For each individual with osteopenia/osteoporosis, any active record document for calculation of daily calcium intake (based on diet, average percentage of meal ingestion, feeding formula, etc.); o For individuals with Down's syndrome, date of last thyroid test;

	o For those going to the ER and not hospitalized, copy of integrated progress notes from start of signs/symptoms to transfer to ER, ER report, discharge orders from ER and copy of Facility chart orders, integrated progress notes/Infirmary progress notes, follow-up to any recommendations, for 10 most recent ER visits at least 30 days prior to Monitoring Team's visit (in order to allow completion of recommendations), including those for: Individual #242, Individual #184, Individual #172, Individual #138, Individual #144, Individual #289, Individual #90, Individual #24, Individual #266, and Individual #239 o For those admitted to hospital, copy of integrated progress notes from start of signs/symptoms to transfer to ER, ER note, hospital admission history and physical, discharge summary, copy of discharge orders/recommendations from hospital, and copy of Facility record orders, integrated progress notes/Infirmary progress notes, and follow-up for any hospital discharge orders and recommendations, 10 most recently hospitalized individuals that have returned for at least 30 days (in order to allow completion of recommendations), including those for: Individual #126, Individual #167, Individual #144, Individual #224, Individual #117, Individual #266, Individual #175, Individual #155, and Individual #156; o For these same 10 most recent hospitalizations that have been completed, copy of hospital liaison nurse documentation of hospitalization; o Length of stay for Infirmary admissions for past six months; o Infectious disease data per quarter by category of infection for last two quarters; o Any summary report or trend analysis of infectious disease/communicable disease for last two quarters; o Avatar pneumonia tracking forms for past six months; o For those with diagnosis of pneumonia in last six months and taking food/liquid by mouth, type of liquid (amount of thickening), and type of texture of solid food ordered, and last swallow study; o Absolute numbers of new cases (prior year, by month) for the following: ▪ Pneumonia; ▪ Decubitus ulcers; ▪ UTIs; and ▪ Bowel obstructions; o Individuals' names, dates of diagnosis, specific diagnoses (e.g., type of cancer, type of sepsis) for past year for individuals who have been newly diagnosed with: ▪ Malignancy; ▪ Cardiovascular disease; Diabetes mellitus; ▪ Sepsis; ▪ Bowel obstruction or bowel perforation; and ▪ Pneumonia; o List of individuals who have diagnosis of constipation or who are receiving anti-constipation medication at least weekly; o All policies and procedures related to seizure management; o A list of individuals being treated for seizure disorders, including:

	▪ Name of individual; ▪ Residence/home; ▪ Diagnosis (type of seizure); and ▪ Medication regimen; o For past six months, for five individuals, documentation of seizure management (e.g., neurologist's notes), including for: Individual #48, Individual #140, Individual #239, Individual #181, and Individual #209; o List of individuals seen by neurologist with dates on which appointments were completed and reason, since the Monitoring Team's last review; o List of those with status epilepticus since the Monitoring Team's last review; o List of seizure medications per individual for diagnosis of seizure disorder; o List of those going to ER for uncontrolled/prolonged /new onset seizure since the Monitoring Team's last visit; o List of individuals with refractory seizure disorder; o List of individuals with refractory seizure disorder who are being evaluated for Vagal Nerve Stimulator (VNS) placement and the stage of evaluation; o Numbers and percentage of individuals on one, two, three, four, and five antiepileptic drugs (AEDs); o Numbers and percentages of persons on older AEDs (Phenobarbital, Dilantin, Mysoline, Felbamate); o Any tracking of data for individuals who have transitioned to community since the Monitoring Team's last visit, including hospitalizations, ER visits, and 911 calls. Any Facility review of adverse outcomes, communication with provider agency, and description of technical assistance provided. Any documentation of the final transfer between Post-Move Monitor and community service coordinator at 90-day transfer; o For the three individuals most recently transitioned to the community for at least 90 days, copy of seven, 45, and 90-day reports. For these three individuals (i.e., Individual #194, Individual #30, Individual #114), copy of CLDP, most recent ISP, BSP, and subsequent addendums, most recent annual medical exam and most recent nursing assessment; o Since the Monitoring Team's last visit, any ethics committee meeting minutes, with attendance rosters, concerning DNR decisions/changes; o Dates of last two completed annual medical assessments and annual physical examinations for all individuals; o Dates of last two completed quarterly medical reviews/IPNs completed for all individuals; o For specialty clinic appointments (on campus and off site), list of appointments that were completed and one not completed (with reasons); o Numbers of individuals with a diagnosis of seizure disorder on no anti-epileptic medications; o Number of individuals with VNS in place, date of placement, date of replacement, if applicable; o For concerns identified needing closure at morning provider/medical meetings for period of 30 to 60 days prior to Monitoring Team's visit, copy of any documents providing

	evidence of closure (minutes of medical staff meeting, copy of ISPA addressing concern, etc.); o For the last five individuals in whom pre-treatment sedation was administered for a medical procedure, all information related to medical pre-treatment sedation used prior to visits, including consents, HRC approval, relevant assessments, ISP entries, any general discussion record, action plan, and integrated progress note entries, including those for: Individual #304, Individual #212, Individual #183, Individual #221, and Individual #268; o Ten most recent PNMT recommendations with physician orders; o ISPAs addressing missed appointments or refusals for the past three months for mammograms and colonoscopies; o List of missed medical appointments with reasons for past six months; o Signature Sheets dated 7/10/12, and 7/11/12 for Integrated Clinical Services Meeting; o Presentation Book for Section L, including: Medical Provider Quality Assurance Audit: Essential and Non-Essential Compliance by Provider: External Audits for Round 5, Internal Audits for Round 5; last two annual medical assessments for all individuals as of 5/31/12; QA medical audit schedule 2012; external medical management audits for Round 5 [three diagnoses], external audits for Round 5 [30 questions]; external audits Round 5 results and action plans; external medical management audits for Round 5 results and action plans; Medical Provider External Review 4/19/12 exit summary; Action Plans follow-up by QA: external audits for Round 5, external medical management audits for Round 5, internal audits for Round 5, internal medical management audits for Round 5; Compliance by Question Category: external audits for Round 5, internal audits for Round 5; Results and Action Plans: internal audits for Round 5, internal medical management audits for Round 5; Inter-rater medical management by diagnosis Round 5 (diabetes, osteoporosis, pneumonia); medical management inter-rater percent agreement Round 5 per PCP; and internal/external audits agreement by questions for Round 5; o IPNs, physician orders, labs, x-rays, consults, from 7/1/12 through 7/1012 for Individual #117 o For Individual #30, Individual #194, and Individual #114, copy of 45-day follow up, and in-service training for medical and psychiatric diagnoses/issues; o Preliminary findings from autopsy, updated as of 7/13/12; and o For each of the following individuals, copies from the active record: DG-1, most current annual medical assessment and physical exam, preventive care flow sheet, most current nursing assessment, past one year of IPNs, past one year of lab results x-rays, scans, MRIs, ultrasound reports, hospital discharge summaries for past one year, ER reports for past one year, consults and procedure reports for past one year, DNR forms if applicable, physician orders for past one year, most recent PSP/ISP and subsequent addendums, most recent BSP, and past three medical quarterly reviews: Individual #215, Individual #31, Individual #244, Individual #213, Individual #251, Individual #144, Individual #103, Individual #294, Individual #210, Individual #65, Individual #86, Individual #158, Individual #299, Individual #356, Individual #181, Individual #253, Individual #42, Individual #156, and Individual #72.

	▪ **Interviews with**: o Sandra Rodrigues, MD; o Norma Brown, MD; o Eugenio Hernandez, MD; o Sharon Alexander, Family Nurse Practitioner (FNP); o Althea Pat Stewart, Medical Compliance Nurse; o Cynthia Velasquez, Quality Assurance Director; and o Esmeralda Vogt, Admission Placement Coordinator. ▪ **Observations of**: o Coral Sea Unit: Individual #122, Individual #232, Individual #15, Individual #334, Individual #101, Individual #79, Individual #126, Individual #260, Individual #303, Individual #244, Individual #340, Individual #342, Individual #21, Individual #205, Individual #205, Individual #366, Individual #176, Individual #104, Individual #212, Individual #57, Individual #124, Individual #179, Individual #189, Individual #183, Individual #160, Individual #280, Individual #70, Individual #150, Individual #24, Individual #93, Individual #207, Individual #270, Individual #305, Individual #272, Individual #307, Individual #16, Individual #266, Individual #252, Individual #276, Individual #23, Individual #28, Individual #134, Individual #239, Individual #319, Individual #250, Individual #299, Individual #25, Individual #50, Individual #113, Individual #130, Individual #146, Individual #163, Individual #292, Individual #327, Individual #328, Individual #324, Individual #350, Individual #301, Individual #236, Individual #293, Individual #139, Individual #127, Individual #240, Individual #68, Individual #201, Individual #290, Individual #37, Individual #32, Individual #195, Individual #77, and Individual #314; o Infirmary: Individual #311, Individual #137, Individual #43, Individual #376, Individual #181, Individual #357, Individual #308, Individual #136, and Individual #156; o Annual ISP meeting, on 7/12/12 for Individual #156; and o Medical morning meetings, on 7/11/12, 7/12/12.
	Facility Self-Assessment: The Facility had engaged in some reasonable activities to measure compliance with Section L. For example, to measure the timeliness of routine, preventive, and emergency medical care, the Medical Department tracked the completion of several aspects of health care, including completion of on-campus appointments, which the Facility measured as greater than 80%. The Facility also looked at whether or not off-campus appointments were kept. For those with Down syndrome, the Facility looked at whether they had the required TSH screening. The Facility measured this as being at 100%. The Facility also looked at the completion of colonoscopies and mammograms, which they indicated occurred in greater than 90% of the eligible population. In its Self-Assessment, the Facility also included information about the External Medical Provider Audits. The Facility indicated that compliance of essential components of the audit ranged from 80 to 100%. For non-essential components, compliance ranged from 89 to 97%. This process and the results are discussed further with regard to Section L.2.

	However, the Facility's Self-Assessment for Section L required significant expansion. For example, the Facility was looking at some discrete aspects of routine and preventative care for Section L.1. Because Section L.1 covers all routine, preventative, and emergency care, the Facility should increase the components of treatment and care that it self-assesses. Overall, the Facility's Self-Assessment did not reference the clinical guidelines State Office had issued or any assessment of whether or not the Facility was implementing them effectively. Similarly, for Section L.4, the Facility focused in on the development of one policy in its self-assessment activities. However, Section L.4 requires the establishment of an entire set of policies related to the provision of medical care. As noted in other sections, it appeared that the Facility was implementing a number of monitoring tools related to the provision of medical services. However, this data was not evident in the Self-Assessment for Section L. The Facility determined it was noncompliant with Section L. This was consistent with the Monitoring Team's findings. However, much work was needed to improve the Facility's self-assessment activities for Section L.
	Summary of Monitor's Assessment: Progress had been made in a number of areas. Preventive medical procedures such as colonoscopies and mammograms were tracked and completed at a relatively high rate (94 to 96%). Several trend analyses were available as a result of medical compliance monitoring. However, the internal quality improvement (QI)/medical compliance monitoring of clinical care was delayed due to a lack of guidance in choosing clinical indicators to be used for specific clinical conditions/diagnoses. At the time of the review, the Facility had no Medical Director to provide guidance in a number of areas, including medical compliance. The morning medical meeting, which was recently renamed as the Integrated Clinical Services Meeting, provided evidence that a basic process was in place to provide quality review and oversight of healthcare. However, a number of areas required further development and fine-tuning, such as ensuring documentation of the actual reason the group was making a referral to the IDT, when applicable. The morning team also needed to focus on asking critical questions, and conducting critical review of the ISPAs that resulted from their referrals. The documents the morning medical meeting produced provided a tracking mechanism. However, the quality of the tracking required further attention. In other areas, a template was needed for quarterly medical reviews that could be completed quickly and accurately. For most records reviewed, these had not been done. Although an external non-facility physician review had been conducted, the Facility had questioned its accuracy. Based on the Monitoring Team's review, concerns were noted with the potential thoroughness of the review of numerous records in a short period of time, as well as a lack of established inter-rater reliability amongst reviewers. In addition, although corrective action plans had been developed to address PCP-specific concerns, no documentation was available to show that follow-up had occurred. In addition,

	no systemic corrective action plans were developed or implemented. Although mortality reviews had been completed, documentation was not submitted to show that follow-up had occurred to address the recommendations they included. The Facility did not appear to have incorporated the clinical protocols/guidelines into the monitoring processes. In addition, the Medical Department was beginning to analyze some of the data it was collecting, but did not yet have a system for writing quarterly reports that focused attention on areas of strengths and weakness. For instance, measuring the impact of the morning medical meeting by providing the number of concerns referred to the IDTs, the number of post-hospital ISPAs reviewed, the number post-hospital ISPAs approved, the number of ISPAs returned to the IDT for further review, the number of concerns provided closure each month, etc. would reflect the activity of the morning meeting and the Medical Department. For many of the functions and clinical areas for which the Medical Department was responsible, it will be important to design key indicators or outcome measures to assist the Facility in identifying areas of high performance and areas requiring attention.

#	Provision	Assessment of Status	Compliance
L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	Given that this paragraph of the Settlement Agreement includes a number of requirements, this section of the report includes a number of different subsections 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, and Do Not Resuscitate (DNR) Orders. <u>Staffing and Administration</u> Based on documentation the Facility provided, for the census of 261 as of 5/18/12, there were four PCPs responsible for this population. The Medical Director position remained vacant. The PCPs had caseloads ranging from 59 to 75. A Medical Compliance Nurse and Medical Program Specialist assisted the Medical Department in medical administration and medical QA/QI. Three physician consultants (i.e., orthopedics, neurology, psychiatry) were listed that provided physician services on site. A list was submitted indicating those members of the Medical Department that remained current in CPR certification. The list was dated 4/1/12. Of the primary care providers in the department, four out of four (100%) were current in CPR. Of the four PCPs in the Medical Department, a list of CME credits was submitted for the prior six months for none of these PCPs. Verification with the former acting Medical Director confirmed that none of the PCPs had completed CME credits in the prior six months, although one PCP was scheduled to attend a medical conference the week	Noncompliance

#	Provision	Assessment of Status	Compliance
		following the Monitoring Team's visit. All PCPs had current licensure, indicating the number of CME hours for licensure had been maintained for renewal purposes. The purpose of reviewing CME was to determine if the CME focused on diagnoses and topics that would enhance the practice patterns of the PCPs at CCSSLC. <u>Physician Participation In Team Process</u> For the two morning medical meetings observed, there was a signed attendance roster for both meetings (i.e., 7/10/12, and 7/11/12). For both the 7/10/12 and 7/11/12 meetings, seven departments attended (i.e., medical, dental, nursing, pharmacy, psychology, psychiatry, and PNMT). For the two morning medical meetings observed, no critical clinical questions were raised during discussions of health care. For example, there was no discussion of review of pre-hospital events or assignment to gather information to review the hospitalization for Individual #270 with an admitting diagnosis pneumonia, which occurred during the Monitoring Team member's attendance at the morning medical meeting. Earlier in the week, a member of the Monitoring Team and the PNMT made environmental observations of this individual's room at which time "dust and unclean environment" were found. Documentation in the 7/12/12 morning medical meeting indicated that the "room has been on environmental checks with poor performance since prior to 8/31/10." For the two morning medical meetings observed, the on-call PCP (from the prior evening) participated by presenting the cases. The attending PCP for the individual (when not the on-call PCP) participated in the discussions/provided additional information with regard to two of four health status changes/on-call concerns for individuals that were hospitalized. For the two morning medical meetings observed, no assignments for further updates were identified. For the two morning medical meetings observed, updated information/ISPA was presented for closure for one individual. Additionally, other business was conducted during the morning medical meetings observed. For example, the group commenced a weekly PNMT review at the morning medical meeting. In preparation for the Monitoring Team's visit, the Facility submitted the morning medical meeting minutes from April 2012. These appeared to include the span of the month, although some submitted information had the date cut off, and two additional	

#	Provision	Assessment of Status	Compliance
		submissions were follow-ups in May 2012. No attendance rosters were included with these initial submissions. The minutes included a brief discussion by the morning medical team with subsequent review of follow-up ISPAs or emails that had been developed or sent to close specific concerns the morning medical team had sent to IDTs. These included closure information for: ▪ Individual #181 (ISPA 4/11/12, orthopedic consult 4/18/12); ▪ Individual #247 (follow-up email 4/25/12, orthopedic consult 4/18/12); ▪ Individual #202 with specific request for the IDT to address her falls (ISPA 3/27/12); ▪ Individual #194 (ISPA 3/30/12 reviewed and was sent back to the IDT for further review of preventing potential aspiration. A follow-up ISPA was submitted 4/17/12 with morning team discussion on 4/23/12. This is discussed further below.); ▪ Individual #326 (team requested PNMP review and review of falling, with email response 4/23/12. This is discussed further below.); ▪ Individual #163 (3/30/12 email confirming coaching of the nurse responsible for a medication error, brought up by the medical team); ▪ Individual #372 (4/4/12 ISPA with action plans in response to medical team request for PNMP review of frequent falls); ▪ Individual #156 (the team noted that intake and refusals were not being logged, indicating the need for direct support professional training. This is discussed further below.); and ▪ Individual #136 had a follow up ISPA to prevent further falling from his bed. There remained a lack of documentation of critical clinical discussion or clear documentation of closure for the following concerns: ▪ With regard to Individual #176 and efforts to reduce repeated hospitalizations (i.e., minutes recorded hospitalization on 3/12/12, 3/20/12, and 4/4/12) with return from the hospital on 4/12/12, no team discussion occurred of precursor events to the hospitalization, or preventive steps to stop future hospitalization. ▪ Individual #202 was discussed at the morning meeting with critical discussion of her falls, especially as she was prescribed Coumadin, which could increase bleeding risk. The IDT responded with an ISPA. However, there were additional concerns that the ISPA did not address, and no additional information or requests were provided in response to the ISPA findings. For instance, one fall was due to slipping on a wet floor, possibly from "a leak in the ceiling or leak on the wall." The ISPA indicated: "a work order was sent to maintenance department to check and repair leak." Given a dangerous combination of a slippery environment and an individual on Coumadin, there needed to be evidence of closure (i.e., date maintenance repaired the problem, or what was found if it was determined that it was not a maintenance issue, and what was	

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		being done to provide safety while repairs were done or delayed). An additional fall occurred when she got out of bed and lost her balance. There was no specific information about her adaptive equipment and how to deter her from taking it off. There was no specific action step about her fall on 3/18/12 when she attempted to get out of bed. The only item mentioned was a change in her seatbelt buckle, which did not appear to apply to her falling out of bed or the fall on the slippery floor. Despite the high-risk situation of frequent falling in an individual on Coumadin, there was no further request for team intervention to prevent a recurrence. More problematic, there was no apparent oversight of the ISPA process from the residential or other administrative services in reviewing the quality of the content of the ISPA. ▪ Individual #194 was further discussed after the medical team reviewed an updated ISPA of 4/17/12 concerning aspiration risk. This was addressed in the ISPA. However, other issues in the ISPA, such as the J-tube clogging two times, and the J-tube being pulled out twice were noted. One of the reasons for the tube being pulled out was his self-repositioning while in the recliner, and staff training was provided as evidence of proactive steps taken. This was clear evidence of a pro-active step. However, the clogging of the J-tube did not appear to be addressed. There was the phrase that the J-tube was "a faulty j tube," which explained the tube clogging. It was not clear how it was decided that this was the problem, because it can be due to medications not being crushed properly, insufficient flushes of water after medication administration, etc., rather than a defective tube. However, if true, the Facility needed to research the availability of better quality J-tubes for its individuals. There was no further request from the morning medical meeting. The issue was closed, although it appeared more steps were necessary to resolve the tube clogging or reviewing the quality of the J-tube. ▪ Individual #326 had frequent falling, and the team requested further action/review by the IDT. The email of 4/23/12 provided further information. However, one of the falls was due to a peer pushing the individual down, but there was no further information concerning ways to prevent a reoccurrence, such as increased supervision of the peer or the individual, etc. There was no further medical team documentation related to review of the email or further questions to address the falls. ▪ Individual #315 had possible ingestion of parts of her feeding tube, and an email from the IDT responded with an ISPA, dated 4/3/12, that put in place an increased level of supervision. However, the documentation stated a part of the tube had been found, and it was not clear where or how it had been found to confirm there was pica or not. The ISPA of 4/3/12 indicated further follow-up to the pica incidents occurring repeatedly on the 2 p.m. to 10 p.m. shift, but there was no further information as to the findings at the 30-day review by the IDT, or	

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		if that information would be shared with the medical team. The ISPA of 4/3/12 appeared to be an interim step while information was being gathered. There was no further document submitted indicating what had been the outcome of the steps taken in the ISPA of 4/3/12, and how further pica would be prevented (e.g., more supervision, more active treatment, etc.). ▪ Individual #43 was discussed in the minutes concerning Infirmary concerns with the direct support professionals and repositioning. A 4/3/12 email discussed the RN's concerns, but there was no further documentation of resolution of the concern. ▪ Individual #156 was reviewed, with the morning team requesting training of the direct support professionals. An email was received on 4/18/12, but did not provide information about training completed or intentions to train, but asked some further questions about the fluids offered to the individual. This remained incomplete. ▪ Individual #172 was reviewed and the medical team questioned his access to a lighter, but the response email dated 5/7/12, although providing information related to the event in which he attempted to light his clothing on fire, did not address changes in his BSP concerning access to a lighter, the mental health status of the individual, and/or whether follow-up with psychology or psychiatry was completed ("psych was notified"). Such vague statements as "psych was notified" provide evidence of action, but did not provide evidence of closure. There was no note that this information was brought back to the medical team for review and/or the response of the medical team. For clarity of information, it is important to indicate if the morning medical meeting specifically reviewed a follow-up document. An appointed member of the Medical Department could review the document ahead of time and select important statements to review at the morning medical meeting. It is also important that as applicable, there be a statement/phrase that the morning medical team agreed with an ISPA as written. If it is to be returned for further review, the minutes should briefly indicate the reason, and future closure can refer back to the reason it was sent back to the IDT. It is recommended that brief concise entries describing discussion of critical questions at the morning meeting be recorded in the minutes. These questions can then be delegated to a member of the team, the PCP, another department, or the IDT, depending on the concern. This practice would assist the Facility in documenting a focus on critical questioning of treatment and prevention, and provide evidence of quality in the medical care process. These focused questions should be followed to closure. There appeared to be closure of the day-to-day clinical concerns, but there was less closure information on critical questions, systems issues, and ISPAs. The section of the minutes entitled: "Other issues discussed" would be the expected location for documenting progress on closure.	

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		For those areas determined to be non-clinical (e.g., environmental, etc.), referral to the appropriate department would be appropriate, with a request for a final document answering the questions or concerns to allow members of the morning medical meeting to discuss and close such issues. Further morning medical team minutes were submitted from 6/13/12 through 7/12/12. Attendance rosters were included for these documents. An example of documentation of an excellent clinical discussion occurred on 6/25/12 concerning Individual #239 and related to approaches to prevent a repeat hospitalization. It also was noted that open book reviews for those with aspiration pneumonia continued to occur, which was positive. On 6/29/12, there was such a review for Individual #327. However, an example of a concern needing closure was a 7/5/12 entry for Individual #179 in which a nurse was to address the IDT and nurses concerning the individual's J-tube recurrently coming out. There was no date recorded when this was accomplished (needed for closure). Additionally, in this case, forwarding a copy of the handout or outline of discussion would be a valuable area of learning for all the morning medical attendees to assist in their understanding of the instructions that are given to staff. It also would be an opportunity to provide feedback to the Nursing Department from other departments on the content of the instructions. There were also concerns that the morning medical meeting process was not critically reviewing/ screening many of the ISPAs that focused on medical concerns to determine if the ISPA action plans were adequate to meet the needs of the individual. There was documentation that some ISPAs were reviewed (as mentioned above) and returned to the IDT for further analysis. However, it appeared that for a number of ISPAs, the initial review/discussion was cursory and did not challenge the teams to include preventive action steps. Much of the role of addressing the quality of the ISPAs rested with the QDDP Department. Although the medical morning meeting was not intended to provide quality oversight for the ISPA process, it does play an important role to provide technical guidance and ensure the teams address adequately the health and safety of the individuals, with the added focus on prevention. An example of the need for the Medical Department to review the ISPA and to record findings through to closure was as follows: On 4/24/12, there was an ISPA for Individual #137 indicating that the IDT discussed replacing the padding on the bedrails. The padding was "no longer considered acceptable." The Habilitation Department was to be consulted. On 6/15/12, the individual then sustained an oblique fracture of the lower leg, and the conclusion/belief was that the body had been wedged between the mattress and the bedrail. Based on the 6/15/12 ISPA, the medical morning minutes did not reflect a discussion or need for an update as to whether the original bed rail concern had been resolved, was still pending, or the replacement padding/wedges, etc. needed further	

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		review. Questions raised from the 6/15/12 ISPA would have uncovered the earlier ISPA and the need for closure information from the IDT. Several ISPAs had been held for this individual during this time, but none documented the findings and intervention of the Habilitation Therapy Department, or the training the direct support professionals and nurses would need for new padding/wedges, or other equipment. It was not further mentioned in subsequent ISPAs. The morning medical meeting participants would not necessarily be aware of the 4/24/12 ISPA (although others at the Facility should have ensured closure of the ISPA concerns), but the 6/15/12 ISPA concerning the fracture should have led to questions and a request for review of the padding and bedrails. The group should have challenged the IDT to provide preventive strategies for the individual's osteoporosis whether the individual's was located in bed, in a chair, in a wheelchair, van, etc. The Facility should have procedures in place to ensure all action steps in ISPAs are addressed and documented, and to ensure progress or lack of progress is communicated to the IDT. <u>Routine Care</u> A list of dates of the last two annual medical assessments and physical exams were submitted. Of these, with the exception of new admissions in the prior year, 153 out of 265 (58%) of the recent annual medical assessments were completed within 365 days of the prior assessment. When reviewing the most recent dates of the completed annual medical assessments, 234 out of 265 (88%) were completed within the prior 365 days, and 31 were overdue. The date of the report was partly cut off, but appeared to be 6/22/12. A cut off of 30 days prior (5/22/12) was used as a window of time to record any completed documents. At the time that this information was submitted, it was noted that the most recent date of physical exam completion was not available for this database for 77 individuals. Only 188 of 265 (71%) had complete information. This suggested the database was not reviewed at regular intervals, as this would have been easily corrected, and that the lack of data made interpretation difficult for the Medical Department. It was learned during the Monitoring Team's visit that the blank spaces for the most recent physical exam occurred in part because, after 1/1/12, the physical exam was completed at the same time as the annual medical assessment. However, there was no key to interpret the blank spaces in the data. For 20 individuals, a copy of the most recent annual medical summary and physical examination evaluation, as well as the prior annual medical summary and physical examination evaluation were submitted for review. These are listed above in the documents reviewed section. Timeliness was determined if the most recent annual medical summary and physical examination evaluation was completed within 365 days of the prior annual evaluation. For the 20 individuals, compliance was 16 out of 20 (80%).	

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		For the 20 most recent annual medical assessments, there was an interval history included as part of the document in 20 of 20 reviews (100%). However, three of these interval histories were noted to be brief. For the 20 most recent annual medical assessments, the major active problems listed had plans of care addressing each of these problems in 16 of 20 assessments (80%). For one plan of care, the documentation for osteoporosis appeared incomplete or may have indicated under-treatment. For one, the document stated there had been no seizures in the past year, when the individual was hospitalized with seizures in 2012. One plan of care was considered brief and needed further development. For the 20 most recent annual medical assessments, 19 out of 20 (95%) addressed smoking history. Family history was adequate in two out of 20 (10%). For 12 out of 20, the document stated "none available." For one, a psychiatric history was provided, but no medical history. For five, the information provided was lacking, brief and incomplete, or otherwise not helpful. It is recommended that the Medical Department initiate a periodic review of the annual medical assessments to ensure all components are included, as well as develop criteria to assess quality of the various subsections of the annual medical assessment. As part of the monitoring review process, the Monitoring Team selected the medical records of 19 individuals to determine compliance with several requirements of Section L.1. These individuals are listed in the documents reviewed section. The reviews selected were based on a couple of sampling methods. First, every 21st name listed on a census was selected, after the first name was chosen by random selection, resulting in 13 individuals being selected. A second group of six was selected by identifying individuals with various diagnoses/health care issues, and selecting one individual rated high risk in each of six at risk categories (e.g., aspiration, GERD, skin breakdown, cardiac issues, etc.). This additional sample was done to allow the Monitoring Team to comment on the appropriateness of the healthcare provided to individuals with various medical needs. Documents reviewed included the preventive care flow sheet, physician orders from the past 12 months up to the present, integrated progress notes from the past 12 months up to the present, most recent BSP, last annual ISP and subsequent addendums, labs, x-rays, consult forms from the past 12 months to the present, the most recent health management plan, the most recent annual medical assessment and physical exam, the DG-1, the most recent nursing assessment, any hospital discharge summary for the past year, ER visits for the past year, and any consult reports and procedure reports from the past year. Each aspect is discussed as the relevant preventive or routine care topic is	

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		discussed. From 19 medical records reviewed: ▪ Fourteen (74%) annual medical assessments had been completed in the past 365 days. ▪ Active problem lists appeared to be thorough in 13 (68%). It was noted that in one annual medical summary, no active problem list was included, and no separate active problem list was submitted. ▪ Fifteen (79%) had information about smoking history and/or substance abuse. ▪ An adequate family history was documented (or there were attempts documented at obtaining this information) in three of 19 (16%) records. For three of 19 (16%), there was a limited family history provided. For 13 of 19 (68%) charts, the family history was "not available" or not listed. ▪ Seventeen (89%) had information/recommendations discussing requirements for transition. ▪ The DG-1 forms were reviewed. Of the 19 DG-1s reviewed, one (5%) had updated and complete diagnoses consistent with the active problem list. These medical records also were reviewed to determine whether the physician IPN notes used the Subjective, Objective, Assessment, and Plan (SOAP) format. In 19 (100%), the SOAP format was used, and included date and time on the IPNs. Two medical records (11%) had a PCP quarterly review of medical progress during any quarter in the prior year. No record had more than one quarterly medical review in the prior year. Contents of the quarterly medical review included: ▪ Listing of new major diagnoses in one of two medical quarterly reviews (50%). ▪ The last three monthly weights in none of two medical quarterly reviews (0%). ▪ Brief comments/entries listing numbers of seizures (if applicable) in zero of one medical quarterly reviews (0%). For one record, this was not applicable. ▪ Changes in medication in two of two medical quarterly reviews (100%). ▪ Important/abnormal labs and drug levels in one of two medical quarterly reviews (50%). ▪ ER visits, and hospitalizations with dates and discharge diagnoses/treatments in one of one medical quarterly reviews (100%). This was not applicable for one record. ▪ Important consultation results (brief) in one of one medical quarterly reviews (100%). This was not applicable for one record. ▪ Two of two medical quarterly reviews (100%) were placed in the IPN section of the active medical record, or referenced by an IPN concerning date of	

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		completion if located elsewhere in record. <u>Access to Specialists</u> The following numbers of off–site visits for consultation or procedures were documented to have occurred from December 2011 through May 2012: ▪ Cancer Center: 11 appointments; ▪ Cardiology: 62 appointments; ▪ Dental: 13 appointments; ▪ Dermatology: eight appointments; ▪ Endocrinology: 14 appointments; ▪ Gastroenterology: nine appointments; ▪ Gynecology: 18 appointments; ▪ Nephrology: six appointments; ▪ Neurology: 30 appointments; ▪ Operative report consultations (not further defined): 31 appointments; ▪ Ophthalmology: 92 appointments; ▪ Podiatry: 21 appointments; ▪ Pulmonary medicine: 11 appointments; and ▪ Urology: 29 appointments. Of a total of 434 appointments scheduled, 355 appointments were kept, and 79 appointments were missed. This was an attendance rate of 82%. Of the 79 appointments missed, 25 were categorized as refusals (32%). Other reasons for missed appointments included: consultant not in office, rescheduled, individual in hospital, pre-visit orders not written, not sedated, behavior, on furlough, no staff available, and paperwork not completed. A tracking log should be maintained to ensure appointments missed are rescheduled and subsequently completed at a future date, and that missed appointments are reviewed at IDT meetings, with evidence of the date of the meeting recorded in the tracking log. On site, several specialty clinics were held to meet the needs of the individuals. These included Audiology, Neurology, Orthopedics, and Psychiatry (further discussed with regard to Section J). For Audiology clinics, from 1/2/12 through 5/10/12, there were 234 completed appointments out of a total of 319 appointments scheduled. The completion rate was 73%. For Neurology clinics, from 2/4/12 through 4/28/12, there were 68 appointments kept and 71 appointments scheduled. The completion rate was 96%. For Orthopedics clinic, from 1/18/12 through 4/18/12, there were 21 appointments completed of 25 appointments scheduled. This was a completion rate of 84%. The quality of the background information provided by the PCPs in the consultation	

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		referrals is reviewed as part of the peer review process. This is discussed in further detail with regard to Sections L.2 and L.3. In addition, the Monitoring Team's findings with regard to the follow–up on consultations are discussed with regard to Section G.2. <u>Preventive Care</u> Preventive care flow sheets were in place to facilitate tracking of standard testing and evaluations in 19 out of 19 records reviewed (100%). Preventive care flow sheets were up-to-date in 14 out of 19 records reviewed (74%). Current vision screening was documented in 19 out of 19 of the records reviewed (100%). Of these 19, two individuals were blind, one was "difficult to assess," and one had "adequate vision." Audiological screening was current in 19 out of 19 records reviewed (100%). Two were completed in 2010, and would be due in 2013. Twelve were completed in 2011, and five were completed in 2012. The influenza vaccination had been given to 19 individuals (100%) in a timely manner during 2011. Whether the individual needed to receive varicella vaccine (depending on birth date and immunity status), and whether it was given if indicated, was recorded in 18 of the 19 active records reviewed (95%). There was one individual for whom lab work was pending to determine immunity. Whether the individual needed to receive a hepatitis B vaccine (depending on immunity status, carrier state, etc.) and whether the series was completed if indicated (or being tracked for completion) was recorded in 19 of the 19 active records reviewed (100%). A list was submitted dated 5/18/12, indicating women residing at CCSSLC who were over the age of 40, along with the date of the last mammogram, and the reason, if it was not done or outdated. A total of 97 women were identified as being over the age of 40 (the list included a few under the age of 40, but these were removed for this review). The American Cancer Society recommendations were to be followed, according to a DADS SSLC policy #009.1, dated 2/16/11. Of these 97 women, 17 had reasons not to have a mammogram (e.g., guardian refusal, inability to physically provide proper positioning for the test, etc.). Of the remaining 80 women, 77 had mammograms within the prior year or were scheduled in the near future. This was a compliance rate of 77 out of 80 (96%).	

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		From the sample of 19 medical records reviews, eight females were over the age of 40. Of these, seven were eligible for a mammogram. One had medical reasons for not completing a mammogram. All seven (100%) were up-to-date on mammogram testing. From the sample of 19 active records reviewed, there were 10 females. From the sample of these 10 active records, seven (70%) did not meet criteria/have risk factors that necessitated testing in the prior three years. For the remaining three individuals, two females (67%) had pap smears completed within the prior three years. The Medical Department submitted a list of those individuals over the age of 50 with the date of the last colonoscopy, with the reason for the colonoscopy. A total of 132 names were submitted. Of these, six had reasons not to order a colonoscopy. Therefore, the eligible population was 126 individuals. Of these, 119 completed a colonoscopy within the prior 10 years or had recently turned 50 years of age, and an appointment was pending. A total of 119 out of 126 (94%) had completed an appropriate procedure in a timely manner. Of the 19 active records reviewed, 11 were at age 50 or greater. Of the 11, 10 (91%) had colonoscopies completed in past seven years. One individual was 50 years of age and there was no information that one had been scheduled. A list of individuals with a diagnosis of osteopenia or osteoporosis was submitted. Identification of the medications and dosages of the medications treating these diagnoses also was requested. Additionally, for all those over the age of 50, a list of the last DEXA scan date and copies of the most recent DEXA scan report were requested. A total of 101 individuals with a diagnosis of osteopenia or osteoporosis were reviewed. Of these, 97 (96%) had a DEXA scan T score submitted. Of the 101 individuals reviewed, 91 were determined to have osteoporosis. Of these 91 individuals, 68 (75%) had documentation of adequate treatment. Fifteen individuals were only receiving calcium or Vitamin D without additional medication, and eight had no documentation of calcium or Vitamin D supplementation. For these 23, there were no notations providing rationale contraindicating usual recommended therapy. Of the 101, 10 had osteopenia. Of these, it was noted that six were provided medication and/or medication dosages that exceeded recommended dosages for osteopenia and were regimens used for osteoporosis. Of these 10, three did not have documentation of calcium or Vitamin D supplementation. For men and premenopausal women with a diagnosis of osteopenia or osteoporosis, the Facility was asked to submit a copy of any lab work used to test for secondary causes (from the current active record) for this disease process. There was no information submitted.	

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		From the sample of 19 medical records reviewed, 11 had a diagnosis of osteoporosis or osteopenia. ▪ Of these 11, nine (82%) had a DEXA scan T score recorded. ▪ Of these, nine of nine (100%) had a T score consistent with the diagnosis of osteoporosis or osteopenia. ▪ For those nine with T scores indicating osteoporosis or osteopenia, nine (100%) had been prescribed supplemental calcium and vitamin D. ▪ Of these, four had a bisphosphonate ordered. ▪ Of these, four had Miacalcin prescribed. ▪ Of these, none (0%) had other alternative medications prescribed for treatment of osteoporosis or osteopenia. ▪ Treatment was considered adequate in eight of nine (89%). A list of those with Down syndrome was submitted, along with the date of the last thyroid test. A total of 12 individuals were identified with a diagnosis of Down syndrome. All 12 (100%) had a current thyroid test. <u>Acute and Emergency Care</u> The active record was reviewed for 10 individuals who had most recently gone to the Emergency Room and returned. These individuals are listed in the documents reviewed section. Eight of the 10 had gone to the ER from their residence. One had gone from the Infirmary to the ER. For one, from the information provided, this could not be determined. The following summarizes the results of this review: ▪ Information was submitted indicating that the ER was notified of the arrival of the individual with appropriate medical background information provided for six of 10 (60%) individuals. ▪ Prior to the transfer to the ER, a PCP was on site for one of these transfers. For one individual, it could not be determined if the PCP was on site from the information submitted. In one of one (100%) record, the PCP had written an IPN that included the date and time. ▪ For none of one (0%), vital signs were recorded. ▪ For one of one (100%), reason for the transfer was documented. ▪ In one of one (100%), the SOAP format was utilized. ▪ A copy of the ER report that was filed in the record was submitted in six of 10 (60%). ▪ Of the 10 ER visits, five were for trauma, two were for respiratory illness, one was for cardiac illness, and one was categorized as other. ▪ When the individual returned to the Facility after evaluation at the ER, 10 of the 10 active records (100%) had an IPN written by a PCP. Of these, eight of 10 (80%) utilized a SOAP format.	

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		▪ These notes included the date and time in 10 of 10 (100%) of the IPNs written by the PCP. ▪ Vital signs were recorded in six of 10 (60%) of these IPNs. ▪ A summary of ER information and findings was included in nine of these IPN notes (90%). ▪ When returning to the Facility, six returned to the individual's residence, and four returned to the Infirmary. ▪ Seven of the 10 records (70%) had additional PCP notes as follow up to the original concern. ▪ For 10 (100%), treatment was considered timely. There were no perceived delays in care in transferring the individuals to the ER once the PCP was notified. Several additional observations were noted from review of these 10 records. It was difficult to determine which individuals were in the Infirmary at the time of the transfer to the ER. For one individual, the IPNs documented the individual was found lying low in the bed (i.e., not correctly positioned) with tube feeding being administered. This suggested the need for review of training of the direct support professionals that support individuals that are fed by tube, training of nursing staff for positioning requirements, and the need for monitoring of homes with individuals that are fed by tube. Additionally, nine active records were reviewed for individuals admitted to the hospital. There were 11 hospital admissions for these nine individuals. The following provides the results of this review: ▪ For six of 11 hospitalizations (55%), the PCP wrote an evaluation/transfer note prior to the transfer. For five of these, the transfer occurred after hours or on weekends. ▪ Eight individuals had documents indicating eight hospitalizations were followed by a return to the Facility. One individual died while in the hospital. Two remained hospitalized at the time of submission of information. Of the individuals that returned to the Facility, eight of eight (100%) had IPNs post hospitalization. ▪ Of the eight post-hospital IPNs submitted, five (63%) included vital signs. ▪ All eight (100%) included date, time, and an adequate summary of hospital events and findings. ▪ Seven of eight (88%) active records used the SOAP format. ▪ Ten of 11 records of the hospitalized individuals (91%) included a copy of the hospital admission history and physical. ▪ Seven of the eight (88%) included a copy of the hospital discharge summary. ▪ Seven of the eight (88%) included a copy of either the hospital admission history or physical, or a copy of the hospital discharge summary. ▪ Ten of the 11 (91%) included hospital liaison nurse notes for the individuals.	

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		▪ For seven of the eight individuals that returned to the Facility (88%), additional PCP follow-up notes were included as part of the post hospital course. ▪ Reasons for hospitalization included hypernatremia, neutropenia, high fever, pneumonia, pulmonary edema, Percutaneous Endoscopic Gastrostomy (PEG) insertion, bowel obstruction, diabetic ketoacidosis, and cardiac arrest. CCSSLC had an Infirmary. The statistics related to admissions of individuals to the Infirmary over the prior six months was as follows: ▪ The length of stay varied from less than one day (the 23 hour admission) to 41 days. ▪ The number staying one day or less was 27. ▪ The number staying two days was 13. ▪ The number staying three days was 11. ▪ The number staying four days was five. ▪ The number staying six to 10 days was 25. ▪ The number staying 11 to 15 days was 17. ▪ The number staying 16 to 30 days was 12. ▪ The number staying over 30 days was two. The number of individuals admitted to the Infirmary per month was as follows: ▪ December 2011 – 19; ▪ January 2012 – 19; ▪ February 2012 – 22; ▪ March 2012 – 20; ▪ April 2012 – 29; and ▪ May 2012 – 23. The reasons for Infirmary admissions included: ▪ Gastrointestinal causes: 20; ▪ Genitourinary causes: 12; ▪ Respiratory causes: 31; ▪ Infection: 11; ▪ Neurological causes: 10; ▪ Cancer: two; ▪ Orthopedic causes: 15; ▪ Ophthalmological causes: one; ▪ Metabolic causes: three; ▪ ENT causes: one; ▪ Dental causes: one; and ▪ Other: 16.	

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		Pneumonia There were three datasets that compiled incidents of pneumonia. For the dataset derived from Avatar, for the time period of December 2011 to April 2012, there were 23 pneumonias in 23 individuals. ▪ Five occurred in December 2011, one occurred in January 2012, four occurred in February 2012, eight occurred in March 2012, and five occurred in April 2012. ▪ Fourteen were considered bacterial pneumonias and nine were considered viral in origin. ▪ Fifteen of these individuals had a feeding tube. Of these 15 individuals, 14 had an intermittent feeding schedule. Zero had a continuous feeding schedule. One had a bolus feeding schedule. ▪ Eight of these individuals were taking food by mouth. Of these, one was on a pureed diet, one had thickened liquids, one was on a ground diet, and five were on a regular diet. . ▪ Seventeen of the 23 individuals were hospitalized. From a different dataset submitted entitled: "Individuals Diagnosed with Pneumonia," there were reported to have been five pneumonias in December 2011, one pneumonia in January 2012, four pneumonias in February 2012, eight pneumonias in March 2012, four pneumonias in April 2012, and three pneumonias in May 2012. This data was consistent with the previously discussed data, except for April 2012. For April, this dataset included one less pneumonia than the other dataset. From the Infection Control Committee Meeting of 1/3/12, pneumonias in the prior quarter included December 2011 - three pneumonias. From the Infection Control Committee Meeting of 4/4/12, pneumonias in the prior quarter were listed as January 2012 - one, February 2012 – four, and March 2012 - four. This data generally was not consistent with the other information. A handout from the 7/912 P&T Committee, "FY2012 infections," documented there were seven pneumonias in June 2012. The three databases provided different statistics per month. The Facility should review the discrepancies and create systems that can verify complete and accurate data from one system to another. Trauma According to information submitted at the start of the Monitoring Team's visit, for the prior six months, there was only one fracture that was reported to have occurred. The type of fracture and bone fractured was not submitted. However, this was found to be an inaccurate report, because there were several more fractures that occurred during this	

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		time period. A corrected list was submitted at the request of the Monitoring Team. Three fractures occurred from December 2011 through May 2012. All were non-displaced fractures. One involved the lower leg, one involved the hand, and one involved the elbow. Based on information submitted in preparation for the Monitoring Team's visit, in the past year, from 6/1/11 through 5/31/12, three individuals went to the ER or were hospitalized for injuries. However, the Monitoring Team requested corrected complete information. Subsequently, a new list was generated for the time period December 2011 through May 2012. During this time, five individuals were referred to the ER for injuries, all of which were lacerations above the neck. <u>Chronic Conditions and Specific Diagnostic Categories</u> As part of the review of 19 records, GERD was reviewed. Of the 19, seven were diagnosed with GERD. Of these seven, seven had appropriate medical treatment (100%). Seven were prescribed medications, none underwent surgery in the past, and one had a procedure performed in the past one year. Information was submitted concerning new diagnoses of chronic conditions that occurred over the past year. Twelve individuals were newly diagnosed with diabetes mellitus type II. Additionally, one individual was newly determined to have a family history of diabetes mellitus, but there was no information the individual had diabetes mellitus. Four individuals were newly diagnosed with cardiovascular disease. One case of a newly diagnosed cancer was reported in the past year. Two individuals were diagnosed with sepsis. According to information provided by the Facility in preparation for the Monitoring Team's visit, between 12/11 and 5/31/11, one individual was referred to the hospital for potential pica ingestion. Subsequently, an updated and complete list of pica or ingestion of inedible objects was submitted for the time period of December 2011 through May 2012. This included 10 events involving six individuals. A total of 199 individuals were treated with routine medication for chronic constipation. According to data submitted, one individual was diagnosed with a bowel obstruction or bowel perforation/complication (in 5/12). <u>Skin integrity</u> A Skin Integrity Committee met on 2/15/12 and 5/31/12. Minutes were submitted for both meetings. In these meeting minutes, for December one Stage 1 decubitus was recorded. For January 2012, one Stage 2 decubitus was reported. For February 2012, two decubiti were reported, one Stage 1 and one Stage 2. For March 2012, there were no	

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		decubiti reported. For April, there was one Stage 2 decubitus reported. For May 2012, there were three decubiti reported, two Stage 1 and one Stage 2. Two of these were reported to occur in the Infirmary and the remainder in the residence. None were reported to have begun in the hospital. In summary, there were four Stage 2 ulcers, no Stage 3 ulcers, no Stage 4 ulcers, and no unstageable ulcers. Separately, submitted were numbers of decubiti that occurred in the past six months. There was one decubitus ulcer in January 2012 and one in April 2012. There were no decubiti reported for February 2012 or March 2012. The information for May 2012 was pending. These numbers did not agree with the Skin Integrity Committee minutes. It is recommended that discrepancies in data be resolved. It is recommended that the different databases be reviewed for accuracy and completeness. It is also recommended that there be clarification of the numbers of decubiti per month that are new versus those that are continuing to be treated. <u>Seizure disorders</u> The Facility submitted information concerning antiepileptic medication usage. As of 5/25/12, 172 individuals were prescribed antiepileptic medication. Of these, 62 (36%) were prescribed one antiepileptic medication, 38 (22%) were prescribed two antiepileptic medications, 19 (11%) were prescribed three antiepileptic medications, 13 (8%) were prescribed four antiepileptic medications, and one (0.5%) was prescribed five antiepileptic medications. Eleven individuals were considered to have a refractory seizure disorder. Eight of these had a VNS implant. From data submitted in preparation for the Monitoring Team's visit, in the prior six months, information submitted indicated no individual was sent to the ER for an uncontrolled/prolonged/new onset seizure. However, when this was requested on site, a corrected document indicated four individuals had been sent to the ER for prolonged seizure activity from December 1, 2011 to May 25, 2012. One individual had status epilepticus in the prior six months. Additionally, 34 individuals with a diagnosis of seizures were on no antiepileptic medications. A list was submitted indicating the percentage of individuals that were prescribed older antiepileptic medications. A total of 23 (13%) of individuals with seizures were prescribed Dilantin, none (0%) were prescribed Primidone, three (2%) were prescribed Phenobarbital, and none (0%) was prescribed Felbamate. Additionally, nine individuals had a VNS implant. Neurology clinics were held on site approximately once per month. The onsite visits included the following dates: 2/4/12, 3/31/12, and 4/28/12. No information was provided for May 2012. For each clinic, there were 19 to 27 individuals seen by the	

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		neurologist, for a total of 68 visits. The Facility submitted neurology consultation notes documenting seizure management for five individuals. These individuals are listed in the documents reviewed section. It was noted that the request was for individuals seen by the neurologist in the prior six months, but none had been seen since October 2011. The reason for not choosing more recent clinic visits was not stated, given that there were 68 visits from which to provide a sample in 2012 alone. The following provides a summary of the review of these records: ▪ One of the five individuals (20%) had been seen twice over the past one year. ▪ For four individuals (80%), the notes included a description of the seizures. ▪ Five (100%) included a review of current medications for seizures and dosages. ▪ One (20%) included recent blood levels of antiepileptic medications. ▪ Five (100%) included recommendations. ▪ For five individuals (100%), reference was made to the presence or not of side effects at the most recent visit. ▪ For four individuals (80%), reference was made to wellness or adequate/good control of seizures. It was noted that the neurology consultation report form (which was completed prior to the neurology visit and included information for the neurologist's review) did not include any information about drug levels or dates of levels. It could not be determined if this was attached to the consultation form. However, the neurology consultation report at times either did not mention the drug levels or did not mention the dates of levels. Since these visits were not recent, the drug levels submitted as part of the documentation occurred after the neurology visit except for one individual's visit. It is recommended that the date of the last neurology visit be included on the report form, as well as the most recent lab value and date of the lab. <u>Do Not Resuscitate Orders</u> A total of 25 individuals at the Facility had DNR orders in place. For 13 (52%), adequate clinical justification was provided for the DNR. Five indicated neurological decline, one respiratory decline, and seven due to osteoporosis. It is recommended that the State Office develop criteria to guide the SSLCs in determining options for resuscitative efforts in those with severe osteoporosis, such as intubation/ventilation with oxygen and medication without chest compression. There were 12 individuals with DNR status with no medical condition listed, but reason indicated "per family request." It is recommended that the medical condition for which the family request was granted be included in the reason/criteria listed for DNR. If criteria do not meet SSLC standards, then further discussion with family and ethics committee documentation is recommended. As DNR reviews occur annually, there was one review that was outdated.	

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		The QA/QI Council meeting minutes of 3/22/12 documented the need to review DNR orders in those individuals without terminal illness. There was no information that the IDTs had met to discuss any of the DNR orders in those without a terminal illness. There also was no Facility policy or procedure to guide which departments were required to be at IDT meetings when there was a discussion of DNR status in those without clinical justification. Administrative guidance would be an important first step in this process. The Facility was asked to provide any ethic committee meeting minutes, with attendance rosters, concerning DNR decisions/changes since the Monitoring Team's last visit. No meeting minutes were submitted. <u>Mock Code Drills and Emergency Response Systems</u> Findings and recommendations related to mock code drills and emergency response systems are discussed with regard to Section M.1 of the Settlement Agreement. <u>Transitions to Community Settings</u> The Facility submitted information documenting that from January 1, 2012 to June 2, 2012, six individuals had transitioned into the community. For two individuals, there were significant incident. Two each had two ER visits. One had a police visit. No serious incidents were submitted for the other four individuals. In reviewing three records of individuals who had transitioned to the community since the Monitoring Team's previous visit, the following was noted: ▪ For one of three (33%), adequate medical assessments had been completed within 45 days of the individuals' transition to the community. From the submitted information, it appeared that all three had been to a PCP in the first 45 days of transition. However, the date of the PCP office visit could only be located in the submitted documentation in one record. ▪ For none of three (0%), all required specialty appointments had occurred timely. Specialties which had not occurred in a timely manner included psychiatry, and monthly counseling for Individual #194; psychiatry, psychology, podiatry, and a substance abuse program for Individual #30; and dentistry, ophthalmology, and psychology for Individual #114. ▪ For three of three (100%), the Facility had provided evidence of documentation of training for the individual's major medical diagnoses. Copies of training documents were received for two of three (67%). ▪ For three of three (100%), the Facility had provided evidence of documentation of training for the individual's major psychiatric diagnoses/and or behavioral issues. ▪ For three of three (100%), the Facility had provided evidence of documentation of training for medications prescribed, the diagnosis for which each was being	

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		used, and the side effects to be monitored. ▪ For none (0%), the Facility departments were asked to provide additional information once the individual was placed in the community. For individuals involved in a significant incident, the community provider should consider contacting the appropriate department of the Facility to gain further information/steps to be considered etc., which might assist in preventing a recurrence. ▪ For none (0%), the Facility was requested to provide specific departmental expertise, provide a site visit, or communicate with professional counterparts in the community. ▪ For three of three (100%), there was documentation of adequate monitoring in the 90 day period after the individual's transition to ensure medical and psychiatric needs were addressed. ▪ For one of three (33%), there were significant incidents documented within 90 days of transition. These totaled three significant incidents (two ER visits and one police call).	
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.	<u>Non-facility Physician Case Reviews</u> During the prior six months, the Facility completed one non-facility physician case review audit, dated 4/19/12 to 4/20/12, which was labeled as Round #5. Discussion with the PCPs indicated that the external peer review occurred over one day, during which 19 records were reviewed. Additionally, the determination by the external peers was that a number of indicators were not found by the auditors but that were correctly located in the active record, according to medical staff. This would indicate that the review might have been rushed, compromising its quality. As a result, it might not provide an accurate picture of the true practice pattern at CCSSLC (i.e., the validity might be questioned based on these concerns). There was no information submitted to establish inter-rater reliability amongst the external peer reviewers. Some of the concerns might have stemmed from the external peers basing the review on expectations at their home facilities regarding the location of data, forms used, etc., rather than relying on a set of accepted or expected standards on which all auditors were trained. The following represents a synopsis of the information: ▪ For the one external peer review dated 4/19/12 to 4/20/12, PCP compliance in essential areas ranged from 80% to 100%. One PCP was considered compliant with the areas considered essential. For areas considered non-essential, compliance ranged from 89% to 97%. All PCPs were considered compliant with the non-essential areas audited. ▪ The prior peer review audit occurred in October 2011. Compliance at that time for essential areas ranged from 74% to 100%. One PCP was compliant. For nonessential areas, compliance ranged from 90% to 98%, and all PCPs were compliant. These results were similar to the current findings.	Noncompliance

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		▪ Areas that appeared to need improvement are listed here, and are numbered according to the question/probe number in the audit tool: (2) dating and signing the Active Problem List when it was last reviewed, (3) updating the Active Problem List with each new problem or as problems were resolved, (5) the annual physical summary was complete including past medical history, family history, and a plan of care, (6) the summary included significant medical events of current and past years (including hospitalizations, ER visits, and outpatient surgery), (10) the appropriate screening services were provided, (11) documentation of the reason for not providing preventive services, (15) documentation of rationale for not following recommendations made by the pharmacist, (21) each IPN and orders were signed, dated and timed, for consultation referrals, (26) the pertinent current and past medical history was included in the communication with the consultant, (27) medical and/or surgical consultant recommendations were addressed in the IPNs within five business days after the consultation recommendations were received, and (29) the IPN included a clinical assessment and a SOAP note from a PCP within 24 hours of the readmission to the SSLC from a hospital/ER or long-term acute care facility. ▪ The external audit also included a medical management component in which three diagnoses were selected and chart review completed for three individuals with each of the diagnoses, totaling nine chart reviews for medical management. The three diagnoses chosen for review were diabetes (six questions), osteoporosis (seven questions), and aspiration pneumonia (12 questions). PCP compliance in medical management of these areas ranged from 57% to 83%. A table of compliance per PCP per diagnosis was not provided, but should be for future comparison when the Facility's medical management team reviewed these same diagnoses. ▪ Compliance by question was provided in a graph form. Areas of concern needing improvement are listed here by the diagnostic code and number of the question: (ASP3) Is there evidence that the individual has had a Modified Barium Swallow completed since a diagnosis of aspiration pneumonia? (ASP5) Did the provider order a gastrointestinal (GI) consult or a pulmonary consult if indicated? (ASP6) Did the provider recommend a suction toothbrush for the individual or refer to dental? (ASP7) Did the provider refer the individual to the QDDP or the PNMT nurse after the last diagnosis of aspiration pneumonia? (ASP8) If the individual has a diagnosis of GERD, is it on the active problem list? (ASP10) Did the provider order respiratory therapy? (ASP11) Did the PCP review the risks and interventions for the individual for aspiration? (ASP12) Did the provider review the medications to see if any changes or additions were needed to [remainder of statement not included] (DB1) Is diabetes listed on the Active Problem List? (DB2) Did the provider prescribe the appropriate follow up lab? (DB3) Did the provider order appropriate diagnostics and consults if warranted? (OST1) Is	

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		osteoporosis listed on the Active Problem List? (OST4) Did the provider order or document findings of a dental exam before initiating a [remainder of statement not included]. The compliance by question for (OST3) "Is there a diagnosis of a pathological fracture?" was not included in the graph provided for the external peer review. ▪ The external medical peer review results were not compared to prior reviews, although the process had been revamped. It is recommended that summaries of the data be tabulated in a cumulative manner to be able to determine progress, with a comparative analysis provided annually. ▪ A follow-up system was initiated to ensure compliance/completion of corrective action plans for each PCP's areas of noncompliance. Initial corrective action plans were distributed to the PCPs once the audit results were placed in a database. ▪ The QA nurse/QA Department compiled initial compliance data with corrective action plans. However, there was no follow-up after the initial corrective action plans were distributed. As a result, there was no determination which deficiencies were corrected. ▪ There was no follow-up every 30 days to track progress of the corrective action plans. As the external peer review audit occurred in April 2012, by the time of the Monitoring Team's visit, there should have been a follow-up audits with summary results available for May 2012 and June 2012. ▪ The number of corrective action plans generated by the audit was provided. The external audit for essential and non-essential areas (30 question monitoring tool) generated 34 correction action plans. The external medical management audit generated 16 corrective action plans. Providing the numbers of completed corrective action plans per month and the number of outstanding corrective action plans in a table format would provide a summary of progress for the PCPs, the Medical Department, and the Facility Administration. ▪ There was no information provided that there were any systemic improvement plans developed or implemented based on the external peer review. This is an area needing review in order for the Facility to see improvement in its scores over time. ▪ Some of the medical management questions might need further review. For specific diagnoses reviewed, some of the questions might also need further validity testing to ensure they are capturing the information that is intended to be measured. ▪ For the Medical Provider External Review conducted on 4/19/12, the dates of review included both 4/19/12 and 4/20/12, which was problematic because the results were being discussed on 4/20/12 at 9 a.m., and the Medical Department confirmed the audit was completed in one day. The contents indicated that 24 records were evaluated. Facility attendance at this exit was documented. Areas	

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		needing improvement were listed as: o Consult forms needed to be developed and implemented to include past medical history, and current history, for all consultants. In addition, they should all be acknowledged in the IPN (the precise meaning of this statement was not clarified). o The active problem list should be separate from the Annual Exam and updates. o For osteoporosis, dental referral before treatment should be documented. o Gynecology exams/Paps should be encouraged. Strengths were also listed, including: o Information in the annual was very helpful, included good family history, included smoking history. o QDRR was complete. o Preventive flow sheets were helpful and complete. o Vaccination records in good shape. Inter-rater reliability is discussed in Section L.3. The "QA Medical Audit Schedule" included an external medical peer review audit at CCSSLC from 1/11/12 to 1/13/12. Updated information indicated the January 2012 external peer review audit was canceled. Also, according to the audit schedule, there was to be an internal audit, including three medical management diagnoses reviews, on 7/12/12. The next scheduled external audit was 11/12/12 to 11/16/12, and was to include medical management auditing of chronic constipation, seizures, and urinary tract infections. <u>Mortality Reviews</u> At the time of the review, the Facility had no outstanding clinical death reviews and one outstanding administrative death review from the most recent death. Since the start of the Monitoring Team's last visit through May 31, 2012, seven deaths had occurred: ▪ The average age was 48 (varied from 30 to 58). ▪ All died under the age of 65. ▪ Of the deaths, four were females, and three were males. ▪ The causes of death were listed as: respiratory cause for three (sepsis associated with bronchopneumonia, pneumonia, and respiratory failure), cancer for one, and cardiac disease for one. Two causes of death were still pending the autopsy report, although all had a report of preliminary findings. ▪ An autopsy was performed in three of the eight (38%). ▪ Five died in a hospital setting. Two died at the Facility. ▪ Four individuals' records included documentation indicating they were	

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		aggressively treated. Two were enrolled in hospice. ▪ Five had a feeding tube. For three of the five, the feeding tube had been replaced prior to the acute medical decline. For two, the feeding tube had been replaced the day of the rapid decline. In one, the decline began to occur 24 hours later. Nursing, Medical, and Facility Administration should consider reviewing this aspect of care to determine the relationship, if any, of changing a feeding tube and sudden decline. Considerations should include technique of replacement, but also whether the individual is allowed to lie flat during the replacement, which could cause reflux and aspiration pneumonia. It also was noted that tube changes appeared to be frequent. The Nursing Department should review the frequency and causes of the replacements. More training to prevent tube clogging and accidental removal would be important considerations. Since the Monitoring Team's last visit, seven administrative death reviews were completed. Seven clinical death reviews were completed. ▪ The clinical death reviews included from one to two recommendations, for a total of nine recommendations. ▪ Administrative death reviews included from one to three recommendations, for a total of 13 recommendations. ▪ All 13 of recommendations from the clinical death reviews related to systemic improvements needed in health care. None of the 13 recommendations related to potential improvement in non-health care related issues. The Facility submitted follow-up documentation for none of the total of 13 recommendations. It is recommended that the QA Department create a tracking system to ensure the recommendations are monitored until closure, with clear evidence of closure. In summary, the Facility remained out of compliance with Section L.2. Although an external non-facility physician review had been conducted, the Facility had questioned its accuracy. Based on the Monitoring Team's review, concerns were noted with the potential thoroughness of the review of numerous records in a short period of time, as well as a lack of established inter-rater reliability amongst reviewers. In addition, although corrective action plans had been developed to address PCP-specific concerns, no documentation was available to show that follow-up had occurred. In addition, no systemic corrective action plans were developed or implemented. In addition, although mortality reviews had been completed, documentation was not submitted to show that follow-up had occurred to address the recommendations they included.	
L3	Commencing within six months of the Effective Date hereof and with	<u>Facility's Medical Department Internal Peer Review System</u> For the internal medical peer review process, the following process was implemented for	Noncompliance

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	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.	inter-rater comparison and reliability: ▪ At the time of the external medical peer review, the internal medical peer review process also began. However, the internal medical peer review (Round #5) was not completed on precisely the same date, because the external medical peer review process was completed in one day. The internal medical peer review process was completed from April 21 through 27, 2012, according to the dates of the individual audit documents submitted. The internal medical peer review process included the same audit of 30 general questions and a review of three records for each of three diagnoses (i.e., aspiration pneumonia, diabetes mellitus, and osteoporosis). ▪ PCP compliance in essential areas ranged from 77% to 100%. One PCP was compliant. ▪ PCP compliance with non-essential areas ranged from 88% to 100%. All four PCPs were considered compliant. ▪ Results identified the following areas needing review and improvement. The number preceding the area of concern is the number of the question from the audit tool: (Q2) Is the Active Problem List dated and signed when it was last reviewed? (Q3) Is there evidence that the Active Problem List was updated with each new problem or as problems were resolved? (Q5) Is the annual physical summary complete including prior medical history, family history, and a plan of care? (Q6) Does the summary include significant medical events of current and past years (including hospitalizations, ER visits, and outpatient surgery? (Q8) Is documentation present to identify whether the individual uses tobacco products or does not use tobacco products. If the individual uses tobacco products was there documentation of recommendation for cessation of tobacco use? (Q14) Is there evidence that the provider responded to the pharmacist quarterly drug regimen review recommendations on the Quarterly Drug Regimen Review Form within 15 business days? (Q15) Did the provider document rationale for not following recommendations made by the pharmacist? (Q26) When a referral for consultation is requested, is pertinent current and past medical history included in communication with the consultant? (Q27) Are medical and/or surgical consultant recommendations addressed in the integrated progress notes within five business days after the consultation recommendations are received? And, (Q29) Does the integrated progress record include a clinical assessment and a SOAP note from a provider within 24 hours of the readmission to the SSLC from a hospital/ER or long-term acute care facility? ▪ For the internal medical peer review audit of medical management of three diagnoses, PCP compliance was 79% to 100%. Areas of concern included: (ASP3) Is there evidence that the individual has had a Modified Barium Swallow completed since a diagnosis of aspiration pneumonia? (ASP6) Did the provider recommend a suction toothbrush for the individual or refer to Dental? And,	

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		(OST3) Is there a diagnosis of a pathological fracture?" ▪ The internal peer review audit of essential/non-essential areas (30 question monitoring tool) generated 26 corrective action plans. The internal peer review audit for the medical management review of three diagnoses generated six corrective action plans. The QA Department did not follow-up every 30 days to determine progress in completing the corrective action plans. Inter–rater reliability rating between the external and internal medical peer review auditors was provided for the medical management section of the audit (i.e., aspiration pneumonia, diabetes mellitus, and osteoporosis). For diabetes mellitus, the external peer review audit demonstrated compliance at 73%. For the internal peer review audit, compliance was 100%. For the external peer review audit for osteoporosis, compliance was 88%. For the internal peer review audit for osteoporosis, compliance was 81%. For the external peer review audit of aspiration pneumonia, compliance was 62%. For the internal peer review audit of aspiration pneumonia, compliance was 87%. Overall agreement in the three diagnoses was 61%. The inter-rater percent agreement for PCPs ranged from 50% to 83%. It is recommended the QA/QI Department and the State Office review these findings and develop system changes to improve inter-rater reliability. There might be a need for detailed guidance and instruction in answering specific questions, as well as identification of the location in the active record where the evidence is to be filed. Data for inter-rater reliability of the general monitoring tool (30 questions) was lacking and is needed. <u>Medical Department Initiatives and Improvement Projects</u> The Medical Department had taken the following steps to improve tracking systems and over-all internal quality improvement of care: ▪ There was expansion of the DG 1 form to include 20 entries for Axis III diagnoses. ▪ The Medical Department created tools/measures to monitor compliance with Section G and H. ▪ A number of databases had become available to the Medical Department and included: o Cardiovascular tracking, which included the specific diagnosis, and medications; o Colonoscopy tracking, which included the date of the last colonoscopy, the reason not done if applicable, and whether it was for a preventive recommendation or active problem; o Mammogram tracking, including date of last mammogram and reason if not done; o Constipation tracking, including the medications and dosages; o Diets, including texture, fluid thickening, bread consistency, portion	

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		size, and therapeutic requirements (e.g., low cholesterol, specific feeding formula); o Thyroid test tracking for those with Down syndrome; o Pain management tracking, including medication and dosage, and diagnostic indication; o Respiratory tracking, including diagnosis and treatment; and o Urinary tract tracking, including history of urinary tract infection (UTI), other diagnoses, date of last UTI, history recurrent UTI, and prophylaxis treatment. It was noted that tracking of the PCPs' completion of quarterly medical reviews had not been initiated. Discussions with the PCPs indicated that a standardized form and content template was not finalized. It is recommended that a standardized form be implemented. There was evidence of analysis by the Medical Department, such as: ▪ The Medical Department had begun to develop a monthly report of record audit findings and trend analysis. The April 2012 report included results of the monthly audit for Section G Monitoring Tool, as well as trends and corrective actions. Trends included important practical information such as "ISPAs are being completed for acute/emergent changes in health status, but they are not filed in the active record, "Risk Action Plans are not being reviewed as required. The Integrated Risk Review Form is also not being updated," and "Diagnoses are not consistent for each individual's assessment across clinical disciplines." Corrective Actions identified steps being taken to resolve some of the challenges identified by the trends such as: indicating a new process was being piloted to replace the ISPA with a Change in Status Form, and the Consult Tracking Log was to be sent to QDDPs on a monthly basis for review. ▪ A similar report "chart audit report and trend analysis 4/12" reviewed the Section H Monitoring Tool results, along with trends and corrective actions. The trends were similar to those mentioned for Section G. Additionally, it was noted that: "the Preventive Care Flow Sheets are not being consistently filled out when an annual medical assessment is completed. The Quarterly Medical Review is not being completed on a consistent basis." It is recommended that the different monitoring results be compiled into one monthly report rather than several different reports. The Facility had made some notable progress with regard to developing helpful databases and continuing to conduct internal audits. In addition, the Facility had begun to analyze some of the results and take action to correct problematic issues. However, the Facility remained out of compliance with this provision. Further work was needed in a number of areas, including development of key indicators or outcome measures in	

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		connection with some of the clinical guidelines, the establishment of inter-rater reliability for and validity of monitoring tools (which likely involved more work on the tools and corresponding guidelines/instructions), continuing development of action plans, and following through to ensure the implementation of action plans resulting from these various activities.	
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 following policies/procedures/protocols indicated there had been no change in the documents since the Monitoring Team's last visit: ▪ HCG – Medical and Nursing: Seizure Management Medical and Nursing, LL. 12. Approved 11/4/10, implemented 12/5/10. ▪ Providing HealthCare Services: Seizure Management, M.24, approved 4/1/11, implemented 5/1/11. ▪ Providing HealthCare Services: Seizure Management – VNS, M.24.3, approved 4/1/11, implemented 5/1/11. Since the Monitoring Team's last visit, several clinical guidelines had been implemented at CCSSLC, which had been created at the State Office. These included: ▪ Aspiration Risk Reduction Interdisciplinary Protocol: Individual receives enteral feedings or ventilation; ▪ Blood Thinner Interdisciplinary Protocol; ▪ Constipation Interdisciplinary Protocol; ▪ Bowel Management and Constipation Prevention Protocol; ▪ Enteral (tube) Feeding Interdisciplinary Protocol; ▪ Gastro-Esophageal Reflux Disease (GERD) Interdisciplinary Protocol; ▪ Pneumonia Interdisciplinary Protocol; ▪ Seizure Management Interdisciplinary Protocol; and ▪ SSLCs Fracture Protocol. It did not appear that these protocols had been used as a source of clinical indicators in developing internal medical QA reviews. Copies of prior drafts included a flow chart and a narrative section with considerable detail guiding standardized expectations of practice for the PCP. The narrative section was also to be utilized as a source of clinical indicators. However, discussion with the Medical Department suggested the flow chart was available, but not the narrative section. It is recommended the Medical Department review this area with the State Office to determine the current status of these protocols.	Noncompliance

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

1. For each hospitalization or ER visit, the morning medical meeting group should critically review/discuss the early health status change prior to the event, as well as potential steps to prevent a repeat occurrence. (Section L.1)

2. With regard to the morning medical meeting groups processes and minutes:
    a. Brief concise entries of discussion of critical questions at the morning meeting should be recorded in the minutes. The follow-up to the questions can then be delegated to a member of the team, the PCP, another department, or the IDT, depending on the concern.
    b. Closure in the morning medical meeting minutes requires specific answers to questions raised. To track this, when referring a concern to the IDT, the specific question of concern should be documented. The response also should be documented.
    c. For those areas determined to be non-clinical (e.g., environmental, etc.), referral to the appropriate department should be made, with a request for a final document answering the questions or concerns. The morning medical meeting group should discuss them and close them, as appropriate.
    d. When the morning medical team specifically reviews a follow-up document, this should be documented in the minutes.
    e. The morning medical team process should include a review of the quality of ISPAs to ensure health and safety of the individual from a clinical perspective.
    f. It is also important that the minutes include a statement/phrase that the morning medical team agreed with an ISPA as written, when this is the case, or an indication that the ISPA has been returned to the team with further questions or recommendations. (Section L.1)
3. The QDDP and QA Departments should review the ISPA process to ensure all action steps are addressed and documented, ensuring progress or lack of progress is communicated back to the IDT, and there is documentation of closure for action steps. (Section L.1)
4. Databases and resulting reports should be reviewed for completeness, and keys should be included when necessary for the accurate interpretation of the data. (Section L.1)
5. The Medical Department should initiate a periodic review of the annual medical assessments to ensure all components are included, as well as develop criteria to assess the quality of the various subsections of the annual medical assessment. (Section L.1)
6. The quarterly medical reviews should be completed and include more focused information that would be helpful to any other PCP needing to quickly review the record. The State Office should provide guidance in this area, and a template form for filling in the blanks might ensure all imperative clinical areas are covered. In constructing such a template, the following should be considered:
    a. Quarterly reviews should reflect updated information from the prior three months.
    b. They should provide brief entries regarding the major diagnoses, record the most recent set of vital signs, the last three monthly weights (verifying the PCP is reviewing this information), a focused brief exam for those who are medically complex, and brief comments/entries listing numbers of seizures (if applicable), changes in medication, important/abnormal labs and drug levels, ER visits and hospitalizations with dates and discharge diagnoses/treatments, and important consultations.
    c. For any one individual, they should be succinct, ideally no more than one page, and should not take more time than writing an IPN entry.
    d. The quarterly reviews should be included chronologically in the IPN section. (Section L.1)
7. The Facility/Medical Department should track consultant appointments that were missed, including a breakdown of the reasons (e.g., refusals, transportation, insufficient staffing, etc.) The log should include information about when the appointments are rescheduled to occur and subsequently completed, and whether the missed appointments are reviewed at IDT meetings, with evidence of the date of the meeting recorded in the tracking log. (Section L.1)
8. For specialties with significant percentages of missed appointments, the Facility should create and implement a plan to reduce these missed appointments, and track improvements. (Section L.1)
9. The Medical Department should review the treatment of osteopenia and osteoporosis. (Section L.1)
10. Infirmary notes should be identified clearly to ensure clarity of the active record. (Color coded pages do not copy and do not reflect the identification that the IPN note was written in the Infirmary.) (Section L.1)
11. For the various pneumonia databases, the Facility should continually review and reconcile the data to ensure accuracy and reproducibility. (Section L.1)
12. For those individuals with pneumonia and a feeding tube, the PCP should review the case to ensure a GERD work-up has been completed, if

clinically indicated, and to ensure that therapy for GERD is maximized, if it is considered a contributing factor for aspiration pneumonia in these individuals. The quality and breadth of the assessment also should be reflected in the action plans of the risk process, and ISP/ISP addendums. (Section L.1)

13. For those individuals with pneumonia and a feeding tube, the Medical Department also should seek ongoing surveillance and guidance from the PNMT for positioning, and the Dietary Department for rate of tube feeding and flushes. (Section L.1)
14. The Skin Integrity Committee minutes should provide a clinical update of each ulcer that healed since the last meeting, or is still being treated. (Section L.1)
15. For decubiti data, the discrepancies in data should be resolved. Clarification also should be provided of the numbers of decubiti per month that are new versus those that are continuing to be treated. (Section L.1)
16. In preparation for the neurology visit, the date of the last neurology visit should be included on the report form, as well as the most recent lab value (e.g., antiepileptic drug level, etc.), and date of the lab. (Section L.1)
17. For each of the individuals with a DNR status, a clear summary of current data should be available as evidence to justify the severity of the condition warranting DNR consideration. Only individuals who meet the criteria in State Office policy and related statutes/regulations should have DNR Orders in place at the Facility. The Facility ethics committee minutes should be part of the summary available in the record to justify DNR status, if the ethics committee met to discuss that individual. (Section L.1)
18. The Medical and Nursing Departments should review all documents for those with DNR entries on various medical and nursing documentation to confirm agreement and remove conflicting information. (Section L.1)
19. The State Office should develop criteria to guide the SSLCs in determining options for resuscitative efforts in those with severe osteoporosis. Such individuals would be at high risk of multiple rib fractures and flail chest should chest compressions occur, but might benefit from other aspects of resuscitative efforts such as intubation/ventilation with oxygen and medication. (Section L.1)
20. The medical condition for which family requests for DNR were granted should be included in the reason/criteria listed for DNR. If criteria do not meet SSLC standards, then it is recommended that there be further discussion with family and the ethics committee, and documentation should be maintained of such activities. (Section L.1)
21. For discussion of potential DNR status for an individual, the Facility should provide guidance regarding required participants in the process (e.g., family, member of ethics committee, community lay representative, PCP, nurse case manager, staff from another SSLC via conference call, etc.), and that this guidance be formalized in a policy/procedure. (Section L.1)
22. The State Office should review the quality of the external medical review process, provide evidence of training concerning standards and expected interpretation of review questions, and provide evidence of inter-rater reliability data of auditors. (Section L.2)
23. For external medical peer review of medical management (e.g., three diagnoses), a table showing compliance per PCP per diagnosis should be provided, and future medical audit results added, in order to track progress per PCP. Similar data should be tabulated to provide a summary of findings for the entire Medical Department to track progress of the department over several audits. (Section L.2)
24. In conjunction with the QA Department, the Medical Department should develop and implement a department plan designed to improve noncompliant essential areas. (Sections L.2 and L.3)
25. The QA Department should complete and document timely and efficient monthly oversight of the Medical Department's compliance with the action plans generated by internal and external audits to ensure they are completed in a timely manner. Quarterly reports also should be provided. (Sections L.2 and L.3)
26. The medical management questions should be reviewed to ensure their validity. (Sections L.2 and L.3)
27. Nursing, Medical, and Facility Administration should review the technique of changing feeding tubes. Consideration should be given to technique of replacement, but also whether the individual is allowed to lie flat during the replacement, which could cause reflux and aspiration pneumonia. (Section L.2)
28. The Medical and Nursing Departments should review the problem of tube clogging and displacement of tubes to minimize the need for tube replacement. Further policies, procedures, and monitoring during tube change should be considered, as well as proof of competency-based

training, and more frequent vital signs following a tube change. (Section L.2)

29. The QA Department should create a tracking system to ensure the recommendations from the mortality review committees (clinical and administrative) are monitored until closure. Evidence of closure should be well documented. (Section L.2)
30. The QA Department and the State Office should review the inter-rater reliability data from the internal peer audit medical management monitoring tool, and determine if further guidance and instructions are necessary to assist reviewers in answering specific questions. Data for inter-rater reliability of the general monitoring tool (30 questions) is also encouraged. (Section L.3)
31. A standardized template for the quarterly medical reviews should be finalized and implemented. (Section L.3)
32. The different monitoring results should be compiled into one monthly report rather than several different reports (i.e., those for Section G, H, L, and the internal and external audits). (Section L.3)
33. The clinical databases should be analyzed at a routine frequency, with information formally shared with the PCPs, including reports containing analyses of the data. At a minimum, quarterly analyses and reports should be made available for each of the datasets (e.g., mammograms, osteoporosis, etc.), and evidence should be maintained that the findings were discussed among the PCPs, including descriptions of any conclusions made or action plans developed at the medical staff meetings. (Section L.3)
34. The Medical Department should clarify with the State Office the current status of the clinical guidelines that had been developed, including the narrative sections, to ensure the Medical Department has all the available documents. (Section L.4)

SECTION M: Nursing Care	
Each Facility shall ensure that individuals receive nursing care consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o CCSSLC's Self-Assessment; o CCSSLC's Provision Action Information; o CCSSLC At-Risk Individuals list; o CCSSLC training rosters contained the Presentation Book for Section M; o CCSSLC's Nursing Department Presentation Book; o CCSSLC's Section I Presentation Book; o CCSSLC's Infection Control Presentation Book; o CCSSLC's Monitoring Tools for Nursing and raw data since January 2012; o CCSSLC's minimum staffing numbers for nursing; o CCSSLC's Infection Control Monitoring Tool data; o CCSSLC's Corrective Action Plans for Section M; o Quality Assurance Program Compliance Nurse's monitoring data; o CCSSLC's lists of individuals who were seen in the Infirmary, emergency room, and hospital; o Infection Control Summary Report; o Resumes for the Assistant Infection Control Nurse, Nurse Administration Coordinator, and Case Manager Supervisor; o Medication Variances Monthly Summary data report; o Medical records for the following individuals: Individual #144, Individual #183, Individual #278, Individual #9, Individual #282, Individual #378, Individual #213, Individual #327, Individual #91, Individual #221, Individual #34, Individual #210, Individual #153, Individual #211, Individual #38, Individual #182, Individual #8, Individual #44, Individual #224, Individual #276, Individual #10, Individual #138, Individual #297, Individual #350, Individual #268, Individual #26, and Individual #95; o Facility list of individuals with Methicillin-resistant Staphylococcus aureus (MRSA); Hepatitis A, B, and C; human immunodeficiency virus (HIV); positive Purified Protein Derivative (PPD) converters; Clostridium difficile (C-Diff); H1N1; and sexually transmitted diseases (STDs); o Real Time Audit tool for Infection Control; o Infection Control Immunizations Action Plan, dated 7/12; o CCSSLC Outbreak timeline; o Infection Control Committee meeting minutes, dated 4/4/12; o CCSSLC's monthly Infection Control summary report list; o Drug Utilization Discrepancy Reports; o Drug Utilization Reports - Antibiotics; o Antimicrobial Usage by Patient report; o Weekly Infection Control Reports; o Pneumonia Tracking Reports, since February 2012;

	○ Medication Administration Observations raw data; ○ Nurse Educator Medication Observation form for onsite medication observation; ○ Medication Variance data by nurse; ○ Medication Peer Review meeting minutes, dated 4/16/12; ○ Pharmacy and Therapeutics Committee meeting minutes, dated 1/4/12, and 4/2/11; Medication Administration Observation raw audit data from February through May 2012; ○ Medication Committee meeting minutes, dated 1/5/12, 2/21/12, 3/28/12, 4/16/12, and 5/30/12; ○ Medication Administration Observation Trend data; ○ Medication Administration Record Blank data; ○ Workgroup for Inter-rater Reliability meeting minutes, dated 2/1/12; ○ Procedure for Establishing Inter-rater Reliability, undated; ○ Nurse Educator Training on Simply Thick Gel and Liquid Medication meeting minutes, dated 4/17/12 and 4/27/12; ○ Protocol for Medication Cart Exchange, dated 2/15/12; ○ Section O PMNT/Administration Meeting minutes, dated 4/16/12; ○ Aspiration Review Meeting, dated 6/29/12; ○ SSLC Medication Room Audit form, dated 3/1/12; ○ Medication Room Audit data and tracking spreadsheet; ○ "Real Time" Infection Control monitoring tool; ○ Raw data from "Real Time" Infection Control audits for Individual #86, Individual #176, Individual #276, and Individual #156; ○ Infirmary Safety Meeting minutes, dated 10/19/11 and 2/28/12; and ○ CCSSLC Emergency Medical Drills data, from January through June 2012. ▪ **Interviews with**: ○ Colleen M. Gonzales, BSHS, Chief Nurse Executive; ○ Jennifer Urban, RN, BSN, Nurse Operations Officer; ○ Mark Cazalas, Director; ○ Peggy Sue Miclan, RN, Program Compliance Nurse; ○ Della Cross, RN, Nurse Educator; ○ Kristen Middleton, RN, Nurse Educator; ○ Pam Tanner, RN, Nurse Educator; ○ Pamela Nichols, Infection Control/Employee Health Nurse; ○ Karen Lanfair, RN, Assistant Infection Control Nurse; ○ Araceli Aguilar, RN, Nursing Administration Coordinator; ○ Bruce Boswell, Assistant Director of Programs; ○ Patty Glass, RN, Nurse Case Manager Supervisor; ○ Brinda Fuller, RN, Psychiatric Nurse; ○ Michelle Lord-Arteaga, RN, Psychiatric Nurse; ○ Mary Hernandez, Competency Training Department, Trainer; ○ Angela Roberts, Au.D., Director of Habilitation Therapies; ○ Donald W. Kocian, R.Ph., Pharmacy Director;

	○ Joe Vulgamore, Risk Management Director; ○ Annette Mireles, LVNMT, Respiratory Department; ○ Leslie Hernandez, RRT, Respiratory Department; ○ Connie Horton, RN, FNP, State Consultant; and ○ Sally Schultz, State Consultant. ▪ **Observations of**: ○ Medication Administration in the Infirmary; and Use of emergency equipment at the Infirmary, and Atlantic Kingfish 2.
	Facility Self-Assessment: Based on a review of the Facility's Self-Assessment, with regard to Section M 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. Although the Facility self-assessment of noncompliance was in alignment with the findings of the Monitoring Team, the Facility's Self-Assessment contained information that could not be interpreted regarding the observations, and especially the findings from monitoring data on which the Facility had based its findings. It was evident that the Facility was conducting regular audits using the Health Monitoring Tools. However, the attempts to present data generated from the Health Monitoring Tools contained in the Facility's Self-Assessment for Section M, the Presentation Book for Section M, and Provision Action Information indicated that staff were challenged in their efforts to report the findings of their data. Although in past reports, the Monitoring Team noted that providing overall compliance scores for audit tools addressing nursing issues was meaningless and gave no indication of the areas of strength, weakness, or the status of progress, several overall audit tool compliance scores continued to be reported throughout the Facility's Self-Assessment and in the Provision Action Information. Additionally, it was often unclear what specific criteria were being used to measure compliance when the item required that something was to be done "according to policy." Also, it was unclear why only certain items from an auditing tool were selected for inclusion in the Facility's Self-Assessment or Provision Action Information versus other items that would have provided more pertinent information regarding the quality of the documentation. Although it was evident that the Facility was investing a great deal of energy in collecting monitoring data, it was unfortunate that due to the overall presentation of the data, it was rendered in most cases uninterpretable. The Facility should consider adopting a standardized format for presenting data in a meaningful way that facilitates its interpretation and analysis and provide training to the disciplines regarding how to analyze their data to identify problematic trends. In addition, some of training activities that were cited in the Self-Assessment did not have the associated training rosters indicating how many staff was required to attend, and how many of those staff actually attended the training. It did not have a description, and curriculum of the training provided. Thus, the Monitoring Team could not verify the quality of some of the trainings.
	Summary of Monitor's Assessment: Since the last review, CCSSLC had some changes regarding the

	Nursing Department and nursing positions, which included the addition of a full-time Assistant Infection Control Nurse, a part-time Registered Nurse for the Nursing Administration Coordinator position to assist in the reviews of Nursing Care Plans, and a full-time Registered Nurse for the Nurse Case Manager Supervisor position. Although the fill rates for nursing staffing had experienced some variability since January 2012 for both RNs and LVNs, nursing staffing remained basically stable at CCSSLC. Some of the Facility's positive steps forward included: ▪ The Facility began implementation of nine additional nursing protocols, including Minimal Documentation, PICA, Seizures and Status Epilepticus, Abdominal Distention/Pain, Hypothermia, Temperature Elevation, Urinary Tract Infection, Enteral Feeding, and Post Anesthesia. ▪ From data generated by comparisons of the Infection Control Reports and the Pharmacy reports for the utilization of antibiotics, the following represented the compliance percentages of antibiotics reported in both reports: 91%, 96%, 97%, 83%, and 89% from February through June 2012, respectively. These data reflected a very positive step forward in not only tracking discrepancies regarding Infection Control information to ensure data reliability, but also reflected a positive increase in compliance regarding the accuracy of the documentation contained on the Infection Control Reports. ▪ In a positive step forward, the Facility indicated that blanks found on a review of the emergency cart checklists had significantly decreased from January to June 2012, since Risk Management, Respiratory Therapy, and Nurse Educators had been completing monthly spot checks of this area. ▪ The Monitoring Team's observations of nurses demonstrating the use of emergency equipment at the Infirmary, and Atlantic Kingfish 2 found that the nurses were familiar with the use and operations of the Facility's emergency equipment. It was clear that the consistent drills and spot checks regarding the emergency equipment were having very positive outcomes. ▪ The Facility had reinitiated a structured system using the Pharmacy Refill Sheets to track the medications being brought to the buildings in an attempt to reconcile the number of medications that were being returned to the Pharmacy without explanation. Although the Facility had made some positive steps forward in the areas noted above, the overall lack of progress, and in some areas, regression, found regarding the nursing care plans, the nursing assessments and documentation in response to changes in status, the quality of the quarterly and annual Comprehensive Nursing Assessments, and the unreliable systems regarding medication variance data were very concerning at this juncture in the review process. Some of the recent system changes, such as transitioning to an Integrated Health Care Plan represented positive forward movement. However, the Facility's decision to remove all the existing Health Maintenance Plans without modifying the current inadequate Risk Action Plans so that all the individuals who resided at CCSSLC would have an appropriate and clinically sound plan of care in place during the transition was troubling.

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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 subsections that address various areas of compliance, as well as factors that have the ability to affect the Facility's compliance with the Settlement Agreement. These sections include staffing, quality enhancement efforts, assessment, availability of pertinent medical records, infection control, and medical emergency 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 above with regard to Section C. In assessing its progress, CCSSLC indicated in the Facility's Self-Assessment that the following steps were initiated since the last review regarding this requirement of the Settlement Agreement: ▪ The Monitoring Team could not interpret the information contained in the Facility's Self-Assessment regarding the Health Monitoring tools (HMTs), inter-rater reliability for Acute Illness and Injuries, Urgent Care, Documentation, Seizures, Skin Integrity, Chronic Respiratory, Infection Control, and Pain to determine if the nursing care was provided according to policy, the inter-rater scores, the data from nursing protocol audits, data regarding results of Active Record reviews, and/or the Pharmacy database regarding antibiotic usage. Based on the findings from this self-assessment, the Facility indicated that: "this provision is not in substantial compliance because review of Health Monitoring tools, Infection Control Data, Emergency Drill data and Emergency checklist audit forms show we are not in compliance. CCSSLC will continue to train as concerns are identified and develop corrective action plans." Although there was no question that the Facility was conducting regular audits using the HMTs, the attempts to present data that were generated from the HMTs for nursing contained in the Facility's Self-Assessment for Section M, the Presentation Book for Section M, and Provision Action Information indicated that staff were challenged in their efforts to report the findings of their data. Although in past reports, the Monitoring Team noted that providing overall compliance scores for audit tools addressing nursing issues was meaningless and gave no indication of the areas of strength, weakness, or the status of progress, several overall audit tool compliance scores continued to be reported throughout the Facility's Self-Assessment and in the Provision Action Information. In addition, when data were reported by specific items from an auditing tool, it was often unclear what specific criteria was being used to measure compliance when the item called for something to be done "according to policy." It was also unclear why only a few	Noncompliance

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		of the items from an auditing tool were selected for inclusion in the Facility's Self-Assessment or Provision Action Information versus other items that would have addressed other pertinent issues such as the quality of the documentation. From past discussions with the QA Department, the Facility's database was capable of presenting compliance data for all the items contained on an auditing tool by month, which would clearly indicate the various trends in compliance data for both the Monitoring Team and the Facility. In addition, it was noted during the review that there was a significant amount of confusion regarding the difference between presenting the data, and analyzing the data. From discussions with Nursing Management regarding how the nursing data is analyzed, they reported that the QA Department analyzed their data and included it in the QA Committee meeting minutes. However, from review of the QA meeting minutes, the QA Department only aggregated the data collected from the nursing HMTs and then could present it in a number of different formats, such as in graphs or charts. However, once the data is aggregated in a meaningful way, it is up to the specific disciplines to regularly review the compliance scores by item, by month in order to determine what the data means related to the clinical area it represents. Based on this analysis, trends should be identified demonstrating strengths and weaknesses. This analysis should then result in the development and implementation of plans of action addressing areas that reflect problematic trends. Although it was clear to the Monitoring Team that the Facility was investing a great deal of energy in collecting monitoring data, because of the overall presentation of the data, it was rendered in most cases uninterpretable. The Facility should consider adopting a standardized format for presenting data in a meaningful way that facilitates its interpretation and analysis, and then provide training to the disciplines regarding how to analyze their data to identify problematic trends. <u>Staffing</u> At the time of the review, CCSSLC had a census of 259 individuals. Since the last review, CCSSLC had some changes regarding the Nursing Department and nursing positions, which included: ▪ In July 2012, a full-time Assistant Infection Control Nurse (RN) was hired; ▪ In May 2012, a part-time Registered Nurse was hired for the Nursing Administration Coordinator to assist in the reviews of Nursing Care Plans; ▪ In May 2012, a full-time Registered Nurse was hired for the Nurse Case Manager Supervisor position; and ▪ The existing Quality Assurance Nurse had been on leave since May 2012 and was expected back to her position by August 2012. In addition, at the time of the review, the Nursing Department had a total of 113.2 allotted positions, including 61.7 for RNs and 51.5 for Licensed Vocational Nurses	

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		(LVNs). Overall, the total nursing position fill rate was 97% for the RN positions, and 86% for the LVN positions. These additional positive staffing advancements should assist the Facility in moving forward in achieving positive clinical outcomes for the individuals residing at CCSSLC. From a review of the Facility's nursing staffing data and discussions with the Chief Nurse Executive, CCSSLC continued to maintain an adequate and fairly consistent nursing staff. Although the nursing staffing fill rates had experienced some variability since January 2012 for both RNs and LVNs, nursing staffing remained basically stable at CCSSLC. As previously recommended, 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 reviewed and/or revised, the Facility should ensure that policies, procedures, or protocols address the integration of any new positions. <u>Quality Enhancement Efforts</u> Unfortunately, at the time of the review, the Quality Assurance Nurse, had been on a leave since May 2012 and was expected back to the position in August 2012. Thus, the Monitoring Team was not able to interview the QA Nurse regarding any updates or analyses of her areas. However, the Facility reported that a workgroup had been established to address the area regarding inter-rater reliability procedures. From the documentation provided by the Facility, it appeared that the workgroup met once on February 1, 2012, and had developed an initial draft of an undated document titled Procedure for Establishing Inter-Rater Reliability. Although the document contained some good information regarding the inter-rater reliability process, albeit not complete information regarding procedures addressing data generated for monitoring tools that have low percentages of inter-rater reliability, it appeared that the document had not been finalized, and no additional workgroup minutes were provided. Consequently, it was unclear to the Monitoring Team if a procedure addressing inter-rater reliability was actually completed as reported. <u>Assessment and Documentation of Individuals with Acute Changes in Status</u> Since the last review, the Facility indicated that the following steps had been implemented to address the nursing assessment and documentation of individuals with acute changes in health status: ▪ The Facility reported that it had begun to implement nine additional nursing protocols, including those for: Minimal Documentation, PICA, Seizures and Status Epilepticus, Abdominal Distention/Pain, Hypothermia, Temperature Elevation, Urinary Tract Infection, Enteral Feeding, and Post Anesthesia.	

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		However, the Presentation Book for Section M.4 did not include a description of the training, so it was unclear what training was provided prior to implementation, or if the protocols had just merely been distributed to all the nurses. Such information should have been provided either as part of the Presentation Book or in response to the Monitoring Team's comprehensive request for training documentation included in the pre-visit request. Although increasing the number of nursing protocols to assist in the development of clinically adequate care plans to guide nursing practices was a positive step forward, at the time of the review, no evidence was found in the care plans or in the nursing documentation reviewed that the nursing protocols were actually being used to drive the identification and implementation of the specific responsibilities of disciplines, provide clear and appropriate timeframes for initiating nursing assessments and the type of assessments that should be conducted, assist in determining the frequency of these assessments, and identify the parameters and time frames for reporting symptoms to the practitioner/physician and PNMT, if indicated. Thus, no supporting documentation was found to substantiate the nursing protocols had actually been implemented. ▪ A promising auditing tool was developed to review the use of nursing protocols since the last review. This is discussed in more detail with regard to Section M.4. A review of 13 individuals' medical records (i.e., Individual #64, Individual #304, Individual #286, Individual #273, Individual #144, Individual #155, Individual #175, Individual #266, Individual #130, Individual #308, Individual #117, Individual #239, and Individual #103) who had been transferred to a community hospital, emergency room, or the Infirmary found: ▪ Nurses promptly and consistently performed a physical assessment on any individual displaying signs/symptoms of potential or actual acute illness in none (0%). ▪ Licensed nursing staff timely and consistently informed the PCP of symptoms that required medical evaluation or intervention in none (0%) of the cases. ▪ Appropriate information was communicated to the PCP in none (0%) of the cases. ▪ The nurse consistently performed appropriate and complete assessments as dictated by the symptoms in none (0%) of the cases. ▪ The nurse conducted frequent assessments of the individual's clinical condition in none (0%) of the cases. ▪ An adequate plan of care was developed including instructions for implementation and follow-up assessments in none (0%) of the cases. ▪ The documentation indicated that acute illness/injuries were followed through to resolution in none (0%) of the cases.	

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		A review of these 13 individuals found basically the same significant problematic clinical issues regarding nursing assessments and documentation that the Monitoring Team identified during the past five reviews. The overall problematic issues that were found in all 13 records included: ▪ 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; ▪ A consistent lack of complete and appropriate nursing assessments was noted in response to status changes in behaviors, vital signs, and oxygen saturations; ▪ The lack of consistent nursing documentation made it impossible to accurately determine when changes in status were initially occurring; ▪ There was a consistent lack of follow-up for health issues noted in previous nurses' progress notes; ▪ There was consistent inadequate documentation and nursing assessments addressing the administration and follow-up of the effectiveness of PRN medications (as needed medications); ▪ There were consistent inadequate assessments and follow-up addressing indications and/or complaints of pain; ▪ The nursing notes lacked specific description, size, and location of skin issues, such as reddened area, injuries, or bruises; ▪ There was a lack of documentation of individuals' activities and tolerance for activities during the day, evening, and night to indicate any associated changes in mental status from physical changes in status; ▪ There were few mental status assessments documented during status changes; ▪ There was a consistent lack of documentation indicating that lung sounds were regularly assessed and documented for individuals with significant respiratory issues; ▪ There was a consistent lack of assessment of bowel sounds, and abdomen exams documented for individuals with constipation or receiving PRN laxatives; ▪ There were gaps in nursing documentation, when the nurses' notes indicated that they were "monitoring" the individual's status; ▪ Physicians/Practitioners were consistently not timely notified of changes in status, due to nurses' inadequate follow-up; ▪ There was consistently no documentation that nursing communicated with the PNMT regarding changes in status for individuals at risk of aspiration/choking; ▪ There was a consistent lack of specific descriptions of the individuals' behaviors, assuming that all staff reading the progress notes were familiar with the individuals; ▪ There were missing weights, and intake and output values for individuals with significant weight loss issues;	

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		▪ Many inappropriate abbreviations were used that could not be interpreted; ▪ A consistent lack of communication was noted between shifts regarding status changes, and the need for regular assessments and follow up; ▪ There was inadequate documentation noted regarding the individual's status and assessment at the time of transfer to the hospital or Infirmary, or emergency room; ▪ In the progress notes, there was inconsistent documentation of the time, date, and/or method of transfer to the receiving facility; ▪ In the nursing notes, there was a consistent lack of analysis of contributing problematic issues affecting changes in status documented; ▪ There was inadequate documentation of a complete nursing assessment upon return to the Facility, especially addressing the same symptoms that precipitated the transfer to a community hospital; ▪ There was inconsistent documentation that the nurse or physician notified the receiving facility of the individual's transfer; ▪ There was a consistent lack of regular follow-up days after the transfer occurred for symptoms related to the initial reason for the hospitalization; ▪ Nursing Care Plans addressing health issues were consistently inadequate with regard to individualized goals and nursing interventions, and were not effectively modified after hospitalizations; ▪ Dates and times were not consistently documented for progress notes; ▪ A significant number of nursing progress notes and signatures were illegible; and ▪ There was inconsistent documentation addressing the care of healthcare equipment individuals required, such as catheters, tracheotomies, and G-tubes. There were some Integrated Progress Notes (IPNs) that contained an adequate nursing assessment, and associated findings. However, due to the inconsistency of these adequate notes, it was clear that these were not the result of any type of structured system. Although the Facility reported that Nursing Protocols had been implemented, there was no indication that they were being used to guide nursing assessments and documentation. The Facility should continue to implement and expand the use of nursing protocols (as is discussed in further detail with regard to Section M.4) to guide nursing practices. In conjunction with the continuation of the adequate competency-based nursing skills training being provided by the State Office Nurse Practitioner Group, mentoring and supervision of nurses should focus on the expanded use of the protocols. As noted in previous reports, due to the number of individuals with complex medical needs at CCSSLC, this area should be considered a priority for Facility review, and the development and implementation of action plans addressing the significant deficits that exist in the nursing care. The Facility's Self-Assessment indicated that it was not in	

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		compliance with these elements of this requirement, which was consistent with the Monitoring Team's findings. <u>Availability of Pertinent Medical Records</u> From a limited review of records while on site, it was noted that few documents were missing from the active records. However, information contained in the Facility's Self-Assessment indicated that from a review of Quarterly and Annual Nursing assessments conducted monthly to determine if they had been completed on time and were in the Active Record, the Facility found that although the assessments were timely completed, they were not being consistently found in the Active Records. The Facility should continue to ensure that documents are available, and filed in a timely manner in the individuals' records, so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services. <u>Infection Control (IC)</u> At the time of the review, the Facility recently had hired a full-time RN in the position of the Assistant Infection Control Nurse who had minimal previous experience in Infection Control. From discussions with the IC Nurse, the new Assistant Infection Control Nurse had received some initial competency-based training regarding infection control principles and was in process of completing on-line modules regarding clinical issues related to infection control. This should be continued and documented in order to ensure competency in this specific clinical area. From the Facility's Self-Assessment, a review of CCSSLC's Action Provision Information report, and the documentation contained in the Presentation Book addressing Infection Control, as well as interviews with the IC Nurse, review of the documentation, and information gathered during the review, some positive steps forward had been made regarding the process of building an infrastructure to meet the requirements of the Settlement Agreement. Some of the progress noted included: ▪ The Facility created a separate Presentation Book addressing Infection Control. It was very organized and contained a significant amount of information regarding the activities of the IC Nurses since the last review. ▪ Prior to the last review, the IC Nurse had initiated a process addressing data reliability, to accurately identify the Facility's trends related to infectious and communicable issues. From data generated by comparisons of the Infection Control Reports and the Pharmacy reports for the utilization of antibiotics, the following represent compliance percentages of antibiotics included in both reports: 91%, 96%, 97%, 83%, and 89% from February through June 2012, respectively. These data not only reflected a very positive step forward in tracking discrepancies regarding Infection Control information to ensure data	

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		reliability, but also a positive increase in compliance regarding the accuracy of the documentation contained on the Infection Control Reports completed by the residential staff. However, at the time of the review, there was no written procedure that outlined CCSSLC's process to ensure the IC data was reliable. A formal procedure addressing this process should be written and included in the Facility's Infection Control Manual. ▪ At the time of the review, the Facility had begun to review monthly the IC Discrepancy Reports with the Case Managers regarding pertinent missing IC information found on the weekly Infection Control Reports. Clearly, this step forward had a positive outcome based on the increases in compliance percentages noted above. Although the information in the IC Presentation Book did not specify when this review took place (i.e., Monthly Nursing Meetings), the Facility should consider formalizing this process to ensure it occurs consistently. ▪ Since March 2012, the IC Nurse developed and implemented a very promising "Real Time" Infection Control monitoring tool focused on issues regarding the overall clinical care of acute infectious episodes. At the time of the review, five audits had been conducted for four individuals who had experienced an acute infectious illness (i.e., Individual #86, who had two infectious episodes; Individual #176; Individual #276; and Individual #156). A review of the raw data indicated that some significant problematic issues were found, such as none of the five audits indicated that the individuals had an adequate nursing care plan in place addressing the infectious illness, that the appropriate precautions were included in the care plans, or that staff training regarding the specific illness was included as an intervention in the care plans. These data, along with other monitoring data addressing IC issues, and data regarding actual infection rates should be aggregated and analyzed in order to better identify systematic and/or staff-related problematic trends that might be impacting the rates of infections at the Facility. ▪ The Infection Control surveillance data was aggregated in a number of different ways such as by infection type, by home, by building, by individual, by month, and by organism. ▪ The documentation the Facility provided regarding infectious illness indicated that a number of appropriate and timely in-service training sessions were provided to staff in response to acute infectious illnesses by the IC Nurse. ▪ The Facility's Self-Assessment indicated that 99% of individuals and 98% of staff were current regarding immunizations. ▪ The format and structure of the minutes of the Infection Control Committee meetings provided clearer information regarding issues discussed, actions implemented, and the effectiveness of the actions on outcomes. Although the IC Nurses made several positive steps forward, there continued to be a	

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		number of significant problematic areas regarding infection control that were in need of further attention, including; ▪ Although the Facility had developed and implemented an immunization database, consistent with past reviews, the Facility could not generate a list of all the individuals whose past immunizations had been researched, and were updated, as appropriate. A formalized schedule should be developed clearly indicating which individuals' immunization status and immunizations have been researched and confirmed or updated to ensure all individuals have received all the required immunizations as outlined in the Health Care Guidelines. ▪ A review of the minutes of the Infirmary Safety Meeting found that the minutes contained very little information that indicated what the exact mission and purpose was of the meeting. In addition, the information that was contained in the minutes had no associated analysis included to indicate how these issues were related or interrelated to safety issues involving the Infirmary. Such issues included the number of aspiration pneumonias, the number of isolation cases, trash pick-up days for the Infirmary, moving electrical outlets in the Infirmary, and issues regarding staff feeding stray cats. In addition, it was difficult for the Monitoring Team to determine how frequently these meetings were required to occur, because the minutes the Facility provided were dated 10/19/11 and 2/28/12. ▪ The Facility's documentation indicated that Infection Control Environmental Checklists were being regularly conducted, and the comments on many of the checklists indicated that the auditors were being more critically observant than in the past. Although a number of significant problems were found such as bathrooms smelling like urine, storage rooms in need of cleaning and organizing, soap dispensers broken or empty, doors and drawers not fully closing, and cracks in the vinyl furniture, there was no indication that these problems had been adequately addressed. In addition, the results of these audits were not trended or analyzed in conjunction with other IC data to determine if there was a correlation between the problematic environmental issues and rates of infections. Such analyses and related discussions about action plans implemented or potential solutions should be included in the minutes of the Infection Control Committee meeting minutes. ▪ Consistent with the same problematic issues that were found during the previous reviews regarding nursing care plans, a review of five individuals with Flu-like symptoms in March 2012 (i.e., Individual #46, Individual #172, Individual #186, Individual #151, and Individual #94) was conducted to determine if the individuals had appropriate care plans to address their needs. Based on the review, the Monitoring Team found that of the five episodes, none (0%) had acute HMPs addressing the infectious issue. ▪ In addition, the Isolation Infection Control Report the Facility provided from	

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		January through June 2012 indicated that 10 Individuals were placed on contact precautions for a total of 13 infectious episodes since January 19, 2012 (i.e., Individual #242, Individual #163, Individual #243, Individual #69, Individual #276, Individual #156, Individual #86, Individual #176, Individual #43, and Individual #353). Of the ten individuals, one (10%) was found to have had two acute HMPs addressing the same infectious issue. One of these HMPs was not signed, and the other the IC Nurse authored. Of the two Nursing Care Plans reviewed addressing the infectious disease, neither was found to be adequate (0%). However, the HMP completed by the Infection Control Nurse contained a promising increase in the clinical content and attempts to individualize the care plan. ▪ Also, a review 12 individuals (i.e., Individual #287, Individual #228, Individual #137, Individual #48, Individual #44, Individual #172, Individual #83, Individual #254, Individual #157, Individual #368, Individual #359, and Individual #95) who had a positive Tuberculin Purified Protein Derivative were reviewed to determine if the individuals had appropriate care plans to address their needs. Of the 12 individuals, 12 (100%) were found to have had a care plan addressing this issue. However, the care plans consisted of three of the HMP template for positive PPDs (i.e., Individual#287, Individual #228, and Individual #137) and the remaining nine were submitted on Risk Action Plans with the associated Integrated Risk Rating Forms. Of the 12 Care Plans reviewed addressing positive PPDs, none (0%) were found to be adequate. This is discussed in more detail with regard to Section M.3. The Facility should develop and implement a system to ensure the HMPs for individuals with infectious/communicable disease are clinically appropriate and consistently implemented; ▪ A review of the Infection Control Committee meeting minutes found that while there were some attempts made at analyzing the Facility's IC data, there were a number of other monitoring data findings that were not being reviewed and analyzed to comprehensively assess the Facility's infection control practices. The Facility should conduct analyses of all the IC monitoring data, implement plans of action addressing problematic issues, and document the interventions implemented, and the resulting outcomes. Although the Facility had made some positive steps forward, there continued to be a significant amount of work yet to be done regarding Infection Control in order to make substantial gains in meeting the requirements of the Settlement Agreement. As noted in previous reports, consideration should be given to having additional expertise in Infection Control provided to the Facility to assist in effectively operationalizing the Infection Control Systems in alignment with IC standards of practice and the Settlement Agreement, as well as providing professional feedback regarding the quality and	

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		completeness of the Infection Control Program. <u>Mock Code Drills and Emergency Response Systems</u> CCSSLC indicated in the Facility's Self-Assessment that since the last review, the following steps were initiated regarding this area: ▪ It was unclear to the Monitoring Team the significance of the information contained in the Facility's Self-Assessment regarding the requirements for passing an emergency mock drill. In addition, the data contained in the Facility Self-Assessment indicated that it reflected the "average percentage of employees passing the drills without prompts," but the graph noted the data indicated the number of drills conducted each month and the percentage of those drills that passes. Thus, the information and data contained in the Self-Assessment addressing the emergency mock drills could not be accurately interpreted. ▪ In a positive step forward, the Facility indicated that blanks found on a review of the emergency cart checklists had significantly decreased from January to June 2012, since Risk Management, Respiratory Therapy, and Nurse Educators have been completing monthly spot checks of this area. ▪ The Nursing Educators continued conducting spot checks addressing emergency equipment use and oxygen flow rates, and added testing for flow rates to the mock drill procedure. The Monitoring Team's observations of nurses demonstrating the emergency equipment at the Infirmary, and Atlantic Kingfish 2 found that the nurses were familiar with the use and operations of the Facility's emergency equipment. It was clear to the Monitoring Team that the consistent drills and spot checks regarding the emergency equipment were having very positive outcomes. ▪ Since the last review, the Facility had purchased eight additional manikins for use in emergency drills. ▪ The Facility had developed an excellent new Mock Code Video 2012 training for emergency procedures and had placed several of them in the buildings to ensure they were assessable to all staff. ▪ The Facility implemented a tracking form that clearly indicated the following information regarding the emergency mock drills: the shift when it was conducted, the date, time, comments/concerns, immediate plan of correction, system plan of correction, and drill status (pass or failed). Although the Facility implemented some positive steps addressing the Emergency Response System, a number of problematic issues were found that should be addressed in order for additional progress to be made: ▪ Since the State Office Emergency Response policy was implemented in December 2011, the Facility ceased the Medical Emergency Code Drill meetings. The CNE reported that since the policy identified Risk Management as being the	

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		department that would be reviewing the data regarding Emergency Mock Drills, the Facility no longer needed the Medical Emergency Code Drill meeting. However, from discussions with the Risk Management Director, he reported that the only information discussed at the Risk Management meeting regarding the Emergency Mock Code Drills was the number conducted, and the number that passed and failed. He reported that during the Risk Management meetings, there were no discussions regarding any problematic trends found during the drills, and there was no clinical review of the drills or the actual medical emergencies that occurred at the Facility. Consequently, the status of the Facility's emergency systems was not being reviewed, discussed, or tracked by any clinical staff. For a Facility that had a significant number of individuals with complex medical needs, this finding was concerning. The Facility in conjunction with the State Office should clarify the role of Risk Management and the role of the clinical staff regarding the review of Emergency Mock Code Drill data and data addressing the actual medical emergencies that have occurred. ▪ There was no analysis or associated plan of correction found regarding the data addressing Emergency Mock Drills, especially in light of some of the low pass percentages of the drills conducted from January through June 2012. The pass rates were 29%, 37%, 78%, 33%, 56%, and 78%, respectively. ▪ Although the CTD staff reported some improvement, there continued to be some staff resistant regarding participation in the Mock Drills. For example, the comments noted on the Emergency Drill form for 5/15/12 at Horizons indicated that one staff had to be prompted to participate in the drill and another staff had to be told to hang up his cell phone when the drill was initiated. ▪ The Nurse Educator reported that the only other scenarios that were included in the drills was choking, and that was only included for one month. As previously recommended, the Facility should expand its emergency drills to include a variety of scenarios so that the emergency drills are more reflective of emergencies that warrant actions in addition to CPR. The data from the drills conducted since the last review were as follows: ▪ 17 drills conducted in January 2012 – five passed (29%); ▪ 19 drills conducted in February 2012 – seven passed (37%); ▪ 18 drills conducted in March 2012 – 14 passed (78%); ▪ 18 drills conducted in April 2012 – six passed (33%); ▪ 15 drills conducted in May 2012 – 10 passed (67%); and ▪ 18 drills conducted in June 2012 - 14 passed (78%). The Facility had made some positive steps forward regarding CCSSLC's Emergency Response System. However, there continued to be a number of problematic issues as noted above that needed to be addressed. The Facility reported that: "based on the	

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		findings from this self-assessment, this provision is not in substantial compliance because review of Health Monitoring tools, Infection Control Data, Emergency Drill data and Emergency checklist audit forms show we are not in compliance. CCSSLC will continue to train as concerns are identified and develop corrective action plans."	
M2	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall update nursing assessments of the nursing care needs of each individual on a quarterly basis and more often as indicated by the individual's health status.	In assessing its progress, CCSSLC indicated in the Facility's Self-Assessment that since the last review, the following regarding this requirement of the Settlement Agreement: ▪ From a monthly review of eight Quarterly and Annual Nursing assessments to determine if they had been completed on time and were in the Active Record, they found that although the assessments were timely completed, they were not being consistently found in the Active Records. Although this was a very pertinent finding, the presentation of the data was difficult to interpret due to the Facility's lack of having a standardized format for presenting data in a meaningful manner. In addition, there was no information provided in the Self-Assessment indicating how the Facility planned to address the problematic issue identified. ▪ In addition, a review was conducted using the Health Monitoring Tools (HMTs) for Acute Illness and Injuries to determine if nursing care was provided according to policy. However, the findings listed in the Facility's Self-Assessment stated: "Quarterly and Annual Nursing Assessments were completed accurately according to guidelines," which did not address the issue regarding the provision of nursing care. In addition, the Self-Assessment contained a graph with a single compliance percentage for each month from December 2011 through May 2012 for an item listed as "Nursing Assessment compliance," without an explanation of what nursing assessment compliance specifically represented. Consequently, the Monitoring Team was not able to accurately interpret the data. ▪ Although the Facility's Self-Assessment indicated that "100% of tenured CCSSLC RNs have completed the State Office Physical Assessment and documentation classes as of 3/16/2012 and the Nurse Educators have completed their competency and have taken over teaching this course to all new hires," it was unclear what constituted a "tenured" registered nurse, and left the question unanswered regarding how many nurses, both RNs and LVNs had actually completed and passed the training. In addition, the documentation the Facility provided at the entrance meeting regarding the accomplishments and progress for Section M indicated that "55.7/59.7 RNs" had completed this training, which did not clarify the issue regarding what percentage of nurses at CCSSLC completed the training. <u>Self Rating:</u> The Facility's Self-Assessment indicated that "based on the findings from this self-	Noncompliance

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		assessment, this provision is not in substantial compliance because after review of the documentation and audits, CCSSLC will need to continue to educate nurses as concerns are found from the HMT's." In addition, the attempts to present data the HMTs generated for nursing in the Facility's Self-Assessment for Section M and Provision Action Information clearly indicated that staff were struggling in their efforts just to report the data. Although in past reports and during past reviews, it was noted that providing overall compliance scores for audit tools addressing nursing issues was meaningless and gave no indication of the areas of strength, weakness, or the status of progress, overall compliance scores continued to be reported throughout the Facility's Self-Assessment and in the Provision Action Information. It was clear that the Facility was investing a great deal of energy in data collection. However, unfortunately in most cases, the overall presentation of the data rendered it uninterpretable. The Facility should consider adopting a standardized format for presenting data in a meaningful way that facilitates its interpretation and analysis. Although the Facility's findings of noncompliance was consistent with the Monitoring Team's findings, the reasons for the Monitoring Team's finding of noncompliance as noted below, were far more specific regarding the significant problems with the quality and content of the Comprehensive Nursing Assessments than what was reflected in the Facility's Self Assessment. A major concern thus far in the review process was that CCSSLC had not generated findings addressing the quality of the documentation contained in the Comprehensive Nursing Assessments, which continued to be inadequate, and in fact, was noted to be worse than what was found during the previous review. In addition, the Facility's Action Plan addressing Section M.2 did not include any action steps regarding how the poor quality of the Comprehensive Nursing Assessments was to be addressed by the next review. However, some positive steps forward that the Facility made since the last review included the following: ▪ In January 2012, the Facility developed and implemented a database to ensure the quarterly and annual Comprehensive Nursing Assessments were timely completed; and ▪ In May 2012, the Facility hired a full-time RN Case Manager Coordinator to oversee the RN Case Managers to ensure they were timely and appropriately executing their duties. The introduction of this new statewide position should increase the accountability of the crucial role of the RN Case Managers at the Facility. The Quarterly/Annual Nursing Assessments for 27 individuals who the Facility identified	

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		as being at risk for specific health indicators were reviewed, including those for: Individual #144, Individual #183, and Individual #278 for weight; Individual #9, Individual #282, and Individual #378 for dental issues; Individual #213, Individual #327, and Individual #91 for urinary tract infections; Individual #221, Individual #34, and Individual #210 for cardiac issues; Individual #153, Individual #211, and Individual #38 for challenging behaviors; Individual #182, Individual #8, and Individual #44 for falls; Individual #224, Individual #276, and Individual #10 for fluid imbalances; Individual #138, Individual #297, and Individual #350 for gastrointestinal issues; and Individual #268, Individual #26, and Individual #95 for polypharmacy. ▪ Of the 27 individuals' nursing quarterly assessments reviewed, 22 (81%) were timely completed. Assessments that were not timely completed included Individual #144, Individual #91, Individual #276, Individual #26, and Individual #95. ▪ There was an adequate analysis of the health/mental health 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. ▪ There was an adequate assessment of the high and medium risk health indicators included in none (0%) of the Comprehensive Nursing Assessments. ▪ Nursing assessments were updated as indicated by the individual's health status in none (0%) of the Comprehensive Nursing Assessments reviewed. Although there were a few positive steps forward, as noted previously, the Monitoring Team found no progress had been made regarding the quality of the quarterly/annual nursing assessments, with even some regression noted from the previous review. In fact, a number of the Comprehensive Nursing Assessments reviewed contained essentially the same identical information repeated under the different subsections in the Summary Section without any type of analysis of the heath indicator. Also, considerably more discrepancies were found between the information contained in the body of the assessments and the Summary Section, as well as discrepancies noted in the risk levels found the nursing assessments as compared to the Integrated Risk Rating Forms, which was not found during the previous review. Consistent with the findings from the previous reviews, none of the Comprehensive Nursing Assessment summaries reviewed included an adequate or appropriate analysis of the individuals' health/mental health issues between quarters indicating if the health issues were improving or getting worse. The chronic lack of analysis of progress and regression regarding the Comprehensive Nursing Assessments, and the Facility's lack of establishing a concrete plan to address this requirement suggested that nursing at all levels within CCSSLC lacked the ability and understanding regarding how to analyze, summarize, and document health/mental health issues to determine whether or not	

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		progress was being made. The Facility should provide appropriate competency-based training regarding the Quarterly/Annual Comprehensive Nursing Assessments from a competent source to ensure that the nursing assessments include an adequate clinical analysis of the individuals' progress. Without adequate and appropriate competency-based training and ongoing mentoring regarding the process and documentation of a clinical analysis, merely collecting monitoring data for this area will not result in the improvement of the quality of the Comprehensive Nursing Assessments as required by the Settlement Agreement. Regarding the nursing documentation for discharges/individuals transitioning to the community, a review of the Nursing Discharge Summaries for six individuals including: Individual #41, Individual #364, Individual #277, Individual #151, Individual #30, and Individual #114 found the following: ▪ None (0%) of the Nursing Discharge Summaries adequately addressed the health/mental issues of the individuals. ▪ There was adequate information contained in none (0%) of the Nursing Discharge Summaries that would guide the community staff in providing the needed nursing care to the individual. ▪ A current nursing assessment was conducted for none (0%) of the individuals prior to discharge/transferring to the community. ▪ There was adequate documentation identifying specific nursing interventions needed for all health/mental issues in none (0%) of the cases reviewed. As clearly noted in past reports and during past reviews, the problematic issues regarding the nursing assessments for discharges/transitions to the community had not been impacted by the implementation of a new state-wide form. In addition, due to the poor quality of the Risk Action Plans/Health Management Plans (as discussed with regard to Section M.3), no nursing documentation was found that provided any specific guidance regarding the type and frequency of nursing interventions the individuals required. It was very troubling that from review of the Facility's Action Plans and discussions with the CNE, the Facility had no plan in place to address this area by the next review in spite of the fact that the lack of clear and comprehensive clinical information was associated with a grave outcome for Individual #351 who resided at CCSSLC and died after being transitioned. Although the details of this tragic case was outlined in a previous report, Individual#351 was transitioned to the community without adequate and accurate information included in the Comprehensive Nursing Assessment 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	

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		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 nursing care plans were sent to the community staff regarding Individual #351's health/mental health issues, although the quality of the nursing care plans would have been substandard. Sadly, less than two months after transitioning to the community Individual #351 died from dehydration associated with Diabetes Insipidus. Overall, the same problematic issues that were found in the case of Individual #351 continued to be found in all six Nursing Discharge Summary Assessments reviewed by the Monitoring Team that included: ▪ A lack of a comprehensive and specific nursing assessment for individuals being discharged/transitioned to the community; ▪ A significant lack of clinical assessments for clinical health indicators; ▪ A lack of an analysis of the individuals' health/mental health issues; ▪ A lack of critical thinking when completing the Comprehensive Nursing Assessments; and ▪ A lack of clear information addressing the nursing interventions that were needed to care for individuals. The lack of attention to this area at this juncture of the review process was extremely concerning. There appeared to be a lack of recognition from nursing as well as the teams that the more information provided to the community staff regarding an individuals' health/mental issues, the greater the potential for consistency in care, and a successful transition. It is imperative that CCSSLC review and revise its current nursing discharge procedures and documentation requirements to ensure that upon an individual's discharge from the Facility, the nursing documentation is specific and detailed enough to maintain continuity of care. The Facility's Self Assessment indicated that it was not in compliance with the elements of this requirement. This 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	In assessing its progress, CCSSLC indicated that since the last review, the following steps were initiated regarding this requirement of the Settlement Agreement: ▪ The Facility's Self-Assessment indicated that audits were conducted from January through June 2012 to determine if Nursing Care Plans were completed according to policy. Although the Facility presented the compliance scores by month as being 14%, 21%, 30%, 28%, 31%, and 33%, respectively, no indication was provided of what the specific item or items were that defined "completed according to policy." This	Noncompliance

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	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.	prevented accurate interpretation of the data. In addition, no information was provided in the Facility Self-Assessment indicating how many audits were conducted each month to generate the data or how the sample was selected. In addition, there was no mention if inter-rater reliability had been established for the specific monitoring tool. ▪ In February 2012, the Facility's Self-Assessment noted that a system was implemented to track the dates an acute nursing care plan was developed and placed in the Active Record, and when it was resolved. Although this was a positive initial step forward, the Facility should consider expanding the system to include a format for monitoring the actual implementation of nursing interventions in alignment with the nursing protocols contained in the acute care plans, which would provide essential information regarding the quality of the nursing care. ▪ In addition, in February 2012, the Facility developed an acute care plan quality review tool. The Monitoring Team noted that this tool was very promising. The tool addressed items such as the alignment of the goals with the etiology of the problem, and the specifics of the "who, what, and where" written into the interventions. However, as noted above, one major missing element was the monitoring of the actual implementation of nursing interventions contained in the acute care plans. Adding this item to the tool would transition it from a document review to a review of nursing clinical care. ▪ The Facility's Self-Assessment indicated that the Nurse Operations Officer had developed a training curriculum addressing Nursing Care Plans. The training was provided to Nurse Educators across the State and will be provided to the Case Manager Supervisors in August 2012. However, the curriculum and training rosters were not included in the Presentation Book for Section M. Although it appeared that there were a few sample care plans contained in the Presentation Book, the Monitoring Team was not able to determine how competency regarding the development of care plans was assessed. ▪ From discussions with the CNE, since the last review, the Facility had made a transition from using the Health Management Plans to address high and medium health and mental health risks to using an Integrated Health Care Plan that will ultimately replace the Risk Action Plans. Although at the time of the review, only two buildings were in the process of conducting a pilot project regarding some proposed changes to the At Risk system, including transition to an Integrated Health Care Plan (which is discussed in further detail with regard to Section I), the CNE reported that essentially all the existing HMPs in the Facility had been withdrawn from the Active Records, except for the acute HMPs, which continued to be utilized at the time of the review. Although the	

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		use of an Integrated Health Care Plan was a very promising clinical move forward, it was of major concern to the Monitoring Team that all of the HMPs were terminated without appropriate modifications made to the existing Risk Action Plans that had been found to be highly inadequate. In addition, no plan was in place addressing how nursing interventions for certain chronic conditions that did not rise to the level of a high or medium risk or were not acute issues would be accounted for in a plan of care. The records of 27 individuals who the Facility identified as being at high risk for specific health indicators were reviewed, including: Individual #144, Individual #183, and Individual #278 for weight; Individual #9, Individual #282, and Individual #378 for dental issues; Individual #213, Individual #327, and Individual #91 for urinary tract infections; Individual #221, Individual #34, and Individual #210 for cardiac issues; Individual #153, Individual #211, and Individual #38 for challenging behaviors; Individual #182, Individual #8, and Individual #44 for falls; Individual #224, Individual #276, and Individual #10 for fluid imbalances; Individual #138, Individual #297, and Individual #350 for gastrointestinal issues; and Individual #268, Individual #26, and Individual #95 for polypharmacy. Of the 27 individuals' Risk Action Plans/Integrated Health Care Plans (nursing care plans) reviewed: ▪ All (100%) were found to have a Risk Action Plan addressing their high-risk health/mental health indicator. ▪ None (0%) of the nursing goals listed in the Risk Action Plans/Integrated Health Care Plans were clinically appropriate. ▪ None (0%) of the nursing interventions contained in the Risk Action Plans/Integrated Health Care Plans 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. Although there were column headings for much of this information, the information that was included was basically generic and did not address what nurse, what shift, what form, and who specifically would review the information and how often it would be reviewed. In addition, the overall quality of the nursing interventions were meaningless in that they were generic, non-specific, and mainly consisted of services provisions such as "will give medications as ordered" that is required by licensure and not specific interventions addressing the individuals' health care needs. In addition, the interventions listed were not in alignment with nursing protocols addressing the specific health issue. ▪ None (0%) of the 27 Risk Action Plans/Integrated Health Care Plans were found	

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		to be clinically adequate. ▪ None (0%) of the 27 Risk Action Plans/Integrated Health Care Plans included proactive interventions addressing the health indicator. Although some generic interventions were found in some ISPs addressing, for example, the need for exercise or encourage fluids, that would have led to a preventative intervention, because these interventions were not written in measurable terms to allow them to be implemented and tracked, they did not result in compliance with this indicator. ▪ None (0%) of the 27 Risk Action Plans/Integrated Health Care Plans were adequately individualized. ▪ Due to the nonspecific interventions contained in all of the 27 Risk Action Plans/Integrated Health Care Plans, validating the implementation of the interventions was not possible, rendering the Risk Action Plans/Integrated Health Care Plans as guides for the provision of care inadequate. As noted above, the Facility reported that they had transitioned from using the traditional nursing care plans (Health Management Plans) to using an Integrated Health Care Plan, which was a positive step forward. However, merely removing the old HMPs from the Active Records and re-titling the Risk Action Plans as Integrated Heath Care Plans without making the appropriate modifications so that the plans were clinically sound did not resolve the problems and was extremely troubling. Consequently, consistent with the findings from the previous reviews, CCSSLC's Risk Action Plans/Integrated Health Care Plans continued to lack the following key elements: ▪ Clinically appropriate goals/objectives related to the etiology of the identified health/mental health problems; ▪ Specific interventions addressing risk indicators; ▪ Proactive interventions directed at preventing or minimizing the specific health risks; ▪ Individual-specific interventions based on the individuals' needs; and ▪ Adequate specific directions for caring for individuals who were identified as being at high risk related to their health/mental health issues. From discussions with the CNE, the formal transition from the Risk Action Plans to the Integrated Health Care Plan would occur at the time of the individuals' ISPs. However, no plan was in place to review and modify the current Risk Action Plans that the Monitoring Team already had identified as being inadequate during past as well as the current review. Such modifications were needed to ensure that they reflected the specific clinical care the individuals' required according to their health needs. Thus, in essence, an individual with high-risk health/mental health needs could be further delayed from having an adequate plan of care until the next ISP, which for some individuals could be up to 12 months. It is essential that the Facility address the lack of clinically adequate	

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		care plans for the individuals under their care. The Facility should continue to develop and implement appropriate care plans based on priority, and risk for all individuals at CCSSLC Regarding nursing care plans addressing infectious illness, the Outbreak Report the Facility provided to the Monitoring Team indicated there were five individuals with flu-like symptoms in March 2012 (i.e., Individual #46, Individual #172, Individual #186, Individual #151, and Individual #94). ▪ Of the five individuals, none (0%) were found to have had acute HMPs addressing the infectious issue. Although a document request was submitted to the Facility prior to the review for the Health Management Plans for all individuals who were affected by any outbreaks since the last review, none were found among the documents provided addressing this issue. This indicated that none had been developed and implemented for these Individuals. ▪ Since no acute HMPs were found, none were reviewed addressing the infectious diseases, and none (0%) were found to be adequate. Regarding nursing care plans addressing other infectious illness, the Isolation Infection Control Report from January through June 2012 indicated that since January 19, 2012, 10 individuals were placed on contact precautions for a total of 13 infectious episodes (i.e., Individual #242, Individual #163, Individual #243, Individual #69, Individual #276, Individual #156, Individual #86, Individual #176, Individual #43, and Individual #353). ▪ Of the ten individuals, one (10%) was found to have had acute HMPs addressing the infectious issue. Individuals who did not have HMPs addressing the infectious issue included: Individual #242, Individual #163, Individual #243, Individual #69, Individual #276, Individual #86, Individual #176, Individual #43, and Individual #353. ▪ Of the two Nursing Care Plans reviewed for one individual addressing the same infectious disease, neither was found to be adequate (0%). Although two HMPs were submitted for Individual #156, one unsigned and one completed by the Infection Control Nurse, review of the one the Infection Control Nurse authored found a promising increase in the clinical content and good attempts to individualize the care plan. In addition, a review 12 individuals (i.e., Individual #287, Individual #228, Individual #137, Individual #48, Individual #44, Individual #172, Individual #83, Individual #254, Individual #157, Individual #368, Individual #359, and Individual #95) who had a positive Tuberculin Purified Protein Derivative (PPD) were reviewed to determine if the individuals had appropriate care plans to address their needs. The Monitoring Team found the following: ▪ Of the 12 individuals, 12 (100%) were found to have a care plan addressing this	

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		issue. However, the care plans consisted of three of the HMP template for positive PPDs (i.e., Individual#287, Individual #228, and Individual #137) and nine were submitted on Risk Action Plans with the associated Integrated Risk Rating Forms (IRRFs). A review of the IRRFs noted that risk levels of medium had been assigned to the positive PPD health indicator without sufficient justification. During the review, discussions with the CNE and nursing staff indicated that the medium risk level was assigned to this indicator in order to justify adding the indicator to the Risk Action Plans, which the Facility was in the process of transitioning into the Integrated Health Care Plan. It was concerning to the Monitoring Team that manipulating the At Risk level system this way was the current plan in place just to be able to integrate a health indicator into the Risk Action Plan/Integrated Health Care Plan. This could potentially dilute or overwhelm the risk system and divert the clinical intensity away from what is required for these risk levels. If indeed the team determined that a health indicator was a high or medium risk, the clinical justification should be adequately addressed on the IRRFs and the interventions listed on the Risk Action Plans/Integrated Health Care Plans in alignment with the level of risk. In addition, risk indicators of low intensity that require care plans also should be integrated into the risk action plans or integrated health care plans as appropriate. ▪ Of the 12 Care Plans reviewed addressing positive PPDs, none (0%) were found to be adequate. In addition, as mentioned above, those that were included on the Risk Action Plans and designated as a medium risk level did not reflect the specific interventions warranted for that particular level of risk. Consistent with previous findings, CCSSLC had no system in place to ensure that individuals with infectious diseases were being provided the appropriate infection control measures, or clinically appropriate interventions to prevent the spread of infections. As noted in previous reports, it was very concerning to find that individuals with contagious/infectious illnesses did not have care plans or adequate care plans addressing these illnesses. Nursing, in conjunction with the Infection Control Nurse should develop and implement a system to ensure that the care plans addressing infectious and communicable diseases are clinically adequate, individualized, and are being implemented consistently. In order for the Facility to make progress regarding this provision of the Settlement Agreement, the Health Care Plans should be: ▪ Individualized to meet the individuals' needs, with appropriate goals, specific nursing interventions that include proactive interventions, and specific identification of who will be implementing the action, how often it will be implemented, where it will be documented, and when the effects of the	

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		interventions will be reviewed and by whom; ▪ In alignment with interventions from the nursing protocols; and ▪ Accurately reflect the clinical needs of the individuals regardless of the format and system utilized. As required by Sections G and F of the Settlement Agreement, the Facility had taken a positive step by beginning collaboration with other disciplines regarding the development of care plans so that an interdisciplinary team approach would be used consistently, and interventions from other disciplines would be integrated in all Health Care Plans. In alignment with this collaboration, the Facility should continue to give thoughtful and serious consideration to how to incorporate an individual's health risks into one plan without compromising the At Risk system or the clinical needs of the individual. The Facility indicated that it was not in compliance with this requirement of the Settlement Agreement. This was consistent with the findings of the Monitoring Team.	
M4	Within twelve months of the Effective Date hereof, the Facility shall establish and implement nursing assessment and reporting protocols sufficient to address the health status of the individuals served.	In response to this requirement, CCSSLC's Self-Assessment indicated the following actions were implemented: ▪ The Facility's Self-Assessment indicated that a number of trainings had been conducted since the last review addressing a variety of subjects such as the new protocol cards, training on Death Reviews, and the Medication Cart Exchange protocol. However, the documentation that was found in the Presentation Book for Section M.4 did not match the titles of the trainings that were found in the Facility's Self-Assessment for Section M.4. In its response to a pre-review documentation request related to training for nurses, the Facility included copies of a policy addressing Integrated Progress Notes and Documentation, the protocol cards and forms indicating that they were the competency-based tests for the protocol card training, a policy addressing Completing/Rounding Client Injury Report, and a form entitled Competency Checklist True Result. However, there was no specific description included regarding how these trainings were conducted, or examples of documentation that confirmed that competency was appropriately determined for each area on which training was provided. In addition, there were no actual training rosters provided to indicate the length of the training sessions provided and/or to allow the Monitoring Team to verify the percentages of attendance. Unfortunately, there was no way to determine the quality of these trainings or to verify staff attendance. ▪ However, information was provided regarding the Nurse Educator Meeting held in May 2012, including an agenda of the meeting, and the content that was presented during the meeting. The topics discussed at the meeting included Mosby and Physical Assessment, Emergency Drills and Method,	Noncompliance

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		Case Manager Training, Physical Assessment Class, Observing and Reporting Clinical Indicators, Medication Observation and reliability, Competency-based Training for Positioning and Presentation for Medication Administration, Acute Care Plans, and Introduction to Risk Policy. A review of the overall content found it to be extremely comprehensive with valuable clinical information included. ▪ In July 2012, the RNs were assigned content from the Mosby Physical Examination Book to be addressed in classes that were scheduled to start in August 2012 to further nurses' assessment skills. ▪ The Facility reported that they had implemented nine additional nursing protocols, including: Minimal Documentation, PICA, Seizures, Status Epilepticus, Abdominal Distention/Pain, Hypothermia, Temperature Elevation, Urinary Tract Infection, Enteral Feeding, and Post Anesthesia. However, as noted above, the Presentation Book for Section M.4 did not include a description of the training, so it was unclear how training was provided prior to implementation, or if the protocols had just merely been distributed to all the nurses. Increasing the number of nursing protocols to assist in the development of clinically adequate care plans to guide nursing practices was a positive step forward and should be continued. However, at the time of the review, no evidence was found in the care plans or in the nursing documentation reviewed to show the nursing protocols were actually being used to drive the identification and implementation of the specific responsibilities of disciplines, provide clear and appropriate timeframes for initiating nursing assessments and the type of assessments that should be conducted, assist in determining the frequency of these assessments, and identify the parameters and time frames for the reporting of symptoms to the practitioner/physician and PNMT, if indicated. Thus, no supporting documentation was found to substantiate the nursing protocols had actually been implemented. ▪ In addition, the Facility's Self-Assessment included compliance data from the Documentation monitoring tool. However, there was no information included that specifically indicated what these compliance scores represented. It appeared that they might have been overall compliance scores for the entire tool for all audits conducted for each month, which as previously mentioned, provide no meaningful information and are uninterpretable. ▪ The Presentation Book for Section M.4 contained a promising Nursing Protocol Spot Check Audit form tool that recently had been developed. From the documentation provided, it appeared that some initial auditing had been conducted to determine if the protocol for total intravenous anesthesia (TIVA) had been appropriately implemented. Although only two completed audits were included in the Presentation Book, both reflected	

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		significant breaches regarding the required nursing documentation for this procedure, which indicated the tool's potential for evaluating nursing practices. Regarding the Facility's self-rating, the information contained in the Self-Assessment indicated that: "Based on the findings from this self-assessment, this provision is not in substantial compliance because after review of documentation for Nursing protocol cards, Death reviews and other required documentation CCSSLC is not in compliance. We will continue to train as concerns are identified and develop corrective action plans." Although the Facility reported that additional nursing protocols were implemented since the last review, the Monitoring Team found the same consistent problematic issues regarding nursing assessments, care plans, and the overall nursing care and documentation as was noted from previous reviews. From discussions with the CNE and NOO, they were able to articulate how they had integrated the use of nursing protocols into the training addressing care plans, which was clearly included in the curriculum. However, it was evident that there continued to be a significant lack of understanding regarding the importance of nursing protocols among the Case Managers and nursing staff. The already present concern regarding the consistent problematic issues found in past reviews by the Monitoring Team regarding individuals with high-risk health indicators, changes in status warranting Infirmary admission, and hospital admissions was heightened during an onsite review of Individual #117's health issues, which ended with the individual's death during the week of the review. While on site, a review of Individual #117'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 high risk for aspiration and was enterally nourished by a G-tube since 4/14/12, due to silent aspiration found on a Modified Barium Swallow Study on 4/10/12; cardiac disease, since he had a pacemaker inserted on 5/24/12 for low pulse rates in the 40s (bradycardia); fluid imbalance related to low sodium levels (hyponatremia); weight issues due to significant weight loss from 185 pounds in July 2011 to 133.8 in July 2012; osteoporosis with a Dexa Scan Score of -3.2; falls due to an increase in falls beginning in January 2012; fractures due to past history of fractures (not specified in the IRRF), and recent fractures on 4/30/12 to the right radial head and an x-ray on 6/7/12 indicating a healing fracture to the right hand; and polypharmacy due to psychotropic medications. In addition, he had been admitted to the Infirmary four times and to the hospital three times since January 2012. 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 significant weight loss, variability in vital signs, and potential issues related to skin breakdown, increase in falls and injuries, low sodium levels, changes in behaviors, and an infection to	

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		his right eye were occurring. In reviewing the documentation, a number of significant problematic issues were found regarding the recent care of this individual. Some of these problems included: ▪ The Growth Record indicated that the weight for July 2011 was 185 pounds and the weight for September 2011 was 174.5 pounds. However, the weight recorded by an LVN for August 2011 was 271pounds indicating that the weight included the individual's wheelchair. There was no indication that the nurse gave any thought to obtaining the weight of the wheelchair alone, and subtracting these measurements to obtain an accurate weight for the individual. Consequently, there was no way to determine if the individual's actual weight loss pattern began in August 2011 due to the inaccurate weight recorded. ▪ The Intake and Output Records reviewed were not consistently filled out, so there was no accurate way to determine how much fluid the individual was taking in each day to be able to accurately assess his nutritional status. ▪ The Comprehensive Nursing Assessment, dated 4/30/12, did not include any information regarding the individual's significant loss of weight in the Nutrition and Weight Management Section or the Summary Section. In addition, the assessment indicated that Individual #117 was on a pureed diet with honey-thickened liquids. On 4/24/12 a nurse monitored his meal, and it was noted that he "tolerated meals." However, on 4/14/12, Individual #117 had a G-Tube inserted, which contradicted the diet and meal monitoring information contained in the assessment. In addition, the fact that the individual had a G-Tube placed was not mentioned anywhere in the Comprehensive Nursing Assessment. • The IPNs contained 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, site inspections for G-Tube, status of eye infection, bowel and urinary output, and daily fluid input. • There were gaps in the nursing documentation indicating that nursing was not regularly checking and assessing an individual with several health risks and changes in status. • Episodes of fever and dehydration were not adequately reassessed or followed up on to resolution. • The IPNs indicated contradictory information stating the individual was agitated and then stating in the same note he was in no distress. • There was a lack of recognition by nursing that some of his behaviors were indicative of changes in status. • No nursing assessments were conducted in response to these changes in status.	

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		• There was no indication that the physician was consistently notified of changes in status. • There was no indication that the PNMT was notified of changes in status. • No IPNs were found indicating that Individual #117 was being followed, assessed, or regularly monitored by the PMNT, when changes in status occurred. • No Nursing HMPs adequately addressed the individual's current health risks in alignment with the nursing protocols. A day after the onsite review of Individual #117, he was admitted to the hospital and sadly died later that day. A Death Review Investigation was conducted by Nursing Services and in spite of the critical deficits found regarding the care of this individual during the Monitoring Team's onsite review, the findings from the Facility's investigation only minimally noted a fraction of the problematic issues listed above. As a result, the needed systematic changes to prevent these problems from reoccurring likely will not occur. A review of an additional 12 individuals that were admitted to the Infirmary and/or hospital (i.e., Individual #64, Individual #304, Individual #286, Individual #273, Individual #144, Individual #155, Individual #175, Individual #266, Individual #130, Individual #308, Individual #239, and Individual #103) found similar problematic issues throughout the nursing documentation. More detailed information is provided with regard to the review of these individuals' records in the discussion about Section M.1. These consistent problematic findings did not support the Facility's report indicating that nursing protocols were actually implemented. Although CCSSLC indicated that they had implemented nursing protocols, there was no indication that nursing was actually using these protocols as part of a structured system guiding nursing practice and documentation to ensure that: ▪ Clinically appropriate nursing assessments were conducted for significant health issues and documented at the appropriate clinical frequency; ▪ Clinical baseline data was established to quickly recognize changes in health status; ▪ Timely communication occurred with practitioners/physicians or other disciplines regarding changes in status; ▪ Appropriate and clinically adequate care plans were developed that outlined specific nursing interventions for specific health issues; and ▪ Audits addressing nursing practice accurately reflected quality standards by which to measure the Facility's nursing care, and documentation.	

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		The findings from this review and the previous five reviews indicated that CCSSLC continued to fail to adequately and timely address the health care needs of the individuals residing at the Facility. The Facility indicated that it was not in compliance with this requirement. This was consistent 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.	In response to this requirement, CCSSLC's Self-Assessment indicated that since the last review, the following activities were implemented: ▪ As noted in Section I in more detail, revisions had been made to the At-Risk Individuals policy (in draft form at the time of the review). Some of the revisions included regrouping the Risk Guidelines so that the risk factors that were clinically inter-related regarding outcomes or provision of services and supports were listed together, linking each risk factor with specific clinical indicators, and reformatting the Integrated Risk Rating Form to follow the same grouping sequence as the Risk Guidelines. In addition, the Risk Action Plans for the identified high and medium risk indicators were replaced with Integrated Health Care Plans designed to provide a comprehensive plan that will be completed annually, supplemental forms regarding IRRF and the IHCP were developed addressing changes in status, the Aspiration Pneumonia Enteral Nutrition evaluation was revised to be used as a data collection tool rather than a format for assessments, and individual-specific Trigger Data Sheets were developed to include observable and measurable clinical signs and symptoms that alert the staff to possible changes in status. ▪ In May 2012, two teams from CCSSLC were trained on the "Enhanced Risk Process" described above. It was implemented at 524A and Porpoise in June 2012. Since the system had only been recently implemented at the time of the onsite review, the Monitoring Team was not able to adequately assess any progress made from the system's revisions. ▪ Also, since the last review, the Facility had implemented a promising monitoring tool with instructions for Section I. However, the data presented in the Facility's Self-Assessment for Section M.5 could not be interpreted, because there was no description included regarding what the compliance scores represented, how the samples were selected, and what the target population was of the sampling pool. In addition, the Facility indicated that because no individuals were diagnosed with Aspiration Pneumonia since January 2012, no audits for Acute Illness and Injury were conducted for this health issue. Unfortunately, only using a specific diagnosis as the criterion for conducting audits will result in the Facility missing critical clinical information. According to the lists the Facility provided, since January 2012, a number of individuals with significant health risks experienced repeated admissions to the Infirmary and hospital. ▪ A review of the Section O PNMT/Administrative Meeting minutes, dated April 16, 2012, indicated that members of the PNMT found that nursing was not	Noncompliance

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		obtaining weights, especially weekly weights for individuals who were at high risk for weight issues. Interestingly, from all the data provided in the Provision Action Information for Section M.5, the data from February through May 2012 regarding weights was clearly identified and presented, and indicated that nursing was not obtaining and documenting weights even based on a small sample of eight audits conducted each month. Had this data been timely reviewed and analyzed by nursing, a plan of action could have been developed and implemented at the time the issue was discovered. However, of great concern was that the Facility's data for May 2012 indicated that weights continued not to be obtained and documented. It was not until during its review, the Monitoring Team requested a copy of any related action plans that the Facility developed a plan of action to address this crucial deficit. ▪ In addition, the Section O PNMT/Administrative Meeting minutes, dated April 16, 2012, indicated that the Facility had significant problems regarding the lack of attendance by the individuals' team members at the PMNT Follow-Up meetings to allow them to receive status updates. In addition, issues noted related to inadequate cleaning of the environment were being associated with possible respiratory and infection control health issues. Although the minutes of the meeting indicated that a number of questions needed to be explored regarding these issues, and Plans of Actions addressing these issues were included, no additional documentation was provided indicating the current status of these issues. Allowing almost two months to pass without any documented following-up regarding problematic issues affecting the health of a number of individuals with health risks was very concerning especially since the Monitoring Team's review continued to identify significant problems regarding individuals at risk. Moreover, the Facility had identified none of these issues in its Self-Assessment or Action Plans. Regarding the Facility's self-rating, the Facility indicated that: "Based on the findings from this self-assessment, this provision is not in substantial compliance because we need to continue to train as concerns are identified and develop corrective action plans." Although the CNE reported that the Comprehensive Nursing Assessment form continued being used for the quarterly and annual nursing assessments, and that they addressed the at-risk individuals' health indicators, the findings from the Monitoring Team noted below indicated the quarterly and annual Comprehensive Nursing Assessments reviewed did not adequately address the risk issues. This was consistent with the findings from past reviews. A review of records for 27 individuals determined to be at risk (i.e., Individual #144, Individual #183, Individual #278, Individual #9, Individual #282, Individual #378,	

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		Individual #213, Individual #327, Individual #91, Individual #221, Individual #34, Individual #210, Individual #153, Individual #211, Individual #38, Individual #182, Individual #8, Individual #44, Individual #224, Individual #276, Individual #10, Individual #138, Individual #297, Individual #350, Individual #268, Individual #26, and Individual #95), found that none (0%) included adequate nursing risk assessments. A review of the most current quarterly or annual Comprehensive Nursing Assessments for the above 27 individuals found that none of them (0%) contained an adequate assessments of the specific high-risk health indicators or provided any type of analysis of the high-risk health indicators in the Summary Section of the Comprehensive Nursing Assessment form. In fact, the Comprehensive Nursing Assessments the Monitoring Team reviewed were noted to have regressed since the previous review. This was due to some of the nursing assessments not reflecting the correct risk rating, and some nursing assessment did not even include all the specific health risk indicators in the Summary Section, especially regarding high risks for dental issues. As noted from the previous five reviews, nursing had no specific procedure in place to address the nursing assessment process and the analysis of the identified risk indicators. Based on some of the problematic issues noted above regarding missing or inaccurate risk ratings, it was clear that some of the Case Managers completing the Comprehensive Nursing Assessments were using past quarterly or annual information without providing any type of update and analysis regarding the current status of the health risk indicators. Consistent with the findings from past reviews, the nursing assessments for the At-Risk individuals were not adequate to address the health risks of the individuals reviewed. A review of these 27 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. Although noted improvements had been made in many of the categories on the Risk Rating forms completed by other disciplines, some of the areas that nursing was responsible for assessing and/or providing information, such as for constipation and dates of injuries/fractures, a decrease in the individual-specific information included in these areas was noted from the previous review. In addition, a review of some the Integrated Risk Rating forms that included dates of revisions found that the health indicator categories that contained deficits in individual-specific information remained unchanged. In addition, a review of 27 records for individuals determined to be at risk (i.e., Individual #144, Individual #183, Individual #278, Individual #9, Individual #282, Individual #378, Individual #213, Individual #327, Individual #91, Individual #221, Individual #34, Individual #210, Individual #153, Individual #211, Individual #38, Individual #182, Individual #8, Individual #44, Individual #224, Individual #276, Individual #10, Individual #138, Individual #297, Individual #350, Individual #268,	

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		Individual #26, and Individual #95), there was documentation that the Facility: ▪ Established an appropriate plan within fourteen days of the plan's finalization, for each individual, as appropriate, in none of the cases reviewed (0%). ▪ Implemented a plan within fourteen days of the plan's finalization for each individual, as appropriate in none (0%) of the cases reviewed. Although the Action Plans included a date of implementation, there was no supporting documentation verifying that the action steps contained in the plan had, in fact, been implemented. In addition, a number of the action steps were nonspecific and thus, impossible to verify. ▪ Implemented a plan that met the needs identified by the IDT assessment in none of these cases (0%). ▪ Included preventative interventions in the plan to minimize the condition of risk in none of the cases (0%). Although some generic interventions were found in some ISPs addressing, for example, the need for exercise or encourage fluids, that would have led to a preventative intervention, because these interventions were not written in measurable terms to allow them to be implemented and tracked, they did not result in compliance with this indicator. ▪ When the risk to the individual warranted, took immediate action in none of the cases (0%). ▪ Integrated the plans into the ISPs in three of the cases (11%). Individuals who had not had their Risk Action Plans integrated into their ISPs included: Individual #183, Individual #278, Individual #9, Individual #282, Individual #378, Individual #213, Individual #327, Individual #221, Individual #34, Individual #210, Individual #153, Individual #38, Individual #182, Individual #8, Individual #44, Individual #224, Individual #276, Individual #10, Individual #138, Individual #297, Individual #350, Individual #268, Individual #26, and Individual #95. ▪ None (0%) of the plans showed adequate integration between all of the appropriate disciplines, as dictated by the individual's needs. ▪ None of the plans (0%) had appropriate, functional, and measurable objectives incorporated into the ISP to allow the team to measure the efficacy of the plan. ▪ None of the plans (0%) included the specific clinical indicators to be monitored. ▪ The frequency of monitoring was included in the plans for none of the individuals (0%). Although the Action Plans contained a heading addressing "Monitoring Frequency," the frequency was noted generally as daily or weekly without the specific shift or day included to ensure accountability. From discussions with the Facility staff and the State Office Consultants, the draft revisions to the At-Risk Individuals Policy and the recent pilot project initiated regarding the At-Risk process has promising potential. However, the significant existing deficits in the current At-Risk system, especially regarding the nursing components of the system,	

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		such as the Comprehensive Nursing Assessments, the individual-specific information contained in the IRRFs from nursing, and the quality of the all the interventions contained in the Risk Action Plans need to be addressed regardless of the changes to the process. In addition, the Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals and provide training and mentoring addressing this area. At the time of the review, CCSSLC indicated that they were not in compliance with this requirement of the Settlement Agreement. This was consistent with the findings of the Monitoring Team.	
M6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall implement nursing procedures for the administration of medications in accordance with current, generally accepted professional standards of care and provide the necessary supervision and training to minimize medication errors. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	In response to this requirement, CCSSLC's Self-Assessment indicated that since the last review, activities addressing this provision included the following: ▪ The data presented in the Facility's Self-Assessment reflected "average overall monthly" scores for the Medication Administration Observations conducted. The Monitoring Team could not interpret these scores. As noted from discussions on site with the CNE and Nurse Educators regarding the determination of passing or failing a medication administration observation, since the items on the tool are not weighted according to priority and safety, single compliance percentages could easily reflect extremely high scores, yet the nurses observed could have inadequately performed a critical procedure, such as drawing up an exceedingly wrong dosage of insulin, which with the current procedure, would not be accurately reflected in the single compliance score for that particular medication observation. Thus, generating average scores for tools such as the Medication Administration Observation tool does not accurately reflect the strengths and weaknesses of the nursing practices regarding medication administration. However, the data from the Medication Administration Observation tool that was contained in the Presentation Book for Section M.6 for February through May 2012 appropriately listed the compliance scores by item for each month. This enabled the Monitoring Team and the Facility to have a clearer picture of specific areas that appeared to be stable from the consistently high compliance scores over the four-month timeframe, and other items that reflected variable compliance in need of further analysis and corrective action plans. The only missing information for this data was the number of observations that were conducted each month to accurately interpret the compliance scores and trends, and the established inter-rater reliability percentage range for the monitoring tool. ▪ In addition, by aggregating data from both the Self-Assessment and Provision Action Information, the Monitoring Team found some very valuable and relevant data regarding problematic concerns found during Medication Observations	Noncompliance

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		regarding the following areas, nurses reviewing the Physical Nutritional Management Plans (PMNPs) during medication administration, giving instructions to the direct support professionals regarding positioning and symptoms to watch for after medication administration according to the PMNP, cleaning of the pill crushers between individuals receiving medications, identifying specific assistive and positioning equipment being present and utilized, verbalizing the rationale between the medical diagnoses and the information contained in the PMNPs, giving water as ordered during medication pass, checking G-Tube placement prior to administration of medications, counting the controlled drugs prior to and after removal, storing medication properly, ensuring that individuals were in the proper position, and implementing individuals' programs for Self Administration of Medication (SAMs)during medication pass. Appropriately, the Facility indicated that any item found below 90% compliance on the Medication Observation Tool were to be addressed in the monthly Medication Administration meetings. Adequate supporting documentation was included in the Presentation Book for Section M.6 addressing a system for consistently implementing the SAMs, and minutes dated 4/17/2012 and 4/27/2012 clearly addressed methods to thicken medications. However, it would have been extremely helpful to the Monitoring Team had the minutes of the Medication Administration meetings addressing the problematic issues listed above been included in the Presentation Book to easily identify what actions were being taken in response to the Facility monitoring findings. ▪ The Self-Assessment contained additional positive data generated from the Nurse Educators' unannounced reviews conducted of the Medication Administration Records (MARs) to determine if all medication variances were being captured through nurses' self report. The Facility's data indicated that from January through June 2012, 327, 190, 266, 334, 220, and 100 MAR blanks were found from the reviews, respectively. Although there was noted to be a positive significant decrease in the number of MAR blanks found over time, there was no additional information explaining if the decrease was a result of the unannounced reviews, or if additional interventions had been implemented contributing to the decrease in blanks on the MARs. ▪ Although the data graph regarding Pharmacy Refill sheets and medication reconciliation contained in the Facility's Self-Assessment could not accurately be interpreted, information from the Pharmacist and CNE indicated that the Facility had reinitiated a structured system using the Pharmacy Refill Sheets to track the medications being brought to the buildings in an attempt to reconcile the number of medications that were being returned to the pharmacy without explanation. At the time of the review, the Pharmacist reported that this	

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		procedure had always been in place, however, it had not been consistently enforced or monitored until recently. An updated Protocol for Medication Cart Exchange, dated 2/15/12, was developed and training rosters provided indicated that 99% of all nurses received training regarding the protocol by March 2012. Although the Pharmacist reported that he did have some data regarding the number of unexplained returned medications, he also noted that these numbers were not reliable across campus as of yet. ▪ In another positive step forward, the Facility indicated that since the last review, the Pharmacy Director, Habilitations Director, and Medical and Nursing Departments had been working to ensure that the MARs and the Physicians' Orders included consistent instructions regarding altered textured diets in alignment with the proper consistencies for medication administration. Regarding the Facility's compliance rating, they indicated that: *"*Based on the findings from this self-assessment, this provision is not in substantial compliance because the review of the Medication HMTs, MARs reviews, and Medication Error reports data shows that CCSSLC needs to continue to train as concerns are identified and develop corrective action plans*."* Although there were some indications from the minutes of the meetings reviewed that the Facility was making attempts to move forward regarding the medication administration system, the overall format of the Pharmacy & Therapeutics Committee Meeting minutes lacked specific content in order to determine precisely what issues were discussed. In addition, it was not clear from the minutes what specific actions were being taken, when they were implemented, and how effective they were in addressing the problematic issues. Including these components in the minutes would significantly enhance the content, close the loop on issues that actually have been resolved, and indicate what issues continue to need interventions. Since the previous review, the CCSSLC continued to have significant problematic issues regarding its overall medication administration system. From review of the Medication Variance Committee meeting minutes, the Pharmacy and Therapeutics Committee meeting minutes, the medication variance data, and discussions with Nursing Department staff and the Clinical Pharmacist, the following were some of the problematic issues identified: ▪ The Facility continued to have problematic issues regarding a number of unexplained medications that were being returned to the Pharmacy each month. These could be reflective of medication variances. Although at the time of the review, the procedure for exchanging the medication cart was being enforced and tracked, the Facility candidly reported that the data regarding this issue	

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		remained unreliable. ▪ Medication variances regarding the pharmacy and the pharmacy technician variances addressing the wrong dose, wrong drug, wrong quantity, missing medication, and wrong person had not yet begun to be tracked, despite initial attempts made by the pharmacy. ▪ Medication variances regarding prescriber variances addressing medication prescribed in the presence of an established allergy, wrong dose, and medication prescribed in the presence of current drugs with the same therapeutic purpose had not yet been tracked. ▪ A review of the raw data for the Medication Administration Observation tools that were completed since the last review found that although there were a number of problematic issues found as noted above, these reviews essentially found no issues regarding the documentation of medication administration. These findings were difficult to explain given that the unannounced MAR reviews as well as the number of known omissions reported by the Facility in the variance data indicated that documentation issues clearly existed. ▪ The minutes of the Medication Committee, dated 1/5/12, indicated that the Pharmacy and Nursing Departments counted omissions differently. There was no indication if this issue had been reconciled to ensure consistent medication variance information. ▪ A review of the minutes of the Medication Committee indicated that there were medication variances involving the wrong time, wrong dose, and the wrong individual that were not reported in the medication variance report provided by the Facility. Consequently, all the medication variance data provided by the Facility was unreliable. This also indicated that the Facility was totally unaware of the actual variances that were occurring at the time of the review, which had the potential to affect the health and safety of the individuals at CCSSLC. ▪ From discussions with the Pharmacist and review of the Medication Committee Meeting minutes, the Facility had discovered that doses of Calcitonin had not been administered as ordered prompting the pharmacy to create a dispensing log to track its use and only dispense enough for 35 days to track reorders. A review of the medication variances reported by the Facility indicated the following: ▪ January 2012 - 289 omissions; ▪ February - 190 omissions; ▪ March - 334 omissions; ▪ April - 220 omissions; and ▪ May - 220 omissions. However, it was unclear from the Medication Errors Month Summary report what	

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		exactly these numbers represented since they were all marked as omissions. Thus, the Monitoring Team could not determine if MAR blanks and/or unexplained returned medications were included in the variances numbers. From the number of omissions recorded, and the discrepancies regarding actual medication variances reported in the minutes of the Medication Committee Meetings, the fact that there were no variances listed for the wrong medication, wrong dose, wrong individual, wrong time, or wrong form/route indicated as noted in past reports, that CCSSLC continued to have a significant problem regarding the under-reporting of medication variances as well as unreliable variance data. Based on observations of medication administration at the Infirmary, the following problematic issues were found: ▪ The Facility had implemented a very promising procedure of having the medication nurse read the PNMP instructions to the individuals receiving medications to ensure the individual was provided information about the procedure and the nurse was aware of the procedure. However, while reading the PNMP instructions about administering medication to an individual in a wheelchair to an individual who had sustained a recent fracture and thus, was not able to get into her wheelchair, the Infirmary nurse proceeded to administer the medications without recognizing that the PNMP instructions no longer were applicable to the individual. The PNMT should have been called to reassess positions for safe medication administration. Unfortunately, this very promising procedure implemented in May 21012 quickly became more task-oriented rather than clinically oriented; ▪ The nurse did not provide education to the individuals regarding the medications that they were receiving; and ▪ The nurse did not perform an assessment for pain in response to an individual's request for pain medication. Based on the problematic issues observed during medication administration at CCSSLC, the Facility should continue to develop and implement a system to ensure that prior to nurses providing care to individuals with a PNMP, and that they are provided competency-based training regarding the PNMPs, and understand the clinical rationale for the instructions contained on the PNMPs. In addition, training should be provided to all nurses that are designated as auditors for medication administration observations regarding how to appropriately assess compliance regarding positioning and other medication administration interventions, including following the instructions in the PNMPs. Although the Facility had initiated some positive steps to review some of the elements of	

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		the medication administration system, there continued to be a number of significant problematic issues regarding the medication administration systems at CCSSLC. The Facility should aggressively continue its efforts to critically review all aspects of the medication administration system in order to accurately identify problematic areas, and implement plans of actions aimed at long-term resolutions. The Facility also should continue to develop and implement strategies to increase the reliability of the medication variance data, and reconcile discrepancies regarding the actual variances that have occurred. In addition, further collaboration should occur between the Pharmacy, Nursing, and the Medical Departments in constructing a solid process that results in a critical review of the overall medication system. The Facility indicated that it was not in compliance with the elements of this requirement. This was consistent with the Monitoring Team's findings.	

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

1. The Facility should consider adopting a standardized format for presenting data in a meaningful way that facilitates its interpretation and analysis, and provide training to the disciplines regarding how to analyze their data to identify problematic trends. (Section M.1)
2. As CCSSLC policies are reviewed and/or revised, the Facility should ensure that policies, procedures, or protocols address the integration of any new positions, such as the Nursing Administration Coordinator position and the Nurse Case Manager Supervisor position. (Section M.1)
3. The Facility should continue to implement and expand the use of nursing protocols to guide nursing practices. In order to ensure this occurs, mentoring of nurses should be offered in conjunction with the adequate competency-based nursing skills training being provided by the State Office Nurse Practitioner Group. Due to the number of individuals with complex medical needs at CCSSLC, this area should be considered a priority for Facility review, and the development and implementation of action plans addressing the significant deficits that exist in the nursing care. (Section M.1)
4. The Facility should ensure that documents are available, and filed in a timely manner in the individuals' records, so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services. (Section M.1)
5. Competency-based training should be expanded and documented for the new Assistant Infection Control Nurse in order to ensure competency in this specific clinical area. (Section M.1)
6. The Facility should develop a written procedure that outlines CCSSLC's process to ensure the IC data are reliable, and it should be included in the Facility's Infection Control Manual. (Section M.1)
7. The Facility should consider formalizing regular reviews of the Infection Control Discrepancy Reports with the Case Managers regarding pertinent missing IC information found on the weekly Infection Control Reports. (Section M.1)
8. The Facility should analyze all monitoring data addressing Infection Control in order to better identify systematic and/or staff–related problematic trends that might be impacting the rates of infections at the Facility. (Section M.1)
9. A formalized schedule should be developed clearly indicating which individuals' immunization status and immunizations have been researched and confirmed or updated to ensure all individuals have received all the required immunizations as outlined in the Health Care Guidelines. (Section M.1)
10. The findings of the Infection Control Environmental Checklists should be trended and analyzed in conjunction with other Infection Control data

to determine if a correlation between the problematic environmental issues and rates of infections exist, and this information should be included in the minutes of the Infection Control Committee meetings. (Section M.1)

11. As recommended in past reports, additional expertise in Infection Control is needed to assist in implementing systems to effectively operationalize the Infection Control program in alignment with IC standards of practice, as defined in the Health Care Guidelines and the Settlement Agreement. Such expertise also should be used to obtain professional feedback regarding the quality and completeness of the Infection Control Program. (Section M.1)
12. The Facility in conjunction with the State Office should clarify the role of Risk Management and the role of the clinical staff regarding the review of Emergency Mock Code Drill data and data addressing the actual medical emergencies that have occurred. (Section M.1)
13. Regarding the data addressing Emergency Mock Drills, the Facility should conduct analyses and generate associated plans of correction, especially in light of some of the low pass percentages of the drills conducted from January through June 2012. (Section M.1)
14. As previously recommended, the Facility should expand its emergency drills to include a variety of scenarios so that the emergency drills are more reflective of emergencies that warrant actions in addition to CPR. (Section M.1)
15. The Facility should provide appropriate competency-based training regarding the Quarterly/Annual Comprehensive Nursing Assessments from a competent source to ensure that the nursing assessments include an adequate clinical analysis of the individuals' progress. (Section M.2)
16. CCSSLC should review and revise its current nursing discharge/transition procedures and documentation requirements to ensure that upon an individual's transition from the Facility to the community, the nursing documentation is specific and detailed enough to maintain continuity of care. (Section M.2)
17. The Facility should consider expanding the system for tracking the dates when an acute nursing care plan was developed and placed in the Active Record and when it was resolved to include a format for monitoring the actual implementation of nursing interventions in alignment with the nursing protocols contained in the acute care plans. (Section M.3)
18. Regarding the Facility's transition to the use of an Integrated Health Care Plan, the Facility should develop and implement a plan addressing how nursing interventions for certain chronic conditions that do not rise to the level of a high or medium risk or are not acute issues would be accounted for in a plan of care. (Section M.3)
19. The Facility should develop and implement appropriate care plans based on priority, and risk for all individuals at CCSSLC, especially while the Facility is in process of transitioning to an Integrated Health Care Plan. (Section M.3)
20. Nursing, in conjunction with the Infection Control Nurse should develop and implement a system to ensure that the care plans addressing infectious and communicable diseases are clinically adequate, individualized, and are being implemented consistently. (Section M.3)
21. The Facility should give thoughtful and serious consideration to how to incorporate an individual's health risks into one plan without compromising the At-Risk system or the clinical needs of the individual. (Section M.3)
22. Although the draft revisions to the At-Risk Individuals Policy and the recent pilot project initiated regarding the At-Risk process is promising, the significant existing deficits in the current At-Risk system, especially regarding the nursing components of the system, such as the Comprehensive Nursing Assessments, the individual-specific information contained in the Integrated Risk Rating Forms from nursing, and the quality of the interventions contained in the Risk Action Plans should be addressed regardless of the changes to the process. (Section M.5)
23. The Facility, in conjunction with the State, should specifically define the nursing assessment process regarding at-risk individuals and provide training and mentoring addressing this area. (Section M.5)
24. The Facility should expand its efforts to ensure that prior to nurses providing care to individuals with a Physical Nutritional Management Plans, they are provided competency-based training regarding the Physical Nutritional Management Plans, and understand the clinical rationale for the instructions contained on the Physical Nutritional Management Plans. (Section M.6)
25. Training should be provided to all nurses that are designated as auditors for medication administration observations regarding how to appropriately assess compliance regarding positioning and other medication administration interventions, including following the instructions in the Physical Nutritional Management Plans. (Section M.6)

26. The Facility should expand its efforts to critically review all aspects of the medication administration system in order to accurately identify problematic areas, and implement plans of actions aimed at long-term resolutions. (Section M.6)
27. The Facility should also expand its strategies to increase the reliability of the medication variance data, and reconcile discrepancies regarding the actual variances that have occurred. (Section M.6)
28. Further collaboration should occur between the Pharmacy, Nursing, and the Medical Departments in constructing a solid process that results in a critical review of the overall medication system. (Section M.6)

SECTION N: Pharmacy Services and Safe Medication Practices	
Each Facility shall develop and implement policies and procedures providing for adequate and appropriate pharmacy services, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Policies, and procedures addressing the provision of pharmacy services; o Pharmacy surveys completed within the last year, plans of correction and/or internal auditing procedures and reports related to pharmacy services; o All Drug Utilization Evaluation (DUE) reports completed since the Monitoring Team's last review (including background information, data collection forms utilized, results, any minutes reflecting action steps based on the results); o Any follow–up studies completed for any prior DUE reports; o Minutes of Pharmacy and Therapeutics (P&T) Committee meetings and any attachments since the Monitoring Team's last visit; o Minutes of any committee addressing polypharmacy for non-psychotropic medications; o Minutes of any committee addressing medication error/variance since the Monitoring Team's last visit; o Minutes of the committee addressing seizures with any attachments, since the Monitoring Team's last visit; o DUE calendar for next 12 months; o For Quarterly Drug Regimen Reviews, for all individuals the Facility services, a listing of the individuals, their review periods, the dates in which reviews must be completed, and the dates on which reviews are actually completed for the last one year period (beginning 1/1/12); o For Quarterly Drug Regimen Reviews, the two most recent per residential home that have been completed with physician signatures and date, including those for: Individual #26, dated 3/22/12; Individual #15, dated 5/14/12; Individual #334, dated 5/2/12; Individual #182, dated 4/12/12; Individual #184, dated 4/4/12; Individual #76, dated 4/20/12; Individual #260, dated 5/14/12; Individual #168, dated 4/26/12; Individual #296, dated 3/21/12; Individual #311, dated 4/4/12; Individual #218, dated 3/7/12; Individual #340, dated 5/14/12; Individual #21, dated 5/14/12; Individual #194, dated 3/5/12; Individual #9, dated 4/25/12; Individual #174, dated 3/9/12; Individual #8, dated 4/9/12; Individual #369, dated 3/23/12; Individual #264, dated 3/1/12; Individual #348, dated 3/22/12; Individual #367, dated 4/23/12; Individual #328, dated 5/9/12; Individual #34, dated 4/16/12; Individual #112, dated 3/23/12; Individual #293, dated 5/9/12; Individual #187, dated 4/3/12; Individual #290, dated 5/9/12; and Individual #156, dated 4/13/12; o For 10 most recent QDRRs in which recommendations were made and accepted, copies of physician orders; for 10 most recent QDRRs in which recommendations were made and not accepted, copy of IPN or other entry indicating reason for non-agreement, including those for: Individual #48, dated 1/27/12; Individual #182, dated 2/9/12; Individual #184, dated 1/20/12; Individual #186, dated 1/10/12; Individual #343, dated 2/6/12;

	Individual #341, dated 3/7/12; Individual #174, dated 3/9/12; Individual #246, dated 3/8/12; Individual #62, dated 3/5/12; Individual #280, dated 2/23/12; Individual #20, dated 3/9/12; Individual #335, dated 1/12/12; Individual #307, dated 2/17/12; Individual #28, dated 2/17/12; Individual #46, dated 1/27/12; Individual #88, dated 3/1/12; Individual #34, dated 2/6/12; Individual #291, dated 1/31/12; and Individual #195, dated 2/23/12; o All "single patient intervention reports" in WORx system since the Monitoring Team's last review; o Since the last review, copy of any internal Pharmacy Department audits/monitoring data to review Section N of the Settlement Agreement (i.e., pharmacist review and placement of new orders in WORx system); o Copy of all "notes extracts" associated with "single patient intervention reports;" o For the past six months, any adverse drug reaction reports (ADR) completed; o Policies and/or procedures regarding medication error/variance, including prescription, dispensing, administration, documentation and potential errors; o Number of medication errors variances per month for prior 12 months by error type, nurse, home, shift, unit, individual, category of severity, error mode, as well as analysis reports, including corrective action plans, and root cause analysis summaries; o Last 10 medication error forms completed and any plans of correction arising from review of the medication errors; o Communication between pharmacy and Nursing Department concerning medication errors/variance (emails, memos, etc.) since the Monitoring Team's last visit; o For the past two months, reports and/or summaries of any medication administration observations conducted; o Policies, procedures and/or other documents addressing medication administration; o List of Antibiograms per months for last six months by building; o Medication history for individuals with J- or Gastrostomy/Jejunostomy (G/J) tubes; o A schedule of when Quarterly Drug Regimen Reviews are conducted by home/unit; o Polypharmacy risk assessment forms for past six months for five individuals most recently rated as being at high risk for polypharmacy, and five individuals rates as being at medium risk for polypharmacy; o All documentation for each emergency chemical restraint, including restraint checklist for: Individual #58 on1/5/12 0306hr; Individual #144 on 3/11/12 2300hr; Individual #246 on 4/14/12 2150hr, and 4/14/12 2315hr; Individual #7 on 1/7/12 0350hr, and 1/7/12 0450hr; and Individual #253 on 3/4/12 1720hr, 4/10/12 1209hr, and 5/17/12 1240hr; o Trend analysis of chemical restraint use (graphs, etc.); o For each database maintained on use of chemical restraints, summary list(s) of all chemical restraints administered over the last six months; o For 10 orders involving drug-drug interactions, copies of serial computer screen shots for each step; o For five orders involving potential allergic reactions for new orders, copies of serial computer screen shots for each step;

	○ For five orders involving drug dosages below or exceeding normally prescribed dosage regimens, copies of computer screen shots for each step; ○ For five new orders in which labs are reviewed/monitored, copies of serial computer screen shots for each step; ○ For five new orders for which there was potential for significant side effects, copies of serial computer screen shots for each step. Copy of written documentation/information provided to PCP and response of PCP; and ○ Presentation Book N for Section N. ▪ **Interviews with**: ○ Donald Kocian, RPH, Pharmacy Director; and ○ Sandy Suri, RPH. ▪ **Observations of**: ○ Pharmacy and Therapeutics Committee meeting, on 7/9/12.
	Facility Self-Assessment: In general, the Facility had engaged in some reasonable activities to conduct its self-assessment of Section N. For example, the Pharmacy Department monitored new orders by sampling 20 per month for the requirements of the Settlement Agreement. The Facility included a review of whether or not significant interactions and side effects were addressed, allergies were checked, lab monitoring was addressed, and dose, duration, and frequency were reviewed. However, the Pharmacy Department's analysis of the data for new orders addressing such areas as drug drug interactions, allergies, etc. did not agree with the findings of the Monitoring Team. This might indicate a lack of sensitivity of the monitoring tool developed by the Pharmacy Department, but also the lack of completeness of the submitted information, as the Pharmacy Department appeared to have additional information for analysis that was not submitted as part of the data review. The Facility reviewed QDDRs for a number of parameters, including timely completion, laboratory review within QDRRs, and monitoring of atypical antipsychotics, benzodiazepines, anticholinergics, polypharmacy, metabolic and endocrine risks, and for laboratory monitoring and therapeutic drug levels. Review by the Monitoring Team found that different compliance rates for most of these indicators than the Facility. The Monitoring Team's findings agreed with the laboratory review, but disagreed in most other areas of QDRR monitoring. In general, there were some problems with the accuracy of the Facility's findings. The internal monitoring tools did not appear to capture the concerns the Monitoring Team identified with regard to Sections N.1 through N.4. In conducting its self-assessment process, the Pharmacy Department utilized the draft of a revised "Texas Health Monitoring Instrument: Pharmacy Services and Safe Medication Practices." This incorporated aspects of the HealthCare Guidelines and the Settlement Agreement for new orders (Section N.1), QDRRs (Sections N.2, N.3, N.4), tardive dyskinesia monitoring if appropriate (Section N.5), review of ADRs (Section N.6), interpretation of DUE data by P&T Committee (Section N.7), and systematic tracking, analysis, and action steps for medication variances (Section N.8). From the submitted information, two active records

	were reviewed, dated 3/29/12, completed by the Pharmacy Director. On 4/29/12, both the Pharmacy Director and the QA RN reviewed one record. An additional record was reviewed by the Pharmacy Director on 4/29/12, but not reviewed by the QA RN. The Pharmacy Director on 5/17/12 reviewed a 4th record. For the one record reviewed by both the Pharmacy Director and the QA RN, inter-rater reliability information was summarized. The new monitoring tool included 19 questions, of which there was agreement on 11 of the answers, for a percent agreement of 58%. Each question for which there was a discrepancy in the answer was also provided. This breakdown of discrepancy by question should be used by the Pharmacy Department in developing guidelines/instructions for interpretation of the monitoring tool, or identification of where to find the required information in answering the question, in order to improve the inter-rater reliability. As QA staff only reviewed one record, it is recommended that several more records be reviewed to determine areas of continued non-agreement that would potentially require further written guidance or training before finalizing the formal process. Compliance by auditor (pharmacist, QA RN) was also submitted in graph form. This appeared to be a piloting of the process. The pharmacy will need to determine the sampling method and sample size to be reviewed each month in order to make the results meaningful. This is discussed in further detail in some of the subsections below. The Pharmacy Department completed two Facility Support Services, HHSC documents: "Facility Support Performance Indicator: Pharmacy Controls 1st Quarter FY 2012," and "Facility Support Performance Indicator: Medication Room Controls 1st Quarter, FY 2012." The information reviewed indicated there were no deficiencies or conditions identified, and no plans of correction were implemented based on the self-reviews. In its Self-Assessment, the Facility determined it was compliant with Sections N.1 (per the narrative), N.2, N.5, and N.7. The Monitoring Team's findings showed the Facility was compliant with Sections N.5 and N.7.
	Summary of Monitor's Assessment: The Pharmacy Department had made considerable progress in providing structure and implementing internal monitoring processes. For example, ensuring an individual's allergies are consistent in all documents across campus was an important endeavor. Improvements in screening for medication that should not be given by J-tube also had been implemented. The DUE program was strong, and the follow-up reviews indicated a positive impact on the practice patterns of the PCPs and on the quality of care of the individuals. However, considerable challenges remained. Timeliness of completion of the QDRR remained problematic, and a resubmission of "corrected" data remained incomplete. It did appear timeliness of QDRRs had improved, but lack of adequate statistical data became an obstacle in verifying this. Patient interventions were categorized, but the choice of categories appeared to require a decision tree or other structure to provide consistent choice among pharmacists. Chemical restraint review remained a challenge in both obtaining the review form in a timely manner and in ensuring the Behavior Services Department's list of chemical restraints agreed with the Pharmacist's list of chemical restraints. In addition, adequate completion of the chemical restraint form was a continuing problem.

	Although a number of steps had been taken to reduce medication errors of administrative omissions [i.e., blanks in the medication administration record (MAR) for which the medication was administered] and true admissions, much work was needed on the numbers and reasons of returned medication. There was a paucity of statistical review for medication variances for pharmacy, nursing, and medical. A quarterly report of medication variances would be important to provide guidance to the Pharmacy Department in relation to follow-up interventions, as well as in educating the Facility Administration concerning the challenges of this area. Concerning adverse drug reaction (ADRs), nurses had been trained as well as the two dentists and four PCPs. As of 6/25/12, no ADRs had gone through the protocol/process. More recently, three potential ADRs were identified, but the Facility was in process of determining if they met the criteria of ADRs.

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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.	The Pharmacy Department staffing included the following: a Pharmacy Director, two additional registered pharmacists, and two pharmacy technicians. A list of those completing CPR certification was submitted, dated 4/1/12. Three of three pharmacists were current in CPR certification at the time the list was submitted. The Monitoring Team provides this information for the Facility's information, but is not related to compliance. The Pharmacy Department submitted a copy of the current departmental policies/procedures/protocols. These included: ▪ DADS SSLC Policy: Pharmacy Services #011, including Exhibit A: Procedures, Exhibit B: Required Facility Procedures, Exhibit C: Identifying Unusable Drugs, effective 9/26/11; ▪ Pharmacy Services and Safe Mediation Practices: o N.1. Pharmacist Review of New Medication Orders, implemented 11/23/09; o N.2. Quarterly Drug Regimen Review, implemented with QDRR form 4/7/11; o N.3. Prescriber Medication Order Policy, implemented 4/6/11; o N.4. Poly-pharmacy Definition Non-Psychotropic Medications, implemented 7/22/09; o N.5. Poly-pharmacy Definition – Psychotropic Medications, implemented 7/22/09; o N.6. Adverse Drug Reaction Policy, implemented 5/1/11, with reporting form, and presentation "Adverse Drug Reaction (ADR)"; o N.7. Drug Utilization Evaluation Policy, implemented 4/6/11; o N.8. Pharmacy Medication Error Reporting Policy, implemented 6/2/10;	Noncompliance

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		o N.9. Prescriber Notification Documentation, implemented 3/3/10; and o N.10. Purchase of After Hours Emergency Medications, implemented 3/1/09, with copy of letter of agreement. It was noted that none of the policies were newly created or implemented. However, the Monitoring Team had not previously reviewed the ADR PowerPoint, and or Policy N.10. "Patient intervention" entries for new orders entered into the WORx software program were submitted for review, including 96 entries. The following lists the number of patient intervention entries generated per month. For June 2012, the available information was tabulated from the original submitted information, and did not represent the entire month: January 2012 – 13, February 2012 – 34, March 2012 – 18, April 2012 – 13, May 2012 - 16, and June 2012 – two to date. Interventions were broken down into several different categories. There appeared to be a large number of categories from which to choose with potential overlap, and there might have been inconsistency in how the category was chosen. The following summarizes the categories and numbers of patient interventions for each category: Adverse drug reaction – 12; Interaction/Compatibility Intervention - 24, Order Clarification /Confirmation - 11, Patient Care – one, Pharmacokinetic Consultation - one, Therapeutic Consultation – four, Activities – five, Allergy/Disease State Contraindication - nine, Antibiotic Regimen Change – four, Drug Information – five, Duplicate/Unnecessary Therapy - eight, uncategorized – two, and insufficient information for categorization - 10. It was not clear the purpose of the categorization. It is recommended that this aspect of the data entry for new orders be reviewed for consistency. The Pharmacy Department might need to determine the usefulness of the various categories in determining potential impact on systems improvement. As part of the Presentation Book for Section N, the pharmacy submitted "Drug Interaction Alerts," which occurred per month, according to individual. It is recommended that this tool be considered as a QA review for the PCPs and as a learning tool for the Medical Department. This would provide information to the PCP on the drug alerts for each individual based on their medication regimen, allergies, etc. It also would have the potential to provide feedback to the pharmacy concerning which alerts are not clinically important for that individual and which continue to be a valuable communication. The pharmacy also provided a system of alerts for medications that should not be administered through a J-tube. This included bright multi-colored warning stickers, addition of the phrase "see J tube instructions" on the MAR of those with J tubes, and a note alert in the WORx software program for new orders. The Facility submitted a copy of medication histories for those individuals with J or G/J	

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		tubes. Five individuals' records were submitted with recent medication histories. None had medications prescribed and administered which were inappropriate via a J-tube. This preliminary information indicated the system appeared to be working and would provide a valuable safeguard in the new order system. The Pharmacy had continued to review all allergies that were listed on all documents of the individuals, so that there was consistency across the system. For important information that was not an allergy, the Pharmacy also had added this information to the physician orders for that individual. One such instance was for Individual #296, in which the allergies listed on the physician order sheet include the following important details: "Allergies: NKDA [no known drug allergies]. Dental records show cannot be given Hydroxyzine with Lorazepam due to paradoxical reaction. Tolerates Lorazepam without incident." A sample of new prescriptions was reviewed. The following summarize the results: ▪ Eleven new orders were submitted in which the pharmacy found concerns with drug –drug interactions with the current drug regimen. For 10 out of 11 (91%), there was documentation submitted of communication between the Pharmacy and PCP (eight handwritten entries, and two patient interventions). A handout was provided to the PCP in seven of 11 (64%). A change in the order occurred in four orders, no change in six orders (no evidence of change was submitted in four, and the order did not appear to indicate the need for further intervention in two), and incomplete information was submitted for one. ▪ Five new orders were submitted in which allergies were reviewed and determined by pharmacy to be a concern. A computer screen shot of the order was submitted for three out of five (60%). A copy of the patient intervention was submitted in none (0%). As a result of the Pharmacy review, there was a documented change in order for none of the five orders. There was confirmatory documentation of no change for three orders. There was insufficient information provided to determine whether an order change occurred in two orders. For one, the submitted document appeared to indicate it was not an order, but an update of campus documents. For one in which no change was made, the PCP disagreed and included a response that there was no allergy to the ordered medication, but there was no documentation of the evidence for this conclusion. For one, the submitted evidence was confusing, because the information also indicated "NKDA." Based on this information, adequate documentation of the new order process for allergies occurred in 0% of submitted cases. ▪ Five new orders were submitted in which side effects were reviewed by Pharmacy and determined to be a concern. A screen shot was submitted in two out of five (40%). Lab results were referenced in four orders, and labs were	

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		submitted for these four orders (100%). Labs were not applicable for one order. Printed information was sent to the PCP and submitted for review in four out of five (80%) of orders. A patient intervention note was submitted for two out of five (40%). Evidence of an order change was submitted in three (60%). In summary, for these five orders submitted, none (0%) had evidence of all the components of adequate documentation (i.e., screen shot, printed information, patient intervention note, etc.) concerning side effect review/collaboration with the PCP. ▪ Five new orders were submitted in which, current laboratory results and potential need for further testing were identified by pharmacy during initial review. New orders were written for two of the medications based on the communication with the PCP, and three orders had no change. Lab data was submitted in five (100%). Documentation was adequate in five (100%). ▪ Six new orders were submitted in which pharmacy had concerns about the potential need for dosage adjustments. For five of six, there was a copy of the screen shot order submitted. For three orders, there was documentation the PCP was contacted. For one order, the PCP was not contacted, and for two orders, it could not be determined based on the information provided whether the PCP was contacted. There was a patient intervention form provided for one of six (17%). A change of order based on pharmacy review and PCP contact occurred in one (17%). In summary, there was adequate documentation of the process in one (17%). The Pharmacy Department completed an internal QA review of new orders. A copy of the April 2012 and May 2012 reviews were submitted in the Presentation Book for Section N. The method of sampling used in the review was not identified. The monitoring tool was entitled "Checklist for Review of New Medication Orders." The review included validation that the order was placed with the correct individual; documented the correct PCP ordered the medication; reviewed for potential allergies; reviewed the appropriateness of the drug, including the indication, dose, dosage form, duration of therapy, administration time and frequency, and other instructions for administration and instructions for monitoring; reviewed compatibility with current medication regimen for significant interactions, therapeutic duplication, disease and contraindications; and notification of PCP if indicated. There were several documents attached to each review, based on the information source needed to verify safe dispensing practices. For those prescribed a medication for which there was a history of allergy to a medication in the same class, there was documentation of prior use without sequelae, with dates of use for verification. The Facility had calculated compliance for new orders as 95% for each month (January 2012 through April 2012) and 100% for May 2012. It is essential to note that the Monitoring Team would have benefited from having been provided with the same information used by the pharmacy in determining	

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		compliance with new order dispensing. The rationale was not clear for not providing these same documents for the requests for new orders with allergy concerns, side effect concerns, etc. At least in part, the Monitoring Team's finding of noncompliance for this section appeared to be affected by the Facility not submitting the needed documents.	
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.	A schedule was submitted concerning the completion of QDRRs per residence/unit. Due dates were provided for the homes of each unit. This was further broken down into the time period of seven days prior to the due date and 14 days after the due date. The entire calendar year into March 2013 was provided, listing the individual and the four 90-day time periods for each QDRR for that individual. In preparation for the Monitoring Team's visit, a schedule of completed QDRRs was submitted for January 2012 through June 2012. Each of the prior QDRRs was reviewed for date of completion and compared to the current QDRR's date of completion. For the January through March 2012 quarter, 132 of 262 (50%) QDRRs were completed in a timely manner. For the April through June 2012 quarter, 162 of 262 (62%) current QDRRs were completed within the agreed upon time period based upon a due date of 90 days after the prior QDRR, with additional parameters established as a time period of seven days prior to the due date to 14 days after the due date. During the Monitoring Team's visit, the most recent quarter was reviewed and the information the Facility provided originally was determined to include misleading information. An updated list was submitted as part of the Presentation Book for Section N. There were 264 individuals on the list, but the second page of eleven pages was missing, providing information for 238 of the 264 individuals. Due to the lack of completeness in the re-submitted data, a full recalculation for compliance could not be done. However, based on a review of the incomplete information, compliance did appear to be much improved from the first quarter of 2012. To avoid problems such as this in the future, it is recommended that the Pharmacy Department and QA/QI Department review final data prior to submission for completeness and accuracy. A sample of 28 QDRRs was reviewed. These are listed above in the documents reviewed section. The following summarizes the results of this review: ▪ Sixteen (57%) were completed in a timely manner (i.e., within the window established for timeliness). ▪ Laboratory information was submitted as part of 27 out of 28 QDRRs (96%). These 27 had lab values recorded. ▪ The lab results did include exact values or indication of normal range for Vitamin D levels, complete blood counts (CBC), electrolytes, glucose, Hemoglobin (Hgb) A1C, lipid panel, hepatic function, ammonia level, thyroid function, as well as blood levels of specific medications (most commonly noted were antiepileptic	Noncompliance

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		drug levels with therapeutic ranges). ▪ Twenty-seven out of 27 QDRRs with labs (100%) had the date the lab was drawn. ▪ Abnormal values were listed under the notes/comments section line for that particular lab or in the recommendations section. Although based on incomplete data the Facility submitted, it appeared that the QDRRs were being completed in a more timely manner towards the end of the review period, record reviews showed this remained a problem. As a result, the Facility remained out of compliance with this provision.	
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 poly-pharmacy, 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. The Pharmacy Department had developed an internal QA QDRR assessment that included the components of Section N.3. Each month the Pharmacy Department reviewed approximately 20 completed QDRRs. It was noted that the scores appeared to indicate compliance in most areas of the QDRR, which was different than the Monitoring Team's review. The monitoring tool used internally did not identify the evidence used for verification of the various aspects of the QDRR. This suggested that the review was broad, but did not guide the reviewer to pursue the needed detailed information/documents to verify compliance with each aspect of Section N.3. <u>"Stat" Emergency Medications/Chemical Restraint Use</u> The Facility submitted completed Restraint Checklist and Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint forms for nine chemical restraints used from 1/5/12 to 5/17/12. These are listed above in the documents reviewed section. The chemical restraint documentation indicated that five individuals had nine chemical restraints from January 2012 through May 2012. For the nine chemical restraints, the pharmacy sections were reviewed for adequacy of completion and compliance. The following summarizes the review of these documents: ▪ Of the nine chemical restraint forms, five forms (56%) included information concerning the justification of use due to the behavior. ▪ Effectiveness of the chemical restraint was documented in eight out of the nine chemical restraint forms completed (89%). Of the nine chemical restraints, five	Noncompliance

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		were considered effective and four were considered ineffective. ▪ A discussion of side effects and adverse effects were noted in seven of nine of the completed chemical restraint forms (78%). ▪ A discussion of drug/drug interactions was noted in seven of nine (78%) of the completed chemical restraint forms. ▪ There were two statements by pharmacy that were considered recommendations. Both involved changes in medication. ▪ The range of time for completion of the forms by the pharmacist was from one to 17 days. All but two were completed within six days. The route of medication was noted to be missing in one of the completed chemical restraint forms. It is recommended that dosage and route of medication be clearly indicated on these forms. The psychiatrist also had a designated space for completion on the Face-to-Face Assessment, Debriefing, and Reviews for Crisis Intervention Restraint. Review of these documented showed: ▪ Of the nine completed, there were three forms (33%) on which the psychiatry comment section was completed. ▪ For none of the chemical restraints used (0%), was there a description of the behaviors and prior steps taken by the IDT/psychologist. ▪ For one of the nine chemical restraints, clinical justification was recorded. ▪ Side effects were mentioned in none of the reviews (0%). ▪ Effectiveness was documented in none of the cases (0%). ▪ Information discussing the risks of drug-drug interactions, or other risks was addressed in none (0%). ▪ There were two recommendations documented. It is recommended that the State Office provide guidance regarding the content that psychiatrists are expected to document on the restraint form. Separately, trending of chemical restraints was provided in graph form. Databases of the Psychology Department and the Pharmacy Department were compared monthly from January 2012 through May 2012. There appeared to be a continued challenge in database management, because the two departments had somewhat different numbers of chemical restraints for March through May 2012. For the month of April 2012, the Pharmacy Department had recorded one more chemical restraint than the Psychology Department, and for March 2012 and May 2012, the Pharmacy Department recorded one less chemical restraint than documented in the Psychology Department database. The two departments are encouraged to continue to resolve discrepancies in information obtained for chemical restraints. <u>Polypharmacy</u>	

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		Of the 28 QDRRs reviewed, polypharmacy was noted in 14 reviews. ▪ Justification by diagnosis of each of the medications listed in the polypharmacy regimen was documented in 14 of 14 (100%). ▪ Clinical justification for the use of polypharmacy was addressed in eight of 14 (57%). Examples of justification could include the following: for multiple seizure medications, neurology clinic notes with date of visit confirming the continued need for the polypharmacy, or reference to polypharmacy committee minutes with a specific date, with comment by the pharmacy that there was sufficient information to justify polypharmacy (for instance, a prior reduction had resulted in increased seizures). Such brief entries would provide evidence for justification, and indicate that the pharmacist agreed that the evidence was sufficient for justification. ▪ Potential interactions with other drugs or food was reviewed in eight of 14 (57%) ▪ For seven of 14 (50%), the QDRRs reviewed whether monitoring/evaluation had occurred for effectiveness and appropriateness of the drug regimen. <u>Benzodiazepine Use</u> Benzodiazepine use was noted in four of the 28 QDRRs. ▪ Of these four, four (100%) documented justification with appropriate diagnoses; and ▪ One QDRR (25%) indicated whether side effects or other adverse risks were present. <u>Anticholinergic Monitoring</u> Of the 28 QDRRs, 17 (61%) were screened for medications associated with potential significant anticholinergic side effects and/or were identified as anticholinergic medications. The results of the review of the QDRRs are as follows: ▪ Ten of 17 (59%) documented clinical justification of the use of each of the medications contributing to anticholinergic load/effect (i.e., the clinical burden of the side effects was less than the benefit). ▪ Four of 17 (24%) QDRRs listed/addressed side effects/significant risks. <u>New Generation Antipsychotic Endocrine and Metabolic Side Effects</u> Out of the 28 QDRRs reviewed, 13 (46%) listed atypical antipsychotic medication. Of these, 12 of 13 (92%) included lab values that reviewed endocrine and metabolic risks (i.e., basic metabolic profile, glucose level, Hgb A1C, and/or lipid panel as appropriate). The Facility remained out of compliance with this provision. As noted above, improvement was needed in a number of areas.	

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N4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, treating medical practitioners shall consider the pharmacist's recommendations and, for any recommendations not followed, document in the individual's medical record a clinical justification why the recommendation is not followed.	The Pharmacy Department created a database to monitor timely response by PCPs and psychiatry to the QDRR recommendations. The Presentation Book for Section N included copies of the raw data, but the information was difficult to interpret. Several pages were handwritten notes from the Pharmacy. The Pharmacy is encouraged to formalize this database and provide quarterly analysis that can be used to track progress and identify opportunities for further improvement. Review of 28 QDRRs showed the following: ▪ Of the28, 28 QDRRs (100%) had the PCP signature. ▪ Of the 28, 28 (100%) had the date the PCP reviewed the document. ▪ There were 35 recommendations from the 28 QDRRs. ▪ For 10 of these QDRRs, there were no comments/recommendations that needed further action. There were 25 recommendations that needed further action. ▪ Evidence of PCP review of recommendations and agreement or disagreement with justification and plan was documented in 21 out of 25 (84%). o There was disagreement by the PCP for five QDRRs of the 25. For five of five (100%), a note of justification and plan (if indicated) was recorded on the QDRR. o For four recommendations/comments, the PCP deferred to psychiatry, o The PCP responded within 14 days of the QDRR being completed by pharmacy in 12 of the 28 (43%) QDRRs. ▪ Psychiatry reviewed the QDRR when there was polypharmacy due to psychotropic medication. A psychiatrist reviewed 16 QDRRs of 28 QDRRs, and agreement was documented in six of 16 (38%). ▪ Disagreement with justification and plan was documented in one out of 16 (6%). ▪ No recommendation was made and no response was documented in three of 16. ▪ The psychiatrist deferred to the PCP in six of 16. ▪ There was no check box of agreement or not for three of 16. ▪ The psychiatrist responded within 14 days of the QDRR being completed by pharmacy in three of 16 (19%) QDRRs. To determine if the recommendations that were agreed upon were actually acted upon, the Facility submitted 10 examples of QDRR recommendations for which there was agreement by the PCP with subsequent orders. These are listed above in the documents reviewed section. In the sample of 10, nine (90%) demonstrated that the PCP/psychiatrist acted upon the recommendation with an order. The Facility submitted nine examples of QDRR recommendations that were not followed, which are listed in the documents reviewed section. In nine cases (100%), the response/ rationale was written on the QDRR.	Noncompliance

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		The Facility remained out of compliance with Section N.4. Additional work was needed to ensure that PCPs as well as psychiatrists completed timely reviews of QDRRs.	
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	This provision of the Settlement Agreement mandates systemic, quarterly monitoring for the emergence of motor side effects related to the utilization of antipsychotic medication with, for example, the Dyskinesia Identification System: Condensed User Scale, and the monitoring of more general systemic side effects related to psychotropic medication with the Monitoring of Side Effects Scale every six months. An important component of this side effect monitoring also includes the latency between the time that the nurse completed the exam and the documentation was reviewed and signed by the prescribing physician. The review of the sample of the records of 20 individuals prescribed psychotropic medication indicated that the documentation that the MOSES evaluation was current (completed within the last six months) and had been performed at least every six months, was present for all of the individuals in this sample (100%). The records of the 20 individuals in the sample contained documentation that the prescribing physician had reviewed the MOSES evaluation in a timely manner for 18 of the 20 individuals (90%). The two individuals for whom the documentation of the review was inadequate were Individual #40 (missing second page with physician signature for 4/12/12 evaluation), and Individual #359 (missing second page with physician signature for 3/26/12). Thus, there was insufficient documentation to confirm that the MOSES evaluations were reviewed in a timely manner for these two individuals. The purpose of the DISCUS was to detect the emergence of motor side effects related to the use of antipsychotic medication. The review of the records of the sample of 20 individuals indicated that the DISCUS had been completed as specified for all of these individuals (100%). Those individuals whose records showed a significant delay between the date the nurse completed the DISCUS evaluation, and the prescribing physician reviewed and signed it were as follows: Individual #279 (5/11/11), no physician's signature); and Individual #359 (3/26/12), also missing physician's signature. Thus, these evaluations had been reviewed and signed in a timely manner for the remaining 18 individuals (90%). These results indicated significant progress, as compared to prior reviews. The date the MOSES and DISCUS evaluations were performed was recorded in the Psychiatric Quarterly Review documentation, including the results for each administration and whether or not any additional action was required. The presence of any significant side effects, as well as any action required, would be discussed in the section of this document that represented the Psychiatrist's narrative summary. Each	Substantial Compliance

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		Quarterly Review document contained the historical information for the prior year and was continuously updated. The DISCUS and MOSES also are necessary to monitor for the side effects of Reglan, which although prescribed for gastroesophageal reflux disease (GERD), has pharmacological properties that are similar to those of antipsychotic agents. One of the Psychiatric Nurses performed the DISCUS for those individuals who were receiving antipsychotic medication. Thus, a Psychiatric Nurse would monitor an individual for side effects if they were receiving Reglan, as well as an antipsychotic medication. Accordingly, a list was obtained from the Pharmacy of all individuals receiving Reglan to develop the sample for this analysis. This list was then cross-referenced with the Facility-wide list of individuals receiving psychotropic medication in an effort to generate a list of individuals receiving Reglan, but not also prescribed psychotropic medication. The rationale for this distinction was that the nurses on the individuals' residential units administer the evaluations for these individuals, rather than the Psychiatric Nurses. This process indicated that, as of 7/10/12, 14 individuals were receiving Reglan, but were not prescribed medication for a psychiatric disorder. The following sample of five individuals (36%) who fit the above criteria was selected, including: Individual #43, Individual #205, Individual #252, Individual #113, and Individual #239. The review of the records related to the MOSES evaluations indicated that the examination had been performed every six months as required for all of the individuals in this sample (100%). All of these MOSES evaluations had been reviewed and signed by the prescribing physician in a timely manner. The same sample of individuals receiving Reglan was used to evaluate the completion of the DISCUS. The results of this review indicated that the DISCUS evaluations were completed every three months as required for all of the five individuals (100%). The documentation indicated that the prescribing physician had reviewed four of the five evaluations in a timely manner (80%). The results for Individual #239 indicated that the 3/7/12 DISCUS had not been reviewed and signed by the prescribing physician until 3/20/12. During the onsite review, a member of the Monitoring Team also inquired about the degree of training that the Unit Nurses receive with regard to performing the DISCUS evaluation. The Psychiatry Team indicated that all of the nurses receive both initial training, as well as annual updates. This training was quite extensive and included both the review of a videotape, as well as a required post-training competency test to assess for skill acquisition. The Facility's Psychiatry Nurses were the instructors for the training. In order to verify that the training was taking place, the attendance for the prior year was reviewed. The Psychiatric Nurses also supplied the results of post-training test	

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		and the DISCUS evaluations the Nurses conducted after viewing the videotapes to illustrate they were able to utilize the correct methods for performing the evaluations. The content of the training materials, the documentation of attendance, and the production of the testing materials/results indicated that the Unit Nurses were receiving adequate training on how to competently complete the DISCUS evaluations for those individuals prescribed Reglan. The MOSES evaluation material had detailed instructions on how to conduct the evaluation embedded into the actual testing material. This evaluation was designed to be completed by individuals with a nursing degree. The finding of substantial compliance for this provision is based on the continued high rates of completion of the MOSES and DISCUS evaluations, and the substantial improvements in the prescribing physicians' timely review of these evaluations.	
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 Pharmacy Department submitted policy N.6. Adverse Drug Reaction Policy (developed 11/12/10, approved 4/6/11, implemented 5/1/11). It included a PowerPoint presentation for ADRs. The policy also included an "Adverse drug reaction reporting form," and an "allergy/ADR reporting form for individuals discharged from the hospital." Additionally, signage was created in bright colors that provided a description of common medication side effects and adverse drug reactions with guidance to notify a nurse immediately should staff observe/identify these signs/symptoms. According to the Action Plan, facility-wide training on ADRs was to be completed by 9/1/12. Training documents were submitted for the following dates: 4/11/12 - 10 staff, 4/12/12 - 11 staff, and an undated roster – 45 staff. The Pharmacy Department will need to collaborate with the employee training department to ensure all direct support professionals are trained and demonstrate that new employees are trained as well as current employees. The number of ADRs reported in the prior six months was zero. The number of ADR reports that were completed and awaiting P&T Committee review were zero. The number of ADR reports that were discussed at the P&T Committee was zero. This lack of any ADRs might indicate the need for more training of direct support professionals and nurses as well as other departments, such as habilitation services.	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	For the calendar year 2012, information was submitted that documented the medications to be included in drug utilization reviews. These included: first quarter 2012 – Benzodiazepines, presented 4/2/12; second quarter 2012 – Keppra, scheduled to be presented 7/9/12; third quarter 2012 - Latuda, to be presented October 2012; and fourth quarter 2012 – Vitamin D, to be presented January 2013.	Substantial Compliance

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	utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	During the prior six months, two DUE studies were completed: ▪ One DUE focused on benzodiazepine use. This included all medications in that drug class. Specifically tracked were the name of the medication, the drug dosage, the indication, and the duration of use. By random sample, 33 active records were reviewed. Results indicated that for five of the cases, the indication needed to be reviewed. Thirty percent of the individuals had been on a benzodiazepine for greater than five years. This review was presented at the 4/2/12 P&T meeting. As a result, the PCPs requested a list of individuals needing diagnoses reviewed for use of benzodiazepine. The Pharmacy Director provided further follow-up. Of the five cases in which the indication needed to be reviewed, three were discontinued, one was on a taper with plans for eventual discontinuation, and one was being reviewed by the psychiatrist for indications. ▪ There was also a follow-up DUE at the 4/2/12 P&T meeting, in which Reclast was the focus. This initial DUE was presented at the P&T Committee in June 2011. Recommendations from that time included use of Tylenol at time of infusion and every six hours for 24 hours to minimize flu like symptoms, administration of adequate calcium, and administration of adequate Vitamin D. As a follow-up, all those administered Reclast from 7/1/11 through 3/29/12 were reviewed, which included 22 individuals, but the computer record was not available for one as the individual was no longer at CCSSLC, leaving a population of 21 individuals for review. It was found that Tylenol was ordered for all cases, which "virtually eliminated 100% of potential flu like symptoms." All 21 had adequate calcium supplement or had medical reasons for a reduction in dosage. Vitamin D administration was also reviewed, with administration of Vitamin D and monitoring of Vitamin D levels. Ninety percent had therapeutic Vitamin D levels, and the two with low Vitamin D levels had feeding tubes and had adjustments in dosages. The follow-up of the initial DUE appeared to show positive clinical impact. At this follow-up discussion, the clinical pharmacist also suggested that Reclast infusion be preceded by documentation of a recent Glomerular Filtration Rate (GFR) value. The Committee decided to require that a GFR be obtained within the month prior to administration of this medication. ▪ At the 7/9/12 P&T Committee meeting, follow-up of the Reclast DUE was further discussed for clarification. It was clarified that the PCPs would order a Blood Urea Nitrogen (BUN) and creatinine within the month prior to the administration of Reclast, and that the Pharmacy Department would calculate the GFR. ▪ Also at the 7/9/12 P&T Committee meeting, there was a follow-up DUE for Reglan. On 12/30/11, there were 20 individuals on Reglan either intermittently or for a period greater than 60 months. From January 2012 through June 2012,	

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		for six individuals, Reglan was discontinued. ▪ At the 7/9/12 P&T Committee meeting, a DUE on Keppra was presented. A sample of 32 individuals was reviewed retrospectively. The focus was the review of the effect on CBCs. Conclusion was that Keppra does affect the neutrophil count. The response was not constant in that the value fluctuated during therapy and often returned to normal. The response of the bone marrow to Keppra appeared to not be dose related, but the duration of therapy might play a role in the effect on formation of blood components. The DUE program was strong. The follow-up reviews indicated a positive impact on the practice patterns of the PCPs and on the quality of care of the individuals. The Facility was found to be in 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.	<u>Pharmacy Review of Categorization of Errors</u> The Pharmacy Department was not active in verifying that the Nursing Department's categorization of medication errors was consistent with the Pharmacy's interpretation of the medication error categorization. There was no submission of any information concerning random sampling of completed medication error forms that were reviewed by pharmacy to ensure the categorization of error was accurate. <u>Committee Monitoring of Medication Errors/Variances</u> The development, progress, and tracking of a medication error process and trend analysis were reflected in the minutes of the Medication Error Committee meetings, which the clinical pharmacist chaired. The following describes some of the findings of this committee: ▪ The minutes of the Medication Committee were submitted for 12/19/11, 1/5/12, 2/21/12, 3/28/12, 4/16/12, and 5/30/12. From the minutes, the medication errors categorized as true errors were as follows: October 2011 - 11, November 2011 - five, December 2011 – three, January 2012 - two, February 2012 - eight, March 2012 - 44, and April 2012 – three. Additionally, the P&T Committee of 7/9/12 documented that there were five true errors in May 2012. From the Medication Committee minutes, the medication errors categorized as omissions were as follows: October 2011 – 200, November 2011 - 148, December 2011 – 215, January 2012 - 327, February 2012 - 190, March 2012 - 334, and April 2012 - 220. The P&T Committee meeting of 7/9/12 documented that for May 2012, the omissions totaled 129. ▪ The 12/19/11 Medication Committee minutes documented a discrepancy in the number of true errors between the Nursing Department and Pharmacy Department (nursing documented seven errors in October 2011 and pharmacy documented 11 errors in October 2011). There was the belief that late	Noncompliance

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		medication passes were underreported as medication variances. A total of 29 medication pass assessments were completed, and 41% did not need prompting. Additional concerns included instructing the direct support professionals to keep individuals upright, and following the PNMP. ▪ The 1/5/12 Medication Committee minutes documented that the reason for the documentation errors was assignment of a nurse to an unfamiliar area or the assignment of covering an additional area. As this administrative assignment of nurses occurred three months prior, this reason was not considered valid, because the nurses would have had three months to get to know the individuals. It was also noted that the Nursing Department and the Pharmacy Department counted omissions differently. The Nursing Department counted each blank separately. The Pharmacy Department counted the event/incident as the omission error, which might have more than one type of medication to be administered at a time. A total of 23 medication pass assessments were completed, and 70% did not need prompting. Additional concerns that were noted included following the PNMP, instructing direct support professionals to keep individual upright, and documenting that medications were given. It was noted that nurse educators continued to do spot checks, and provided on site education and training when concerns were observed. It is recommended that the pharmacy summarize information and include totals per month of the number of doses which were medication errors (blanks on the MAR), as well as separately the number of incidents so that there is not misinterpretation of information. ▪ The 2/21/12 Medication Committee minutes documented the two true errors in January 2012 were administration at the wrong time. There was need for increased coordination between the nurse and direct support professionals, because the individuals were not ready to receive their medication. It was believed this was self-correcting, because the direct support professionals' role would be important in getting the individuals to the medication pass in a timely manner. An error occurred on 2/5/12 in which medication was given to the wrong person. It was determined there was also a need for updating the photos of the individuals for placement on the MAR, and that they should be in color on white card stock. It was noted that the PNMPs continued to not be followed. ▪ The 3/28/12 Medication Committee minutes documented that medication pass assessments did not need prompting in 83% of cases. It was noted that direct support professionals were not always present during medication administration, and there appeared to be some lack of cooperation. ▪ The 4/16/12 Medication Committee minutes documented that there were a number of medication errors involving Calcitonin. This was corrected in the Pharmacy by creating a log to track dispensing of this medication. A total of 13	

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		medication pass assessments were completed, with all needing prompting. For improved accountability of omissions and errors, and to determine reason for overages (returned medication), the pharmacy was to check the cart exchanges on a weekly basis and forward information to the Nursing Department to reconcile and enter into the medication variance database. ▪ The 5/30/12 Medication Committee minutes documented that for all 20 medication pass assessments, prompting was needed. ▪ At the end of each of the meeting minutes a table was included outlining action steps, evidence, staff responsible, target date, etc. This method ensured many concerns were tracked based on the discussion in the minutes. Some areas were further discussed in the minutes, such as the findings of the medication pass assessments. The concern of reconciliation of omissions with overages by pharmacy was less well documented in the minutes, and only briefly in the action steps. This would benefit from progress updates, including descriptions of system protocols that were implemented, or findings based on the pharmacy weekly review of cart exchanges. A monthly/quarterly summary/analysis of progress toward reconciling overages would be beneficial, along with corrective actions taken by the Pharmacy based on the data. It is recommended that this be a priority area for the Pharmacy Department. <u>Medication Error Reports</u> Copies of the last 10 medication errors forms completed were submitted for review. There were no Class A medication errors, three Class B medication errors, five Class C medication errors, and two Class D medication errors. Follow-up of the errors was documented in nine of 10 errors. However, three of the follow-ups provided information concerning how the medication error occurred, but did not provide next steps or a procedure to prevent a recurrence of the medication error. Nursing and Pharmacy were each responsible for five of the 10 medication variances. The node of variance included several categories: transcription, administration, dispensing, and documentation. One medication error included three nodes of variance. It was noted that one error represented 20 missed doses of medication. Another error involved the discovery of a medication not refilled for 37 individuals over the prior two years. The latter error generated a corrective action plan from the Pharmacy Department. A systemic approach followed, with improved monitoring in the Pharmacy when renewals of the specific long-term medication are requested. This could theoretically prevent a recurrence of the error. <u>Medication Observation Monitoring</u> Monthly medication pass assessments were discussed at the Medication Committee	

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		meeting, and listed the number of assessments for the month and the number of those in which prompts were needed. The monitoring tool used was a 61-point list. The pharmacy provided a "summary observed medication passes – 2012 for February through May." For the most recent month, areas that remained a challenge included the following areas: "Does the nurse refer to the current PNMP prior to beginning administration of medications?" Compliance was 68%. "Pill crusher is cleaned per medication administration policy." Compliance was 64%. "Master signature list initials match the initials on the MAR." Compliance was 59%. "DSP instructed per PNMP." Compliance was 82%. "Nurse identifies that specific assistive and positioning equipment is present and being utilized according to the PNMP." Compliance was 82%. "Privacy was afforded during medication pass." Compliance was 86%. Interventions/steps taken by the Pharmacy to reduce the numbers of medication errors included the following: ▪ For errors originating in the Pharmacy Department: o On 2/15/12, a "Protocol for Medication Cart Exchange" was implemented to ensure the Pharmacy provided the correct medication and the correct count for each medication. The receiving nurse was to complete the "Fill List" the pharmacy system provided, and this document was to be returned to the pharmacy within 24 hours. Detailed instructions were provided for discrepancies found. The Facility submitted a document entitled: "Medication Cart Exchange" listing dates 2/12/12 through 2/17/12, 2/23/12, 2/29/12, 3/7/12, and 3/9/12. It appeared to be a training roster in which 99 of 103 nurses were trained on this new process. ▪ For errors originating in the Nursing Department: o As part of the "Protocol for Medication Cart Exchange," detailed instructions also were provided for documentation of furlough medication returned, and shortage of medication due to waste, spilling, etc. When a medication was not administered, the nurse was to remove the medication from the individual's drawer and store it separately in a locked box, with the reason for the missed medication. These instructions provided a system to document the reason for shortages and overages of medication, in an attempt to reduce medication variances across the campus. o The pharmacy also included instructions on the MAR when medications needed to be crushed, according to the "Adaptive Dining Textures Report," which included 125 individuals. Additionally, the physician order form (the State form POR-MR-31) included a statement: "Pharmacy Alert: Please ensure medications are dispensed in a form	

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		that allows for administration in accordance with texture or liquid consistency requirements." o Pharmacy collaborated with nursing in developing the correct thickening of liquids for administration of medication in those needing thickened liquids. There was discussion also with nursing concerning the medications that should be crushed. The pharmacy was to determine which medications should not be crushed, according to minutes of a meeting entitled: "Thickening Liquid Medication – Minutes/Notes 4/27/12." The plan was for the Nursing, Pharmacy, and Medical Departments to collaborate in determining the best/safest form of medications for the individuals. There was no information concerning returned medications that were not considered omissions. This aspect of monitoring (unexplained returned medications) was in the development stage. The Facility submitted a chart entitled "Medication Errors 12 month summary," which appeared to provide the "true" error rate according to home, category, and type or error. There were some discrepancies in the monthly totals and the numbers provided in the Medication Committee. It is recommended that these differences be reviewed to determine the reason, and provide corrective action to ensure the different databases and data sources have the same information. Overall, there were three quarters of fiscal year 2012 available. For the 1st Quarter (September 2011 through November 2011), there were 17 reported true errors. For the 2nd quarter (December 2011 through February 2012), there were seven errors. For the 3rd quarter (March 2012 through May 2012), there were 46 errors. For the category of error, there were three Class A errors, 42 Class B errors, 20 Class C errors, five Class D errors, and one Class E error. The errors were also reviewed according to type of error. Two were the wrong medication, eight were the wrong dose, 43 were considered true omissions, two were the wrong patient, and 15 were the wrong time. The Facility also submitted a chart with the same title as the chart discussed in the prior paragraph: "Medication Errors 12 month summary," but this appeared to reflect the administrative error of incomplete MAR documentation. For the three quarters of the current fiscal year, there were a total of 1929 omissions reported in one section of the table, 2000 errors reported in another part of the table, and 2020 errors in a third area of the table. The Pharmacy Department should review information prior to submission to ensure consistency across the tables and charts submitted. These errors appeared to be all administrative errors in which the MAR was not completed, but the medication was presumed administered. However, no information was submitted that explained how	

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		the Pharmacy Department came to that conclusion. There remained no information concerning returned medications and the reasons for these. From September 2011 through May 2012, there appeared to be no trend, and no improvement in administrative omissions (categorized as Class A). The Facility remained out of compliance with this provision. Although some activities had occurred to correct some of the areas in need of improvement, the Facility did not yet have a system to accurately identify the full scope of medications variances, analyze the information, and develop appropriate actions to correct deficiencies.	

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

1. The process and criteria for choosing the category for the patient intervention should be reviewed and revised as needed to reduce variability in interpretation by pharmacists and narrow the selection if applicable. (Section N.1)
2. The "drug interaction alerts" log should be used as a QA review for the PCPs. (Section N.1)
3. The Pharmacy Department should review data submitted to the Monitoring Team to ensure completeness and accuracy prior to signing off on the completed request. (Sections N.1 and N.2)
4. For the pharmacy recommendation section of the chemical restraint form, the dosage and route of medication should be clearly indicated on these forms. (Section N.3)
5. The State Office should provide guidance regarding the expectations for psychiatrists regarding their contribution to the content of the chemical restraint form. (Section N.3)
6. The Pharmacy Department should collaborate with the Psychology Department in reducing the time from the use of the chemical restraint to review by pharmacy. (Section N.3)
7. The Pharmacy and Psychology Departments should resolve discrepancies in information obtained for chemical restraints. (Section N.3)
8. The Pharmacy Department should continue to track the review of the QDRR by the PCP, and provide periodic summary of the results to the medical staff. This should include tracking timeliness of review. (Section N.4)
9. The Pharmacy Department should collaborate with the Training Department to ensure all direct support professionals are trained on the ADR identification and reporting system, including all new employees as well as current employees. (Section N.6)
10. All of the departments involved in the medication ordering and administration process should work closely in providing information related to medication variances, and cooperate in investigating medication errors. (Section N.8)
11. The Pharmacy Department should sample the medication errors and independently categorize the errors to determine agreement or non-agreement with the nurses completing the forms. (Section N.8)
12. The Pharmacy Department should summarize information for medication errors and include totals per month of the number of doses for which there were medication errors (blanks on the MAR, for example), as well as separately, the number of incidents. A quarterly report should be generated that tracks errors from all departments (i.e., pharmacy, nursing, medical). (Section N.8)
13. There appeared to be different databases with different statistics for medication errors. These differences should be reviewed to determine the reason, and provide corrective action to ensure the different databases and data sources have the same information. (Section N.8)
14. Track should occur of unexplained returned medications, the date of return, the residence, and the reason for the return. (Section N.8)
15. The QA Department should review additional records in conjunction with the Pharmacy Department to establish inter-rater reliability. This should include continued review of the tool with development of guidelines or instructions, as well as the training for those responsible for

implementing the pharmacy monitoring tool until results are consistently replicated. The pharmacy should also determine the sampling method and sample size to be reviewed each month. (Facility Self-Assessment)

16. The internal pharmacy review tool should incorporate evidence of verification/source of the information for justification, review of side effects, etc. (Facility Self-Assessment)

SECTION O: Minimum Common Elements of Physical and Nutritional Management	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents:** o Presentation Book for Section O; o The following documents for 11 individuals in Sample #1 that included individuals identified with PNM concerns; who had received enteral nourishment; and/or had experienced a change of status as evidenced by admission to the Facility Infirmary, emergency room (ER), and/or hospital, including Individual #340, Individual #274, Individual #68, Individual #126, Individual #124, Individual #142, Individual #266, Individual #122, Individual #269, Individual #273, and Individual #176: Occupational Therapy/Physical Therapy (OT/PT) comprehensive assessment, assessment of status, update in individual record, Nutrition assessments, Aspiration Pneumonia/Enteral Nutrition (APEN) assessment, Speech Language Pathology (SLP) comprehensive assessment, assessment of status, update in individual record, Head of Bed Elevation (HOBE) assessment, annual Individual Support Plan and Individual Support Plan Addendums (ISPAs) for past year, Integrated Risk Action form, Interdisciplinary Team Risk Action Plan/ Integrated Care Plan, Integrated Progress Notes for past six months, OT/PT/SLP/Registered Dietician (RD) consultations for past year, Aspiration Trigger Sheets for past six months, Physical Nutritional Management Plan (PNMP) and dining plans with supporting written and pictorial instructions, for individuals hospitalized within this sample the Hospital Liaison Nurse reports across the past six months, therapeutic/pleasure feeding plan, individual-specific monitoring for the past six months, PNMT Post Hospitalization assessment, documentation of staff successfully completing Physical Nutritional Management (PNM) foundational training, documentation of staff successfully completing individual-specific training, supporting documentation to substantiate an individual's progress with PNM difficulties, incident reports and Facility investigations for choking incidents, PNMP Clinic minutes, monthly review of OT/PT direct intervention, quarterly review of OT/PT programs, supporting documentation for implementation of OT/PT direct interventions, and supporting documentation for implementation of OT/PT programs; o The following documents for seven individuals on the current Physical and Nutritional Management Team (PNMT) caseload who were assessed or reviewed in the last six months, including Individual #278, Individual #144, Individual #89, Individual #43, Individual #117, Individual #239, and Individual #378, and three individuals who had been discharged from the PNMT in the past six months, including Individual #86, Individual #113, and Individual #10: PNMT assessment, PNMT action plan and supporting documentation, Head of Bed Elevation assessment, Aspiration Pneumonia/Enteral Nutrition assessment, annual Individual Support Plan and Individual Support Plan Addendums for past year, Integrated Risk Rating form prior to referral to PNMT,

	Integrated Risk Action form completed by PNMT and IDT upon referral, Integrated Progress Notes for past six months, Aspiration Trigger Sheets for past six months, Physical Nutritional Management Plan and dining plans with supporting written and pictorial instructions, for individuals hospitalized within this sample the Hospital Liaison Nurse reports across the past six months, therapeutic/pleasure feeding plan, individual-specific monitoring for the past six months, PNMT Post Hospitalization assessment, Nursing Care Plan/Integrated Care Plan, documentation of staff successfully completing Physical Nutritional Management foundational training, documentation of staff successfully completing individual-specific training, supporting documentation to substantiate an individual's progress related to PNM difficulties, and PNMT Discharge and supporting documentation; o List of Physical and Nutritional Management Team members and curriculum vita, revised 5/18/12; o List of all individuals seen by the PNMT and corresponding caseload, dated 6/4/12; o List of all individuals assessed by the PNMT and the date of assessment, from 1/12 through 4/12; o List of all individuals discharged by the PMNT, from 12/11 through 5/12; o Physical Nutritional Management Policy and Procedure, revised 5/25/12; o List of continuing education sessions participated in by PNMT members, from 1/12 through 5/12; o Agenda, curriculum, attendance rosters, and certificates of completion for PNMT staff, from 2/12 through 6/12; o Minutes and documentation of attendance for PNMT meetings, from 1/12 through 5/12; o List of changes in PNMT evaluation forms, dated 5/12; o Policy and procedures addressing identification of PNM health risk levels, including criteria for establishment of risk levels, dated 5/24/12 and 5/25/12; o List of individuals with PNM needs, dated 5/22/12; o List of individuals without PNM needs, undated; o Wheelchair/Mobility/Assistive Equipment Work Orders, from 4/12 through 5/12; o Completed PNMPs and Dining Plans, from 10/11 through 5/12; o List of tools PNMP Coordinators use to monitor staff compliance, revised 2/15/12; o List of individuals for whom PNM monitoring tools were completed during last quarter, from 3/12 through 5/12; o Tools utilized for validation of staff responsible for PNM monitoring, revised 5/3/12; o Inter-Rater Reliability Scores, from 2/12 through 4/12; o Dining Plan (template) with changes, undated; o PNM and PNMT related database reports, and spreadsheets generated by Facility during past six months, dated 5/22/12; o List of individuals on modified/thickened liquids, dated 5/30/12; o List of individuals who require mealtime assistance, dated 5/30/12; o List of individuals who receive nutrition through non-oral methods, dated 5/22/12; o List of individuals whose diets have been downgraded or changed to a modified texture or

	consistency, from 3/12 through 5/12; o List of individuals with Body Mass Index (BMI) equal to or greater than 30, dated 5/12; o List of individuals with BMI equal to or less than 20, dated 5/12; o List of individuals who have had an unplanned weight loss of 10% or greater over a six months period, from 12/11 through 5/12; o List of individuals who have had a choking incident during the past six months, dated 6/3/12; o List of individuals who have had an aspiration and/or pneumonia incident during past six months, dated 6/1/12; o List of individuals who have had a fall during the past six months, dated 6/4/12 o List of individuals who have had a decubitus/pressure ulcer during the past six months, from 9/11 through 2/12; o List of individuals who have experienced a fracture during the past six months, dated 6/3/12; o List of individuals who have had a fecal impaction during the past six months, undated; o List of individuals who are non-ambulatory or require assisted ambulation, dated 6/1/12; o List of individuals with poor oral hygiene, dated 6/5/12; o List of individuals who received a feeding tube since the last review, dated 6/6/12; o List of individuals who are at risk of receiving a feeding tube, undated; o List of individuals who have received a Modified Barium Swallow Study (MBSS) or other diagnostic swallowing evaluation during the past year, from 6/11 through 5/12; o Schedule of meals by home, undated; o Schedule of all PNM-related meetings occurring during the week of the onsite review, from 7/9/12 through 7/13/12; o Curricula on PNM used to train new staff responsible for directly assisting individuals, various dates from 4/11 through 10/11; o Agenda and curriculum for competency-based annual refresher training related to PNM, various dates from 6/11 through 11/11; o Inter-Rater Reliability Scores, from 2/12 through 4/12; o Facility Self-Assessment and Provision Action information, dated 3/12/12, 4/7/12, and 5/8/12; o List of completed PNMT Nursing Post Hospitalization Assessment/Evaluations, from 2/12 through 5/12; o The following documents for Individuals #117 and Individual #239 were submitted prior to the on-site review: PNMT Minutes, PNMT Assessments, Integrated Risk Rating forms, APEN Assessments, HOBE Assessments, PNMT Action Plans, Staff Competency-based Check-offs, PNMT Monitoring Forms, individual PNMPs, PNMT Nursing Post Hospitalization Assessments, and ISPA meeting documentation related to integration of PNMT assessments and Action Plans, from 1/12 through 6/12; o Quality Assurance/Quality Improvement (QA/QI) meeting minutes related to PNM, PNMT, and the Habilitation Therapy (HT) Department, from 1/12 through 5/12; o Minutes from the HT Department meetings for the past six months, from 1/12 through

	6/12; o External PNM consultant reports since last review, dated 3/16/12 and 3/22/12; o Changes to Physical Nutritional Management Plan templates since last review, dated 5/25/12; o Raw data for Section O monitoring for May 2012; o QA/QI Quarterly Section Review for Section O for last two quarters; o Continuing education for PNMT core and alternate members for June 2012; o Draft PNMP template for Individual #340; o Action plans for environmental survey, receiving enteral nutrition, and weekly weights related to PNMT systemic issues; o Documentation developed by PNMT Nurse for timeline notification of needed environmental surveys, tracking of enteral nutrition (i.e., "counting cans") and weekly weights; o All documentation for resolution of systemic issues identified by PNMT; o HT Department meeting minutes for June 2012; o Competency performance check-offs for New Employee Orientation (NEO) PNM instructors; o Number of staff who successfully completed NEO PNM foundational performance check-offs over the past six months; and o Facility Continuing Education policy. ▪ **Interviews with:** o Dr. Angela Roberts, Habilitation Therapy Director; o Mary Wilcox, PNMT RN, Dedicated Core Member; o Rosie Cortez, PNMT OT, Dedicated Core Member; o Maria I. Garcia, Alternate PNMT PT Member; o Linda Merryman-Scrifes, Alternate SLP Member; and o Sally Schultz, State Consultant. ▪ **Observations of:** o Infirmary, residences and dining rooms in Coral Sea, Pacific, and Atlantic for five individuals on the PNMT caseload; o PNMT Pre-Conference meeting on 7/9/12; and o PNMT Reviews on 7/10/12.
	Facility Self-Assessment: Based on a review of the Facility's Self-Assessment, with regard to Section O of the Settlement Agreement, the Facility found it was in noncompliance with all of the subsections of Section O. This was consistent with the Monitoring Team's findings. The Facility submitted three documents, including: CCSSLC Self-Assessment, Action Plans, and Provision Action Information. The CCSSLC Self-Assessment listed the steps the Facility staff completed to conduct the self-assessment and the subsequent results for the completion of these tasks. The Action Plans documented the status of action steps that had been completed, were in process, and/or had not been started. The CCSSLC Provision Action Information listed actions completed since the Monitoring Team's

	previous visit. The Facility Self-Assessment presented the results of auditing activities the HT Director and Program Compliance Monitor (PCM) completed using the Section O Monitoring tool for each month. One individual was monitored each month for a total of three individuals per quarter. Monthly reports were developed for each month that included a separate compliance score for each indicator for the Section Lead (i.e., HT Director) and the PCM. An inter-rater compliance score was generated for each indicator as well as a compliance percentage. This was a positive development and provided the HT Director with valuable information to assess the compliance status for each indicator. Furthermore, the HT Director and PCM reported they continued to revise instructions for the form to enhance their inter-rater agreement. The HT Director and PCM generated a monthly Section O Analysis report. The report defined how inter-rater agreement was achieved and discussed how the sample was chosen. The analysis report discussed the compliance for each of the eight sections in Section O and presented plans to address areas of non-compliance. The Monitoring Team discusses the Facility Self-Assessment results at the beginning of each section.
	Summary of Monitor's Assessment: Although a list of PNM team members included a Registered Nurse (RN), Physical Therapist, Occupational Therapist, Registered Dietician, and Speech Language Pathologist, prior to the Monitoring Team's visit, the PNMT SLP and PT resigned. Based on interview with the HT Director, the PNMT alternate SLP and PT assumed the vacant PNMT SLP and PT core positions until the vacant positions were filled and/or current therapists were assigned to a PNMT core position. Attendance by core and/or an alternate PNMT members for 46 meetings conducted during the time frame from 1/10/12 to 5/29/12 ranged from 65% for the RD to 85% for the RN. The PNMT member attendance was not adequate, because the PNMT was meeting without the required membership as outlined in the Settlement Agreement. A review of individuals who had been hospitalized since the last review revealed the Facility IDTs were not consistently referring individuals to the PNMT and/or the PNMT was not consistently initiating an assessment within five working days. Based on interview, the HT Director reported the IDTs would not be provided training on the draft PNMT Referral policy until the revised ISP and risk process had been implemented. A review of PNMT assessments and actions plans identified multiple missing components. In addition, individuals the PNMT discharged did not have adequate discharge plans as multiple components were missing. Lists presented by the Facility to identify individuals having physical and nutritional management problems were not accurate. When comparing lists the Facility provided of individuals with PNM needs

	with a list of individuals' risk ratings, some individuals with PNM needs as evidenced by a high and/or medium risk ranking in choking, aspiration, falls, fractures, skin integrity and/or weight were not on the list of individuals having PNM needs. Consequently, the Monitoring Team did not have confidence in the accuracy of this list. The Facility had updated its PNMP Directions to address the placement of medication administration instructions on the PNMP, add a more comprehensive list of adaptive equipment to the PNMP, and clarify that revision of a PNMP required the completion of an Assessment of Current Status, and completion of an in-service by the therapist with the PNMP Coordinator on the revised PNMP. These additions to the PNMP directions were a positive addition. However, a review of PNMPs for individuals revealed PNMPs were missing components such as staff instructions to achieve safe elevation ranges in wheelchair and alternate positioning, bathing/showering, oral and dental care, and personal care. The Monitoring Team and the PNMT Nurse completed direct observations of the implementation of PNMP strategies in the Infirmary and residences for five individuals on the PNMT caseload. The PNMT nurse had to intervene with staff during every observation to correct staff's approach for wheelchair positioning, alternate positioning, mealtime fluid consistency and presentation techniques, and transfers. These observations revealed that staff were not competent in implementing individuals' PNMPs. However, in reviewing monitoring data for these same individuals, it did not identify similar problems. New staff continued to be responsible for completing 22 PNM foundational performance check-offs. Based on information provided by the Facility, 192 new employees had successfully completed the PNM core competencies performance check-offs since the last on-site review. Based on interview, the Facility annual refresher training was to be expanded. Current staff will be responsible for successfully completing performance check-offs for transfer lifts, two-person manual lift, bed positioning, mechanical lift, stand-pivot transfer, wheelchair positioning, adaptive dining equipment, thickening liquids, and mealtime safety. The Facility had not implemented an effectiveness monitoring system to assess the progress of individuals with PNM difficulties or provide evidence that interventions were modified if an individual was not making progress. More specifically, individuals' Risk Action Plans did not generate individual-specific clinical data to substantiate an individual progress or to assess if the individual was better or worse; monthly progress notes were not completed to report on the effectiveness of an individual's supports and services; individuals at high risk for aspiration had multiple months that aspiration pneumonia trigger data sheets had not been completed; and individuals' who experienced ongoing weight loss did not have their plans revised. APEN assessments for individuals who received enteral nutrition were not: following the Facility-established template and content guidelines; completed within a 12-month period for 12 of the 16 individuals; including the participation of recommended disciplines; and/or providing justification that the continued use of the tube was medically necessary or assessing the individual's potential to receive a less restrictive form of enteral nutrition or transition to oral intake, if appropriate.

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O1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide each individual who requires physical or nutritional management services with a Physical and Nutritional Management Plan ("PNMP") of care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with 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,	**Facility Self-Assessment** A review of the Facility's Self-Assessment indicated the following: ▪ Review of Section O monitoring tools indicated that three out of three (100%) had compliance scores analyzed, trended and aggregated. ▪ The PNMT membership indicated that four out of five (i.e., OT, PT, SLP and RN) (80%) were dedicated. However, the dedicated SLP and PT had recently resigned. The PNMT did not have a dietician and the Facility was recruiting a dietician. The PNMT "will consult with a medical doctor on as needed basis." ▪ PNMT members had completed continuing education in specialized areas. ▪ A review of PNMT minutes indicated zero out of three individuals (0%) had IDT members represented; for zero out of three (0%) individual-specific monitoring was conducted; and three out of three (100%) were re-assessed after admission to the Infirmary, emergency room and/or hospital. The Facility's Self-Assessment indicated that: "based on findings from this self-assessment, this provision is not in compliance because we do not have all required members on the Physical Nutritional Management Team (PNMT). Although all individuals who are seen by the PNMNT receive a Physical Nutritional Management Plan (PNMP) and appropriate recommendations are made, often times these recommendations are not consistently implemented and/or completed." As noted above with regard to the documents reviewed section, two samples were selected for the review of Section O. These included: ▪ **Sample #1 (IDT Caseload) -** eleven individuals identified with PNM concerns who received enteral nourishment, and some of whom had experienced a change of status related to PNM difficulties as evidenced by an admission to the Facility Infirmary, ER, and/or hospital, including: Individual #340, Individual #274, Individual #68, Individual #126, Individual #124, Individual #142, Individual #266, Individual #122, Individual #269, Individual #273, and Individual #176. ▪ **Sample #2 (on active PNMT Caseload) -** seven individuals on the current PNMT caseload who were assessed or reviewed in the last six months, including: Individual #278, Individual #144, Individual #89, Individual #43, Individual #117, Individual #239, and Individual #378. This sample also included three individuals who had been discharged from the PNMT in the past six months, including: Individual #86, Individual #113, and Individual #10. 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, the following summarizes the	Noncompliance

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<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td>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.</td><td>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. The evaluations and planning processes in which the PNMT 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. In addition, this provision specifically requires that "the 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 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 status of these requirements is discussed with regard to Section O.3.

<u>PNMT Membership</u>
A list of PNM team members included a Registered Nurse, Physical Therapist, Occupational Therapist, Registered Dietician, and Speech Language Pathologist. However, prior to the Monitoring Team's visit, the PNMT SLP and PT resigned. PNMT alternate members included a Registered Nurse, Physical Therapist, Occupational Therapist, and Speech Pathologist. Based on interview with the HT Director, the PNMT alternate SLP and PT assumed the vacant PNMT SLP and PT core positions until the vacant positions were filled and/or current therapists were assigned to a PNMT core position. The alternate PNMT RD position was vacant. There were three allocated RD positions, but two of these three positions were vacant. Based on interview and submitted documentation, the base salary for RDs had impacted the Facility in hiring RDs. The HT Director was working with administration, in collaboration with the State, to explore increasing the salary base for RDs to, hopefully, assist in recruitment.

The following chart provides the caseload of core PNMT members at the time of the review:
<table>
<tr><th>Core PNMT Members</th><th>Current Caseloads</th></tr>
<tr><td>Occupational Therapist</td><td>Dedicated member and supported 18 individuals on the PNMT caseload</td></tr>
<tr><td>Speech Language Pathologist</td><td>Supported 94 individuals in Atlantic and 18 individuals on the PNMT caseload</td></tr>
<tr><td>Registered Dietician</td><td>Supported 241 individuals and 18 individuals on the PNMT caseload</td></tr>
<tr><td>Registered Nurse</td><td>Dedicated member</td></tr>
<tr><td>Physical Therapist</td><td>Supported 80 individuals in Pacific and 18 individuals on the PNMT caseload</td></tr>
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#	Provision	Assessment of Status	Compliance
		As noted in the chart above, the alternate SLP and PT had extensive caseloads beyond their responsibilities for individuals on the PNMT caseload. **Ancillary PNMT Members** With regard to PNM ancillary members, the Facility's "Physical and Nutritional Management (PNM) PNMT Membership" Policy O.1 stated: "as needed, the team consults with a medical doctor, nurse practitioner, physician's assistant and IDT of individual to be seen in the meeting." Although not required by the Settlement Agreement, in the absence of a Medical Director, the Facility had not appointed a medical liaison to the PNMT. **Continuing Education** The Habilitation Therapies Continuing Education Unit (CEU) draft policy defined: ▪ The disciplines responsible for completing CEUs; ▪ Minimum requirements for yearly CEUs; ▪ Specialized areas for completion of CEUs; ▪ CEU tracking system; and ▪ "Lunch and Learn" which provided verification of integration of knowledge obtained in CE courses. The draft Facility policy was a positive development in defining the expectations for the completion of continuing education requirements for clinicians. Four of the five core PNMT members (80%) attended community continuing education courses. Attendance rosters, course certificates of completion, and agendas were submitted. The continuing education courses the PNMT staff attended provided relevant and appropriate clinical instruction for PNMT members. With regard to Core PNMT Members: ▪ Former PT attended: Autism and Sensory Processing Disorders; Bedside Evaluation of the Dysphagia Patient; The Dysphagia Patient: Modified Barium Swallow and Therapeutic Intervention; and Neurorehabilitation Conference 2012; ▪ Former SLP attended: Autism and Sensory Processing Disorders; Bedside Evaluation of the Dysphagia Patient; The Dysphagia Patient: Modified Barium Swallow and Therapeutic Intervention; and Neurorehabilitation Conference 2012; ▪ OT attended: Autism and Sensory Processing Disorders; Bedside Evaluation of the Dysphagia Patient; The Dysphagia Patient: Modified Barium Swallow and Therapeutic Intervention; and Neurorehabilitation Conference 2012; ▪ RD attended: None submitted; ▪ RN attended: Autism and Sensory Processing Disorders; Bedside Evaluation of	

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		the Dysphagia Patient; The Dysphagia Patient: Modified Barium Swallow and Therapeutic Intervention; Neurorehabilitation Conference 2012; North American Menopause Society Guidelines Back Hormone Therapy Use for Menopausal Symptoms; New Dietary Guideline on Irritable Bowel Syndrome; and Gum Chewing Quickens Bowel Recovery After Liver Resection. Three of the four alternate PNMT members (75%) attended community continuing education courses. With regard to alternate PNMT Members: ▪ PT attended: Neurorehabilitation Conference 2012; ▪ SLP attended: Autism and Sensory Processing Disorders; ▪ OT attended: Autism and Sensory Processing Disorders; Bedside Evaluation of the Dysphagia Patient; The Dysphagia Patient: Modified Barium Swallow and Therapeutic Intervention; Neurorehabilitation Conference 2012; and Managing Dysphagia 2012; and ▪ RN attended: None submitted; and ▪ RD attended: Vacant. These continuing educations courses were appropriate instruction in working with individuals with complex physical and nutritional management needs. **PNMT Meeting Minutes** The Facility PNMT minutes format and Facility PNMT policy stated meetings were to be held twice a week, but could also occur: when feeding/health problems arise, after esophagrams/medical diagnostic tests were performed, to perform follow-up activities, and at any phase in the PNM procedure. A review of the PNMT minutes for 46 meetings from 1/10/12 to 5/29/12 represented four different types of PNMT meetings, including: ▪ PNMT pre-assessment meetings to assign assessment/monitoring responsibilities to begin the assessment process; ▪ PNMT/IDT meeting to present PNMT assessment findings to the individual's IDT; ▪ PNMT follow-up meetings to review and revise, as needed, multiple individuals' PNMT action plan; and ▪ PNMT administrative meetings. Attendance by core and/or an alternate PNMT members for 46 meetings conducted during the time frame from 1/10/12 to 5/29/12 was: ▪ RN: 85%; ▪ PT: 69%; ▪ OT: 83%;	

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		▪ SLP: 78%; and ▪ RD: 65%, The attendance of PNMT members at meetings was not adequate, because the PNMT was meeting without the required membership in attendance as outlined in the Settlement Agreement. Attendance by ancillary PNMT members for PNMT/IDT and follow-up meetings conducted during the time frame from 1/10/12 to 5/29/12 was: ▪ A Facility physician attended the PNMT meeting on 2/17/12; and ▪ A Facility Nurse Practitioner attended the PNMT meeting on 3/7/12. As stated in the last report, in the absence of a Medical Director, the PNMT did not have a medical liaison appointed to provide a resource for medical consultation to PNMT members. **PNMT Systemic Issues** A PNMT administrative meeting was held on 4/16/12 to address resolution of systemic issues identified by the PNMT. The Facility Director, Assistant Director of Programs, Chief Nurse Executive, HT Director, PNMT PT, PNMT SLP, PNMT OT, and Program Compliance Monitor attended the meeting. The systemic issues raised were: ▪ Weights; ▪ IDT attendance at PNMT follow-up meetings; and ▪ Environmental issues. **Weights** Members of the PNMT explained they "are still" not getting weights from across campus especially for individuals at high risk for weight. The plan of action detailed the following: the Chief Nurse Executive would review the weights policy and discuss where to document weights with nurses during a nursing meeting on 4/20/12; and PNMT members would email the Nurse Manager for the unit and copy the Nurse Operations Officer when they discovered missing weights. This would be addressed on a case-by-case basis unless it became apparent that it was more of a systemic issue. If this were a systemic issue, it would be readdressed with the Chief Nurse Executive. However, although it appeared to remain problematic, the Habilitation Therapy Department did not submit any documentation to show that the issue had again raised the issue with the Chief Nurse Executive or other members of the Facility's Administration. For example, the PNMT Follow-Up meeting on 7/10/12 continued to discuss the challenge of receiving weekly weights. For example, Individual #58's weight continued to not improve. Based on information presented during the follow-up meeting, the PNMT members were "counting cans" to ensure calories were given. Documentation the PNMT Nurse submitted, not dated, indicated "counting of cans" for Individual #58 had been initiated three weeks prior to the 7/10/12 PNMT meeting. This was an unacceptable solution to a	

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		systemic issue that had been raised approximately three months previously. The PNMT had the responsibility to proceed with urgency to address the systemic issue that impacted seven individuals on their caseload (i.e., Individual #58, Individual #278, Individual #311, Individual #144, Individual #89, Individual #179, and Individual #117) who were at high risk for weight. This issue was discussed with the Monitoring Team during the onsite review. The Monitoring Team requested copies of any action plans or other documentation to show what steps the PNMT, Habilitation Therapy Department, or Facility had taken to address the issue. At the conclusion of the Exit Meeting, the Assistant Director of Programs informed the Monitoring Team that the Facility was in the process of developing an action plan. The action plan was submitted to the Monitoring Team on 7/20/12. The action plan identified 11 steps to support individuals receiving prescribed nourishment/formula and fluids, and to have weights recorded as ordered. Although it was positive that an action plan was developed, development of this more comprehensive plan should have occurred as soon as the PNMT identified that the initial plan put in place in April was not having the necessary impact. The necessary communication about the ongoing nature of the systemic concerns and development of an action plan to address resolution of these issues should not have required the presence of the Monitoring Team. In the future, the PNMT should be aggressive in not only raising systemic issues in a timely manner, but also acting with urgency to ensure the issues are resolved. The Monitoring Team was hopeful the action plan step for the presentation of systemic issues by the PNMT in the Integrated Clinical Services Meeting would support timely resolution of identified issues. If concerns are not resolved through this forum, the PNMT and Habilitation Therapy Department should use the QA/QI Council and/or other administrative interventions as additional pathways for the PNMT to present ongoing concerns and work toward a speedy resolution for those individuals at highest risk. **IDT Attendance at PNMT Follow-Up Meetings** Facility Policy O.2 specified "a member of the individual's IDT will attend each subsequent follow-up meeting to review progress with the PNMT recommendations until the individual is discharged from the PNMT caseload. The IDT member will act as the liaison between the PNMT and the IDT. The purpose of their attendance at these meetings is to share information, update status and progress of plans." At the PNMT administrative meeting on 4/16/12, the PNMT members reported that IDT members were attending the initial meeting and discharge meeting, but did not consistently attend the PNMT follow-up meetings. The plan of action developed specified the PNMT would have a flexible schedule during the follow-up meetings to accommodate IDT members that were present. In addition, the PNMT administrative assistant would assign a specific	

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		person to attend the next follow-up meeting and would send an appointment reminder. However, no follow-up documentation was submitted and/or discussion recorded in PNMT minutes regarding the success and/or lack of success with this action plan. A review of PNMT Follow-Up meeting attendance sheets after 4/16/12 did not signal that the problem had been resolved. For example, at the follow-up meeting on 5/29/12, the group reviewed 12 individuals on the PNMT caseload. The PNMT signature page denoted attendance by a QDDP for King Fish 4, QDDP for Ribbon Fish 1, as well as another QDDP and RN but these staff did not identify the residence they represented. There was no IDT representation from Coral Sea and/or the Infirmary. The PNMT should consider a revision to their follow-up meeting attendance sheet to require the IDT member to identify which individual they are supporting. Furthermore, the PNMT should continue to document when an IDT member does not attend a follow-up meeting as required by Facility policy. The PNMT should request timely meetings with Facility Administration to report on progress and/or lack of progress with action plans related to systemic issues. **Environmental Issues** The PNMT indicated there had been an increase in respiratory issues for individuals in Coral Sea. The plan of action that the group decided upon at the 4/16/12 meeting involved the HT Director contacting the Support Services Director. A meeting was to be set up with Housekeeping, Infection Control, the PNMT and, possibly, the Safety Manager to discuss issues of cross contamination with cleaning supplies, protocols to be followed after floor stripping (data revealed an increase in respiratory issues), a schedule for vent cleaning, and schedule for cleaning respiratory equipment. However, the HT Director did not contact the Support Services Director via email until 5/23/12, which was not adequate to address these environmental concerns that had been described as urgent. Furthermore, the PNMT Nurse indicated the room where Individual #239, Individual #247 and Individual #270 resided had received poor environmental checks prior to 8/31/10, close to a year ago. Again, the PNMT should have notified Facility Administration of their concerns prior to the 4/16/12 meeting. The Facility's action plan developed at the time of the Monitoring Team's onsite review to support individuals residing in respiratory safe environments identified four action steps. The Monitoring Team would recommend a joint meeting between the PNMT, Support Services Director, Infection Control Nurse, and Respiratory Therapist to further expand and implement an interdisciplinary approach to supporting a safe environment not only for these three individuals, but individuals across the campus. During the next onsite visit, members of the Monitoring Team will review the implementation of this action plan. The Facility's Self-Assessment indicated that it was not in compliance with this	

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		requirement of the Settlement Agreement. This was consistent with the Monitoring Team's findings.	
O2	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall identify each individual who cannot feed himself or herself, who requires positioning assistance associated with swallowing activities, who has difficulty swallowing, or who is at risk of choking or aspiration (collectively, "individuals having physical or nutritional management problems"), and provide such individuals with physical and nutritional interventions and supports sufficient to meet the individual's needs. The physical and nutritional management team shall assess each individual having physical and nutritional management problems to identify the causes of such problems.	**Facility Self-Assessment** A review of the Facility's Self-Assessment indicated the following: ▪ Based on the Facility's review of its PNMT policy, it concluded that an adequate referral process was in place, which included a formal review process. However, based on the Monitoring Team's review, the Facility's IDTs had not received training on the PNMT referral policy. Based on interview with the HT Director, the IDTs would receive training after the revised ISP and risk process had been implemented. In addition, the Monitoring Team's review of the adequacy of IDT referral and/or PNMT self-referral for individuals in Sample #1 and Sample #2 is discussed in further detail in this section. ▪ Based on the Facility's review of three PNMT assessments, two out of three (67%) had a comprehensive review of identified high and medium risks; one out of three (33%) had an adequate action plan developed and strategies to minimize risk indicators; and none (0%) did had individual-specific clinical baseline data established, adequate analysis to provide rationale for development of recommendations, adequate documentation or re-assessment of individuals' PNMP strategies, defined clinical indicators, criteria for referral back to PNMT from nursing upon health status change, or discharge summaries. ▪ A review Medical Morning meeting sign-in sheets the last six months demonstrated the Hospital Liaison and/or the PNMT Nurse were present at 105 out of 120 (88%) meetings. The Facility's Self-Assessment indicated that: "based on the findings from this self-assessment, this provision is not in compliance because the PNMT assessments and subsequent action plans continue to lack the essential components necessary to provide supports sufficient to meet the individuals' needs. The Monitoring Team's findings also showed the Facility was in noncompliance as illustrated in the compliance indicator data in this section. **Facility's Lists of Individuals with PNM Problems** The Facility produced the following lists which identified individuals with PNM concerns: ▪ Fifty-two individuals (20% of the census) were found as requiring mealtime assistance. The list, dated 5/30/12, was generated from the HT database. ▪ Twenty-eight individuals (11% of the census) were identified at high risk and 125 (48% of census) were identified at medium risk for aspiration. The Integrated Risk Rating by Home, dated 5/31/12, categorized risk ratings Facility-wide, by home, and individual specific. The State recently had revised the criteria for high risk of aspiration to include all individuals who received	Noncompliance

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		enteral nutrition. As a result of this change, IDTs will need to revise the risk rating for aspiration for individuals who receive enteral nutrition. ▪ Twenty-two individuals (8% of the census) were recognized at high risk and 132 (51% of the census) at medium risk for choking. However, Individual #42 who experienced a choking incident on 3/11/12 was ranked incorrectly at medium risk. Consequently, it did not appear that the Facility had an accurate list to identify individuals who were at high risk of choking. ▪ A list developed by the HT Department noted 31 individuals (12% of the census) had a diagnosis of dysphagia (i.e., difficulty swallowing). A second list of Individuals diagnosed with dysphagia from ICD-9 codes, dated 6/5/12, identified 38 individuals (15% of the census). The disparity between these two lists illustrated the Facility did not have an accurate list to identify individuals, who had difficulty swallowing. ▪ One hundred and thirty individuals (53% of the census) utilized a wheelchair as primary mobility. The list, dated 5/21/12, was generated from the HT database. However, an individual on the wheelchair priority list (i.e., Individual #350) was not identified on the list of individuals who utilized a wheelchair. Consequently, it did not appear that the Facility had an accurate list to identify individuals who used a wheelchair. ▪ The Facility did not have a list to specifically identify individuals who required positioning assistance associated with swallowing activities. As noted above, the lists presented by the Facility to identify individuals having physical and nutritional management problems were not accurate. The Facility should develop a sustainable system to maintain and update these lists on the HT database to ensure their validity. A basic component of compliance with this provision is the accurate identification of individuals with PNM concerns. Without an accurate list(s), it would be difficult for the Facility to ensure that it provides such individuals with adequate physical and nutritional interventions. **PNMT Referral Process and Initiation of Assessment** A draft Facility Policy O.3, Physical and Nutritional Management: Referral to the PNMT had been developed. Based on interview, training would not be provided to IDT members until after the new ISP and Risk Process were rolled out. The IDT, PCP (primary care physician), or PNMT could refer individuals to the PNMT for whom the team needed additional assistance in formulating a plan. Individuals were to be referred to the PNMT when: ▪ An individual's risk level was determined to be in the highest range of one or more categories and the IDT had not been able to improve outcomes using action plans; ▪ An individual's health or risk status changed or deteriorated, even though an IDT	

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action plan had been developed and implemented;
▪ An individual had continued hospitalizations even though an IDT action plan was in place; and
▪ The PNMT could also self-refer an individual based on evaluations consults, or data from the Facility's monitoring systems.
The policy also indicated the PNMT was to begin an assessment within five working days of the referral or sooner to "determine possible causes for change in status, analyze assessment findings, integrate recommendations, and propose a plan with goals and desirable outcomes."

The Facility presented a list, dated 7/2/12, identifying who had been referred to the PNMT as a result of an Integrated Risk Rating meeting. Since the Monitoring Team's last review, 16 individuals had been referred to the PNMT. A review of the PNMT's caseload over the past five months (January through May, 2012) showed that the IDTs had referred individuals to the PNMT that were currently on the PNMT caseload, individuals had been discharged from the PNMT but the IDT referred these individuals to the PNMT again, and/or the PNMT had not completed a review. The following summarizes the status of the individuals referred to the PNMT:

<table>
<tr><th>Individual</th><th>IRR Meeting Date resulting in PNMT Referral</th><th>PNMT Referral Status</th></tr>
<tr><td>Individual #79</td><td>1/17/12</td><td>PNMT assessment on 10/20/11 and 1/24/12, but not on PNMT caseload</td></tr>
<tr><td>Individual #223</td><td>Referral on 3/7/12, but already on PNMT caseload</td><td>PNMT caseload January to May, 2012</td></tr>
<tr><td>Individual #244</td><td>Referral on 6/6/12, but already on PNMT caseload</td><td>PNMT caseload from January to May, pending discharge</td></tr>
<tr><td>Individual #177</td><td>1/25/12</td><td>Not assessed by PNMT</td></tr>
<tr><td>Individual #43</td><td>Referral on 4/9/12, but already on PNMT caseload</td><td>PNMT caseload January to May, 2012</td></tr>
<tr><td>Individual #194</td><td>2/21/12</td><td>Discharged from PNMT on 2/23/12</td></tr>
<tr><td>Individual #9</td><td>6/1/12</td><td>Not assessed by PNMT</td></tr>
<tr><td>Individual #179</td><td>Referral on 2/2/12, but already on PNMT caseload</td><td>PNMT caseload from January to May 2012</td></tr>
<tr><td>Individual #153</td><td>2/17/12</td><td>Discharged from PNMT on 1/18/11, but</td></tr>
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		the PNMT did not reassess
Individual #86	Referral on 5/11/12, but already on PNMT caseload	PNMT caseload from January to May 2012; pending release from PNMT caseload meeting with IDT on 5/11/12
Individual #117	Referred on 6/14/12 but already on PNMT caseload	10/6/11 - will not be referred to PNMT-actions in place; added to active PNMT caseload on 4/27/12
Individual #348	2/23/12	Discharged from PNMT on 5/10/11; not reassessed by PNMT
Individual #274	4/13/12	Per report of HT Director accidentally checked for PNMT referral on IRR form
Individual #166	4/9/12	PNMT assessment with IDT on 9/22/11; not reassessed by PNMT
Individual #247	Referral on 4/12/12, but already on PNMT caseload	PNMT caseload from January to May 2012
Individual #141	1/6/12	Not assessed by PNMT

The preceding results showed the Facility should review the PNMT referral database to assess the accuracy of information contained within the database. The Facility's database should not only reflect when a referral was made to the PNMT, but also identify the status of the PNMT referral. In addition, the Facility should audit compliance with the Facility PNMT referral policy.

Four individuals from Sample #1 who had been hospitalized with PNM-related issues were reviewed to determine if a referral had been made to the PNMT. Seven individuals from Sample #2 were reviewed to determine if the PNMT had initiated an assessment within five working days. The review of these individuals' records found:

- In none of the four records in Sample #1 of individuals who had a hospitalization indicating a change in status that should have initiated a referral to the PNMT (i.e., Individual #340, Individual #273, Individual #176, and Individual #124) (0%) was evidence found of an IDT referral to the PNMT and/or a PNMT self-referral within five working days of the ISPA meeting. For example, Individual #340 had been hospitalized with pneumonia and had experienced two respiratory infections within the past six months; Individual #273 had been hospitalized two times with pneumonia; Individual #176 had been hospitalized three times and had an unplanned weight loss of 20.4% within the past six

#	Provision	Assessment of Status	Compliance
		months; and Individual #124 had been discharged from the PNMT but was hospitalized with a diagnosis of aspiration pneumonia. ▪ In one of seven individual records reviewed in Sample #2 (i.e., Individual #278) (14%), the PNMT self-referral and/or IDT referral met the timeline criteria for the initiation of an assessment (i.e., five working days) established by the Facility PNMT referral policy and as established in the State At-Risk Individuals policy. For the remaining individuals, the PNMT did not begin an assessment within five working days and/or there was no referral date provided to determine if an assessment had been initiated within five working days. For example, Individual #89's PNMT assessment did not note a referral date; Individual #239 was referred by the IDT in February 2012, although the PNMT did not initiate an assessment until 4/13/12; Individual #144's IDT referral date was 2/23/12, although the PNMT assessment date was 3/8/12; Individual #89 and Individual #43's referral dates could not be determined; and Individual #117's referral date was 3/20/12, but the PNMT assessment date of 4/27/12 exceeded the five working days. These examples showed the Facility IDTs were not consistently referring individuals to the PNMT and the PNMT was not consistently initiating an assessment within five working days. Based on interview, as noted previously, the HT Director reported the IDTs would not be provided training on the draft PNMT Referral policy until the revised ISP and risk process had been implemented. **PNMT Assessment** At the time of the review, the current PNMT caseload was 18 individuals. Since the last review, three individuals the PNMT supported had died (i.e., Individual #316, Individual #175, and Individual #117). Individual #117 died during the week of the onsite review. Seven individuals had been discharged from the PNMT (i.e., Individual #79, Individual #10, Individual #194, Individual #56, Individual #113, Individual #244, and Individual #86). The Facility PNMT policy indicated the PNMT was responsible for completing a comprehensive assessment and action plan, as well as monitoring the efficacy of the interventions. The policy further defined the content of the assessment and action plan. The Monitoring Team reviewed the content of PNMT assessments and action plans for the seven individuals in Sample #2 and found: ▪ None of the seven individual PNMT assessments reviewed (0%) were adequate to identify the physical and nutritional interventions and supports sufficient to meet the individual's needs. For example: o None of the seven individual PNMT assessments reviewed (0%) followed the Facility-established PNMT assessment template. PNMT	

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		assessments reviewed were missing components from the Facility PNMT assessment format. o In none of seven individual PNMT assessments reviewed (0%), the assessment identified the cause of the individual's physical and nutritional management problems. PNMT assessments did not provide an adequate analysis to identify the cause of the individual's PNM concerns. o In five of the seven individual PNMT assessments reviewed (71%), a PNMT self-referral and/or IDT referral date was noted. Individual #89 and Individual #43's PNMT assessments did not have referral dates. o In none of the seven individual PNMT assessments reviewed (0 %), the assessment reviewed and updated the individual's risk rating(s), as appropriate. o In none of seven individual PNMT assessments reviewed (0%), there was documentation of adequate PNMT assessment of an individual's PNM high and related medium risk levels. Individuals at high risk for PNM concerns were not adequately assessed (i.e., weight, aspiration). For example, the PNMT assessments did not provide an assessment that identified the comprehensive supports that would be necessary to mitigate the risk indicators. In addition, the assessment did not identify the clinical indicators that would signal a healthy and/or unhealthy status for the individual. o In three of the seven individual PNMT assessments reviewed (i.e., Individual #89, Individual #239, and Individual #117) (43%), a HOBE assessment had been completed following the State-established assessment template. However, the HOBE assessment format did not include an assessment of a recommended safe range for dental procedures. A therapist has the clinical expertise to establish a safe elevation range while an individual is positioned. The therapist should work in collaboration with the dentist to achieve the goal of a safe elevation range during dental procedures. o In none of the seven individual PNMT assessments reviewed (0%) were individual-specific clinical baseline data established to assist teams in recognizing changes in health status. o In none of the seven individuals' PNMT assessment (0%), individualized clinical criteria defined when nursing staff should contact the PNMT. Given that multiple components as identified above were not present, PNMT assessments were not adequate.	

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		PNMT Action Plan The Facility PNMT policy stated action plans would include action steps: which reported assessment results and provided measurable objectives to be incorporated in the ISP, included clinical indicators and timelines for reassessment to determine if the plan was successful and/or required amendment, addressed the development and implementation of direct interventions and supports to lower the individual's risk level and promote stable health, and recommended competency-based training to support the implementation of action steps. Actions plans were to minimally include measurable objectives, action steps, frequency of monitoring or reporting, person responsible, schedule for follow-up, outcomes, timelines, and other information, as applicable. The Monitoring Team reviewed individuals' PNMT action plans and found: ▪ In none of the seven individuals' PNMT action plans reviewed (0%), the plan adequately addressed the individual's identified PNM problems as presented in the PNMT assessment. ▪ In three of the seven individuals' PNMT action plans reviewed (i.e., Individual #89, Individual #239, and Individual #117) (43%) the HOBE recommendations were integrated into PNMT action plan. ▪ In none of the seven individuals' PNMT action plans reviewed (0%), preventative interventions were included in the plan to minimize the conditions of identified risk indicators. For example, the action plans for individuals who experienced significant weight loss did not provide aggressive interventions to minimize their continued weight loss. ▪ In none of the seven individuals' PNMT action plans reviewed (0%), there were appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan. ▪ In none of the seven individuals' PNMT action plans reviewed (0%), the plans included the specific clinical indicators to be monitored. For example, action plans did not identify clinical indicators to be monitored by nursing and/or the PNMT members that would indicate the individual was experiencing a change of status. ▪ In none of the seven individuals' PNMT action plans reviewed (0%), the frequency of monitoring was included in the plans. Action plans would identify frequency of monitoring for some steps, but identification of monitoring frequency was not consistent in the plans. ▪ In none of the seven individuals' PNMT action plans reviewed (0%), the action plan was integrated into the ISP. ▪ For seven of the seven individuals reviewed (100%), a PNMT/IDT meeting had been conducted to discuss the Integrated Risk Rating Form, PNMT assessment, and action plan. ▪ In none of seven individuals' documentation reviewed (0%), supporting documentation was present to confirm implementation of PNMT action plan	

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		within 14 days of the plan's finalization. Given that multiple components as identified above were not present, individuals' PNMT action plans were not adequate. **PNMT Follow-up and Problem Resolution** A review of PNMT follow-up meetings for individuals in Sample #2 showed: ▪ In seven of the seven individuals' PNMT action plans reviewed (100%), action plan steps had established timelines. ▪ In none of the seven individuals' PNMT action plans reviewed (0%), action plan steps had been completed within established timeframes. Unmet action steps were reported from PNMP follow-up meeting to meeting that exceeded the timeframes established by the PNMT members. For example, weights for individuals who required weekly weights to assess their weight status would not be provided from week to week. ▪ In none of the seven individuals' PNMT action plans reviewed (0%), when risk to the individual was warranted, the PNMT took immediate action. For example, multiple individuals' weight status that placed them at risk was not addressed clinically within an adequate timeframe. ▪ In none of the seven individual records reviewed (0%), documentation was present for adequate closure of PNMT action plan steps. The following concerns were noted during the review of individuals' PNMT action plans: ▪ PNMT members did not attend ISPA post-hospitalization meetings to review the PNMT action plans for revisions, if appropriate. ▪ PNMT Follow-Up meetings reported action plan steps not being met by due date and/or were being followed from month to month without resolution. ▪ PNMT Follow-Up meetings stated a recommendation was completed, but there was no analysis provided to assess the efficacy of the intervention or report if the individual's health status was better and/or worse. ▪ Aspiration trigger sheets had not been consistently completed on a monthly basis. **Individuals Discharged by the PNMT** The Facility's PNMT policy did not address the procedures to be followed by the PNMT and the IDT for discharging an individual from the PNMT. However, the Facility had developed a draft PNMT Discharge template that had not been implemented. The template sections included general information, risk factors, active problem list, behavioral challenges, medication side effects, physical clinical indicators, nutritional indicators, diagnostic tests, hospitalization/Infirmary admissions, treatments, PNMP, Health Management Plan, PNMT analysis/summary, PNMT recommendations completed	

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		and pending. The PNMT draft Discharge template was a positive step forward to formalize the discharge process. Since the last review, the PNMT had discharged seven individuals. The Monitoring Team reviewed the records of three of these seven individuals: Individual #86, Individual #113, and Individual #10. A review of the three individuals' records indicated the Facility should expand the PNMT policy to define PNMT discharge protocols. Facility records submitted indicated Individual #10 had been discharged by the PNMT on 2/10/12. However, a review of Individual #10's requested documentation noted he was "currently still on [the] PNMT." However, his PNMT assessment stated: "the team and the PNMT agree that for the accomplishment of [Individual #10's] goals there is no need for the PNMT to continue to follow his case," and there was no additional documentation (i.e., PNMT action plan, IPNs) to substantiate PNMT involvement. However, for review purposes, Individual #10 was removed from the sample, leaving two individuals in the sample. Finding regarding these individuals were as follows: ▪ In none of the two individuals' records reviewed (0%) for individuals discharged by the PNMT, an ISPA meeting occurred. ▪ In none of the two individuals' records reviewed (0%) for individuals discharged by the PNMT, the ISPA meeting provided objective clinical data to justify the discharge. ▪ In none of the two individuals' records reviewed (0%) for individuals discharged by the PNMT, the PNMT recommendations were integrated into the ISP or an ISPA. ▪ In none of the two individuals' records reviewed (0 %) for individuals discharged by the PNMT, there was criteria for referral back to the PNMT. Individuals discharged by the PNMT did not have adequate discharge plans as multiple components were missing from a PNMT discharge summary. The Facility should provide additional guidance through the development of procedures to further define the PNMT discharge process to include, at a minimum: status of efficacy of implemented PNMT recommendations, justification for an individual to be discharged from the PNMT through the provision of objective clinical data to document stable or improved health, integration of the PNMT recommendations into the ISP, and objective clinical data for referral back to 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,	**Facility Self-Assessment** A review of the Facility's Self-Assessment indicated the following: ▪ The Facility's review of three PNMPs indicated 100% (three out of three) compliance score for adequate instructions for amount of time to remain upright after a meal, medication administration specifically positioning, and positioning	Noncompliance

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	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.	while receiving oral hygiene. A 67% compliance score (two out of three) was achieved for adequate instructions for positioning and alternate positioning, and positioning while performing personal care. ▪ Three dining plans were audited and the following data was presented: 100% had adaptive equipment, 67% had triggers that would prompt review; 33% had behavioral concerns related to intake, and 0% had presentation techniques. ▪ The Facility's review of the individuals' ISPs noted that PNMPs were integrated in 33% of the ISPs. ▪ The Facility's review of individuals' ISP/ISPAs data revealed 0% PNMPs were reviewed and/or changed when the individual was admitted to the Infirmary, emergency room and/or hospital. The Facility's Self-Assessment indicated that: "based on the findings from this self-assessment, this provision is not in compliance because although PNMPs prescribe adequate mealtime, oral hygiene and oral medication plans for individuals, dining plans continue to lack adequate feeding and mealtime techniques and positioning of the individual during personal care and during other activities that are likely to provoke swallowing difficulties. When they do contain the necessary components, the plans are not consistently integrated into the ISP. When they are integrated into the ISP they are not consistently reviewed and/or changed upon change in status or setting." The Monitoring Team's findings also showed that the Facility was not compliant with this provision. PNMPs were reviewed for individuals in Sample #1 and Sample #2, and the results of this review are discussed in this section. **<u>Identification of Individuals Requiring a PNMP</u>** The Facility provided an additional list that identified individuals with PNM needs, dated 5/18/12. The list noted that 237 of 260 (91%) individuals had PNM needs and had a PNMP. Twenty-three of 260 (9%) individuals did not have PNM needs or a PNMP. A review of these 23 individuals risk rankings presented in the CCSSLC Integrated Risk Ratings-by Home, dated 5/31/12, showed that some of these individuals had PNM needs as evidenced by a high and/or medium risk ranking in choking, aspiration, falls, fractures, skin integrity, and/or weight. However, these individuals were identified with "no PNM needs." In addition, one of the 23 individuals (i.e., Individual #61) had been admitted to the Facility on 5/15/12, and her risk rankings were not provided. The following concerns were noted for individuals who received a high and/or medium PNM risk ranking, but did not have a PNMP: ▪ An individual's high and/or medium risk rating for aspiration indicates the need for a PNMP. Individual #7's IDT ranked her at high risk for aspiration, but she was not on the list of individuals with PNM needs. ▪ Individuals at high risk for choking have a need for a PNMP. Individual #7 was ranked at high risk for choking, but was not on the list of individuals with PNM	

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		needs. ▪ Individuals at high and/or medium risk for falls had a need for a PNMP. However, individuals were identified as not having PNM needs, but were ranked at high and/or medium risk for falls (i.e., Individual #193 and Individual #353). ▪ Individuals at high and/or medium risk for skin integrity required a PNMP. However, individuals were identified with "no PNM needs," but were ranked at high and/or medium risk for skin integrity (i.e., Individual #255 and Individual #353). ▪ Individuals at high and/or medium risk for weight indicated the need for a PNMP. However, individuals ranked at high and/or medium risk for weight did not have a PNMP (i.e., Individual #48, Individual #238, Individual #5, Individual #46, Individual #88, Individual #255, Individual #325, Individual #174, Individual #318, Individual #109, Individual #312, and Individual #353). Based on the examples above, individuals who had been identified with "no PNM needs" did, in fact, have PNM needs. Consequently, the Monitoring Team did not have confidence in the accuracy of this list. The HT Department should follow the State Office policy that defined the PNM criteria for individuals who require a PNMP. The State Office policy PNM criteria should be utilized to review the list of 23 individuals with "no PNM needs" to determine which of these individuals meet the PNM criteria and should be provided with a PNMP sufficient to meet their needs. **PNMP Format and Content** On 5/30/12, the Facility PNMP Directions had been revised. The directions had been updated to address the placement of medication administration instructions; add adaptive equipment such as a continuous positive airway pressure (C-Pap) devices, glasses, dentures to the PNMP if the individual required staff assistance for placement of the equipment; and specify that revision of a PNMP required the completion of an Assessment of Current Status, and completion of an in-service by the therapist for the PNMP Coordinator on the revised PNMP. These additions to the PNMP directions were positive changes. The PNMP Coordinator Supervisor was responsible for maintaining the HT Database to ensure current information was entered when an individual's PNMP was revised. These revisions could occur during an annual ISP meeting and/or when an individual experienced a change in status. Based on interview with the PNMP Coordinator Supervisor, the content of the revised PNMP was reviewed to ensure compliance with the Facility PNMP directions. If not, the PNMP would be returned to the therapist for correction. The PNMP Coordinator had the ability to run individual-specific PNMP reports and PNMPs by home.	

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		A review of 11 individuals' PNMPs who received enteral nutrition (i.e., Individual #122, Individual #126, Individual #142, Individual #340, Individual #273, Individual #176, Individual #124, Individual #266, Individual #274, Individual #269, and Individual #68) in Sample #1 found: ▪ Eleven of the 11 individuals (100%) had a PNMP. ▪ Eleven of the 11 individuals' PNMPs (100%) were current within the last 12 months. ▪ None of the 11 individuals' annual ISPs (0%) noted that the appropriate disciplines were present to approve and integrate the PNMP in the ISP. The Settlement Agreement requires that PNMPs be developed based on input from the IDT, home staff, medical and nursing staff, and the physical and nutritional management team. o Medical staff were present in 9 of 11 annual ISP meetings (82%); o Nursing staff were present in 10 of 11 annual ISP meetings (91%); o Registered Dietician staff were present in none of 11 annual ISP meetings (0%); o Physical therapists were present in two of 11 annual ISP meetings (18%); o Occupational therapists were present in 1 of 11 annual ISP meetings (COTA attended) (9%); o Speech language pathologists were present in two of 11 meetings (18%); o Psychologists were present in five of 11 annual ISP meetings (45%); and o Direct support professionals were present in eight of 11 meetings (73%). ▪ None of the 11 individuals' PNMPs (0%) were integrated into the ISP (e.g., PNMP strategies integrated into nursing care plans, skill acquisition programs, BSPs). ▪ Eleven of 11, individuals' PNMPs (100%) noted individual-specific risks and related triggers. ▪ In none of 11 individuals' PNMPs (0%) were adequate positioning instructions included for wheelchair positioning, including written and pictorial instructions and safe elevation ranges. More specifically, the wheelchair positioning instructions did not provide adequate instructions for staff to achieve a safe elevation range. ▪ In three of 11 individuals' PNMPs (i.e., Individual #274, Individual #126, and Individual #269) (27%), there were adequate alternate positioning instructions including written and pictorial instructions and safe elevation ranges. ▪ In 10 of 11 individuals' PNMPs (i.e., Individual #266, Individual #176, Individual #340, Individual #273, Individual #124, Individual #126, Individual #68, Individual #122, Individual #142, and Individual #274) (91%), bedtime positioning options were noted. Individual #269's PNMP stated: "requires	

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		assistance with all bed mobility." However, her PNMP did not provide staff instructions for alternate bed positions. ▪ In 11 of 11 individuals' PNMPs (100%), there were transfer instructions (i.e., mechanical lift, two-person, pivot). ▪ Individual #269 ate orally and received enteral nourishment. The following related findings were made with regard to this individual's PNMP: o In none of one individual's PNMPs/dining plans for individuals who ate orally (0%), mealtime plans included written and/or pictorial instructions for positioning. o In one of one individual's PNMPs/dining plans for individuals who ate orally (100%), mealtime plans included written and/or pictorial instructions for food texture. o In one of one individual's PNMPs/dining plans for individuals who ate orally (100%), mealtime plans included written and/or pictorial instructions for fluid consistency. o In one of one individual's PNMPs/dining plans for individuals who ate orally (100%), mealtime plans included staff presentation techniques. ▪ None of 11 individuals' PNMPs (0%) noted safe positioning elevation ranges to be utilized during dental appointments. ▪ Eleven of 11 individuals' PNMPs (100%) stated the time an individual needed to remain upright after eating and/or receiving enteral nutrition. ▪ In none of 11 individuals' PNMPs (0%), medication administration strategies included positioning options with safe elevation ranges. ▪ Individual #269 received medication by mouth. The following related findings were made with regard to this individual's PNMP: o In one of one individual's PNMPs (100%), the medication administration strategies for individuals that received medication by mouth included instructions for diet texture and fluid consistency. o In one of one individual's PNMPs (100%), the medication administration strategies for individuals who received medication by mouth included instructions for mealtime adaptive equipment. o In none of one individual's PNMPs (0%), medication administration strategies for individuals who received medication by mouth included instructions for presentation techniques. ▪ In none of 11 individuals' PNMPs (0%) included adequate strategies for oral hygiene, including positioning with safe elevation ranges. Specifically, the safe elevation ranges were missing. ▪ Seven of 11 individuals' PNMPs (i.e., Individual #340, Individual #274, Individual #68, Individual #142, Individual #266, Individual #269, and Individual #273) (64%) included the reasons for an individual's prescribed adaptive equipment.	

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		▪ Five of 11 individuals' PNMPs (i.e., Individual #340, Individual #126, Individual #124, Individual #266, and Individual #176) (45%) included bathing/showering positioning instructions to achieve a safe elevation range. ▪ One of 11 individuals' PNMPs (i.e., Individual #274) (9%) included adequate personal care instructions, with elevation strategies during checking and changing. ▪ Eleven of 11 individuals' PNMPs (100%) stated how an individual would communicate with staff. A review of seven individuals' PNMPs on the PNMT caseload in Sample #2 found: ▪ Seven of the seven individuals (100%) had a PNMP. ▪ Seven of the seven individuals' PNMPs (100%) were current within the last 12 months. ▪ None of the seven individuals' annual ISPs (0%) noted that the appropriate disciplines were present to approve and integrate the PNMP in the ISP. o Medical staff were present in one of seven annual ISP meetings (14%); o Nursing staff were present in four of seven annual ISP meetings (57%); o Registered dietician staff were present in none of seven annual ISP meetings (0%); o Physical therapists were present in one of seven annual ISP meetings (14%); o Occupational therapists were present in one of seven annual ISP meetings (14%); o Speech language pathologists were present in none of seven meetings (0%); o Psychologists were present in two of seven annual ISP meetings (29%); and o Direct support professionals were present in four of seven meetings (57%). ▪ None of the seven individuals' PNMPs (0%) were integrated into the ISP (e.g., PNMP strategies integrated into nursing care plans, skill acquisition programs, BSPs). ▪ Seven of seven individuals' PNMPs (100%) noted individual-specific risks and related triggers. ▪ In two of seven individuals' PNMPs (i.e., Individual #89 and Individual #144) (29%), there were adequate positioning instructions for wheelchair positioning, including written and pictorial instructions and safe elevation ranges. ▪ In two of seven individuals' PNMPs (i.e., Individual #89 and Individual #144) (29%), there were adequate alternate positioning instructions including written and pictorial instructions and safe elevation ranges. ▪ In four of seven individuals' PNMPs (Individual #89, Individual #144, Individual	

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		#278, and Individual #43) (57%), bedtime positioning options were noted. ▪ In seven of seven individuals' PNMPs (100%), there were transfer instructions (i.e., mechanical lift, two-person, pivot). ▪ Three individuals ate orally within Sample #2: Individual #144, Individual #278 and Individual #378. The following related findings were made with regard to these individuals' PNMPs: o In one of three individuals' PNMPs/dining plans (i.e., Individual #144) for individuals who ate orally (33%), mealtime plans included written and/or pictorial instructions for positioning. o In three of three individuals' PNMPs/dining plans for individuals who ate orally (100%), mealtime plans included written and/or pictorial instructions for food texture. o In three of three individuals' PNMPs/dining plans for individuals who ate orally (100%), mealtime plans included written and/or pictorial instructions for fluid consistency. o In two of three individuals' PNMPs/dining plans (Individual #278 and Individual #378) for individuals who ate orally (66%), mealtime plans included staff presentation techniques. ▪ None of seven individuals' PNMPs (0%) noted safe positioning elevation ranges to be utilized during dental appointments. ▪ Four of seven individuals' PNMPs (i.e., Individual #278, Individual #378, Individual #239, and Individual #117) (57%) stated the time an individual needed to remain upright after eating and/or receiving enteral nutrition. ▪ In three of seven individuals' PNMPs (i.e., Individual #144, Individual #278, and Individual #117) (43%), medication administration strategies included positioning options with safe elevation ranges. ▪ Three individuals received medication orally within Sample #2: Individual #144, Individual #278 and Individual #378. The following related findings were made with regard to these individuals' PNMPs: o In three of three individuals' PNMPs (100%), medication administration strategies for individuals that received medication by mouth included instructions for diet texture and fluid consistency. o In three of three individuals' PNMPs (100%), medication administration strategies for individuals who received medication by mouth included instructions for mealtime adaptive equipment. o In none of three individuals' PNMPs (0%), medication administration strategies for individuals who received medication by mouth included instructions for presentation techniques. ▪ None of seven individuals' PNMPs (0%) included strategies for oral hygiene, including positioning with safe elevation ranges. ▪ None of seven individuals' PNMPs (0%) included the reasons for an individual's	

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		prescribed adaptive equipment. ▪ Five of seven individuals' PNMPs (i.e., Individual #144, Individual #278, Individual #378, Individual #239, and Individual #43) (71%) included bathing/showering positioning instructions to achieve a safe elevation range. ▪ Three of seven individuals' PNMPs (i.e., Individual #144, Individual #278, and Individual #378) (43%) included adequate personal care instructions, with elevation strategies during checking and changing. ▪ Seven of seven individuals' PNMPs (100%) included strategies for how staff was to communicate with an individual. ▪ Seven of seven individuals' PNMPs (100%) stated how an individual would communicate with staff. Areas of noncompliance in PNMP strategies were not significantly different from individuals in Sample #1 or Sample #2. The following concerns were noted: ▪ HOBE assessments had not been completed to establish safe elevation ranges in wheelchair and alternate positions, bathing/showering, personal care, oral care, dental appointments, or other activities that were likely to provoke swallowing difficulties. HT Department meeting minutes, dated 5/18/12, indicated "according to State policy we must have HOBEs on file for the following categories as part of standard assessment: requiring ventilation, enteral feedings, and have had aspiration pneumonia in the past year." The HT Director was to schedule refresher training on HOBE assessments. Individuals' PNMPs will need to have HOBE assessment data integrated to provide staff instructions for safe elevation ranges in daily activities. ▪ Wheelchair positioning instructions instructed staff to place an individual in the most "upright position." Based on interview with staff during an observation and the PNMT nurse, the "upright position" on the PNMP referred to the individual being upright not the tilt of the wheelchair base. For example, individuals' wheelchairs were designed to be tilted within a range of degrees. However, the PNMP did not provide instructions for staff to achieve the safe elevation range and/or ranges for an individual in the wheelchair. During an interview with the PT Director, a draft PNMP was shared with the Monitoring Team to address this concern. The positioning instructions on Individual #340's PNMP had been revised to state: "use most allowed ranges of the WC 45-75 degrees position in wheelchair when receiving nutrition or medication via G-tube. 75 [degrees] is preferable but if his head is flexing forward he may be reclined to 45 degrees." These instructions were an improvement. These instructions provided direction for placement of the wheelchair base within recommended degrees of elevation to support safety for the individual. ▪ The absence of clinicians (i.e., OT, PT, SLP, and RD) during the annual ISP meetings negatively impacted the discussion related to the integration of PNMP	

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		and dining plans into the ISP, risk assessment, and multiple support plans. These clinicians were the authors of the PNMPs and their contribution was critical to the team understanding the purpose of the individual's PNMP. According to Facility documentation, a PNMP audit tool had been developed but had not been implemented. The Facility should review the Facility PNMP audit tool to determine if the tool includes the PNMP compliance indicators presented in this section. **Implementation of Individuals' PNMP Off-Campus (i.e., community outing, hospitalization)** There was no Facility policy that specifically addressed the implementation of individuals' PNMP off-campus (i.e., hospitalization, community outing). Nine individuals' (i.e., Individual #126, Individual #124, Individual #176, Individual #273, Individual #340, Individual #304, Individual #156, Individual #266 and Individual #198) in Sample #1 and four individuals (i.e., Individual #239, Individual #117, Individual #144 and Individual #239) in Sample #2 were hospitalized since the last review. A review of Hospital Liaison reports for these individuals noted the following concerns: ▪ Hospital Liaison Reports noted the presence of an individual's PNMP, but did not discuss if the PNMP strategies were being implemented as prescribed. ▪ IPNs completed by Hospital Liaison Nurse noted the presence of a copy of the PNMP and the position of the individual (e.g., Individual #176, Individual #124, Individual #340, Individual #304, Individual #156, and Individual #198). The IPNs addressed the position of the individual(s), however, the notes did not indicate if the position and the elevation range were in alignment with the PNMP strategies. The State Office policy 012.2 stated: "the plan [PNMP] is designed to span a 24-hour day, seven days per week, and is designed to meet the needs of a specific individual." The Facility should develop local procedures to address the implementation of PNMPs off-campus. **Change in Status Update for Individuals' PNMPs Conducted by the IDT and/or Individuals on the PNMT Caseload** Individuals' revised PNMP were reviewed to determine if an ISPA meeting had been conducted to address the proposed revisions and the following was found: For the individuals in Sample #1, four of the 11 individuals' PNMPs had been revised after their annual ISP meeting (i.e., Individual #340, Individual #126, Individual #142, and Individual #176). ▪ None of the four individuals (0%) had an ISPA meeting conducted to address the	

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		PNMP revisions. ▪ None of the four individuals' records (0%) had supporting documentation to show that the individuals' revised PNMPs had been implemented (i.e., IPN notes, individual-specific monitoring). For the individuals in Sample #2, seven of the seven individuals' PNMPs had been revised after their annual ISP meeting. ▪ One of seven individuals' ISPA meeting(s) (i.e., Individual #278) (14%) noted the PNMP had been reviewed and revised, as appropriate, based on the individual's change in status. ▪ One of the seven individuals' records (i.e., Individual #278) (14%) had supporting documentation to show that the individuals' revised PNMPs had been implemented (i.e., IPN notes, individual-specific monitoring). The Facility PNMP Directions, revised 5/30/12, included a section related to PNMP revisions, and discontinuing and/or placing strategies on hold. However, this section did not instruct clinicians to request an ISPA meeting to present PNMP revisions. The Facility PNMP Directions should discuss requesting an ISPA meeting to ensure that an interdisciplinary discussion of the proposed revisions occurs and the IDT members provide approval of the revised PNMP.	
O4	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure staff engage in mealtime practices that do not pose an undue risk of harm to any individual. Individuals shall be in proper alignment during and after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	**Facility Self-Assessment** A review of the Facility's Self-Assessment indicated the following: ▪ The Facility had completed competency-based training for 48 out of 82 dining room monitors (59%). The Facility's Self-Assessment indicated that: "Based on findings from this self-assessment, this provision is not in compliance because although the system is in place, not all required employees have been trained. The system has produced data; however, it has not been in place long enough to analyze that data or to make necessary corrective changes." The Monitoring Team discusses this initiative within this section. **Monitoring Team's Observation of Staff Implementation of Individuals' PNMPs** The Monitoring Team and the PNMT nurse completed direct observations in the Infirmary and residences, including the dining rooms for five individuals on the PNMT caseload, including: Individual #43, Individual #239, Individual #89, Individual #378, and Individual #278. ▪ In none of three observations during mealtimes of individuals (0%), staff followed mealtime plan instructions for positioning (Individual #278, Individual #378, and Individual #89). ▪ In one of two observations during mealtimes of individuals who ate orally	Noncompliance

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		(50%), staff presented the correct food texture. The incorrect food texture was presented to Individual #378. ▪ In one of two observations during mealtimes of individuals who ate orally (50%), staff presented the correct fluid consistency. Individual #378's prescribed fluid consistency was nectar, but she was presented a regular fluid. ▪ In two of two observations during mealtimes of individuals who ate orally (100%), the individual and/or staff used the prescribed adaptive equipment. (Individual #278 and Individual #378). ▪ In none of two observations during mealtimes of individuals who ate orally (0%), staff followed mealtime presentation techniques (i.e., Individual #378 and Individual 278). ▪ In none of one observation (0%), staff completed a transfer (i.e., mechanical lift, pivot, two-person manual) as instructed in the PNMP (i.e., Individual #378). ▪ In none of one observation (0%) staff followed alternate positioning instructions (i.e., Individual #43). ▪ In none of two observations (0%) was the individual positioned correctly in a wheelchair (i.e., Individual #239 and Individual #89). The following concerns were noted: ▪ The PNMP provides the foundation for health and safety. Observations of these five individuals by the Monitoring Team and the PNMT nurse revealed that PNMPs had been breached. The PNMT nurse had to intervene with staff during every observation to correct staff's approach for wheelchair positioning, alternate positioning, mealtime fluid consistency and presentation techniques, and transfers. ▪ A pulled staff member in the Infirmary stated that additional training would be helpful. Another pulled staff in Ribbonfish was not familiar with the correct procedure for a pivot transfer. Pulled/relief staff required additional support to implement individuals' PNMPs correctly. These observations substantiated that staff were not competent in implementing foundational and/or individual-specific PNMP strategies. The PNMT and IDT members should provide additional support to staff to enhance their competency in the implementation of PNMPs, particularly for those individuals at highest risk. **<u>Facility Initiatives</u>** Since the last review, the Facility continued to work on improving their mealtime delivery system to ensure staff did not engage in unsafe mealtime practices. Dining Room Monitors had been added to provide an additional level of oversight in the dining rooms. Facility Policy P.5, Ensuring Safe Practices During Meals, defined the role of a Dining Room Monitor (DRM). The DRM was responsible for monitoring the overall	

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		function of the dining room. A DRM was a Team Leader or Residential Coordinator. There were 82 Dining Room Monitors. The DRM did not directly assist individuals. The DRM was responsible for completing one Dining Room Observation Report per meal which included the following sections with multiple indicators under each section: ▪ Environmental; ▪ Presence and use of PNMP/Dining Plan and Diet Card; ▪ Presence and use of materials/equipment; ▪ Implementation of dining plan techniques; and ▪ Individuals assisted by staff. Based on interview with the HT Director, these indicators were pulled from a variety of sources: ICF/ID survey, Mock Survey, Independent Monitor's Reports, and Facility staff. Dining Room Monitoring Training rosters were submitted which reported 49 DRMs (i.e., Team Leaders and Residential Coordinators) completed a three-hour training conducted by the HT Director. The training included a review of Facility Policy P.5, Ensuring Safe Practices During Meals, Safe Mealtime Practices Protocol, Dining Room Observation Report and Instructions, Mealtime Safety Objective, and visits for competency in the dining room. The Facility self-assessment results for Section O.4 indicated 48 out of 82 DRMs (58%) had completed this training. The final component of the competency-based training required a joint observation with a therapist in the dining room without the Dining Room Observation Report, the second observation required the completion of one form by the DRM in conjunction with the therapist, and the final requirement entailed the independent completion of a report form in the dining room by the DRM and the therapist. An inter-rater reliability agreement score of 80% had to be achieved to complete competency for dining room supervision/monitoring. This initiative was in the beginning stages. The Monitoring Team will observe DRMs during the next on-site review as well as review the Facility's tracking and trending of data from these reports.	
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.	**Facility Self-Assessment** A review of the Facility's Self-Assessment indicated the following: ▪ The Facility did not have data available to substantiate that competency-based training for staff had been completed for individuals that required individual-specific PNMP training. The Facility reported it was in the process of developing a system to document "individual-specific" training. The Facility's Self-Assessment indicated that: "based on the findings from this self-assessment, this provision is not in compliance because although 100% of the staff has completed competency-based training for foundational skills, they continue to need support with implementing and documenting the implementation of 'individual-specific' training." The Monitoring Team concurs with these self-assessment findings.	Noncompliance

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		NEO Orientation Since the last review, the NEO training schedule and curriculum had not been revised. New staff were responsible for completing the following PNM foundational performance check-offs: mechanical lifting; transfers, including stand pivot transfer, and two person manual transfer; bed positioning/positioner; wheelchair positioning; bath trolleys; rolling shower; toilet chair; stationary shower chair; hearing; speech-language communication objectives; adaptive dining equipment; mealtime safety; Simply Thick; heel protector and soft shoes; hosiery and compressions stockings; elbow pad; palm protectors; wrist and hand splints; ankle foot orthotics; helmets; gait belts; and walking/program/walking. The content of the performance check-offs were relevant and appropriate to test staff competencies with foundational PNM skills. Based on information provided by the Facility, 192 new employees had successfully completed the PNM core competencies performance check-offs since the last on-site review. The Facility should provide the total number of new employees who required training (N) and the number of new employees who have completed foundational PNM training (n) to yield a percent of training compliance. **PNM Core Competencies for Current Staff** The Facility reported that 323 current staff had successfully completed the performance check-offs for PNM foundational skills in the past six months. The Facility should provide the total number of current staff who required training (N) and the number of current staff who have completed foundational PNM training (n) to yield a percent of training compliance. **Annual Refresher Training** Based on interview, the Facility's annual refresher training was to be expanded. Current staff would be responsible for successfully completing performance check-offs for transfer lifts, two-person manual lift, bed positioning, mechanical lift, stand-pivot transfer, wheelchair positioning, adaptive dining equipment, thickening liquids, and mealtime safety. Again, the Facility should provide the total number of current staff who required annual refresher training (N) and the number of current staff who have completed foundational PNM training (n) to yield a percent of training compliance. **Individual-specific PNMP Training** The Facility reported the process for the provision of individual-specific competency-based training for PNMPs, dining plans and other intervention plans was "still under development." **Training of Relief/Pulled Staff** As stated above, the Facility acknowledged current staff had completed PNM	

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		foundational competency-based training and performance check-offs. However, observations of relief/pulled staff in the Infirmary and Ribbonfish showed that these staff did not implement individuals' PNMP as prescribed. These observations substantiated that relief/pulled staff that provided supports to individuals on the PNMT caseload required additional support to implement PNMPs correctly. **Trainer Competencies** At the time of the review, PNMP Coordinators were the primary trainers for NEO and annual refresher training. PNMP Coordinators had successfully completed the PNM foundational performance check-offs. Based on interview, the Facility had not formalized a train-the-trainer process for the PNMP Coordinators. The Facility should develop and implement train-the-trainer competency check-offs for PNMP Coordinators to substantiate their competency as trainers.	
O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	**Facility Self-Assessment** A review of the Facility's Self-Assessment indicated the following: ▪ The Facility had developed and implemented a Dining Room Monitor training curriculum. In addition, an identification, training, and validation process was developed for monitors to achieve accurate scoring. An auditing process was used for monitoring forms with analysis of individual-specific concerns and systemic issues and the establishment of a threshold for staff training. This initiative will be discussed below within this section. ▪ The Facility's audit of four PNMT action plans indicated four out of four (100%) identified the frequency of monitoring in measurable terms and none of the four included monitoring results. The Facility's Self-Assessment indicated that: "based on the findings from this self-assessment, this provision is not in compliance because although there is a policy which clearly outlines the monitoring system to ensure implementation of mealtime and positioning plans, the system has not been in place long enough to determine effectiveness. Additionally, a system is in place to ensure that the staff demonstrated competency in safely and appropriately implementing such plans, however, staff continue to need support with documenting the implementation. PNMT action plans, although often adequate, continue to lack proper documentation of completion." However, no trend analysis of compliance monitoring data was presented to substantiate that staff demonstrated competency in implementing PNMP plans. Furthermore, a review of Facility monitoring results for individuals within Sample #2 showed that the Facility's monitors had found 90 to 100% compliance. These monitoring results were not consistent with the Monitoring Team's and the PNMT nurse's observations as described in detail with regard to Section O.4.	Noncompliance

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		Facility Monitoring of Staff Competency with PNMPs On 1/9/12, the Compliance Monitoring form was initiated. This form replaced the individual-specific meal monitoring and PNMT pre-assessment monitoring forms. Since the last review, no revisions had been made to the Compliance Monitoring form instructions. Staff responsible for completing this form included the PT, PTA, OT, COTA, SLP, and PNMP Coordinators. The Facility Policy P.4, Documenting Meal Monitoring, stated the Compliance Monitoring form could be used to monitor compliance with positioning, snack administration, medication administration, oral care, bathing, lifting/transferring, and communication. However, the current focus for the use of this form was related to staff compliance with meals. The policy indicated nursing was to conduct meal monitoring quarterly. Therapists were responsible for meal monitoring for individuals at high and/or medium risk for aspiration, respiratory compromise, and choking. Individuals at medium risk within these categories were monitored once per month. HT staff monitored individuals at high risk twice a month. The PNMT used this tool prior to evaluating an individual, with no set schedule. The results of these forms were entered into the Compliance Monitoring database. As of 6/1/12, reports were available. The Facility did not provide these reports and/or an analysis of the monitoring results. The Monitoring Team reviewed the monitoring results for the five individuals (i.e., Individual #43, Individual #239, Individual #89, Individual #378, and Individual #278) in Sample #2 who the Monitoring Team and the PNMT nurse observed. Various Facility staff monitored these individuals' staff while they implemented the PNMPs. However, the Facility monitoring results were not congruent with observations conducted during the onsite review. The Monitoring Team reviewed individual-specific monitoring for the past six months and found: ▪ Individual #89's staff was monitored a total of five times, including by a PNMP Coordinator three times, a PNMT Nurse, and a RN Case Manager. Each individual-specific monitoring conducted was scored at 100% compliance. No monitoring was conducted for oral care, bathing, transfers, or alternate positioning. ▪ Individual #278's staff was monitored eight times using the Compliance Monitoring form. The monitors included the PNMT Nurse, PNMP Coordinator, SLP, Nurse, and Certified Occupational Therapy Assistant (COTA). Seven monitoring sessions were scored at 100% compliance and one was scored at 90% due to the PNMP not being available. No compliance monitoring was conducted for alternate positioning, medication administration, oral care, bathing, and lifting/transfer. ▪ Individual 43's staff was monitored eight times. The monitors included the PNMT Nurse (four times), PNMT PT (two times), Nurse (one time), Physical	

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		Therapy Assistant (one time). Seven monitoring results were scored at 100% compliance. The remaining monitoring results scored at 90% compliance as a result of staff acknowledgment of not having received training. No compliance monitoring was conducted for alternate positioning, medication administration, oral care, bathing, and lifting/transfer. ▪ Eight Compliance Monitoring forms for Individual #378 were completed, including by a PNMP Coordinator (three times), PNMT Nurse (two times), SLP (two times), and RN Case Manager (one time). The compliance score was 100% for seven and 90% due to staff not being trained. No compliance monitoring was performed for alternate positioning, oral care, bathing, and lifting/transfer. ▪ Seventeen Compliance Monitoring forms were completed for Individual #239 by PNMP Coordinators (four times), COTA (five times), RT Tech III (two times), PNMT PT (three times), RN (two times), PNMT Nurse (one time). The compliance scores for each of these 17 individual-specific monitoring was 100%. No compliance monitoring was done for alternate positioning, oral care, and lifting/transfer. The monitoring data for these individuals reflected 90 to 100% staff compliance with PNMPs. The Facility's monitoring results were not in alignment with the Monitoring Team's observations. Consequently, the Monitoring Team did not have confidence in the individual-specific monitoring data presented. These monitoring results would lead the Facility to the conclusion there were no problems with staff compliance of PNMPs. However, the Monitoring Team and PNMT nurse witnessed multiple breaches in the implementation of individuals' PNMPs for the five individuals observed. These monitoring results would not be useful in identifying problematic trends that needed to be addressed. The Facility should have confidence in monitoring data to allow it to substantiate identified problematic trends and, as a result, develop corrective action plans to address the trends. In addition, no evidence was presented to confirm inter-rater reliability between monitors. Inter-rater reliability should be established for the monitoring tools to ensure that all auditors/monitors were consistently determining compliance using the same process and criteria.	
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	**Facility Self-Assessment** A review of the Facility's Self-Assessment indicated the following: ▪ The HT Director and the PCM audited the records of four individuals on the PNMT caseload. Their findings indicated none (0%) of the individual records provided "consistent completion of adequate individuals-specific monitoring to address implementation status of risk action plan steps" and "did not determine if PNMPs were effective as evidenced by improved clinical indicators." The	Noncompliance

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	difficulties, and revise interventions as appropriate.	Monitoring Team's findings also showed similar problems. The current monitoring system provided data on staff compliance with individual's PNMPs. However, the Monitoring Team questioned the validity of monitoring results for individuals observed during the on-site review. However, the provision language in this section requires the Facility to develop and implement an effective monitoring system to assess the progress of individuals with physical or nutritional management difficulties. The Facility's Self-Assessment indicated that: "based on the findings from this self-assessment, this provision is not in compliance because although a system has been developed and implemented to monitor the progress of individuals with physical or nutritional management difficulties, it still lacks the specificity needed in order to determine effectiveness. Additionally, because no baseline is established using specific clinical indicators, it is unclear whether interventions are effective and subsequently revised appropriately." The Monitoring Team's findings also showed that the Facility's current monitoring system did not assess and/or monitor the effectiveness of individual-specific risk action plans supports and services to minimize and/or remediate physical or nutritional management concerns. **Effectiveness of Monitoring to Assess the Progress of Individuals with Physical or Nutritional Management Difficulties** The State At Risk Individuals policy in the Risk Review section indicated: "each discipline or program staff identified as responsible in the plan must review the support plans that address identified risk to assess the effectiveness of the support for which they are responsible. This review must be completed as indicated by an individual's risk severity or status change, in order to assess effectiveness. Documentation of the review will be recorded in the Integrated Progress Notes." A review of individuals' Risk Action Plans and IPNs in Sample #1 found: ▪ None of the 11 individuals' records (0%) contained evidence of effectiveness monitoring by therapists to assess the efficacy of risk action plan interventions for individuals with PNM difficulties. ▪ None of the 11 individuals' records (0%) contained evidence that interventions were changed due to a lack of an individual's progress. The following concerns were noted: ▪ Therapists had not conducted effectiveness monitoring to assess the progress of an individual's risk action plan interventions. ▪ Individuals' Risk Action Plans did not generate individual-specific clinical data, which should be used to substantiate an individual progress and to assess if the individual was better or worse.	

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		▪ Individuals' IPNs did not include an assessment an individual's clinical indicators to provide an update on health stability and/or instability. ▪ Monthly progress notes were not completed to report on the effectiveness of an individual's supports and services as identified in a risk action plan. **PNMT Monitoring to Assess Individual's Progress** The Facility PNMT policy discussed monitoring an individual's PNMP. The monitoring of PNMPs was one component that should have been evaluated to assess an individual's progress. However, the policy did not specifically address the implementation of effectiveness monitoring for individuals with PNMT interventions as outlined in action plans. Based on the Monitoring Team's review of the records for individuals in Sample #2: ▪ None of the seven individuals' records (0%) contained evidence that the progress of individuals with PNM difficulties was monitored to assess the efficacy of the risk plan interventions. ▪ None of the seven individuals' records (0%) contained evidence that interventions were changed due to a lack of progress. The following concerns were noted: ▪ Individuals at high risk for aspiration did not have Aspiration Trigger Data Sheet(s) implemented, and/or there were multiple months during which data sheets had not been completed. ▪ Individuals' who experienced ongoing weight loss did not have their plans revised. ▪ Individuals' PNMT action plans did not consistently specify individual-specific clinical indicators to define an individual's stable and/or unstable health status. ▪ Individuals did not receive individual-specific effectiveness monitoring. ▪ IPNs did not include a report on the effectiveness of an individual's supports and services as identified in a risk action plan. The Facility should implement an effectiveness monitoring system to report on the progress of individual's risk action plans supports and services, and revise interventions as appropriate.	
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	**Facility Self-Assessment** A review of the Facility's Self-Assessment results indicated the following: ▪ The HT Director and PCM audited three individuals' APEN data collection tools. None of the three (0%) APENs "contained information supporting the medical necessity of the tube" and "potential transition to a less restrictive form of enteral nutrition and/or oral eating."	Noncompliance

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	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.	▪ The Facility PNMT policy was reviewed and the Facility found the policy did not define the frequency and depth of assessment to be completed by the following disciplines: nursing, medical, SLP, and OT. The Facility PNM policy indicated individuals "who eat by tube are evaluated to determine whether a tube is medically necessary and plans are made to return to the least restrictive method of eating as appropriate." The Facility PNM policy had not been revised to define the PNMT and IDT members' responsibilities during the initial PNMT/IDT meeting to assess the rationale for the continued need for enteral nutrition, if appropriate. The Facility's Self-Assessment indicated that: "based on the findings from this self-assessment, this provision is not in compliance because although individuals who are enterally nourished are evaluated the Aspiration Pneumonia Enteral Nutritional (APEN), data collection tools do not consistently document the continued use of the tube as medically necessary. Subsequently, it is unclear from the documentation whether a plan to return the individual to oral feeding has been considered." The Monitoring Team's review of APEN data collection tools for individuals in Sample #1 and Sample #2 also found the Facility was not in compliance with this provision. **<u>Individuals Who Receive Enteral Nourishment</u>** Based on interview with the HT Director, on a regular basis, the Hospital Liaison Nurse was to update the list of individuals who received enteral nutrition. A Section O.8 action plan indicated a protocol had been completed for the maintenance of this list. However, the protocol was not provided to the Monitoring Team. Two lists were submitted that identified individuals who received enteral nutrition: ▪ CCSSLC: Individuals who receive nutrition through non-oral methods, dated 5/22/12, identified 81 individuals. The list presented the name of the individual, their home, dining method, type of tube, date tube placed, method of delivery, and if they received pleasure foods. ▪ Enteral Dining Report, dated 7/3/12, identified 80 individuals. The list presented the name of the individual, home and residential unit, type of tube, and delivery method. This list reflected one less individual, because one individual with a feeding tube had died. **<u>Individual(s) Who Received a Feeding Tube</u>** Since the Monitoring Team's last review, on 4/14/12, one individual (i.e., Individual #117) received a gastrostomy tube. On 3/12/12, a Facility physician referred Individual #117 to the PNMT for a history of falls. The PNMT assessment, dated 4/27/12, exceeded the five working days timeline to initiate an assessment. In addition, the PNMT had not	

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		completed an assessment prior to the placement of his gastrostomy tube. The Facility should revise the draft Facility PNMT Referral policy to state an individual should be referred to the PNMT prior to placement of a feeding tube and/or after an emergency tube placement. **<u>APEN Assessments</u>** Since the Monitoring Team's last review, the draft State At-Risk Individuals policy and procedures, dated 5/24/12, presented a revised process for completing an APEN assessment. The Aspiration Pneumonia/Enteral Nutrition (APEN) was identified as a data collection tool that should be completed at least annually if the individual: ▪ Had aspiration pneumonia during the past year; and/or ▪ Received enteral nutrition or medication. The APEN Data Sheet instructions, dated 6/13/12, indicated: "for individuals who receive enteral nutrition, the APEN should be used to help identify potential for return to oral eating and establish medical necessity of continuing enteral nutrition." The analysis and related rationale was to be documented in the individual's Integrated Risk Rating (IRR) form. The purpose of the APEN was to "provide a vehicle for recording the data needed to guide the team in determine appropriate risk assignment." Multiple disciplines were to contribute APEN data. The Nurse Case Manager was responsible for bringing the completed form to the ISP meeting. The IDT would utilize the APEN data for a "comprehensive discussion of enteral nutrition, aspiration and other related risk factors." The IDT was to "formulate plans based on the discussion and analysis to determine the best course of treatment or action for individuals who have had aspiration pneumonia and to assess individuals for possible return to oral eating." However, these revisions had not been formally implemented. The Monitoring Team will review the implementation of the revised APEN process during the next review. The Facility list(s) of individuals who received enteral nutrition did not indicate the date of the most current APEN assessment. The Facility list(s) should include the date of the APEN assessment to track if these assessments were completed at least annually for individuals who received enteral nutrition. Eleven individuals in Sample #1, whose IDTs were supporting them, received enteral nourishment: Individual #122, Individual #126, Individual #142, Individual #340, Individual #273, Individual #176, Individual #124, Individual #266, Individual #274, Individual #269, and Individual #68. A review of these individuals' APEN assessments, action plans, and ISPs found: ▪ None of the 11 individuals' APEN assessments (0%) followed the Facility-established template and content guidelines. ▪ Three of the 11 individuals' APEN assessments (i.e., Individual #122, Individual	

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		#340, and Individual #124) (27%) were completed within a 12-month period. ▪ None of the 11 individuals' APEN assessments (0%) indicated that there was input from appropriate IDT members as outlined in the Facility-established APEN assessment format. APEN assessments reviewed did not have a signature sheet and/or required disciplines were not in attendance. ▪ None of the 11 individuals' APEN assessments (0%) provided justification that the continued use of the tube was medically necessary. The assessment should provide clinical justification and an analysis of why the tube remains a medical necessity. APEN assessments results addressed the individual's risk for aspiration pneumonia. The assessment did not assess the medical necessity of a tube or assess the individual's potential to receive a less restrictive form of enteral nutrition or transition to oral intake, if appropriate. ▪ None of the 11 individuals' APEN action plans (0%) were integrated in the ISP and/or an ISPA. ▪ None of the 11 individuals' APEN recommendations and action plans (0%) were implemented. ▪ None of the 11 individuals' APEN assessments (0%) recommended the implementation of a plan to return the individual to oral feeding, if appropriate. Five of the seven individuals in Sample #2, who were supported by the PNMT, received enteral nourishment: Individual #89, Individual #239, Individual #117, Individual #43, and Individual #278. A review of these individuals' APEN assessments, action plans, and ISPs found: ▪ None of the five individuals' APEN assessments (0%) followed the Facility-established template and content guidelines. ▪ One of the five individuals' APEN assessments (i.e., Individual #89) (20%) were completed within a 12-month period. ▪ None of the five individuals' APEN assessments (0%) indicated that there was input from appropriate IDT members as outlined in the Facility-established APEN assessment format. ▪ None of the five individuals' APEN assessments (0%) provided justification that the continued use of the tube was medically necessary. The assessment should provide clinical justification and an analysis of why the tube remains a medical necessity. ▪ None of the five individuals' APEN action plans (0%) were integrated in the ISP and/or an ISPA. ▪ None of the five individuals' APEN recommendations and action plans (0%) were implemented. ▪ None of the five individuals' APEN assessments (0%) recommended the implementation of a plan to return the individual to oral feeding, if appropriate.	

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		As documented above, there was no discernible difference between the content of APEN assessments and action plans for the individuals in Sample #1 or Sample #2. These assessments and action plans did not meet the requirements of the Settlement Agreement to: "evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary" and "where appropriate, the Facility shall implement a plan to return the individual to oral feeding." **<u>Pathway to Return to Oral Intake and/or Receive a Less Restrictive Approach to Enteral Nutrition</u>** The Facility did not have written procedures for returning an individual to oral eating. The Facility list CCSSLC: Individuals who receive nutrition through non-oral methods, dated 5/22/12, identified one individual in Sample #1 (i.e., Individual #68) who received pleasure feedings. None of the individuals in Sample #2 participated in a formal therapeutic/pleasure feeding program. A review of Individual #68's records found: ▪ None of the one individual who had returned to oral intake (0%) had a plan to return to oral feeding. ▪ Because no plan had been developed, its implementation could not be assessed. ▪ None of the one individual who returned to oral intake (0%) had received a mealtime assessment. ▪ Because no plan existed, none of the one individual's plans (0%) identified individual-specific triggers for when the plan should be stopped. ▪ Because no plan existed, none of the one individual's plan (0%) identified monitoring oversight for staff compliance with plan. ▪ Because no plan existed, none of the one individual's plans (0%) were monitored as outlined in the plan. ▪ Because no plan existed, none of the one individual's plans (0%) were modified, if appropriate. The Facility should establish procedures for IDTs and/or PNMT members to follow for individuals who were recommended to receive a less restrictive method of enteral nutrition and/or return to oral intake.	

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

1. The Facility should identify a physician to provide PNMT members a resource for medical consultation. (Section O.1)
2. The Facility should implement the action plan developed to provide resolution for identified PNMT systemic issues. (Section O.1)
3. Lists the Facility maintains to identify individuals having physical and nutritional management problems should be accurate. The Facility should develop a sustainable system to maintain and update these lists on the HT database to ensure their validity. (Section O.2)
4. The Facility should improve its PNMT referral database. The Facility's database should not only reflect when a referral was made to the PNMT, but also identify the status of the PNMT referral. In addition, the Facility should audit compliance with the PNMT referral process. (Section

O.2)

5. PNMT assessments should be sufficient to identify physical and nutritional interventions and supports to meet the individual's needs. They should follow the Facility-established PNMT assessment template; provide an adequate analysis to identify the cause of the individual's PNM concerns; include a PNMT self-referral and/or IDT referral date; update the individual's risk rating(s), as appropriate; address HOBE assessment data; establish individual-specific clinical baseline data to assist teams in recognizing changes in health status; and identify individual-specific clinical criteria to alert nursing staff to contact the PNMT. (Section O.2)
6. PNMT action plans should include: the individual's identified PNM problems as presented in the PNMT assessment; integration of HOBE assessment data; preventative interventions to minimize the conditions of identified risk indicators; appropriate, functional, and measurable objectives to allow the PNMT to measure the individual's progress and efficacy of the plan; and specific clinical indicators to be monitored. (Section O.2)
7. The Facility should provide additional guidance through the development of procedures to further define the PNMT discharge process to include, at a minimum: status of efficacy of implemented PNMT recommendations, justification for an individual to be discharged from the PNMT through the provision of objective clinical data to document stable or improved health, integration of the PNMT recommendations into the ISP, and objective clinical data for referral back to the PNMT. (Section O.2)
8. The HT Department should follow the State Office policy for individuals who require a PNMP. The State Office policy should be utilized to review the Facility's list of 23 individuals with "no PNM needs" to determine which of these individuals meet the PNM criteria and should be provided with a PNMP sufficient to meet their needs. (Section O.3)
9. The Facility should develop procedures to further define the implementation of PNMPs off-campus. (Section O.3)
10. The Facility should review its PNMP audit tool to determine if the tool includes a comprehensive set of PNMP compliance indicators. (Section O.3)
11. The Facility PNMP Directions should discuss requesting an ISPA meeting to ensure an interdisciplinary discussion occurs of proposed revisions to PNMPs and the IDT members approve the revised PNMP. (Section O.3)
12. The PNMT and IDT members should provide additional training and/or support to staff to enhance their competency in the implementation of PNMPs for those individuals at highest risk. (Section O.4)
13. When providing data on training, the Facility should provide the total number of employees who required training (N) and the number of employees who have completed training (n) to yield a percent of training compliance. (Section O.5)
14. The Facility should provide additional training and/or support to relief/pulled staff to ensure PNMPs are implemented as prescribed. (Section O.5)
15. The Facility should develop and implement train-the-trainer competency check-offs for PNMP Coordinators to substantiate their competency as trainers. (Section O.5)
16. Inter-rater reliability should be established for the Facility monitoring tools to ensure that all auditors/monitors are consistently determining compliance using the same process and criteria. (Section O.6)
17. The Facility should implement an effectiveness monitoring system to report on the progress of individual's risk action plans supports and services, and revise interventions as appropriate. (Section O.7)
18. The Facility should maintain accurate list(s) of individuals who receive enteral nutrition. (Section O.8)
19. The Facility should revise the draft Facility PNMT Referral policy to state that an individual should be referred to the PNMT prior to placement of a feeding tube and/or after an emergency tube placement. (Section O.8)
20. The Facility list(s) identifying individuals who receive enteral nutrition should include the date of the APEN data collection tool and IRRF to track if assessments have been completed annually to determine whether or not the continued use of the tube is medically necessary, as required by the Settlement Agreement. (Section O.8)
21. The Facility should establish procedures for IDTs and/or PNMT members to follow for individuals who were recommended to receive a less restrictive method of enteral nutrition and/or return to oral intake. (Section O.8)

SECTION P: Physical and Occupational Therapy	
Each Facility shall provide individuals in need of physical therapy and occupational therapy with services that are consistent with current, generally accepted professional standards of care, to enhance their functional abilities, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section P; o CCSSLC Self-Assessment, Action Plans, and Provision Action Information; o For the following 15 individuals in Sample #1, which included individuals identified with PNM concerns and/or had experienced a change of status as evidenced by admission to the Facility Infirmary (if applicable), emergency room, and/or hospital: Individual #47 Individual #251, Individual #97, Individual #304, Individual #159, Individual #246, Individual #7, Individual #198, Individual #181, Individual #350, Individual #332, Individual #42, Individual #156, Individual #243, and Individual #46, the following documents: Occupational Therapy/Physical Therapy comprehensive assessment, assessment of status, update in individual record, Nutrition assessments, Aspiration Pneumonia/Enteral Nutrition assessment, Speech Language Pathology comprehensive assessment, assessment of status, update in individual record, Head of Bed Elevation assessment, annual Individual Support Plan and Individual Support Plan Addendums for past year, Integrated Risk Action form, Interdisciplinary Team Risk Action Plan/ Integrated Care Plan, Integrated Progress Notes for past six months, OT/PT/SLP/RD consultations for past year, Aspiration Trigger Sheets for past six months, Physical Nutritional Management Plan, dining plans with supporting written and pictorial instructions, for individuals hospitalized within this sample the Hospital Liaison Nurse reports across the past six months, therapeutic/pleasure feeding plan, individual-specific monitoring for the past six months, PNMT Post Hospitalization assessment, documentation of staff successfully completing Physical Nutritional Management foundational training, documentation of staff successfully completing individual-specific training, supporting documentation to substantiate an individual's progress with PNM difficulties, incident reports and Facility investigations for choking incidents, PNMP Clinic minutes, monthly review of OT/PT direct intervention, quarterly review of OT/PT programs, supporting documentation for implementation of OT/PT direct interventions, and supporting documentation for implementation of OT/PT programs; o Facility Policies and Procedures related to the provision of OT/PT supports and services implemented since last monitoring visit, revised 4/23/12 and 5/25/12; o Organizational chart of Habilitation Therapy Department, dated 5/14/12; o Current OT, Certified Occupational Therapy Assistant (COTA), PT, Physical Therapy Assistant (PTA), and Assistive Technology (AT) staff, corresponding caseloads, and curricula vita for new hires, revised 5/17/12; o Continuing education completed by OTs and PTs since last onsite visit, from 1/12 through 6/12; o List of individuals who use wheelchair as primary mobility, dated 5/21/12; o List of individuals with transport wheelchairs, dated 5/21/12;

	○ List of individuals with other ambulation assistive devices, dated 5/21/12; ○ List of individuals with orthotics and/or braces, dated 6/5/12; ○ Physical Nutritional Management Maintenance Log, dated 6/4/12; ○ OT/PT Assessments and Updates (templates) with changes made since last review, revised 5/10/12; ○ Completed OT/PT Assessments for newly admitted individuals since last review, dated 12/20/11 and 2/27/12; ○ Tracking Log of completed individual assessments since last review, from 1/12 through 7/12; ○ Wheelchair seating and PNM clinic assessment (templates), revised 5/30/12; ○ Individual-specific mealtime monitoring schedule, undated; ○ Monthly individual-specific PNMP check sheet, revised 2/15/12; ○ Monthly Home Equipment check sheet, revised 2/15/12; ○ Compliance Monitoring, revised 2/2/12; ○ PNMP Clinic minutes, revised 5/30/12; ○ Competency-based performance check-off sheets for PNM core competencies and individual-specific PNMPs along with dining plans and other intervention plans, various dates; ○ Summary reports and monitoring results related to OT/PT, from 12/11 through 5/12; ○ List of individuals receiving direct OT and/or PT services and focus of intervention, dated 5/21/12; ○ Completed audits of OT/PT documentation, from 1/12 through 4/12; ○ Habilitation, Training, Education and Skill Acquisition State Policy #017, effective date 5/10/12; ○ Use of Protective Devices Policy #05, undated; ○ ISP Meeting Guide (Preparation/Facilitation/Documentation Tool), revised 2/16/12; and ○ Most current Facility Section P policies, multiple dates. ▪ **Interviews with**: ○ Dr. Angela Roberts, Habilitation Therapy Director; ○ Paul Osborne, PT Director; and ○ Rosalinda Cortez, OT Director. ▪ **Observations of**: ○ Infirmary, residences and dining rooms in Coral Sea, Pacific, and Atlantic.
	Facility Self-Assessment: Based on a review of the Facility's Self-Assessment, with regard to Section P of the Settlement Agreement, the Facility found it was in noncompliance with all of the subsections of Section R. This was consistent with the Monitoring Team's findings. The Facility submitted three documents, including: CCSSLC Self-Assessment, Action Plans, and Provision Action Information. The CCSSLC Self-Assessment listed the steps the Facility staff completed to conduct the self-assessment and the subsequent results for the completion of these tasks. The Action Plans documented the status of action steps that had been completed, were in process and/or had not been

	started. The CCSSLC Provision Action Information listed actions completed since the Monitoring Team's previous visit. The Facility Self-Assessment presented the results of auditing activities completed by the HT Director and Program Compliance Monitor using the Section P Monitoring tool for each month. One individual was monitored each month for a total of three individuals per quarter. Monthly reports were developed for each month that presented a separate compliance score for each indicator for the Section Lead (i.e., HT Director) and the PCM. An inter-rater compliance score was generated for each indicator as well as a compliance percentage. This was a positive development and provided the HT Director with valuable information to assess the compliance status for each indicator. Furthermore, the HT Director and PCM reported they continued to revise instructions for the form to enhance their inter-rater agreement. The HT Director and PCM generated a monthly Section P Analysis report. The report defined how inter-rater agreement was achieved and discussed how the sample was chosen. The analysis report discussed the compliance for each of the four sections in Section P and presented plans to address areas of non-compliance. The Monitoring Team discusses the Facility self-assessment results at the beginning of each section.
	Summary of Monitor's Assessment: The OT Director supervised two full-time OTs and two part-time OTs, who filled one full-time equivalent position. There were two Certified Occupational Therapy Assistants (COTAs) on staff. The PT Director supervised two full-time PTs, two contract PTs, two physical therapy assistants (PTAs), and four orthopedic equipment technicians. One contract PT provided 10 hours of service per week and the second 15 hours per week. There was one PT vacancy at the time of the review. There were 11 PNMP Coordinators and a PNMP Supervisor. Five of five individuals newly admitted (100%) received an OT/PT assessment within 30 days of admission or readmission. Based on a review of individuals' OT/PT assessments, they were missing important elements and, consequently, were not considered adequate OT/PT assessments. OT/PT direct interventions and/or programs were not integrated into individuals' ISPs. In addition, monthly and/or quarterly progress notes were not completed to provide the results of effectiveness review/monitoring of the individual's progress with direct and/or indirect OT/PT supports. No evidence of individual-specific competency-based training for the implementation of indirect OT/PT programs was provided. Based on interview with the HT Director, the Facility was currently in the process of developing objectives and performance check-offs to document this process. The Monitoring Team will review this process during the next review.

	The Facility OT/PT Maintaining Adaptive - Assistive Equipment Policy #P.3 included some important components. However, it was missing the process for identification, training, and validation for monitors; the process of inter-rater reliability; and a process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic). Individuals' Physical/Nutritional Management Data sheets for direct and/or indirect OT/PT programs were not completed on a monthly basis. Consequently, the data presented was unreliable to track the implementation of OT/PT programs.

#	Provision	Assessment of Status	Compliance
P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of each individual residing at the Facility. The Facility shall ensure that individuals identified with therapy needs, including functional mobility, receive a comprehensive integrated occupational and physical therapy assessment, within 30 days of the need's identification, including wheelchair mobility assessment as needed, that shall consider significant medical issues and health risk indicators in a clinically justified manner.	**Facility Self-Assessment** A review of the Facility's Self-Assessment indicated the following: ▪ The Facility's review of 100% of Section P monitoring tools indicated that 12 out of 12 (100%) had compliance scores analyzed, trended, and aggregated. 4 ▪ An Facility's audit of OT/PT assessments indicated that four out of four (100%) included health risk factors; three out of four (75%) contained a rationale for services/supports and assessment data to justify an OT/PT program; two out of four (50%) included individual-specific triggers to alert staff of change in status, indicated efficacy of services and supports, and included an analysis of data. Two of three (67%) had adequate service and supports for medium and high-risk indicators; one out of three (33%) included functional outcomes for OT/PT programs and had measurable objectives including skill acquisition plans as appropriate. The self-assessment did not describe the sample and/or why the sample size decreased from four to three for certain indicators. The Facility's Self-Assessment indicated that: "based on the findings from this self-assessment, this provision is not in compliance because although each individual residing at the SSLC receives a comprehensive occupational and physical therapy assessment which includes functional mobility, wheelchair mobility (as needed), consideration of significant medical issues and health risk indicators, the documentation does not consistently show specific triggers, efficacy of current supports or functional outcomes in a clinically justified manner." The Monitoring Team completed a review of ten individuals' OT/PT assessments to determine if they were adequate. The results of this review are reported in this section. As described above with regard to Section O.1, the Monitoring Team selected Sample #1. It included 15 individuals with PNM concerns and/or who had experienced a change of status (i.e., admission to the Facility Infirmary, emergency room, and/or hospital). The sample consisted of Individual #47, Individual #251, Individual #97, Individual #304, Individual #159, Individual #246, Individual #7, Individual #198,	Noncompliance

#	Provision	Assessment of Status	Compliance
		Individual #181, Individual #350, Individual #332, Individual #42, Individual #156, Individual #243, and Individual #46. This section addresses current staffing, and continuing education as factors that have the ability to affect compliance. The discussion related to new admissions, and OT/PT assessments address the specific requirements of this paragraph. **Current Staffing** The OT Director supervised two full-time OTs and two part-time OTs, who filled one full-time equivalent position. There were two Certified Occupational Therapy Assistants (COTAs) on staff. The PT Director supervised two full-time PTs, two contract PTs, two physical therapy assistants (PTAs), and four orthopedic equipment technicians. One contract PT provided 10 hours of service per week, and the second provided 15 hours per week. There was one PT vacancy at the time of the review. Each of these therapists held a license to practice in the state of Texas. There were 11 PNMP Coordinators and a PNMP Supervisor. **Continuing Education** Documentation of continuing education courses the OTs and PTs completed was submitted. Based on documentation submitted, in the past six months, no State-sponsored webinars had occurred. The continuing education the clinicians attended included the following topic areas: ▪ Autism and Sensory Processing Disorders; ▪ Bedside Evaluation of the Dysphagia Patient; ▪ The Dysphagia Patient: Modified Barium Swallow and Therapeutic Intervention; ▪ Ethics and Professional Responsibility Part 1: PT; ▪ Introduction to Benign Paroxysmal Positional Vertigo; and ▪ Introduction to Pediatric Medical Screening; and Management of Cerebral-Origin Spasticity. Attendance sheets and continuing education certificates of completion documentation were submitted for the preceding courses. The OTs and PTs attended appropriate continuing education courses. **New Admissions** Since the last review, five individuals (i.e., Individual #5, Individual #40, Individual #61, Individual #63, and Individual #97) had been admitted to CCSSLC. An examination of their admission and OT/PT assessment dates established: ▪ Five of five individuals newly admitted (100%) received an OT/PT assessment within 30 days of admission or readmission.	

#	Provision	Assessment of Status	Compliance
		OT/PT Assessments An OT/PT assessment should include the following: ▪ Signature and date by the clinician upon completion of the written report; ▪ Date showing it was completed 10 days prior to the annual ISP meeting; ▪ Diagnoses and relevance to functional status; ▪ Individual preferences, strengths, and needs; ▪ Medical history and relevance to functional status; ▪ Health status over the last year; ▪ Medications and potential side effects relevant to functional status; ▪ Documentation of how the individual's risk levels impact their performance of functional skills; ▪ Functional description of motor skills and activities of daily living with examples of how these skills are utilized throughout the day; ▪ Evidence of observations by OTs and PTs in the individual's natural environments (e.g., day program, home, work) ▪ Discussion of the current supports and services provided throughout the last year and effectiveness, including monitoring findings; ▪ Discussion of the expansion of the individual's current abilities; ▪ Discussion of the individual's potential to develop new functional skills; ▪ Comparative analysis of health and impact on functional status over the last year; ▪ Comparative analysis of current functional motor and activities of daily living skills with previous assessments; ▪ Identification of need for direct or indirect OT and/or PT services, as appropriate; ▪ Reassessment schedule; ▪ Monitoring schedule; ▪ Recommendations for direct interventions and/or skill acquisition programs as indicated for individuals with identified needs; ▪ A recommendation regarding the individual's appropriateness for community placement; ▪ Manner in which strategies, interventions, and programs should be utilized throughout the day. Ten individuals' OT/PT comprehensive assessments (i.e., Individual #159, Individual #304, Individual #7, Individual #251, Individual #47, Individual #246, Individual #46, Individual #198, Individual #97, and Individual #156) in Sample #1 were evaluated for the presence of the following: ▪ Ten of 10 individuals' OT/PT assessments (100%) were signed and dated by the clinician upon completion of the written report;	

#	Provision	Assessment of Status	Compliance
		▪ Five of 10 individuals' OT/PT assessments (i.e., Individual #304, Individual #7, Individual #251, Individual #198, and Individual #97) (50%) were dated as having been completed 10 days prior to the annual ISP; ▪ Two of 10 individuals' OT/PT assessments (i.e., Individual #7 and Individual #97) (20%) included diagnoses and relevance to functional status; ▪ Four of 10 individuals' OT/PT assessments (i.e., Individual #7, Individual #46, Individual #198, and Individual #97) (40%) introduced individual preferences, strengths, and needs; ▪ None of 10 individuals' OT/PT assessments (0%) included medical history and relevance to functional status. Multiple individuals' OT/PT assessments had not been updated to reflect a change in status. For example, Individual #246's OT/PT assessment had not been updated to reflect his current medical history and health status related to his Modified Barium Swallow study (MBSS) on 5/30/12. In addition, Individual #251's OT/PT assessment had not been updated to address the results of his MBSS on 12/21/11 or his ISPA meeting on 11/28/11, at which the team discussed four falls within 30 days. Individual #304's OT/PT assessment, dated 8/3/11, did not discuss medical history and relevance to functional status and health status over the last year. For example, his assessment did not discuss his diagnosis of gastroesophageal reflux disease (GERD) and the impact on his functional status; ▪ None of 10 individuals' OT/PT assessments (0%) adequately addressed health status over the last year. Individuals' OT/PT assessments had not been updated to provide an accurate health status over the past year. For example, Individual #159's assessment did not address a choking incident on 5/4/11 or her PICA behavior. Individual #7's OT/PT assessment, dated 3/20/12, did not discuss her overweight status and the impact on her health and functional status (i.e., Body Mass Index 30). Individual #47's OT/PT assessment, dated 10/11/11, did not discuss his history of falls within the past year (i.e., IRR form, dated 9/20/11, documented 10 falls within the past year); ▪ Three of 10 individuals' OT/PT assessments (i.e., Individual #7, Individual #97, and Individual #156) (30%) listed medications and discussed the potential side effects relevant to functional status. Three individual's OT/PT assessments did not address medications (i.e., Individual #251, Individual #304, and Individual #47). Four individual's OT/PT assessments presented medications and side effects, but did not adequately address the impact on an individual's functional status; ▪ One of 10 individuals' OT/PT assessments (Individual #97) (10%) provided documentation of how the individuals' risk levels impacted their performance of functional skills; ▪ Three of 10 individuals' OT/PT assessments (i.e., Individual #7, Individual #251, and Individual #97) (30%) included a functional description of motor	

#	Provision	Assessment of Status	Compliance
		skills and activities of daily living with examples of how these skills were utilized throughout the day; ▪ Three of 10 individuals' OT/PT assessments (i.e., Individual #7, Individual #46, and Individual #97) (30%) provided evidence of observations by OTs and PTs in the individuals' natural environments (e.g., day program, home, work); ▪ None of nine individuals' OT/PT assessments (0%) reviewed the current supports and services provided throughout the last year and effectiveness, including monitoring findings (Note: Individual #97 was newly admitted); ▪ One of 10 individuals' OT/PT assessments (i.e., Individual #46) (10%) discussed the expansion of the individual's current abilities; ▪ One of 10 individuals' OT/PT assessments (i.e., Individual #46) (10%) presented the individual's potential to develop new functional skills; ▪ One of 10 individuals' OT/PT assessments (i.e., Individual #46) (10%) gave a comparative analysis of health and impact on functional status over the last year; ▪ One of 10 individuals' OT/PT assessments (i.e., Individual #46) (10%) offered a comparative analysis of current functional motor and activities of daily living skills with previous assessments; ▪ Six of 10 individuals' OT/PT assessments (i.e., Individual #159, Individual #304, Individual #251, Individual #46, Individual #97, and Individual #156) (60%) identified the need for direct or indirect OT and/or PT services, as appropriate; ▪ Nine of 10 individuals' OT/PT assessments (i.e., Individual #159, Individual #304, Individual #7, Individual #251, Individual #47, Individual #246, Individual #46, Individual #198, and Individual #156) (90%) had a reassessment schedule; ▪ Seven of 10 individuals' OT/PT assessments (i.e., Individual #159, Individual #304, Individual #7, Individual #251, Individual #47, Individual #246, and Individual #156) (70%) supplied a monitoring schedule; ▪ Four of 10 individuals' OT/PT assessments (i.e., Individual #159, Individual #304, Individual #97, and Individual #156) (40%) had recommendations for direct interventions and/or skill acquisition programs; ▪ Eight of 10 individuals' OT/PT assessments (i.e., Individual #159, Individual #304, Individual #251, Individual #47, Individual #246, Individual #46, Individual #198, and Individual #156) (80%) made a recommendation about the appropriateness for community transition; ▪ None of 10 individuals' OT/PT assessments (0%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. These 10 individuals' OT/PT assessments were missing essential components and, consequently, were not adequate comprehensive OT/PT assessments. The Facility	

#	Provision	Assessment of Status	Compliance
		should review the revised OT/PT assessment template and content guidelines to ensure these essential elements are addressed. The OTs and PTs should consider each of these elements as they complete assessments to ensure assessments were comprehensive as required by the Settlement Agreement. In addition, the OT/PT audit should include these elements.	
P2	Within 30 days of the integrated occupational and physical therapy assessment the Facility shall develop, as part of the ISP, a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment and shall implement the plan within 30 days of the plan's creation, or sooner as required by the individual's health or safety. As indicated by the individual's needs, the plans shall include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement; objective, measurable outcomes; positioning devices and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	**Facility Self-Assessment** A review of the Facility's Self-Assessment indicated the following: ▪ The Facility's audit of four OT/PT programs indicated none of the plans (0%) were developed within 30 days of the ISP, individualized based on objective findings, had effective analysis to justify identified strategies, and had objective, measurable and functional outcomes. Progress notes were not completed to identify implementation of plans, status of progress, or justification of the initiation, continuation or discontinuation of the plan. Programs were not embedded in the ISP including skill acquisition programs, as appropriate. The Facility's Self-Assessment indicated that: "based on findings from this self-assessment, this provision is not in compliance because although the integrated occupational and physical therapy assessments are consistently completed within 30 days of the ISP, they are not consistently integrated as part of the Individual Support Plan (ISP). Subsequently, the documentation does not support that a plan to address the recommendations of the integrated occupational therapy and physical therapy assessment are implemented within 30 days of the plan's creation. The plans include: individualized interventions aimed at minimizing regression and enhancing movement and mobility, range of motion, and independent movement, however, they still lack objective, measurable outcomes and justification for the continuation or discontinuation of the plans." The Monitoring Team's findings were similar to the Facility's findings, and the status of direct and indirect OT interventions is discussed in detail below. **Integration of OT/PT Direct Intervention(s) and Indirect OT/PT Program(s) in the ISP** The primary OT/PT intervention provided to individuals was the Physical Nutritional Management Plan. Compliance data related to PNMPs is discussed above with regard to Section O.3. Direct OT/PT therapy was provided to one individual (i.e. Individual #243). PNMP Coordinators provided indirect OT/PT programs to 10 individuals in Atlantic, 36 individuals in Pacific, and 33 individuals in Coral Sea. Residential staff implemented OT/PT programs for three individuals in Atlantic, 42 individuals in Pacific, and 62 individuals in Coral Sea. One of the 15 individuals in Sample #1 (i.e., Individual #243) was reported to receive	Noncompliance

#	Provision	Assessment of Status	Compliance
		direct OT/PT interventions. Three of the 15 individuals were provided indirect OT/PT programs. Of these three, one individual (i.e., Individual #42) had an OT/PT program implemented by a PNMP Coordinator, and two individuals (i.e., Individual #181 and Individual #350) had indirect OT/PT programs implemented by residential staff. A review of these individuals' records found: ▪ For one of the four ISPs reviewed (i.e., Individual #181) (25%), an OT and/or PT attended the annual meeting. ▪ In none of the four ISPs reviewed (0%), the OT/PT intervention and/or program was identified. ▪ In none of the four ISPs reviewed (0%) were skill acquisition programs recommended to promote skills learned in direct therapy intervention and/or OT/PT programs. ▪ In none of the four ISPs reviewed (0%) were skills learned integrated into the individual's daily routine. For adequate integration of OT/PT direct interventions and/or indirect therapy programs, the individuals' ISPs should include: attendance by an OT and/or PT; identification of the direct intervention and/or OT/PT program; as appropriate, skill acquisition programs to promote reinforcement of new skills learned; and as appropriate, integration of skills learned from the direct interventions and/or OT/PT programs into the individual's daily routine. **Direct OT/PT Interventions** The direct OT/PT intervention plan for one individual (i.e., Individual #243) was reviewed. Comprehensive progress notes related to OT/PT interventions should include: ▪ Information regarding whether the individual showed progress with the stated goal; ▪ Description of the benefit of the goal to the individual; ▪ A report on the consistency of implementation; and ▪ Recommendations/revisions to the OT/PT intervention plan as indicated related to the individual's progress or lack of progress. Documentation of OT/PT review for none of the one individual (0%) was comprehensive. The progress notes did not incorporate the elements outlined above. **Indirect OT/PT Programs** Based on documentation submitted: "CCSSLC does not currently have any documentation regarding the quarterly review of OT/PT programs."	

#	Provision	Assessment of Status	Compliance
		For individuals who receive indirect OT and/or PT programs, monthly documentation from the OT/PT should include: ▪ Information regarding whether the individual showed progress with the stated goal(s); ▪ A description of the benefit of device and/or goal(s); ▪ Identification of the consistency of implementation; and ▪ Recommendations/revisions to the direct intervention and/or program as indicated in reference to the individual's progress or lack of progress. The completion of monthly progress notes should provide effectiveness review/monitoring of the individual's progress with direct and/or indirect OT/PT supports.	
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.	**Facility Self-Assessment** A review of the Facility's Self-Assessment indicated the following: ▪ The Facility's audit of OT/PT programs found four of four staff (100%) implemented the program; none of four (0%) programs indicated that staff had received individual-specific competency-based training. The Facility's Self-Assessment indicated that: "based on the findings from this self-assessment, this provision is not in compliance because although staff implement OT/PT plans at the foundational level, documentation does not support they have successfully completed competency-based training in implementing 'individual-specific' plans (plans requiring skill that deviated from the standard foundational training)." The Monitoring Team's review resulted in similar findings. Individual-specific competency-based performance check-offs had not been completed by PNMP Coordinators and/or staff to test their competency for the implementation of individuals' OT/PT programs. **Competency-Based Training** The status of Facility compliance with competency-based training and monitoring for continued staff competency and compliance of direct support professionals was addressed in Section O.4, O.5, and O.6. No evidence of individual-specific competency-based training for the implementation of indirect OT/PT programs was provided. Based on interview with the HT Director, the Facility was currently in the process of developing objectives and performance check-offs to document this process. The Monitoring Team will review this process during the next review.	Noncompliance
P4	Commencing within six months of the Effective Date hereof and with	**Facility Self-Assessment** A review of the Facility's Self-Assessment indicated the following:	Noncompliance

#	Provision	Assessment of Status	Compliance
	full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and the implementation by direct care staff of these interventions.	▪ A review of the HT database report for four individuals found one individual's monitoring results (25%) included the condition, availability, and effectiveness of supports. ▪ A review of PNMP Clinic minutes indicated that one individual's therapists (25%) reviewed equipment annually. ▪ A review of training rosters for those with individual-specific PNMP programs indicated that one out of four (25%) individual's staff had successfully completed competency-based training. The Facility's Self-Assessment indicated that: "based on the findings from this self-assessment, this provision is not in compliance because although a system to monitor physical supports and adaptive equipment has been developed and implemented it does not consistently address the effectiveness of those supports. Additionally, staff continues to need support in documenting the implementation of these interventions." The Monitoring Team's findings were similar. These and additional findings are discussed below. **Monitoring System** The Occupational/Physical Therapy Services Policy #014 stated: "the State Center shall implement a system to monitor and address: ▪ The status of individuals with identified occupational and physical therapy needs; ▪ The condition, availability and appropriateness of physical supports and assistive equipment; ▪ The effectiveness of treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and ▪ The implementation of programs carried out by direct support staff." However, as acknowledged by the Facility's self-assessment findings and the Monitoring Team's findings presented below, the Facility's current monitoring systems did not adequately address these policy components. The Facility's OT/PT Maintaining Adaptive - Assistive Equipment Policy #P.3 included the following information on the monitoring of adaptive/assistive equipment: ▪ Monthly monitoring by the PNMP Coordinators for the presence of adaptive/assistive equipment using the Monthly Person-Specific PNMP Check Sheet; and ▪ Therapists' monitoring of the adaptive-assistive equipment and condition by documenting on the PNMP Clinic Minutes annually prior to the annual ISP meeting.	

#	Provision	Assessment of Status	Compliance
		However, this policy did not include the following key elements: ▪ The process for identification, training, and validation for monitors; ▪ The process of inter-rater reliability; and ▪ A process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic). A review was conducted of the four individuals' monitoring results (i.e., Individual #243, Individual #181, Individual #350, and Individual #42) who received direct therapy intervention and/or indirect OT/PT programs ▪ Four of the four individuals (100%) were monitored at the recommended frequency using the Monthly Person-Specific PNMP Check Sheet. ▪ Four of the four individuals (100%) were monitored for the condition and availability of their equipment using the Monthly Person Specific PNMP Check Sheet. ▪ None of these four individuals (0%) were monitored for the status of their identified occupational and physical therapy needs. ▪ None of the four individuals (0%) were monitored for the effectiveness of their therapy OT/PT programs. ▪ One of four individuals' PNMP Clinic Minutes documentation (25%) indicated a comprehensive annual review of an individual's prescribed adaptive/assistive equipment for condition, availability, and effectiveness. Based on documentation submitted, "currently, CCSSLC is revising the process of monthly reviews of OT/PT programs." Data sheets for the four individuals receiving direct therapy intervention and/or indirect OT/PT programs were submitted indicating if the program was completed and/or not completed. The data sheet contained a section at the bottom of the form that indicated a review by the therapist. The data sheets were being revised to be more comprehensive and capture data regarding effectiveness. However, a review of Physical/Nutritional Management Data sheets for the four individuals found: ▪ None of the four individuals' Physical/Nutritional Management Data sheets for direct and/or indirect OT/PT programs (0%) were completed on a monthly basis. ▪ None of the four individuals' Physical/Nutritional Management Data sheets (0%) monitored the status of identified occupational and physical therapy needs. Consequently, the data presented was unreliable to track the implementation of OT/PT programs.	

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

1. The Facility should review the revised OT/PT assessment template and content guidelines to ensure essential elements are addressed. The OTs and PTs should consider each of these elements as they complete assessments to ensure assessments are comprehensive as required by the Settlement Agreement. In addition, the OT/PT audit should include these elements. (Section P.1)
2. For adequate integration of OT/PT direct interventions and/or indirect therapy programs, the individuals' ISPs should include: attendance by an OT and/or PT; identification of the direct intervention and/or OT/PT program; as appropriate, skill acquisition programs to promote reinforcement of new skills learned; and as appropriate, integration of skills learned from the direct interventions and/or OT/PT programs into the individual's daily routine. (Section P.2)
3. The Facility should ensure comprehensive progress notes related to OT/PT direct interventions and indirect programs include:
    a. Information regarding whether the individual showed progress with the stated goal;
    b. A description of the benefit of the goal to the individual;
    c. A report on the consistency of implementation; and
    d. Recommendations/revisions to the direct intervention or OT/PT program as indicated related to the individual's progress or lack of progress. (Section P.2)
4. The Facility should develop and implement individual-specific competency-based training and performance check-offs for PNMP Coordinators and staff. (Section P.3)
5. The Facility OT/PT Maintaining Adaptive - Assistive Equipment Policy #P.3 should include:
    a. The process for identification, training, and validation for monitors;
    b. The process of inter-rater reliability; and
    c. A process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic). (Section P.4)
6. Individuals who receive OT/PT direct interventions and/or programs should be monitored for the following:
    a. The status of their identified occupational and physical therapy needs; and
    b. The effectiveness of their OT/PT therapy programs. (Section P.4)

SECTION Q: Dental Services	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Policies, and procedures addressing the provision of dental care; o For the past six months, minutes from the statewide Dental Committee; o Lists of individuals who within the past six months: ▪ For newly admitted individuals, were seen for dental services, including date of admission, and date of initial evaluation; ▪ Were seen for dental services during the past six months other than for the annual exam, date of visit, and reason or type of visit; ▪ Have refused dental services; ▪ Have missed an appointment (other than refusals), the date of the missed appointment, the reason for the missed appointment, and the date of the completed make-up appointment; ▪ Have had a tooth/teeth extraction, including name, date of extraction, and number of teeth extracted; ▪ Have been seen for dental emergencies (e.g., abscess tooth, complications, etc.), including name, date of emergency visit and reason, whether individual complained of pain, documents confirmed pain, and treatment documented; ▪ Have had preventative dental care; ▪ Have had restorative dental care including name, date of completed restorative work, and for each appointment completed, type of restorative work, and ▪ Were due for annual dental exams, whether they have had exams, and whether the dentist was able to complete those exams, including name, and date of completed annual exam; o Most recent comprehensive exams for one individual from each residence – copy from dental office's record of visit and copy from active record of same visit for: Individual #26, Individual #238, Individual #341, Individual #339, Individual #305, Individual #183, Individual #13, Individual #371, Individual #198, Individual #228, Individual #368, Individual #127, Individual #209, and Individual #314; o Five most recent off site oral surgery consults and progress notes past six months for: Individual #376, Individual #50, Individual #60, Individual #111, and Individual #231; o List of abbreviations used in all dental records/reports; o For the past six months, data summaries used by the Facility related to dental services, and/or quality assurance/enhancement reports, including subsequent corrective action plans; o Attendance tracking sheet for dental appointments for the past six months; o List of refusals for the past six months per date of refusal, including reason for appointment (e.g., prophylaxis, annual, etc.); o List of those who have not seen dentist in one year and reason; o List of those who have outstanding need for dental x-rays, according to current

	professional standards, and type of x-ray that is needed to fulfill requirement/recommendations, including date of last full mouth x-rays; o List of those who were edentulous at time of the last onsite visit, and those who have become edentulous since that time; o List of other reasons for missed appointments per date for past six months, including reason for appointment (e.g., prophylaxis, annual, etc.); o List of no shows/missed appointment per building per month for the last six months o List of refusals per building per month for the last six months; o List of interventions per individual for missed appointments (i.e., follow-up appointment scheduled, whether follow-up completed, any correspondence to QDDP, home manager, team, etc.); o QDDP, IDT minutes that review, assess, develop, and implement strategies for dental visit refusals and no shows during the last six months, including ISPAs that documented discussion/action plans concerning dental refusals; o For five most recent emergency exams, integrated progress notes from start of emergency to closure, and copy of Dental Department evaluation and treatment for: Individual #168, Individual #144, Individual #62, Individual #117, and Individual #7; o Appointment schedule for those undergoing general anesthesia/conscious sedation, including individuals for whom general anesthesia was scheduled but the appointment was not completed, and the reason; o For six individuals undergoing general anesthesia/conscious sedation, complete copy of dental record from start of concern to closure, including copy of any operative reports, copy of any monitoring tapes, consents, second opinions, consult reports, pre-operative checklist or evaluation, and post-operative checklist or monitoring forms, etc. for: Individual #38, Individual #169, Individual #369, Individual #225, Individual #113, and Individual #69; o For the past six months, copies of correspondence concerning restraint and sedation use of office visit (to QDDP, team, psychologist, etc.); o Complete dental records for prior three years at SSLC (i.e., all documentation including progress notes, prophylactic, annual, emergency, restorative forms completed, x-ray consult reports, restraint checklist, oral surgeon consults, etc.), for one individual most recently seen from each residential unit. Also table with name, dates of annual exams, prophylactic exams, and dates of other treatment for: Individual #215, Individual #137, Individual #169, Individual #176, Individual #57, Individual #109, Individual #158, Individual #250, Individual #300, Individual #321, Individual #269, Individual #209, Individual #234, and Individual #77; o For 10 individuals given dental pre-treatment sedation, copies of progress notes/vital sign logs, other pre-appointment assessments from active record and dental office from start of sedation in residence (if applicable) to release from monitoring, including pre-treatment sedation sheets for: Individual #145, Individual #379, Individual #334, Individual #218, Individual #212, Individual #210, Individual #321, Individual #187, Individual #42, and Individual #136;

	o Current list of HRC approved dental medical restraints with sedation, including type of sedation, such as by mouth (PO) sedation, intravenous (IV) or general anesthesia; o Restraint and sedation tracking list/system used by the Dental Department (i.e., type of restraint, reason, sedation plan, drug used and dosage, effectiveness of restraint, trial of less restrictive approach); o In past six months, per month, percentage of individuals utilizing general anesthesia/IV sedation for dental exam and treatment; o In past six months, per month, percentage of individuals utilizing oral sedation for dental visits; o In past six months, per month, percentage of individuals utilizing mechanical restraints for dental visits; o For most recent five extractions in past six months, initial evaluation for this, second opinion, and subsequent documentation until closure for: Individual #169, Individual #250, Individual #308, Individual #69, and Individual #191; o For those completing annual exams in past six months, oral hygiene rating in each exam listed per individual and date of exam; o List of those who receive suction tooth-brushing treatment; o List of those who have been identified as benefiting from suction tooth-brushing treatment, but who are not receiving suction tooth brushing (e.g., waiting for equipment, training, care plan revision, etc.); o Ten annual dental assessments completed in last 30 days and for the prior year of these same individuals for: Individual #218, Individual #323, Individual #205, Individual #304, Individual #355, Individual #3, Individual #157, Individual #239, Individual #13, and Individual #211; o List of dental record annual examinations/assessments and treatment plan record completed in last six months, and the date of previous dental record annual examination/assessment and treatment plan record for all individuals; o Most recent annual dental summaries provided for the ISP for: Individual #244, Individual #78, Individual #71, Individual #287, Individual #305, Individual #46, Individual #371, Individual #198, Individual #367, and Individual #332, Individual #195; o Most recent/current Facility oral hygiene data (numbers and percentage good, fair, poor ratings), with date of data; o For those individuals for which care plans/ISP indicate they brush their own teeth, the most recent two oral hygiene scores, with dates of the scores; o List of those individuals that floss their own teeth; o List of individuals provided instructions on flossing, with dates of training; o For those that are edentulous, list of those with dentures; o For those edentulous without dentures, list of reasons with documentation as indicated; o Summary information on desensitization plans since the Monitoring Team's last visit; o For those undergoing total intravenous anesthesia (TIVA), any incident of injury in 24 hours following TIVA administration in prior six months; o For those with documented pneumonia, for each individual, date pneumonia documented,

	date of last dental visit, type of procedure/visit completed, and type of anesthesia (TIVA, oral, local, none, etc.) in past six months; and o Presentation Book for Section Q. ▪ **Interviews with**: o Enrique Venegas, DMD, Dental Director; and o Kathy Roach, RDH.
	Facility Self-Assessment: The Dental Department reviewed a number of reports/logs/databases to assess its compliance with comprehensive dental care. For example, the timeliness of annual exams and initial dental exams for newly admitted individuals was assessed. Oral hygiene ratings were tracked. Tooth-brushing instruction to individuals and/or support staff also was tracked. The number of individuals that in the past year received preventive care, completion of dental appointments, as well as the timeliness of response to dental emergencies, and the closure of emergencies were assessed. The Facility reviewed the rate of classroom training for direct support professionals. The Facility assessed whether ISPs had the most current dental assessment available. The Facility also tracked whether desensitization nominees from the Dental Department completed behavioral evaluations. Generally, these were reasonable components of a self-assessment for Section Q. Inter rater reliability was available from the March monitoring. Inter rater agreement ranged from 91 to 96%. The Facility assessed it remained noncompliant in both subsections of Section Q, although considerable progress had been made in approaching threshold levels of compliance in several areas. This was consistent with the Monitoring Team' s findings.
	Summary of Monitor's Assessment: The Dental Department had made considerable strides toward compliance. Although the Facility had not achieved compliance with either of the subsections of Section Q, several specific aspects of dental care had reached the level necessary for compliance, such as completion of annual exams and tooth-brushing instruction. Oral hygiene scores had continued to improve. It will be important for the Dental Department to sustain these efforts while it focuses on areas that remain in need of improvement. The quality of self-tooth brushing required review and intervention for those individuals that still had poor oral hygiene scores. Dental desensitization and other procedures to reduce the use of sedation remained underdeveloped after three years. Those that would benefit from desensitization had been methodically chosen, and recently, a small sample of these had been selected to begin the desensitization process. Quarterly reports reflecting the activity and progress of the Dental Department would be beneficial to the Dental Department and Facility Administration, but periodic reports were not part of the internal QA program of the Dental Department. Of concern, the current software program had allowed the department to advance and make improvement. There were two to three years of data available and trend analysis was available. It appeared user-friendly and much information could be quickly queried from it. The new

	statewide system appeared to be replacing it, but the challenges of implementation were significant and the benefits to the Dental Department needed clarity. It will be imperative to be able to use the prior data and incorporate the prior data into the new system to continue to provide trend analysis.

#	Provision	Assessment of Status	Compliance
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 included the following: Dental Director, one additional staff dentist, three dental hygienists, and two dental medication aides. Three other consultant dentists were listed that were not on staff. A list of dental staff certified in CPR was submitted, dated 4/1/12. Of the dental staff, seven of seven (100%) were current in CPR certification. There was an unusual entry in the CPR status of one of the dentists. CPR certification, from the roster provided, extended two years until the next renewal. For one dentist the CPR completion date was 5/18/10, with an expiration date of 5/17/14. A copy of the certification was verified. It is recommended the Dental Department review the dates of submitted entries for CPR certification with the SSLC training department or training instructor to verify that the certification was intended for a four-year period. <u>Annual Assessments</u> A list of those individuals having annual examination appointments was submitted for the time period from 12/1/11 through 5/31/12. Of these, 154 were listed with a prior annual examination dates. Of these, 151 had an annual examination date completed within 365 days of the prior annual exam. This was a compliance rate of 98%. The Dental Department documented that there was no individual residing at CCSSLC who had not seen a dentist during the time period between 5/31/11 and 5/31/12. Separately, copies of the annual dental assessment that were completed in the prior 30 days to the Monitoring Team visit along with the prior year's completed assessment were submitted. For the time period from 5/29/12 through 6/13/12, a total of 10 annual assessments were submitted. For 10 out of 10 (100%) of these individuals, an annual dental assessment had been completed within 365 days. Copies of the completed annual assessments for 14 individuals were submitted, one from each residence. Each included the annual assessment from the dental office record and a copy from the active record for the same visit. The following findings were made with regard to the dental office record documents and the active record documents related to the annual assessments: ▪ Fourteen of the 14 individual annual assessments had identical information in both the dental office record and active record (100%).	Noncompliance

#	Provision	Assessment of Status	Compliance
		▪ Fourteen of the 14 submitted assessments (100%) had an entry concerning cooperation, behavioral issues, and need for sedation/restraint use. ▪ Fourteen of the 14 assessments (100%) had entries for oral hygiene rating, teeth restorations, and periodontal condition. ▪ Intra-oral and extra-oral exam screening was documented in 14 out of 14 (100%). ▪ The dental treatment plan was documented in 100% of the cases. ▪ Oral hygiene recommendations were documented in 14 assessments (100%). ▪ Risk rating was documented in 14 out of 14 (100%) assessments. ▪ Community transition preparedness was documented in 14 out of 14 (100%) assessments. Additionally, during the time period from 12/1/11 through 5/31/12, there were five individuals newly admitted to the Facility. Five out of five (100%) had completed an initial dental exam in the first month (from six to 26 days). <u>Dental Records</u> The Facility submitted the complete dental records for the prior three years for one individual from each residence, as a separate measure of completeness and timeliness in dental documentation. Fourteen records were submitted, and the following findings were based on the review of this material: ▪ For 13 out of 14 (93%), the most recent annual dental assessment was within 365 days of the prior assessment. ▪ A periodontal chart was completed/documented in three of 14 (21%) records. None of the 14 was edentulous. ▪ A permanent dentition chart was submitted for 14 individuals (100%). ▪ The dental treatment plan was documented in 14 of 14 (100%) records. ▪ A sedation plan was submitted for six of 14, but was outdated in five of six. A current sedation plan was in place for one individual. ▪ Four individuals had undergone oral surgery consultation. ▪ Ten had a TIVA anesthesia record. ▪ Fourteen of 14 (100%) had a current annual dental summary. ▪ Eight of 14 had information submitted concerning missed appointments in the prior year. ▪ Thirteen of 14 had information submitted concerning the completion of dental x-rays. A chart was submitted for dental exams completed from FY2010 (starting in June 2010) and ending in FY 2012 (May 2012). For the time period December 2011 through February 2012, there were 493 appointments listed. Of these, 421 had documentation as having been completed (85% completion rate). There were 27 appointments cancelled.	

#	Provision	Assessment of Status	Compliance
		There were 43 missed appointments (no shows and refusals), which was 9% of the appointments scheduled. For two appointments, attendance was not documented. For the time period March 2012 through May 2012, there were 580 appointments listed. Of these, 497 had documentation as having been completed (86%). There were 41 cancellations. There were 40 missed appointments (no shows and refusals), which was 7% of the appointments scheduled. For two appointments, attendance was not documented. <u>Oral Hygiene</u> An oral hygiene rating was completed on each individual at the time of the annual exam. The most current ratings for each individual were used in determining the percentage of the campus with good/fair/poor oral hygiene. For 260 individuals, current oral hygiene ratings indicated 42% had a good oral hygiene rating, 40% had a fair oral hygiene rating, and 18% had a poor oral hygiene rating. As a comparison, the prior oral hygiene ratings from November 2011 for 271 individuals were provided. At that time, 100 out of 271 (37%) had a good oral hygiene rating, 98 (36%) had a fair oral hygiene rating, and 73 (27%) had a poor oral hygiene rating. The Dental Department also had cumulative data indicating trending of oral hygiene rating in each residential unit. This allowed for more focused interventions and interdisciplinary strategizing in units in which oral hygiene ratings were still a challenge. According to the Provision Action Information, updated 6/29/12, the Dental Department tracked oral hygiene ratings monthly for all residential units. Trend lines could then be created reflecting the monthly data. Through email communication, the Dental Department provided each unit a monthly progress report of the trend of good/fair/poor oral hygiene, as well as a request to the units to identify individuals needing additional focus. Two of the staff also provided dental hygiene hands-on instruction in the residences. There was also video training of oral hygiene care. For more recent data, an oral hygiene rating was completed on each individual at the time of the annual exam for the prior six months. The most recent oral hygiene scores were submitted. According to this document, for these 154 individuals, 37% had a good oral hygiene score, 46% had a fair oral hygiene score, and 17% had a poor oral hygiene score. **Oral Hygiene Ratings for Previous Six months - %** **Rating** | 1/1/12 to 6/30/12 | 7/1/11 to 12/31/11 | 1/1/11 to 6/30/11	

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Good	37%	39%	26%
Fair	46%	35%	43%
Poor	17%	26%	31%

The trend indicated plateauing of those with good oral hygiene, continued increase in those with fair oral hygiene and a continued decrease in those with poor oral hygiene.

From a separate document entitled "Dental Services Department - monthly trending report," for the most recent quarter (March through May 2012), there were 280 appointments for which oral hygiene ratings were recorded. Of these, 106 out of 280 (38%) had an oral hygiene rating of good, 115 (41%) had an oral hygiene rating of fair, and 59 (21%) had a score of poor. This more recent list, compared to the prior six-month trend, indicated a normal variability from quarter to quarter, based on small numbers.

A total of 81 individuals had care plans/ISPs that included brushing one's own teeth. The oral hygiene scores of these 81 individuals were submitted for the prior two ratings. These ratings occurred from a few days to approximately five months apart. For the most recent scores, 36 individuals (44%) had a good oral hygiene rating, 37 individuals (46%) had a fair oral hygiene rating, and eight (10%) had a poor oral hygiene rating. The prior score indicated 37 individuals (46%) had a good oral hygiene rating, 32 individuals (40%) had a fair oral hygiene rating, and 10 (12%) had a poor oral hygiene rating. Two individuals were new admissions and did not have prior scores. As some of the ratings were only days apart, it was not possible to determine if oral hygiene was improving or stable in those that brushed their own teeth. For those with continued poor oral hygiene rating that brushed their own teeth, it is recommended that additional assistance be considered, and that the Dental Department participate in IDT meetings to discuss additional steps to be taken.

As part of preventive oral care, suction tooth brushing was provided to those with dysphagia and other indications for this procedure. A list submitted indicated 41 individuals received suction tooth brushing, which was 41 out of 261 (16%) of the population. There was one individual identified that would benefit from suction tooth brushing, but was not receiving suction tooth brushing. The reason provided was that the individual had fragile health. As many of those that receive suction tooth brushing have fragile health, the reason documented did not provide adequate detail for not providing suction tooth brushing. For instance, if there was a prolonged hospitalization that prevented this procedure, that would have been important to document.

On 12/20/11, the Dental Department participated in a Dental Departmental conference

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		call with other SSLC Dental Departments. There was a presentation on the preferred suction toothbrush system. The Dental Department implemented/tracked other action steps to improve oral hygiene across the campus. These included: ▪ The Dental Department, as part of its self-assessment, tracked tooth-brushing instruction for the individual and/or staff. The Dental Department submitted a table of 262 names, including those who were edentulous, entitled: "Summary for Tooth-brushing Instruction for Individual and/or Staff." The table indicated that all those with teeth had been provided tooth-brushing instruction (100%). However, the time period of the data was not included (i.e., whether it was 12 months, six months, one quarter, etc.). ▪ Additionally, the Dental Department submitted a roster of direct support professionals that had completed dental training on tooth brushing, and those direct support professionals that remained to be trained. The difficulties of this task were evident based on the submitted color coded chart in which employees that no longer worked at CCSSLC were listed, along with new hires, as well as all other direct support professionals from all residential units, including the Infirmary. There appeared to be considerable turnover in the direct support professional staffing, which was an added challenge for the Dental Department to ensure adequate training in this oral hygiene task. The Dental Department indicated that 447 of 492 (91%) of direct support professionals that were currently employed had received training in tooth brushing, although the date of the data to which this calculation referred was not indicated. However, the extensive table submitted was updated as of 6/12/12, indicating the information was current. Additionally, the list of those to be trained included two administrative staff, habilitation therapy staff, three psychiatry department staff, two QDDPs, one staff described as "ortho," and several active treatment staff. It was not indicated if these other department numbers were part of the tabulation of the 447 out of 492 staff. Flossing was discouraged reportedly due to injuries of the mouth and fingers, as well as floss being used as a weapon. Therefore, no training was conducted on use of floss. Flossing was allowed during dental procedures for only 61 individuals. It is recommended that the State Office/Facility Administration review current and prior guidance concerning allowing individuals to floss. With adequate supervision and appropriate storage, opportunities to include flossing as part of dental hygiene should be considered. <u>X-rays</u> The Facility submitted a list of those who had outstanding need for dental x-rays. These	

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		were categorized by priority. In the highest priority category were those with poor oral hygiene, observed decay, mobility of teeth, and imminent need for dental restorations and/or extractions. There was no one identified in this category. The "medium priority" group included those with fair to poor oral hygiene, those that exhibited psychotic or irrational behavior, were combative, and frequently refused dental services. Three individuals were listed in this category. In the "low priority" category were those with good to fair oral hygiene, no visible decay, had severe bruxism, were unable to be still for x-rays, had limited dentition, and/or had safety concerns such as pica or self-injurious behavior. This group had 23 names. There was an additional category in which there was no ability to take dental x-rays because of anatomic anomalies of the mouth, medically compromised state, there were contraindications for TIVA, had fixation of the temporomandibular joint, had a terminal condition, and/or had a compromised airway. This included 20 names. <u>Preventive, Restorative, Emergency Dental Services</u> Information submitted indicated 20 individuals residing at CCSSLC were edentulous, for a rate of 20 out of 261 (8%). It was noted that individuals' transitions to the community played a role in making databases appear to be in non-agreement, because the list identifying 20 individuals as edentulous also included two individuals that had moved to the community. A separate database indicated that there were 21 individuals without teeth. Five individuals had dentures. Sixteen individuals were edentulous and did not have dentures. Reasons given were that all sixteen had inability to comprehend/ cooperate with dental procedures of fabrication. Additionally, six of the 16 had an inadequate ridge needed for a dental prosthesis. One of the 16 had an anatomic contraindication. The Dental Department did provide the breadth of services required to care for the individuals at CCSSLC. Since September 2011 (the beginning of FY 2012) through May 2012, from a table labeled "Type of Services Provided," 194 annuals were completed, 87 annuals with cleanings, 14 annuals with edentulous individuals, 57 appointments for cleaning, 389 appointments for cleaning with fluoride treatment, 21 dental visits for denture care, 31 emergency dental exams, 175 appointments for extractions, 94 appointments for restoration, and 116 visits for x-rays. Separately, tables of a monthly trending report entitled "routine or emergency appointments" indicated there were 47 emergencies for the September 2011 –through May 2012 time period, not 31 as mentioned in the prior paragraph. From a table submitted for "Dental Services Department – monthly trending report for	

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		FY 2012," in the most recent six months from December 2011 through May 2012, there were 400 appointments for prophylactic care (included annual/cleaning, cleaning, cleaning/fluoride treatment, cleaning/periodic exam, fluoride treatment). A total of 17 individuals underwent 51 restorative care procedures. There were 16 appointments for dental emergencies. Separate information submitted by the Dental Department entitled "Self -Assessment: Summary for Preventive Services" listed 262 individuals, including those that were edentulous. Of the individuals listed with teeth, all (100%) had been provided preventive services. However, the document did not include the time period during which the preventive services occurred (e.g., yearly, quarterly, etc.), or if this was current information (2012) or prior year information. <u>Oral Sedation</u> Monitoring and evaluation of use of oral sedation was reviewed. Ten active records were submitted for individuals who underwent oral sedation. The following summarizes the results of this review: ▪ One out of nine (11%) confirmed nothing by mouth (NPO) status or nothing per G-tube. One individual was documented to not need NPO status. ▪ Ten (100%) listed the medication administered, the dose, and the route. ▪ Ten (100%) listed pre-procedure vital signs. ▪ Three (30%) documented intra-procedure vital signs. ▪ Ten (100%) documented post- procedure vital signs. ▪ Adequate documentation regarding effectiveness was found in eight of the 10 (80%) of the active records. ▪ None (0%) documented a post dental procedure IPN note. ▪ Ten (100%) included documentation of current sedation consent. ▪ Ten (100%) included a restraint checklist. The Provision Action Information, updated 6/29/12, documented that the Dental Department had concerns about the number of individuals arriving for dental appointments without being sedated due to no sedation orders. This was a business agenda item at the 3/26/12 Nursing Quality Assurance meeting. This also was to be discussed at the Morning Medical Meeting. An email directive from the CNE dated 4/4/12 went to nurses and the Dental Department. This provided clear guidance regarding the documents to send after administration of a sedative for dental clinic, although it did not address the issue related to a lack of sedation orders. Nurses were to forward the original restraint checklist and the vital sign flow sheet (but not to be confused with TIVA documents). As a baseline prior to sedation, the nursing staff was instructed to obtain a full set of vital signs with pulse oximetry, document gait/balance/coordination, and mental status. This information was to be obtained	

#	Provision	Assessment of Status	Compliance
		every 30 minutes once sedation was administered until the individual was sent to the dental clinic. The Dental Department was to continue to take vital signs at the appointment, and nurses were to resume vital signs once the individual returned to the home. Nurses were to obtain the same pre-dental visit information as well as additional information (i.e., lung sounds, skin color, signs/reports of nausea/vomiting, review of record for time of sedation administration and time of dental procedure), with a schedule of decreasing frequency of monitoring until the individual had recovered from the sedation. There was an additional 4/30/12 Nursing Quality Assurance meeting that noted improvement in the pre-treatment sedation, but did not describe further if this reflected improvement in ordering of the sedation or in monitoring of the sedation, or some other aspect of care. The 5/14/12 Dental Team Meeting documented that the Sedation Care Plan logs were increasingly incomplete, with lack of vital sign documentation. There was also a concern about the filing location in the active record. The nursing coordinator, as well as case managers were emailed concerning this information. <u>General Anesthesia/TIVA</u> The active record was submitted for six individuals who had undergone general anesthesia in 2012. One individual underwent TIVA twice during this time. The date range of these procedures was from 4/16/12 through 6/12/12. The procedures under general anesthesia included one or more aspects of dental care. The list varied in each case, and included the following: annual exam, prophylaxis, extractions, and restorative care. Review of these records revealed the following: ▪ Consent for the dental procedures/anesthesia was up-to-date in seven of seven (100%) procedures. ▪ A pre-operative anesthesia clearance was completed and submitted in seven of seven cases (100%). ▪ A pre-operative medical clearance was completed and submitted in seven of seven cases (100%). ▪ The operative anesthesia record was completed in seven of seven cases (100%). ▪ The post anesthesia care "Respiration, Energy, Alertness, Circulation, and Temperature (REACT)" score was documented in seven of seven cases (100%) of the active records. ▪ A recovery note was documented for seven of seven cases (100%). This consisted of a phone call to the home the following day in seven of seven cases. A follow-up visit occurred in three of seven cases (43%). ▪ Pre-operative vital signs were recorded in seven of seven cases (100%). ▪ Post-operative vital signs were recorded in seven of seven cases. (100%).	

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		▪ A periodontal chart was submitted for five of seven (71%) cases/six (83%)individuals. For one individual that required extensive dental work under TIVA, hypoxia developed toward the end of the procedure. It was not clear whether the periodontal chart was not completed at the first TIVA appointment because of the hypoxia (anesthesiologist suggested limiting anesthesia time to less than two hours). The periodontal chart was completed at the second TIVA appointment. ▪ A treatment plan was submitted for six of seven cases (86%)/six (100%) individuals. For the one individual, who required two TIVA appointments, the State asserted in its comments on the draft report that the treatment plan for the first TIVA appointment applied to the second TIVA appointment. However, at the time of the second TIVA appointment, the plan did not appear to be updated to include current information. The treatment plan of 4/16/12 indicated that he was a candidate for desensitization, but the Dental Progress Note of 6/11/12 indicated Behavioral Services determined the individual was not appropriate for desensitization. ▪ Pain medication was prescribed in two of two cases in which extractions occurred (100%). From 1/10/12 through 5/16/12, 35 individuals underwent dental procedures using TIVA. The QA/QI Quarterly Section Review of Settlement Agreement Progress, dated 3/22/12, identified one of the Dental Department challenges was to reduce the time in obtaining the required consents, medical clearances, etc., for TIVA procedures. The minutes of the subsequent QA/QI Council did not provide any progress on this concern, and the Dental Department did not provide further information on this identified challenge. The quality of the sedation and the type of sedation were tracked via two databases. A "Sedation Usage Report" tracked sedation use per chronological date. For any date requested, the use of sedation (individual, medication, dosage, effectiveness) was logged. Additionally, to aid the dentist and IDT in determining sedation needs, a log of all sedations were listed per individual, along with level of effectiveness. This provided historical information and guidance in ordering the appropriate amount of sedation for the next dental visit. The Facility was asked to submit information concerning any injury to an individual who had been administered TIVA in the following 24 hours (e.g., falls with injury, etc.). A list of 35 individuals was submitted who had undergone TIVA from January 10, 2012 through 5/16/12. All were considered to have " normal recovery," and there were no adverse reactions documented.	

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		The Facility was asked to submit the date of the most recent dental visit for those individuals that were diagnosed with pneumonia from 12/1/11 through 5/31/12. This was to include the type of dental procedure completed, and the type of anesthesia or sedation provided. A list of 26 individuals was submitted who had documented pneumonia. No trend was identified in which dental procedures/sedation that was provided preceded the development of pneumonias. There was only one individual identified that developed a viral pneumonia three days after a dental visit that involved a physical evaluation and fluoride treatment without sedation. There were two other individuals at CCSSLC that also had viral pneumonia at the same time, suggesting a local spread of viral infection unrelated to dental care. <u>Extractions</u> The Dental Department submitted a document entitled "Extraction Chart reviewed Summary" for the time period 12/1/11 through 5/31/12. This log included the individual's name, the number of teeth extracted, and the reason for the extraction. All 31 individuals with tooth extractions were listed. Ten individuals had one tooth extracted, eight individuals had two teeth extracted, seven individuals had three teeth extracted, one individual had four teeth extracted, one individual had five teeth extracted, two individuals had eight teeth extracted, one individual had 12 teeth extracted, and one individual had 22 teeth extracted. For clinical justification of the extraction, the reason for the extraction of each tooth was listed. The list of reasons included decay non-restorable, impacted wisdom tooth, impacted wisdom tooth with discomfort, pulpitis with discomfort, abscessed non-restorable, root fragment non-restorable, broken non-restorable, and root fracture non-restorable. For five individuals that underwent extractions on campus, the dental record was submitted. The following findings were made: ▪ Consent was obtained in five of five (100%). ▪ A prior dental IPN/DPN indicating the need for extractions was documented in five of five (100%). ▪ For four of the five cases, IV sedation was used. For one of the five cases, oral pre-treatment sedation was used in preparation for TIVA. One had a local anesthetic. ▪ From one to three teeth were extracted at a visit. ▪ Pain medication was provided in five of five cases. ▪ A follow-up phone call was documented in four cases. ▪ A follow-up visit was documented in five cases. For five individuals that underwent extractions off campus at the oral surgery consultant's office, the dental record was submitted. The following findings were made:	

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		▪ None of the five had prior refusals for dental appointments or unsuccessfully completed appointments, according to the submitted information. ▪ Five of five (100%) had completed IPNs/DPNs in the record prior to referral to the oral surgeon indicating the need for the extraction or other procedure. Four cases were referred for non-restorable decay. One was referred for a partially avulsed tooth. ▪ One to three teeth were extracted for the four cases needing extraction. ▪ Five (100%) included an oral surgery consult report. ▪ Five (100%) submitted a copy of the anesthesia report. ▪ A copy of the consent was submitted for five of these oral surgeries (100%). ▪ There was one or more post-operative IPN/DPN notes from the SSLC Dental Department submitted for five off-site dental procedures (100%). <u>Emergency Treatment</u> The Dental Department provided a "Dental Emergency Log" for the months December 2011 through May 2012. These logs reflected 16 emergencies. A prior document referred to 31 to 47 emergencies over a longer time period, but the small current number suggested inconsistency in database management. For these 16 recent emergencies listed in the "Dental Emergency Log," 15 out of 16 (94%) were seen the same day as the emergency contact with the Dental Department, and all were seen within one business day. The "Dental Emergency Log" also tracked these emergencies to completion. Fourteen out of 16 (88%) were tracked to closure. Two remained outstanding, awaiting consultation with the oral surgeon. Emergency treatment was reviewed for five individuals. The reasons for the emergency were as follows: post TIVA treatment, partially dissolved capsule causing irritation in mouth, cheek bite, fall, and a non-emergency (individual wanting braces). The following findings are made based on this review: ▪ Four records (80%) documented the presence or not of pain. ▪ Pain was documented in two cases. Pain was treated in these two cases. ▪ All five cases (100%) were seen on the same day the complaint was made known to the Dental Department. ▪ Follow-up occurred for four of four cases considered an emergency (100%). Because of the scope and detail of the above information, the following summary of this section is provided to focus the Dental Department on areas necessary for substantial compliance to be achieved. There are many areas outlined above with 90% or greater compliance. Maintenance of these areas will be required. However, a few areas need further refinement. The role of individuals in flossing their teeth was in need of review. Determining the previous Facility or State Office documents or policies that did not allow	

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		it would be the initial step, and then decisions made about what is currently necessary and appropriate for adequate dental care. In addition, review of those individuals who brush their own teeth, but have poor oral hygiene scores is needed, and as appropriate, new plans implemented and results tracked. Intra-visit recording of vital signs when oral sedation is administered should be provided and documented, where applicable. It also would be important to document whether an individual was made NPO when an order/expectation for NPO is included in the dental visit record, prior to initiating the dental procedure. These are all areas that appear to be challenges that the Dental Department can be met in the near future.	
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 IDTs, refusals and missed appointments, tracking of use of sedating medications and restraints, and interventions to minimize the use of sedating medications. <u>Policies and Procedures</u> The Dental Department submitted one revised policy that was implemented during the prior six months. This was Dental Services: Annual Dental Examination – Dental Q.16, revised 4/12/12 and implemented 4/19/12. Changes/revisions were highlighted. The following statements had one or more changes: ▪ "All notes will be written in the Integrated Progress Notes of the individual's Active Record with copies made for the Dental Section of the Active Record and the Dental Clinical Record." ▪ "A complete extra and intra-oral examination will be completed within 365 days of the previous annual examination but no more than 31 days prior." ▪ "10 days prior to ISP's Annuals the most current Dental Assessment will be filed in the Client Information Record folder. If Dental Assessment is dated more than 60 days prior to ISP Annual date, an updated and revised assessment will be placed in the Client Information Record." A copy of the in-service training roster was submitted for "Revision of Dental Policy Q.16 – Annual Dental Examination – In-service changes in scheduling of Annual Examination (eleven month recalls)." This occurred on 4/19/12. Five dental staff attended. This policy was part of Dental Services manual that included 21 policies and procedures. <u>Provision of Dental Records to IDTs</u> The Dental Department provided an annual dental summary to the IDT, a portion of which was also copied directly into the "Rationale" section of the Integrated Risk Rating	Noncompliance

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		Form, with dental risk determined. Content of the document included dental treatment performed in the prior year, oral hygiene ratings, present condition of the teeth, periodontal condition, mobility, missing teeth, intra-oral and extra-oral assessment, behavior assessment while under dental treatment, sedation utilized, effectiveness of sedation, community transition requirements, and whether a desensitization program was in place. The ten most recent annual dental summaries provided for the ISP process were submitted. Each was completed according to the above description. The annual dental summary was completed from three to five weeks prior to the date of the Integrated Risk Rating Form, indicating up-to-date information was provided by the Dental Department. The Dental Department submitted several tables in which the ISP date of the individual was listed, the date the annual assessment was due (10 days prior to the ISP), along with the date of the annual dental summary. For the 15 ISPs that occurred in December 2011, all 15 had received the annual dental summary by the due date. For the 27 ISPs that occurred in January 2012, all 27 had received the annual dental summary by the due date. For the 29 ISPs that occurred in February 2012, all 29 had received the annual dental summary by the due date. For the 25 ISPs that occurred in March 2012, all 25 had received the annual dental summary by the due date. For the 24 ISPs that occurred in April 2012, all 24 had received the annual dental summary by the due date. For the 26 ISPs that occurred in May 2012, all 26 had received the annual dental summary by the due date. Additionally, according to the Self-Assessment, a member of the Dental Department attended 95 out of 146 ISPs (annuals) from December 2011 through May 2012, which was a 65% attendance rate. However, the 3/22/12 QA/QI Quarterly Section Review of Settlement Agreement Progress indicated that the Dental Department needed to review accuracy of the attendance data for the ISP meetings. The subsequent 4/19/12 QA/QI Council minutes did not provide an update, and the Dental Department did not submit further updates concerning this issue. As part of the process to discuss dental concerns with the IDT, the Dental Department tracked its attendance at ISPs/ISPAs. For November 2011, two out of 22 (9%) were attended. For December 2011, Dental Departmental attendance was seven out of 15 (47%). For January 2012, Dental Departmental attendance was 12 out of 27 (44%). For February 2012, Dental Departmental attendance was 17 out of 29 (59%). For March 2012, Dental Department attendance was 13 out of 24 (54%). For April 2012, Dental Department attendance was 21 out of 24 (88%). For May 2012, Dental Departmental attendance was four out of 25 (16%).	

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		Refusals/Missed Appointments A review of information from a chart entitled "List of refusals for the past six months per date of refusal (list reason for appointment)" for dental appointments for the prior six months (12/1/11 to 5/31/12) indicated that 28 individuals refused appointments. One individual refused four times, and two individuals refused two times. Of these, 21 of the 28 subsequently completed a dental visit, and six remained incomplete as of the date of the document submitted. One individual referred for a dental emergency subsequently had resolution of the signs and symptoms, and did not require additional follow-up. Reasons for the scheduled appointments that were refused included cleaning (17 appointments), extraction (one appointment), annual exam (seven appointments), and restoration (two appointments). Separately, a list entitled "Individuals Identified to have refused Dental Treatment between 12/1/11 and 5/31/12" listed 26 individuals. Additionally, one individual that had refused no longer resided at CCSSLC. Although not in exact agreement, the two databases were similar. For the time period December 2011 through May 2012, there were 108 missed/no show appointments that were not categorized as refusals. Reasons for the scheduled appointments that were missed included cleaning (74 appointments), annual exams (15 appointments), and restorations (four appointments). From submitted graphs entitled "CCSSLC Dental Services Department monthly trend report from 12/1/11 through 5/31/12," more information was provided concerning missed appointments. The number of cancelled appointments was greater on Shift 1 than Shift 2, but the number of "no shows" was about equal between the two shifts. The major reasons identified for missed appointments included medical illness, dental clinic issues, refusals, and staffing issues. Information was also provided concerning appointment attendance per unit. Atlantic Unit had the highest numbers of "came as scheduled," "no show" and refused treatment, compared to the other units. Specific residences had the highest rate of cancelling (Residence #515 and #516), had the highest rate of "no show" (Residences #518, #522A, and #522B), and the highest rate of refusal (Residence #522A). Separately, a document entitled "Have missed an appointment (other than refusals), the date of the missed appointment, the reason for the missed appointment, and the date of the completed make-up appointment for the time period 12/1/11 through 5/31/12" identified 83 individuals that missed 116 appointments. The reasons for the appointments that were missed included cleaning (82), restorations (seven), post op care	

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		(three), denture care (six), annual exams (eight), TIVA (two), exam (two), and other (two). The reasons listed for the missed appointments included behaviors (six), medical reasons (34), staffing concerns (11), dental clinic reasons (16), weather (four), conflict in the individual's schedule (five), refused (17), home issues (six), administrative issues (one), nursing (eight), furlough (six), and reason not submitted (two). It was unclear why this information included refusals despite the report heading indicating it was data that had separated refusals from all other missed appointments. It is recommended that the Dental Department review the reasons for refusals to remain as part of the missed (non-refusal) data. For rescheduling of the missed appointments for the 83 individuals, there was one individual that moved from CCSSLC, six that remained to be completed, and one that did not need to be rescheduled as the concern resolved. The other 75 individuals completed appointments (90%). Of these 75, it was noted that 13 individuals completed the appointment more than 60 days after the date of the original missed appointment. A total of 62 completed an appointment within 60 days (83%). It is recommended the Dental Department continue to decrease the time between missed appointments and completed appointments. The Dental Department submitted a table entitled "Missed Dental Appointments without ISPA 2/1/11-6/1/12." During this time, there were 149 missed appointments. This included both appointments that had been refused, as well as all other "no shows." There were three categories of missed appointments that did not require an ISPA, including Dental Department issues (16 missed appointments), illness (29 missed appointments), and weather (4 missed appointments). These totaled 49 missed appointments not needing a follow up ISPA. The other categories of reason for "no show" were identified as behaviors at home, staffing issues, scheduling conflicts, furlough and nursing issues and totaled 100 missed appointments without an ISPA as of 6/1/12. Subsequent to this information, 14 of the 100 individuals had an ISPA completed. There was no evidence submitted that the other 86 individuals had ISPAs created and implemented to address the "no show" appointments. The Dental Team Meeting of 5/14/12 documented that the Dental Department would maintain a list of missed appointments as well as ISPAs received. A copy was to be filed following the missed appointment log kept in the dental chart. This allowed the Dental Department to determine whether there was closure by the IDT in follow-up to communication of a missed appointment. <u>Interventions to Minimize the Use of Sedating Medications and/or Restraints</u>	

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		Information was submitted concerning use of restraints for dental procedures. For the prior six months, the dental office did not use mechanical restraints. For oral sedation, from December 2011 through May 2012, according to the data provided, 903 appointments were kept. Of these, there were 41 appointments in which oral sedation was given (4.5%), and 32 (3.5%) for which IV sedation was administered. Separately, a list of HRC-approved dental and medical restraints was submitted, including the use of sedation, dated 9/1/11 through 5/31/12. A total of 81 individuals were listed that required dental sedation. Of these, 35 had approval for TIVA, 33 had approval for oral sedation, and 13 had approval for both oral sedation and TIVA. <u>Desensitization</u> The Dental Department collaborated with the Psychology Department, PCPs, Pharmacy, and Psychiatry Department in advancing the dental desensitization program at CCSSLC. The Dental Department also referred individuals to the IDT if there was the need to consider dental desensitization. An outline/timeline of progress was submitted by the Dental Department for desensitization. The Dental Department had nominated 174 individuals for behavior evaluations. Reportedly, the Psychology Department had updated and implemented 110 new desensitization plans as of 12/9/11. All HRC approvals had been obtained since 9/7/11. Beginning in February 2012, the Annual Pre-Treatment Sedation Psychiatric Clinic, an interdisciplinary team, reviewed the pre-treatment sedation needs for individuals by Unit. According to the Provision Action Information, Pacific Unit was discussed on 2/7/12, Kingfish 3 and 4 on 3/7/12, Coral Sea Unit on 3/21/12, Dolphin and Porpoise Units on 3/23/12, Kingfish 1 and 2 on 3/28/12, and Dolphin and Porpoise Units on 4/11/12. This series of dates completed the yearly pre-treatment sedation reviews by this committee. When comparing email correspondence from the Dental Department to confirm the accuracy of the above meeting content, there was one meeting for which information was in conflict. An email indicated that Ribbonfish was reviewed on 2/7/12. The reason for the discrepancy was not determined. The Pre-Treatment Sedation Psychiatric Clinic started with a review of pre-treatment sedations with pharmacy, dental, and psychiatry participation. Approvals were provided at that meeting, based on effectiveness of prior usage and dosage. For orders exceeding or outside of prior committee approval, prior interdepartmental review and approval were necessary. Beginning on 2/15/12, a Desensitization Plan Workgroup discussed the decision tree evaluation process, baseline information, the potential for two mock clinics for desensitization, trials of appropriate replacement behavior, and data collection.	

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		Separately, on 2/28/12, a Desensitization Committee reviewed the nomination lists of the Dental Department, and compared this list to the Psychology Department nominations. There were further meetings of this committee on 3/21/12 and 4/19/12, which tracked progress of the mock clinics, the establishment of dental nominations, and the creation of a list of those considered inappropriate for a desensitization program. According to the "Section Lead Monthly Report –Dental," dated 5/30/12, the Desensitization Committee had identified an initial group of individuals for desensitization plan development. A document entitled "CCSSLC Dental Tentative List of Individuals for Initial Desensitization Trial Program," with a hand written date of 4/19/12, listed eight individuals, who were among 23 individuals who received Strident Treatment (suction tooth-brushing) and had been approved for a desensitization program. A Restrictive Practice Committee met at frequent intervals from March to May 2012 (starting 3/21/12) to review the restrictive practices of dental pre-treatment sedation utilized in the prior week. A policy was created, Behavioral Services: Restrictive Practices Committee, K.19, dated 3/22/12, to provide guidance to this process. To provide efficiency in the system, dental pre-treatment sedations were discussed at the Wednesday meetings (personal, mechanical, and chemical restraints were discussed at Monday meetings, and medical pre-treatment sedation was discussed at Friday meetings). Restraint review included determining whether the data supported the need for the restraint and whether documentation was correct. As preparation for the discussion, the Dental Department provided a list of individuals that had received sedation the prior week, along with a historical sedation log of medication and effectiveness. At the 3/21/12 Restrictive Practices Committee Meeting, there was discussion concerning the need to differentiate those requiring desensitization due to fear from those needing reinforcement programs due to non-compliance and oppositional behavior. Additional meetings of the Restrictive Practices Committee occurred on: 3/28/12, 4/4/12, 4/18/12, 4/25/12, 5/2/12, 5/9/12, 5/16/12, 6/6/12(?), 6/13/12, 6/20/12, and 6/27/12. A Desensitization Committee meeting of 3/21/12 identified 65 individuals for whom the Psychology Department and Dental Department disagreed concerning the need and role of desensitization. A separate document entitled "CCSSLC: Individuals with Desensitization Plans" was submitted as part of the 3/21/12 Desensitization Committee meeting, although the document was undated. A total of 179 individuals were listed, of which 157 had listed the dates of the decision tree discussion, and 118 had a date under the column of baseline data (possibly representing the date of completion of the data for that	

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		individual). There were 61 determined to be "NA," and it was not clear the reason for the "NA" category of baseline data. A total of 94 of the 179 individuals had the baseline step defined (derived from a dental task analysis of 12 steps). A total of 154 individuals had ISPAs, and nine had implementation dates documented for desensitization plans. As part of the 4/19/12 Desensitization Committee agenda, a list of those not considered appropriate for desensitization plans was distributed with rationale. A total of 59 names were listed. Main reasons for not offering a desensitization program were "physiological" for 19 individuals, "physiological spasticity" for 16 individuals, and edentulous state for three individuals. For seven, the rationale listed "no sedation," which did not provide a rationale. There were 12 others with no rationale listed. On 4/22/12, the Dental Department provided feedback to this list. A total of 16 of the 59 were noted to be individuals needing desensitization for medical reasons and were not referred for dental needs. This list appeared to be incomplete, but did indicate progress in reviewing the needs of the individuals. The result of these deliberations was documented in a summary statement on 5/31/12. Reportedly, at that time 99 of the 174 dental nominees had a desensitization plan, 37 dental nominees had outstanding behavior evaluations, and 38 dental nominees were considered inappropriate for dental desensitization plans. This information derived from a "Dental Desensitization Nominees Roster List," which was undated. There was no data indicating implementation and progress of desensitization plans. <u>Quality Assurance/Improvement Initiatives</u> The State Office had developed a new dental database, but according to the 12/20/11 dental conference call, the software did not appear to be reliable due to multiple "crashes." From notes taken during a dental scan call of 3/27/12, all SSLCs were provided this new database. One of the initial limiting steps was data input into the system. There was lack of personnel support to enter data at some SSLCs. Database input could occur at the SSLC level, but data could not be deleted at the SSLC site. During discussions with the Dental Department during the Monitoring Team's visit, it was learned that there continued to be delays in implementing the system, as the medical database had to be completed before the dental database could be developed and/or implemented. The software program was extensive, and creating a simple query was perceived as potentially difficult given the complexity of the software program. There was also the problem that older data could not be transferred into the new database system. Notes from a 4/17/12 dental scan call indicated the new database continued to have	

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		challenges, and that different SSLCs were at different stages of implementation. It is recommended that the Dental Department keep a copy of all data from the prior software program. Additionally, the State Office is encouraged to review the perceived obstacles in implementation and utilization of the new software database program. Although it has been provided to all SSLCs for implementation, piloting one SSLC would help to identify the degree to which these concerns/perceptions are accurate, and provide the opportunity for early program/system changes to minimize disruption in database entry and management. A major concern was that the older data could not be transferred into the new software program. The ability to demonstrate progress requires trending over several quarters/years. If the software program is to be changed, one of the major requirements should be its ability to incorporate the historical data for comparison with the new. If the new software program is unable to incorporate past information, then the State Office should provide an alternative route to the SSLCs to create charts, graphs, and trend lines. The QA/QI Department used the following monitoring tools to review the quality and completeness of dental care: ▪ For tools used both by the QA Department and the Dental Department, there was information concerning inter-rater reliability provided. A new Dental Department monitoring tool was implemented for the March 2012 review. Inter-rater reliability for the Dental Department and QA Department was assessed for the composite score. There was no inter-rater reliability score for each of the subsections. As a result, this information was not very helpful. For the months of March 2012, April 2012, and May 2012, the score was over 90% each month. It is recommended that the analysis be reviewed, and review be based on each question. This would allow for practical review of where there was additional need for instructions/guidelines, development of monitoring criteria, and/or training for auditors. CCSSLC provided a training workshop for dental and other clinical departments on 12/13/11 to 12/14/2011, focusing on the Quality Assurance Data Project being developed with the assistance of outside consultants. The Dental Director attended this workshop. The Dental Department forwarded a copy of monitoring databases utilized for the Settlement Agreement to the QA/QI Department on 3/30/12, along with "additional reports" generated by the department. On 4/27/12, the Dental Director met with the QA/QI Director and staff to review this list of databases and reports. It will be important moving forward that this collaboration continue and that key indicators be identified to assist the Facility in measuring its effectiveness in providing dental services to the	

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		individuals it supports.	

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

1. For one dental staff member, the Dental Department should review the dates of submitted CPR certification with the training department or training instructor to verify that the certification was intended for a four-year period. (Section Q.1)
2. For those with continued poor oral hygiene ratings that brush their own teeth, additional assistance should be considered. The Dental Department should participate in their IDT meetings to discuss additional steps to be taken. (Section Q.1)
3. In collaboration with the QA Department, the Dental Department should review and compare the findings in the different databases, and determine the reasons for the apparent differences in the final data, and corrections should be made prior to distribution of the information. (Section Q.1)
4. The Dental Department should review the State Office policy/communication providing guidance concerning flossing at SSLCs, and meet with the State Office to determine if current interpretation prohibits individuals from using floss. With adequate supervision and appropriate safe storage, opportunities for using floss as part of dental hygiene should not be denied campus-wide and should be considered for those who brush their own teeth, similar to any other personal hygiene skill. (Section Q.1)
5. The Medical and Dental Departments should review the current system to minimize delays in obtaining the required consents, medical clearances, etc., for TIVA procedures. This should be demonstrated in the form of a policy or protocol. A tracking log for the consent process is recommended. . (Sections Q.1 and Q.2)
6. The Dental Department should review the reason for refusal data to be located in the non-refusal database. (Section Q.2)
7. The Dental Department should continue to decrease the time between missed appointments and completed appointments. (Section Q.2)
8. While beginning to use the new database, the Dental Department should maintain a copy of all data from the prior software program. The State Office is encouraged to review the perceived obstacles in utilization of the new software. Additionally, if the new software program is unable to incorporate past information, then the State Office should provide an alternative route to the SSLCs to assimilate this information so charts, graphs, and trend lines will include data from the past three years and any new data moving forward. (Section Q.2)
9. For the QA tools, composite scores should not be used, but scores based on individual questions or subsets of questions that focus on specific clinical areas. (Section Q.2)
10. The Dental Department is encouraged to develop quarterly reports, including a brief synopsis and series of charts to reflect the activities of the department (oral hygiene, number of visits for restorative, prophylaxis, etc. per month/quarter, numbers and percentage of refused appointments, number using sedation, progress in dental desensitization, etc.). Such information should be used as a guide for developing future QI endeavors, or other dental plans or programs. (Section Q.2)

SECTION R: Communication	
Each Facility shall provide adequate and timely speech and communication therapy services, consistent with current, generally accepted professional standards of care, to individuals who require such services, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents:** o Presentation Book for Section R; o CCSSLC Self-Assessment, Action Plans, and Provision of Information; o For the following 24 individuals who had communication deficits, AAC system(s), and/or received direct and/or indirect communication supports: Individual #238, Individual #297, Individual #235, Individual #278, Individual #325, Individual #137, Individual #339, Individual #154, Individual #119, Individual #251, Individual #176, Individual #110, Individual #221, Individual #268, Individual #229, Individual #307, Individual #69, Individual #191, Individual #141, Individual #145, Individual #343, Individual #367, Individual #91, and Individual #99 in Sample #3, the following documents: Communication Comprehensive assessment, Update and Assessment of Current Status from individual record, ISP and ISPAs for past year, Positive Behavior Support Plan, skill acquisition programs related to communication and supporting documentation for implementation (indirect supports), direct SLP therapy intervention plans and supporting documentation such as IPNs, monthly reviews by SLP, AAC programs and supporting documentation for implementation of indirect supports, individual-specific communication monitoring for past six months, evidence of effectiveness monitoring for SLP interventions (direct) and programs (indirect); o Speech assessments for five individuals newly admitted to CCSSLC, including: Individual #5, Individual #40, Individual #61, Individual #63, and Individual #97, various dates; o Policy and procedures addressing the provision of speech and/or communication services and supports including changes since last monitoring visit, revised 5/25/12; o Continuing education and other training completed by SLPs since last monitoring visit with certificates of completion, from 1/12 through 6/12; o List of current SLP and audiology staff along with corresponding caseloads and curriculum vitas for newly hired SLPs, revised 5/17/12; o List of individuals with AAC devices, dated 5/22/12; o Communication Master Plan List, dated 5/31/12; o AAC Screening forms, various dates; o Speech language (SL) comprehensive assessments and updates (templates) used by SLPs along with any changes, dated 5/10/12; o Tracking Log of SLP assessments completed since last review, from 1/12 through 7/12; o Monitoring forms used by SLPs, Speech Language Pathology Assistants (SLPAs), and PNMP Coordinators, various dates; o Copies of blank communication competency-based performance check-off sheets for new employees, undated; o Inter-Rater Reliability Compliance Scores and corresponding Audits, from 12/11 through 4/12; o List of individuals receiving direct speech services and focus of intervention, undated;

	○ List of individuals with behavioral issues and coexisting severe language deficits and risk level/status for challenging behavior, dated 6/5/12; ○ List of individuals with PBSPs and replacement behaviors related to communication, dated 6/5/12; ○ Minutes for Communication committee meetings held since last review, dated 3/22/12; ○ Minutes for Speech Department meetings held since last review, various dates between 2/12 and 5/12; ○ List of all general common area devices, undated; ○ OT/PT Assessments, ISPs, and PNMPs for four individuals most recently assessed by an SLP for whom AAC device was recommended, from 1/12 through 5/12; ○ Copies of blank communication competency-based performance check-off for individual-specific communication programs, undated; ○ Copies of external consultant reports since last review, dated 3/22/12; ○ Copies of completed audits of SLP documentation, from 1/12 through 4/12; ○ Behavior Support Committee minutes and attendance sign-in sheets for meetings held since last review, from 1/12 through 5/12; ○ Copies of American Speech Hearing Association (ASHA) certification for SLPs; ○ Individuals Support Plan Process policy #0045.1, effective date 6/1/12; and ○ Raw data for SLP audits for April 2012. ▪ **Interviews with:** ○ Dr. Angela Roberts, Habilitation Therapy Director; ○ Linda Merryman-Scrifes, SLP Director and alternate PNMT SLP member; ○ Melissa Grothe, CCC-SLP; and ○ Bryanna Gutierrez, CCC-SLP. ▪ **Observations of:** ○ Individuals with AAC devices in residences of Ribbonfish, Atlantic, and the Infirmary.
	Facility Self-Assessment: Based on a review of the Facility's Self-Assessment, the Facility found it was in noncompliance with all of the subsections of Section R. This was consistent with the Monitoring Team's findings. The Facility submitted three documents, including: CCSSLC Self-Assessment, Action Plans, and Provision Action Information. The CCSSLC Self-Assessment listed the steps the Facility staff completed to conduct the self-assessment and the subsequent results for the completion of these tasks. The Action Plans documented the status of action steps that had been completed, were in process and/or had not been started. The CCSSLC Provision Action Information listed actions completed since the Monitoring Team's previous visit. The Facility Self-Assessment presented the results of auditing activities completed by the HT Director and Program Compliance Monitor using the Section R Monitoring tool for each month. Monthly reports were developed for each month that presented a separate compliance score for each indicator for the Section

	Lead (i.e., HT Director) and the PCM. An inter-rater compliance score was generated for each indicator as well as a compliance percentage. This was a positive development and provided the HT Director with valuable information to assess the compliance status for each indicator. Furthermore, the HT Director and PCM reported they continued to revise instructions for the form to enhance their inter-rater agreement. The HT Director and PCM generated a monthly Section R Analysis report. The report defined how inter-rater agreement was achieved and discussed how the sample was chosen. The analysis report discussed the compliance for each of the four sections in Section R and presented plans to address areas of non-compliance. The Monitoring Team discusses the Facility self-assessment results at the beginning of each section.
	Summary of Monitor's Assessment: The Facility had four full-time SLP positions allocated. There was one vacant SLP position. In addition, there were two contract SLPs who provided services 15 hours per week for each contract therapist. The Facility documented appropriate qualifications for licensed SLPs. A Facility policy entitled CCSSLC – Communication Services, dated 10/7/09 existed. However, the Facility policy did not provide clear operationalized guidelines for the delivery of communication supports and services. Prior to the previous review, the Speech Department had established a Master Communication Plan schedule to re-assess each individual using a priority system and the revised SLP assessment format. However, the completion of this schedule was not in alignment with the Facility's annual ISP schedule. Consequently, teams did not have the most current assessment and recommended supports and services available during the annual ISP meeting. Due to the fact that every individual needed to be re-assessed with an updated SLP assessment format and content, the Speech Department made the decision to abandon the priority list and follow the Facility ISP calendar. Based on documentation submitted, this decision enabled SLPs to be contributing members of the IDT and support the individual. It was positive that IDT members and the individual would be provided with a current assessment prior to the annual ISP meeting to assist in annual planning. Unfortunately, individuals identified through the priority system in need of communication supports would have to wait for these services until their annual ISP meeting. As of 5/31/12, 152 of the 271 (56%) individuals had received an SLP assessment using the revised format. Ten of these individuals had transitioned to the community or had died. An evaluation of individuals' SL comprehensive assessments revealed these assessments were missing some key components. Based on interview with the HT Director, the decision had been made to not have a SLP attend the Facility Positive Behavior Support Committee meetings, because their attendance was not productive in supporting opportunities for collaboration between a SLP and psychologist. The SLPs reported that it was more productive to work one-on-one with a psychologist in achieving implementation of shared functional communication recommendations. However, documentation of this collaboration was not consistently

	presented in the SLP assessments and PBSPs reviewed. Observations by the Monitoring Team and two Facility SLPs of individuals with AAC systems did not reveal the presence and/or use of the AAC system. In addition, individuals' skill acquisition programs did not support the use of an AAC system. Staff also had not been provided with individual-specific competency training and performance check-offs to demonstrate their competency in supporting individuals in the use of their AAC system in various environments and daily activities. Although the Facility's Communication Services policy included some important components, a number were missing. It did not include the following key elements: the frequency of monitoring; the process for identification, training, and validation for monitors; the process of achieving inter-rater reliability; and a process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic).

#	Provision	Assessment of Status	Compliance
R1	Commencing within six months of the Effective Date hereof and with full implementation within 30 months, the Facility shall provide an adequate number of speech language pathologists, or other professionals, with specialized training or experience demonstrating competence in augmentative and alternative communication, to conduct assessments, develop and implement programs, provide staff training, and monitor the implementation of programs.	**Facility Self-Assessment** A review of the Facility's Self-Assessment indicated the following: ▪ The Facility's review of 100% of Section R monitoring tools indicated that 12 out of 12 (100%) had compliance scores analyzed, trended and aggregated. ▪ The Facility's audit of four speech-language assessments indicated that four out of four (100%) had an assessment of the individual's need for an AAC system, and had a description of significant health care issues and/or risk indicators. Three of four assessments (75%) had an analysis of assessment data to identify strengths and potential for functional communication, strategies for communicating and justification [for recommendations. One of four assessments (25%) had measurable, functional outcomes for direct speech therapy. The Facility's Self-Assessment indicated that: "based on the findings from this self-assessment, this provision is not in compliance because the department is still in the process of providing the assessments to the entire CCSSLC population. Additionally, the assessments are being audited to ensure they include the necessary components." In order to review speech language supports provided to individuals at the Facility, a sample or individuals was drawn. It is referred to as Sample #3. It included 24 individuals identified with severe expressive or receptive language disorders, receiving direct speech interventions, having a Positive Behavior Support Plan (PBSP), having an AAC system, and/or receiving indirect communication supports. The individuals included in the sample were: Individual #238, Individual #297, Individual #235, Individual #278, Individual #325, Individual #137, Individual #339, Individual #154,	Noncompliance

#	Provision	Assessment of Status	Compliance
		Individual #119, Individual #251, Individual #176, Individual #110, Individual #221, Individual #268, Individual #229, Individual #307, Individual #69, Individual #191, Individual #141, Individual #145, Individual #343, Individual #367, Individual #91, and Individual #99. This paragraph of the Settlement Agreement includes a number of requirements that are addressed in subsequent sections within Section R. This section will address compliance with current staffing, staff qualifications, adequate numbers of speech language pathologists, continuing education, and Facility policy. The SLP assessment process and the development and implementation of programs are discussed with regard to Section R.2. Staff training is addressed with regard to Section R.3, and the Facility's monitoring system is discussed with regard to Section R.4. **Staffing** The Facility had four full-time SLP positions allocated. There was one vacant SLP position. In addition, there were two contract SLPs, who each provided services 15 hours per week. The Provision Action Information stated: "Speech-Language Pathologists are no longer assigned to a specific unit. Instead, assessments are completed according to the ISP calendar and evenly distributed between therapists, regardless of their unit." The Facility did not indicate what an adequate caseload for SLPs at Corpus Christi would be. The Facility should complete an analysis, including consideration of the various requirements of the job, as well as the acuity of the individuals in relation to SLP needs. **Qualifications** The Facility had documentation to show appropriate qualifications for licensed SLPs. ▪ Three of three full-time SLP staff (100%) were licensed to practice in the state of Texas. ▪ Two of two contract SLP staff (100%) were licensed to practice in the state of Texas. ▪ Two of two full-time SLP staff (100%) had evidence of American Speech and Hearing Association certification. The third SLP did not hold the Competency of Clinical Certification (CCC) issued by ASHA, because she was "grandfathered" into the profession of Speech Language Pathology in January 1986. ▪ One of two contract SLP staff (50%) had evidence of ASHA certification. The second contract SLP did not have a copy of her ASHA certification to provide for the document request. The Facility reported it would be available during the next review.	

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		Continuing Education Documentation of continuing education courses completed by the SLPs was submitted. Based on documentation submitted, no State-sponsored webinars were offered in the past six months. The continuing education attended by the clinicians included the following topics: ▪ Autism and Sensory Processing Disorders; ▪ Interactive Training on AAC Devices; ▪ Bedside Evaluation of the Dysphagia Patient; ▪ The Dysphagia Patient: Modified Barium Swallow and Therapeutic Intervention; ▪ Neurorehabilitation Conference 2012; ▪ Texas Assistive Technology Network Statewide Conference; and ▪ Management Dysphagia 2012. Based on a review of continuing education completed in the last 12 months: ▪ Three of three full-time SLP staff (100%) had completed continuing education relevant to communication and transferrable to the population served. **Facility Policy** A Facility policy number 016, CCSSLC – Communication Services, dated 10/7/09, existed. However, the Facility policy did not provide clear operationalized guidelines for the delivery of communication supports and services. The following components were included in this policy: ▪ Timelines for completion of new admission assessments (within 30 days of admission or readmission). The following components were not included in this policy: ▪ Roles and responsibilities of the SLPs (e.g., meeting attendance, staff training etc.); ▪ Outline of assessment schedule; ▪ Frequency of assessments/updates; ▪ Timelines for completion of comprehensive assessments (i.e., within 30 days of identification via screening); ▪ Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication (i.e., within five days of identification as indicated by the IDT); ▪ Description of a process for effectiveness monitoring by the SLP; ▪ Criteria for providing an update (Assessment of Current Status) versus a Comprehensive Assessment; ▪ Methods of tracking progress and documentation standards related to	

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		intervention plans; and ▪ Monitoring of staff compliance with implementation of communication plans/programs, including frequency, data and trend analysis, as well as, problem resolution. The Facility should expand the Communication Services policy to incorporate the preceding content. As noted above, in its Self-Assessment, the Facility indicated that it was not in compliance with this provision. This was consistent with the Monitoring Team's findings.	
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.	**Facility Self-Assessment** A review of the Facility's Self-Assessment indicated the following: ▪ The Facility's audit of four speech-language assessments found none (0%) had collaboration with speech and psychology, and jointly developed skill acquisition plans, if necessary. Three of four assessments (75%) indicated training on individual communication systems was provided. ▪ A review of the Facility's policy noted speech-language pathologist's responsibilities were not defined. The Facility's Self-Assessment indicated that: "based on the findings from this self-assessment, this provision is not in compliance because although individuals are receiving speech-language assessments, they continue to lack documentation of collaboration with psychology. Additionally, there are no policies/protocols clearly defining the role of the Speech-Language Pathologists." The findings of the Monitoring Team related to collaboration between the SLP and psychologist are discussed within this section. The Monitoring Team findings also showed the Facility was in noncompliance with this provision. Although policy is discussed with regard to Section R.1, the Monitoring Team reviewed additional indicators in relation to the Facility's compliance with Section R.2. **Assessment Plan** Prior to the previous review, the Speech Department had established a Master Communication Plan schedule to re-assess each individual using a priority system and the revised SLP assessment format. However, the completion of this schedule was not in alignment with the Facility's annual ISP schedule. As a result, the implementation of the priority schedule placed IDT members and the individuals at a disadvantage at the annual ISP meeting. The team did not have access to the most current assessment and recommended supports and services during the annual ISP meeting. Since the last review, the Facility had developed a revised ISP schedule. Assessments would be	Noncompliance

#	Provision	Assessment of Status	Compliance
		completed throughout the year at a rate of approximately six ISPs per week (i.e., two per day on Tuesday, Wednesday, and Thursday). Due to the fact that every individual needed to be re-assessed with an updated SLP assessment format and content, the Speech Department made the decision to abandon the priority list and follow the Facility ISP calendar. Based on documentation submitted, this decision enabled SLPs to be contributing members of the IDT and support the individual. It was positive that IDT members and the individual would be provided with a current assessment prior to the annual ISP meeting to assist in annual planning. Unfortunately, individuals identified through the priority system in need of communication supports would have to wait for these services until their annual ISP meeting. As of 5/31/12, 152 of the 271 (56%) individuals had received an SLP assessment using the revised format. Ten of these individuals had transitioned to the community or had died. **New Admissions** Since the last review, five individuals (i.e., Individual #5, Individual #40, Individual #61, Individual #63, and Individual #97) had been admitted to CCSSLC. An examination of their admission and SLPs assessment dates established: ▪ Five of five individuals (100%) received a communication screening or assessment within 30 days of admission or readmission. **Communication Assessment** A Speech Language (SL) comprehensive assessment should include the following: ▪ Signature and date by the clinician upon completion of the written report; ▪ Date showing it was completed 10 working days prior to the annual ISP; ▪ Diagnoses and relevance of impact on communication; ▪ Individual preferences, strengths, and needs; ▪ Medical history and relevance to communication; ▪ Medications and side effects relevant to communication; ▪ Documentation of how the individual's communication abilities impact their risk levels; ▪ Description of verbal and nonverbal skills with examples of how the individual utilizes these skills in a functional manner throughout the day; ▪ Evidence of observations by SLPs in the individual's natural environments (e.g., day program, home, work); ▪ Evidence of discussion of the use of a Communication Dictionary, as appropriate, as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who do not communicate verbally; ▪ Discussion of the expansion of the individual's current abilities; ▪ Discussion of the individual's potential to develop new communication skills;	

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		▪ Effectiveness of current supports, including monitoring findings; ▪ A description of the individual's AAC needs, including clear clinical justification and rationale as to whether the individual would benefit from AAC; ▪ Comparative analysis of health and functional status from the previous year; ▪ Comparative analysis of current communication function with previous assessments; ▪ Identification of the need for direct or indirect speech language services, as appropriate; ▪ Specific and individualized strategies to ensure consistency of implementation among various staff; ▪ Reassessment schedule; ▪ Monitoring schedule; ▪ Recommendations for direct interventions and/or skill acquisition programs, as appropriate, including the use of AAC as indicated for individuals with identified communication deficits; ▪ A recommendation regarding the individual's appropriateness for community placement; and ▪ Manner in which strategies, interventions, and programs should be utilized throughout the day. Eight individuals' Speech Language comprehensive assessments (i.e., Individual #367, Individual #99, Individual #145, Individual #91, Individual #343, Individual #191, Individual #339, and Individual #268) in Sample #3 were evaluated for the presence of the following: ▪ Eight of eight individuals' SL assessments (100%) were signed and dated by the clinician upon completion of the written report; ▪ Three of eight individuals' SL assessments (i.e., Individual #367, Individual #145, and Individual #339) (38%) were dated as completed 10 working days prior to the annual ISP; ▪ Seven of eight individuals' SL assessments (88%) included diagnoses and relevance of impact on communication (i.e., Individual #91's assessment did not); ▪ Four of eight individuals' SL assessments (i.e., Individual #367, Individual #99, Individual #339, and Individual #268) (50%) introduced individual preferences, strengths, and needs; ▪ Seven of eight individuals' SL assessments (88%) included medical history and relevance to communication (i.e., Individual #91's assessment did not); ▪ Eight of eight individuals' SL assessments (100%) listed medications and discussed side effects relevant to communication; ▪ Seven of eight individuals' SL assessments (88%) provided documentation of	

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		how the individual's communication abilities impacted his/her risk levels (i.e., Individual #91's assessment did not address this element); ▪ Eight of eight individuals' SL assessments (100%) incorporated a description of verbal and nonverbal skills with examples of how these skills were utilized in a functional manner throughout the day; ▪ Two of eight individuals' SL assessments (i.e., Individual #367 and Individual #268) (25%) provided evidence of observations by the SLs in the individuals' natural environments (e.g., day program, home, work); ▪ One of seven individuals' SL assessments (i.e., Individual #367) (14%) contained evidence of discussion of the use of a Communication Dictionary, as appropriate, as well as the effectiveness of the current version of the dictionary with necessary changes as required for individuals who did not communicate verbally (Individual #191 communicated verbally); ▪ Five of eight individuals' SL assessments (i.e., Individual #367, Individual #145, Individual #191, Individual #339, and Individual #268) (63%) included discussion of the expansion of the individuals' current abilities; ▪ Three of eight individuals' SL assessments (i.e., Individual #145, Individual #191, and Individual #268) (38%) provided a discussion of the individuals' potential to develop new communication skills; ▪ None of eight individuals' SL assessments (0%) included the effectiveness of current supports, including monitoring findings; ▪ None of eight individuals' SL assessments (0%) offered a comparative analysis of health and functional status from the previous year; ▪ Eight of eight individuals' SL assessments (100%) gave a comparative analysis of current communication function with previous assessments; ▪ Three of eight individuals' SL assessments (i.e., Individual #145, Individual #191, and Individual #339) (38%) identified the need for direct or indirect speech language services; ▪ Two of eight individuals' SL assessment (i.e., Individual #99 and Individual #339) (25%) had specific and individualized strategies outlined to ensure consistency of implementation among various staff; ▪ Seven of eight individuals' SL assessments (88%) had a reassessment schedule (i.e., Individual #91's assessment did not have this element); ▪ Five of eight individuals' SL assessments (i.e., Individual #367, Individual #99, Individual #343, Individual #191, and Individual #268) (63%) supplied a monitoring schedule; ▪ Eight of eight individuals' SL assessments (100%) had recommendations for direct interventions and/or skill acquisition programs, including the use of AAC as indicated for individuals with identified communication deficits. This included three individuals (i.e., Individual #145, Individual #191, and Individual #339), for whom direct therapy was recommended. The remaining five were	

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		identified as requiring skill acquisition programs; ▪ Eight of eight individuals' SL assessments (100%) made a recommendation about the appropriateness for community transition; and ▪ Two of eight individuals' SL assessments (i.e., Individual #339 and Individual #268) (25%) defined the manner in which strategies, interventions, and programs should be utilized throughout the day. These eight individuals' SL comprehensive assessments were missing important elements and were not considered comprehensive SL assessments. The SLPs should consider each of these elements when completing assessments to ensure assessments are comprehensive as required by the Settlement Agreement. In addition, the SL audit should include these elements. **SLP and Psychology Collaboration** Based on review of 13 of 24 records for individuals in Sample #3 with Positive Behavior Support Plans (i.e., Individual #325, Individual #367, Individual #343, Individual #145, Individual #141, Individual #191, Individual #69, Individual #307, Individual #268, Individual #176, Individual #251, Individual #119, and Individual #297), the following was noted: ▪ In one of 13 communication assessments and PBSPs reviewed (i.e., Individual #367) (8%), these documents addressed the connection between the PBSP and the recommendations contained in the communication assessment. ▪ In four of 13 communication assessments reviewed (i.e., Individual #367, Individual #343, Individual #141, and Individual #191) (31%) contained evidence of review of the PBSP by the SLP. However, only a summary of the individual's PBSP was provided in the assessment. The assessment should offer information on collaboration between the SLP and the psychologist related to functional communication and behavioral concerns. The SLP assessment and PBSP should discuss how related recommendations will be made to the team to improve and enhance functional communication skills. Based on review of the Positive Behavior Support Committee meeting minutes from 1/10/12 to 5/25/12, participation by the SLP was noted in none of the 31 meetings (0%). Based on interview with the HT Director, the decision had been made to not have a SLP attend the Facility Positive Behavior Support Committee meetings, because their attendance was not productive in supporting opportunities for collaboration between a SLP and psychologist. The SLPs reported that it was more productive to work one-on-one with a psychologist in achieving implementation of shared functional communication recommendations. However, documentation of this collaboration was not consistently presented in the SLP assessments and PBSPs reviewed.	

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		The Facility remained out of compliance with this provision. In addition to improving the content and quality of assessments, the Facility also needed to complete updated assessments for individuals at the Facility, finalize and implement an assessment review schedule, and improve the collaboration between SLPs and psychologists for individuals with PBSPs.	
R3	Commencing within six months of the Effective Date hereof and with full implementation within three years, for all individuals who would benefit from the use of alternative or augmentative communication systems, the Facility shall specify in the ISP how the individual communicates, and develop and implement assistive communication interventions that are functional and adaptable to a variety of settings.	**Facility Self-Assessment** The Facility's Self-Assessment findings were indistinguishable from the findings for Section R.2. **Integration of Communication in the ISP** Based on review of the ISPs for 10 of the 24 individuals in Sample #3 (i.e. Individual #235, Individual #278, Individual #339, Individual #137, Individual #154, Individual #110, Individual #221, Individual #229, Individual #91, and Individual #99), the following was noted: ▪ In four of 10 ISPs reviewed for individuals with communication needs (i.e., Individual #235, Individual #154, Individual #110, Individual #229) (40%), a SLP attended the annual meeting. ▪ In one of 10 ISPs reviewed (i.e., Individual #110) (10%), the type of AAC and/or communication supports (might include, but not be limited to, the Communication Dictionary and strategies for staff use) was identified. ▪ Communication Dictionaries for none of the 10 individuals (0%) were reviewed at least annually by the IDT as evidenced in the ISP. ▪ One of 10 ISPs reviewed (Individual #110) (10%) included a description of how the individual communicated, including the AAC system if they had one. ▪ One of 10 ISPs reviewed (i.e., Individual #110) (10%) included how communication interventions were to be integrated into the individuals' daily routines. ▪ One of 10 ISPs reviewed (Individual #110) (10%) contained skill acquisition programs to promote functional communication. ▪ None of 10 ISPs reviewed (0%) included how communication interventions were to be integrated into the individuals' daily routines. The individuals' ISPs should include: attendance by a SLP for individuals with communication needs; the type of AAC and/or communication supports provided and their effectiveness; review of the effectiveness of the current version of communication dictionary and description of necessary changes, as appropriate; a description of how the individual communicates including the AAC system, if they have one; and how communication interventions will be integrated into the individual's daily routine.	Noncompliance

#	Provision	Assessment of Status	Compliance
		Individual-Specific AAC Systems The Facility provided a list of individuals with Alternative and Augmentative Communication devices (high and low tech). Twenty-three of the 258 individuals (9%) at CCSSLC had an AAC device. During the last review, 24 of 271 individuals (9%) had an AAC system. There was no discernible increase in the number of individuals who had been prescribed an AAC system since the last review. The Monitoring Team and two Facility SLPs conducted observations in the residences of Atlantic and Ribbonfish, and the Vocational Annex for seven individuals identified by the Facility with AAC systems (i.e., Individual #339, Individual #268, Individual #251, Individual #221, Individual #141, Individual #69, and Individual #137) in Sample #3. The Monitoring Team completed an additional individual-specific observation in the Infirmary (i.e., Individual #137). Observation findings included the following: ▪ AAC systems for none of seven individuals (0%) were present. ▪ AAC systems for none of seven individuals (0%) were noted to be in use. ▪ For none of seven individuals with AAC systems (0%), staff instructions/skill acquisition plans related to the AAC system were available. Individuals with AAC systems should be present, in use, portable, and functional. In addition, an individual's use of an AAC system should be enhanced through the implementation of skill acquisition programs, as appropriate. Staff should be provided with individual-specific competency training and performance check-offs to demonstrate their competency in supporting the individual in the use of the individual's AAC system in various environments and daily activities. **General-Use AAC Devices** The Facility provided a List of General Common Area Devices that identified the location, type of device, and intent of device. Observations of general-use AAC devices by the Monitoring Team and two Facility SLPs were completed in Ribbonfish, Atlantic, and the Vocational Annex to determine the presence and use of general AAC devices. Findings included the following: ▪ Two of the two residences (100%) had general use AAC devices present in the common areas. ▪ None of the general use AAC devices (0%) observed contained clear directives on how staff should use these devices. ▪ One of the multiple general use AAC devices observed had a clear function within that setting/situation. The Vocational Annex had a general AAC device that provided photographs of various activities to enable individuals to choose an activity. These photos were attached to a board with Velcro. ▪ During the Monitoring Team's observations, none of the individuals used any of	

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		the general use AAC devices. The Facility should re-assess the functionality of general-use AAC devices in residences and other environments. **Direct Communication Interventions** Direct communication-related intervention plans for eight individuals in the Sample #3 who received direct speech services (i.e., Individual #297, Individual #251, Individual #69, Individual #154, Individual #307, Individual #110, Individual #229, and Individual #191) were reviewed. Comprehensive progress notes related to communication interventions should include: ▪ Information regarding whether the individual showed progress with the stated goal. ▪ A description of the benefit of device and/or goal to the individual. ▪ A report regarding the consistency of implementation. ▪ Recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress. For none of eight individuals (0%), documentation of the SLP's review of communication interventions was comprehensive. The progress notes did not incorporate the elements outlined above. **Indirect Communication Supports** Individuals with AAC devices did not have indirect communication supports/programs designed to assist the individuals and/or staff in using the AAC device or to enhance their skills in utilizing the AAC system. For such indirect supports, the SLPs monthly documentation should: ▪ Provide information regarding whether the individual showed progress with the stated goal(s); ▪ Describe the benefit of device and/or program for the individual(s); ▪ Identify whether or not implementation is consistent; and ▪ Identify recommendations/revisions to the program as indicated in reference to the individual's progress or lack of progress. The completion of monthly progress notes should provide effectiveness review/monitoring of the individual's progress with direct and/or indirect SL supports.	
R4	Commencing within six months of the Effective Date hereof and with	**Facility Self-Assessment** A review of the Facility's Self-Assessment indicated the following:	Noncompliance

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	full implementation within three years, the Facility shall develop and implement a monitoring system to ensure that the communication provisions of the ISP for individuals who would benefit from alternative and/or augmentative communication systems address their communication needs in a manner that is functional and adaptable to a variety of settings and that such systems are readily available to them. The communication provisions of the ISP shall be reviewed and revised, as needed, but at least annually.	• Based on the Facility's review of four ISPs, two (50%) indicated how the individual communicates and none (0%) indicated how the AAC system was individualized, meaningful and functional, and adaptable to a variety of settings. • Three out of four training rosters (75%) indicated staff working with each individual who uses an AAC system received individual-specific competency-based training on the individuals' AAC system. However, the Monitoring Team's observation of seven individuals with prescribed AAC systems did not provide evidence of individual-specific competency-based training for their AAC devices. The Facility's Self-Assessment indicated that: "based on the findings from this self-assessment, this provision is not in compliance because the Inter-Disciplinary Teams continue to need support including the necessary components of Speech-Language assessments." Based on it review, the Monitoring Team also found that the Facility was not in compliance. However, this provision requires the Facility to develop and implement a monitoring system to monitor compliance with an individual's communication supports. In addition, the Facility's SLPs should conduct effectiveness monitoring to assess the efficacy of direct and indirect communication supports. **Monitoring System** The Facility Communication Services policy #016, effective date of 10/7/09, included the following information on the monitoring of communication supports: ▪ Monitoring for the presence of communication adaptive equipment or other AAC supports/materials; ▪ Monitoring for the use of communication adaptive equipment in multiple environments (home, day program, work); and ▪ Monitoring for the working condition of communication adaptive equipment. This policy did not include the following key elements: ▪ The frequency of monitoring; ▪ The process for identification, training, and validation for monitors; ▪ The process of inter-rater reliability; and ▪ A process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic). Based on documentation submitted, the Facility HT Department staff (i.e., SLPs, SLP Assistants, and PNMP Coordinators) implemented the following forms to monitor individuals' communication equipment: ▪ Monthly Person-Specific PNMP Check Sheet with instructions; ▪ Monthly Home Equipment Check Sheet with instructions located on form; and ▪ Compliance Monitoring Form with instructions; and ▪ Therapists used the PNMP Clinic Minutes form to annually monitor an	

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		individual's adaptive equipment. The Facility reported the following information for each form: date monitoring form(s) use was initiated, presence of monitoring form instructions, staff positions responsible for monitoring, process used to confirm monitors' competency with the use of the forms, monitoring schedule, monitoring schedule for individuals at high risk, how monitoring forms were analyzed and by whom, and Facility protocols for the monitoring forms. This information further defined the Facility's protocols for the implementation of these forms. However, additional work needs to be done to establish inter-rater agreement between therapists and PNMP Coordinators to confirm PNMP Coordinators competency for the completion of these forms. The Facility did not provide monitoring reports analyzing and trending results from the Monthly Person-Specific PNMP Check Sheet, Monthly Home Equipment Check Sheet, and Compliance Monitoring Form related to communication. These reports should address at a minimum the following indicators: ▪ Compliance with established monitoring frequency; ▪ Equipment presence; ▪ Equipment in working order; ▪ Equipment used in various environments; and ▪ In the case a problem was identified, there was evidence of resolution. Seven individuals' (i.e., Individual #339, Individual #268, Individual #251, Individual #221, Individual #141, Individual #69, and Individual #137) for the last six months were reviewed. The Monthly Person-Specific PNMP Check Sheet was completed for these individuals. ▪ Two of seven individuals (i.e., Individual #221 and Individual #137) (29%) were monitored at the recommended frequency. ▪ Four of seven individuals (57%) were monitored for the presence of their communication system. ▪ Monitoring for four of seven individuals (57%) included review of whether or not their communication system was in working order. ▪ Four of seven individuals (57%) were monitored for use in a variety of environments. Problematic areas needing focus or improvement included: ▪ Individuals with AAC devices were not monitored (i.e., Individual #141, Individual #339, and Individual #268). ▪ Monitoring forms consistently reported the communication device was being used. However, these findings were not congruent with the Monitoring Team's observations of these seven individuals.	

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

1. The Facility should complete an analysis, including consideration of the various requirements of the job, as well as the acuity of the individuals in relation to SLP needs. (Section R.1)
2. The Facility should expand and implement the Communication Services policy to incorporate the following:
    a. Roles and responsibilities of the SLPs (e.g., meeting attendance, staff training etc.);
    b. Outline of assessment schedule;
    c. Frequency of assessments/updates;
    d. Timelines for completion of comprehensive assessments (i.e., within 30 days of identification via screening);
    e. Timelines for completion of Comprehensive Assessment/Assessment of Current Status for individuals with a change in health status potentially affecting communication (i.e., within five days of identification as indicated by the IDT);
    f. Description of a process for effectiveness monitoring by the SLP;
    g. Criteria for providing an update (Assessment of Current Status) versus a Comprehensive Assessment;
    h. Methods of tracking progress and documentation standards related to intervention plans; and
    i. Monitoring of staff compliance with implementation of communication plans/programs, including frequency, data and trend analysis, as well as, problem resolution. (Section R.1)
3. The Facility should review the revised SL assessment template and content guidelines to ensure the minimum elements for comprehensive assessments are addressed. The SLPs should consider each of these elements as they complete assessments to ensure assessments are comprehensive as required by the Settlement Agreement. In addition, the SL audit should include these elements. (Section R.2)
4. Individuals' ISP should include: attendance by a SLP for individuals with communication needs; the type of AAC and/or communication supports provided and their effectiveness; review of the effectiveness of the current version of communication dictionary, and identification of necessary changes as appropriate; a description of how the individual communicates, including the AAC system, if they have one; and how communication interventions will be integrated into the individual's daily routine. (Section R.3)
5. AAC systems should be present, in use, portable, and functional. In addition, as appropriate, an individual's use of an AAC system should be enhanced through the implementation of skill acquisition programs. Staff should be provided with individual-specific competency-based training and performance check-offs to demonstrate their competency in supporting the individual in the functional implementation of the AAC system in various environments and daily activities. (Section R.3)
6. The Facility should re-assess the functionality of general-use AAC devices in residences and other environments. (Section R.3)
7. The Facility should ensure comprehensive progress notes related to communication interventions for direct and indirect supports:
    a. Contain information regarding whether the individual showed progress with the stated goal;
    b. Describe the benefit of device and/or goal to the individual;
    c. Report on whether there is consistency in implementation; and
    d. Identify recommendations/revisions to the communication intervention plan as indicated related to the individual's progress or lack of progress. (Section R.3)
8. The monitoring sections of the Facility Communication Services Policy #016 should include:
    a. The frequency of monitoring;
    b. The process for identification, training, and validation for monitors;
    c. The process of inter-rater reliability; and
    d. A process for data trend analysis and utilization of findings to drive training and problem resolution (individual and systemic). (Section R.4)
9. The Facility's monitoring reports for the Monthly Person-Specific PNMP Check Sheet, Monthly Home Equipment Check Sheet, and Compliance Monitoring Form related to communication should be completed at the established monitoring frequency. In addition, they should address, at

a minimum, the following indicators:

a. Equipment presence;
b. Equipment in working order;
c. Equipment used in various environments; and
d. In the case a problem is identified, evidence of resolution. (Section R.4)

SECTION S: Habilitation, Training, Education, and Skill Acquisition Programs	
Each facility shall provide habilitation, training, education, and skill acquisition programs consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Section S Presentation Book completed by Kimberly Benedict, Director of Day Programs; o Section S – Habilitation, Training, Education, and Skill Acquisition Programs Bi-Annual Report (December 2011 to May 2012) completed by Kimberly Benedict, Director of Day Programs; o For Section S.1, Individual Support Plans, ISP Monthly Reviews (for last three months), Functional Skills Assessments, Personal Focus Assessments (PFAs), as provided, as well as selected Skill Acquisition Plans (SAPs) for: Individual #295 (family visit SAP, dated July 2012); Individual #167 (privacy SAP, dated July 2012), Individual #236 (sensory experience SAP, dated June 2012), Individual #272 (activate switch SAP, dated June 2012), Individual #95 (money management SAP, dated July 2012), Individual #172 (anger management SAP, dated July 2012); Individual #275 (bus SAP, dated July 2012), Individual #65 (paper shredding SAP, dated July 2012), Individual #184 (fire drill SAP, dated June 2012), Individual #315 (choice of outfit SAP, dated July 2012), Individual #58 (sensory activity SAP, dated July 2012), and Individual #153 (community access SAP, dated June 2012); o For Section S.2, Personal Focus Assessment, Functional Skills Assessment (FSA), Vocational Assessment, and Individual Support Plan, as available, for: Individual #295, Individual #167, Individual #236, Individual #272, Individual #95, Individual #172, Individual #275, Individual #65, Individual #184, Individual #315, Individual #58, and Individual #153; and o For Section S.3, Selected Skill Acquisition Plans and ISP Monthly Reviews (for last three months), as available, for: Individual #295, Individual #167, Individual #236, Individual #272, Individual #95, Individual #172, Individual #275, Individual #65, Individual #184, Individual #315, Individual #58, and Individual #153. ▪ **Interviews and Meetings with**: o Section K review with Judy Sutton, M.S., LPC, BCBA, Chief Psychologist on 7/9/12 and 7/10/12; o Section S review with Kimberly Benedict, Day Program Director, on 7/10/12; o Section F review with Rachel Martinez, QDDP Coordinator, on 7/11/12; o Section C meeting with Judy Sutton, M.S., LPC, BCBA, Chief Psychologist, and George Zukotynski, State Office Coordinator for Psychology/Behavioral Services, on 7/11/12; o Psychologists and Assistant Psychologists, including Daniel Rivera, Shesheia Neal, Tiffany Carranza, Melina Pineda, Lloyd Halliburton, Linda Cardwell, Robert Meza, Christina Mautinez, Edith Cahlik, Laurie Roberts, Robert Cramer, Gina Hawkins, Andy Spear, Samantha Mendoza, John Guerra, Gilda Montelegro, Everett Bush, Karen Hernandez, and Tabitha Anastasi, on 7/11/12;

	○ Meeting with QA/QI and Section K and S Program Compliance Monitors, including Judy Sutton, M.S., LPC, BCBA, Chief Psychologist; Araceli Matehala, Program Compliance Monitor; Cynthia Velasquez, QA Director; Pearl Quintanilla, QA Administrative Assistant; Sharon Davis, QA Administrative Assistant; Karen Ryder, QA/Program Compliance Monitor; and Tabitha Anastasi, on 7/12/12; and, ○ Coordinators and Supervisors of Day Treatment, Habilitation, Vocational, and Educational Staff, including Janie Martinez, Denise Aguilar, Malinda Valdemar, Lucy Tigeria, David McKinney, Sofia Fores, Jose Soto, Brigette Escamilla, Patricia Zagorski, Mary Clauss, Erin Willis, and Kimberly Benedict, on 7/12/12. ▪ **Observations**: ○ Observation and discussion with staff members at the Skill Plan Review Committee meeting, on 7/10/12; ○ Observation and discussion with staff members and individuals at the "Top Chef ○ Competition," on 7/10/12; ○ Observation and discussion with staff members at the Restrictive Practices Committee, on 7/11/12; ○ Observation of Skill Plan Integrity checks at Apartment 524-A and 522-D, on 7/11/12, and Sand Dollar, on 7/12/12; ○ Onsite direct observations, including interaction with direct support professionals, and other staff and professionals, were conducted throughout the day and/or evening hours at the following residential and day programming, and habilitation sites: ▪ Apartment 522A (Kingfish 1), on 7/9/12; ▪ Apartment 522 C (Kingfish 3), on 7/9/12; ▪ Apartment 522D (Kingfish 4), on 7/9/12 and 7/11/12; ▪ Horizons/ALS Building on 7/10/12; ▪ Apartment 524A (Ribbonfish 1), on 7/11/12; ▪ Apartment 524B (Ribbonfish 2), on 7/11/12; ▪ Apartment 518 (Porpoise), on 7/11/12; ▪ Gymnasium, on 7/11/12; ▪ Sand Dollar, on 7/12/12; ▪ Outer Reef, on 7/12/12; ▪ Apartment 514 (Dolphin), on 7/12/12; and ▪ Angel Fish (Building 517) - Kaleidoscope Day Program and Comfort Zone, on 7/13/12.
	Facility Self-Assessment: The Facility developed a Self-Assessment with regard to Section S of the Settlement Agreement. According to the current Self-Assessment, the Facility found that it was out of compliance with all of the subsections within Habilitation, Training, Education, and Skill Acquisition Plans (Sections S.1 to S.3). This finding was consistent with the Monitoring Team's review. The Self-Assessment identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating based on findings of the self-assessment. Although this format

	appeared helpful in monitoring the Facility's progress toward compliance, a number of concerns were noted: ▪ Additional specificity within some assessment areas appeared necessary. For example, in Section S.1, SAPs were reviewed to determine if they contained "ABA components." There are many critical ABA components and these need to be specified here. In addition, for Section S.2, vocational assessments were reviewed to assess whether or not community-based situational assessments were completed "when appropriate." Criteria for "appropriate" needs to be defined. In addition, these were examined and "100% … contained the required elements." These elements need to be specified. Consideration should be given to examining the quality of the elements contained in these reports as well. ▪ More detail was necessary to adequately interpret scores in some areas. For example, although engagement rates were provided in Section S.1, detailed information on the number of observations made, which residential programs were targeted, etc., was not available. For example, review of SAP competency rosters reflected a score of 91% of successful completion was vague. How many individuals or programs were related to this score? Did this just include NEO or ongoing integrity checks? ▪ It was unclear why sampling was not utilized. That is, in some cases, all (100%) of certain documents were reviewed. For example, 96 vocational assessments were reportedly reviewed. This seems excessive and unnecessary. A smaller, more detailed and comprehensive review appeared preferable. ▪ Although evidence indicated ongoing use of the previous monitoring tool by active treatment and QA staff, it was unclear how the QA Department was only involved in developing or facilitating the use of this new Self-Assessment. ▪ Inter-rater reliability scores were not provided on measures used to assess compliance. Inter-rater reliability needs to be established across auditors to ensure the accuracy of the data, as well as the consistency across raters. ▪ At times, it was unclear how the Facility selected its sample. For example, " a review of the engagement database and unit based active treatment committee meetings" was completed for Section S.1, but the parameters of this sample were not described. Four sets of ISP discipline assessments were selected for Section S.2, and 39 treatment integrity checklists were reviewed for Section S.3. However, it was unclear how these were selected (i.e., if they were randomly selected or sampled across units, etc.). Overall, the Facility demonstrated ongoing progress in the collection of data that appeared helpful in monitoring compliance. With the assistance of the Quality Assurance Department, the self-assessment should continue to be improved and expanded to address the requirements of the Settlement Agreement, while ensuring validity and reliability of the data.
	Summary of Monitor's Assessment: Progress was noted in many areas of Section S of the Settlement Agreement. However, concerns remained throughout all areas. Continued effort and related progress were noted in the area of habilitation training and services, in

	particular with regard to the development of skill acquisition plans (SAPs). However, it was evident that more robust support and expertise were needed to improve the quality of the SAPs as well as to effectively monitor their implementation (i.e., using integrity checks) and individual progress (i.e., using ISP monthly progress notes) overtime. Lower than expected estimates of engagement were noted during the current review. Progress in supporting individuals in off-campus vocational positions was evident. This included active efforts at informal job exploration and the slow, but increasing trend in successfully placing individuals in meaningful employment positions in the community. This trend might be enhanced by increased completion of formal situational assessment within off-campus settings.

#	Summary of Provision	Assessment of Status	Compliance
S1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall provide individuals with adequate habilitation services, including but not limited to individualized training, education, and skill acquisition programs developed and implemented by IDTs to promote the growth, development, and independence of all individuals, to minimize regression and loss of skills, and to ensure reasonable safety, security, and freedom from undue use of restraint.	Continued effort and progress was noted in the area of habilitation training and services, in particular the development of skill acquisition plans. However, it was evident that more robust support and expertise was needed to improve the quality of the SAPs reviewed. The Monitoring Team's previous reports documented improvement over time in the number of plans developed as well as the quality of SAPs at CCSSLC. However, in the Monitoring Team's last report, based upon continual observations of inadequacies within SAPs, the Monitoring Team strongly encouraged the Facility to: 1) review previously reported findings and recommendations regarding SAPs (because the majority of concerns were still applicable); 2) identify ways to write SAPs to allow more flexibility in moving through the steps of the task analysis, and, ultimately, toward mastery of the entire skill without having to re-write the entire program; and 3) most importantly, provide frequent and robust clinical and technical support to the staff writing and reviewing these programs. Based on the current Monitoring review, it appeared that these recommendations were still valid and, as a result, they continue to remain in place. To be clear, the Monitoring Team strongly believes that robust technical support has been needed for some time and the provision of that support, if provided, has been inadequate to date. This is an area where additional and significant support at the State level appears necessary. It should be noted that it was obvious to the Monitoring Team that Facility staff members who are developing, implementing, and monitoring these SAPs appeared well meaning and committed to producing well-designed SAPs. Indeed, there appeared to be no lack of effort in the revision of the SAP format as well as related trainings. That is, since the Monitoring Team's last review, documentation suggested at least three revisions (dated 2/23/12, 3/20/12, and 5/15/12) and dozens of trainings, including administrative, professional, clinical, and direct care staff. However, these authors continued to lack the expertise and technical support in writing SAPs. Specific	Noncompliance

#	Summary of Provision	Assessment of Status	Compliance
		findings related to review of SAPs are reported below. In an effort to review the adequacy of the most recently developed SAPs, a sample of 12 SAPs was selected from individuals with ISPs held since the Monitoring Team's last visit. That is, one recently completed SAP was randomly selected from each of the 12 individuals identified for review. In addition, efforts were employed to ensure a representative sample across residential programs. Indeed, the sample included individuals from 12 different residential programs and all of the SAPs were implemented in June or July. This sample reflected approximately 5% of the total number of individuals with ISPs and approximately 10% of those individuals with ISPs held since the Monitoring Team's last visit. The following quantifies the results of the Monitoring Team's most recent review: ▪ In general, rationales for development were found in all 12 (100%) of the sampled SAPs. However, one appeared incomplete (i.e., Individual #58). One rationale was very detailed and cited the specific need and assessment (i.e., Individual #275). ▪ Several SAPs had stated rationales that targeted a specific need (as identified by the FSA) that, upon review, did not appear consistent with and/or conspicuously identified within the FSA. For example, an identified need as the rationale for the privacy SAP for Individual #167 was not found, as stated, in the FSA. Other examples included the lack of evidence within FSAs as identified for Individual #272, Individual #95, and Individual #65. ▪ Of the currently sampled SAPs, 11 (92%) were identified in the most recent ISP. Reference to the sampled SAP within the ISP for Individual #167 was not evident. ▪ All 12 (100%) of the plans reviewed had an identified task analysis section. However, only the task analysis found in one (8%) of the sampled SAPs was found to be adequate (i.e., switch activation SAP for Individual #272). ▪ One (8%) of the sampled SAPs offered an adequate operational definition. That is, almost all plans combined the operational definition section within the behavior objective section, which in most cases overlooked defining the actual target. These are distinct and should be separated. ▪ The behavioral objective in only 40% (five SAPs) included any description of the actual skill being targeted. ▪ Ten (83%) of the SAPs prescribed specific implementation schedules. However, of these, plans prescribed daily (50%), weekly (20%), or monthly (30%) implementation schedules. For many individuals, this schedule appeared insufficient to provide the frequent opportunities to respond that are necessary to promote learning. In most cases (60%), opportunities to respond were either unclear or at a rate judged insufficient (once a week or less).	

#	Summary of Provision	Assessment of Status	Compliance
		▪ The listed discriminative stimuli (SD) appeared adequate in eight (67%) of the SAPs sampled. In some cases, it appeared that this cue contained additional or unnecessary verbal prompts (e.g., Individual #167), inappropriately included explanations or rationales (e.g., Individual #172), or could not be easily identified (e.g., Individual #58). Consideration should be given to the fact that an SD can be the last completed step of a task analysis, and the potential negative outcomes associated with utilizing all verbal prompts. ▪ The instruction sections in none (0%) of the SAPs reviewed appeared adequate. Many of these sections either repeated the task analysis (e.g., Individual #72 and Individual #65), included explanations or rationales (e.g., Individual #58), were too complex or convoluted (e.g., Individual #236), or introduced additional unnecessary and potentially counter-therapeutic verbal prompts (e.g., Individual #272, Individual #95, individual #275, Individual #184, and Individual #315). ▪ It was unclear why data collection appeared the same across different forms of instruction (i.e., whole task versus forward chaining). That is, for some cases where whole task presentation was prescribed, data was collected for only one step (e.g., Individual #295). In this case, the description of "whole [total] task presentation" was not accurate (i.e., the task analysis appeared designed as a forward chaining procedure). ▪ Correct responding and/or error correction procedures were judged adequate for none (0%) of the SAPs reviewed. These procedures in most cases focused more on how staff should document correct or incorrect responding rather than how staff should reinforce or not reinforce correct or incorrect responding, respectively. In addition, directions for incorrect responding often included a "2nd chance," rather than following the prompt hierarchy. ▪ Generalization and maintenance procedures were combined in all SAPs and were viewed as adequate in none (0%) plans. It appeared that a fundamental misunderstanding regarding generalization and maintenance strategies continued, as evidenced in the currently reviewed sample. ▪ Individualized reinforcers were noted in none (0%) of the SAPs, with all relying on the use of verbal praise. ▪ It was unclear why mastery criteria (when to change step levels) was included in behavioral objectives, as well as why the criteria was inconsistent across plans. ▪ It was unclear why graphs were included in the majority of SAPs. That is, progress was noted in the more consistent use of ISP monthly progress notes for all (100%) of the individuals sampled. However, concerns were noted with regard to data collection of SAPs (for specific information, this is discussed with regard to Section S.3 of the Settlement Agreement). Overall, the current review evidenced: 1) difficulty in writing objective, measureable, meaningful, and, in some cases, attainable behavioral objectives; 2) incomplete,	

#	Summary of Provision	Assessment of Status	Compliance
		subjective, too complex, or insufficiently detailed task analysis; 3) teaching conditions that did not conspicuously identify relevant elements and precise training schedules; 4) a continued misunderstanding of chaining methodologies; 5) inappropriate and/or insufficient data collection; 6) insufficient use of robust and individualized reinforcers; 7) the lack of adherence to typical prompting methodology, or in other words, misuse of excessive verbal prompting at the beginning and the end of behavioral responding; 8) the lack of programmed differential reinforcement; 9) at times, overly complex, redundant and/or disorganized content; and, 10) the continued misunderstanding of strategies related to maintenance and generalization as well as their application. The previous report noted that the Facility had started probing the accuracy of task analyses with individuals prior to the development, training, and implementation of skill acquisition plans. This practice appeared thoughtful as well as likely to promote the efficient and effective development of meaningful SAPs. Based on verbal reports during the Monitoring Team's current visit, this practice had continued and continued to be beneficial to staff. It should be noted that the more complete, precise, and individualized (accurate) the task analysis, the more likely that skill well be acquired efficiently. Staff should continue to expect that validation of the task analysis will confirm adequate construction, but perhaps might prompt the need for further adjustment. Consistent with the Monitoring Team's previous visits, observations during the July 2012 onsite visit attempted to estimate levels of engagement in recreational, leisure, and/or other activities across residential 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 (i.e., individuals engaged: total number of individuals) in relation to staff-to-individual ratios across residential programs. <u>Engagement Observations</u> ***Location*** | ***Engaged*** | ***Staff-to-individual ratio*** 522A | 0:1 | 2:1 522A | 2:2 | 2:2 522C | 2:2 | 1:2 522C | 4:4 | 2:4 522D | 3:3 | 2:3	

#	Summary of Provision	Assessment of Status			Compliance
		524A	2:6	1:6	
		524A	1:2	0:2	
		524A	0:4	0:4	
		522D	2:9	2:9	
		524D	3:6	5:6	
		524B	2:7	3:7	
		524B	0:2	0:2	
		524B	2:2	2:2	
		516	2:4	1:4	
		510 (Outer reef)	0:8	0:8	
		510 (Outer reef)	1:5	1:5	
		517 (Kaleidoscope)	3:4	3:4	
		517 (Comfort Zone)	1:1	1:1	

Overall engagement was 42%. An engagement level of at least 75% would be a typical target for a facility like CCSSLC. As previously observed, poor staff-to-individual ratios in some programs appeared related to poor engagement.

The Facility continued to actively monitor engagement using 5-Minute Engagement Tools and, as noted in the previous report, a database had been developed to manage engagement data, and allow examination of current estimates and trends over time, including monthly review by program staff. Although reports at times indicated potential over-estimation of engagement scores as well as inconsistencies in the number of programs audited per month, this monitoring system continued to appear functional and provide meaningful data. Currently, it appeared that the Facility was responsive to Monitoring Team data and graphing recommendations, and had created graphs displaying the number of engagement tools completed each month (i.e., between December 2011 and May 2012) across programs. In addition, estimated engagement based on these completed tools was also similarly graphed. The Monitoring Team viewed this as progress. Based on data provided, it appeared that the number of tools completed each month across residential programs ranged from zero to 16, with some programs not completing any tools in certain months from December through February (i.e., Sand Dollar and Sea Horse). In addition, it appeared that the number of tools completed each month across vocational and day programs ranged from zero to eight with some programs not completing any tools in certain months from December through February (i.e., Horizons and Kaleidoscope). Some programs during this time period had not completed any engagement tools (i.e., Outer Reef). Indeed, this might be related to the low engagement rates observed at the Outer Reef during the Monitoring Team's current onsite visit. The Facility reported a range of engagement rates between 46.5% and 100%. No average score across programs was provided. It should be noted that

#	Summary of Provision	Assessment of Status	Compliance
		approximately 36% of the monthly engagement rates were based on the completion of three or less engagement tools per month. Consequently, caution should be used when interpreting engagement estimates based on assessments that occurred less than once a week. The Facility might want to consider only reported engagement rates for a month if a certain criteria has been met (e.g., at least two per week). Overall, active efforts aimed at improving engagement were noted. These included: 1) clear expectations appeared to be set (i.e., eight per residence each month – two per week across the 6-2 and 2-10 shift; and, eight per vocational/day program each month – two per week across the morning and afternoon); 2) trainings on conducting these monitoring sessions as well as the revision of the form; and 3) ongoing formal review and subsequent action plans when levels were lower than expected (e.g., at Dolphin and Sand Dollar). The Monitoring Team's previous reports evidenced progress over time in developing new vocational, day program, and "retirement" settings on campus in an effort to support individuals off their residential programs. In addition, targeted programming for individuals with Autism also had been in development. Previous reports also highlighted evidence that the Facility continued to examine reasons why individuals did not participate in day, vocational, or education programs. Previous recommendations included the collection of data on work refusals and/or percentage of time at day or vocational programming to ensure adequate monitoring over time. In response, as evidenced during the Monitoring Team's previous visit, the Facility had started collecting and displaying data on the number of available work and classroom opportunities refused. Currently, the Facility had enhanced this data collection and monitoring system to include graphic displays of day program and vocational attendance for each residence over time (by month). Overall, increasing trends (based on the average of residential programs) were noted within each day program as well as for work attendance across residential programs. The collection of this data and graphic display reflected progress and appeared likely to provide important data and effective ongoing monitoring. The Monitoring Team looks forward to examining how this data is used to improve attendance, perhaps for those residences and/or programs with the lowest attendance rates or with declining or variable rates. However, as discussed in more detail with regard to Section F, this needs to be an individualized process. ISPs that the Monitoring Team reviewed continued to provide little, if any, justification for individuals not participating in full-day offsite programming, or expanding individuals' opportunities for appropriate, individualized day and vocational supports. Consequently, data targeting attendance over time for one or more residents could be more closely monitored to assess the success of individualized interventions. Indeed, documentation revealed that this data was already being collected. In fact, documentation evidenced a program (incentive program) where individuals were praised for excelled attendance. One of these settings, for example, the Horizons program, verbally praised individuals with attendance of 80% or better (per month). This appeared to be an informal program that	

#	Summary of Provision	Assessment of Status	Compliance
		had not been formally evaluated. The Facility should consider monitoring attendance data on an individual basis for select individuals who are the most resistant to attending vocational or day programming. This would establish a baseline to examine the effectiveness of future interventions (similar to the incentive program) developed to enhance attendance. The Monitoring Team's previous reviews had noted concerns with the limited opportunities for individuals to work off campus in competitive employment positions. Over time, the numbers of individuals in supported community-based employment positions had slowly, but gradually grown from approximately seven (at baseline) to 19 (January 2012). Currently, according to summary documentation, 20 individuals were working in supported employment positions within 15 community-based sites. Overall, the data reflected a slow, but increasing trend in supporting individuals in meaningful employment positions in the community. Due to the continued inadequacy and concerns as noted above, the Facility remained out of compliance with this provision of the Settlement Agreement.	
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 completion of assessments that examine individuals' preferences, strengths, skills, needs, and barriers to community integration as well as in the areas of living, working, and leisure activities. As previously described in the Monitoring Team's previous reports, the Personal Focus Assessment was expected to be completed prior to the ISP to help teams identify an individual's goals, interests, likes/dislikes, achievements, and lifestyle preferences across a wide range of areas. As previously reported, although PFAs appeared to be completed for the majority of individuals sampled (i.e., 93% in July 2011 and 94% in January 2012), only a minority of these assessments appeared to be adequately completed (i.e., 31% in July 2011 and 53% in January 2012). In an effort to review the adequacy of the most recently completed PFAs, a sample of 12 individuals who had ISPs held since the Monitoring Team's last visit was selected. The sampling was controlled to ensure adequate representation across residential programs. Indeed, the sample included individuals from 12 different residential programs. This sample reflected approximately 5% of the total number of individuals with ISPs and approximately 10% of those individuals with ISPs held since the Monitoring Team's last visit. Currently, of the 12 individuals sampled, 10 (83%) had PFAs that appeared to be adequately completed. The exceptions were two PFAs that were missing or incomplete for Individual #295 and Individual #272. Of the 11 available PFAs, 10 (91%) were dated prior to the ISP. The one exception was a PFA that was not dated (i.e., Individual #95). Consequently, it appeared that most PFAs were available prior to the ISP. A change in	Noncompliance

#	Summary of Provision	Assessment of Status	Compliance
		format was noted as 10 of the 11 available PFAs were the most recent format, dated 9/15/11. This format differed from previous formats, because it no longer included a comprehensive list of assessments that the IDT recommended for completion prior to the ISP. Lastly, only six of the 11 PFAs were signed. It should also be noted that the Monitoring Team recognizes that the Facility was in the process of initial implementation of the new Preferences and Skills Inventory (PSI) that will replace the PFA. The same sample as described above was utilized to examine the completion of the Functional Skills Assessment. The Monitoring Team's previous report indicated that 91% of the individuals sampled had FSAs that appeared fully completed and adequately summarized. However, at that time, several of these FSA were completed after the ISP meeting and, as a result, were unlikely to adequately inform the IDT as intended. Currently, of twelve individuals sampled, 12 (100%) had completed FSAs. However, upon closer examination, only 11 (92%) appeared to be summarized and offer recommendations. The exception was the FSA for Individual #58 that appeared completed (all the items were scored), but the assessment was not summarized and recommendations were not provided. In addition, three individuals appeared to have FSAs completed using the new summary and recommendation format (i.e., Individual #236, Individual #272, and Individual #184). It appeared that this new format was implemented in February 2012. However, it was unclear why IDTs for three other individuals (with ISPs completed in March 2012) did not utilize this new format (i.e., Individual #95, Individual #275, and Individual #65). Overall, the change to the new format appeared potentially more helpful, because it provided an opportunity for the IDT to examine additional assessment information, including 1) barriers to community integration in living and leisure; 2) supports needed to overcome barriers; 3) skill training recommendations; and 4) ideas for the future. However, this change did not necessarily provide any more detail in some of the information provided. That is, review of sampled FSAs evidenced recommendations that appeared quite brief and non-specific. More specifically, most of the FSAs reviewed contained three to five recommendations that each included only one word (or just a few words) describing a common label or category of skills/activities of daily living (e.g., "Community," "Leisure," or "Money Management"). It was unclear to the Monitoring Team why such a very comprehensive assessment (47 or more pages), that requires significant resources to be completed, would produce such brief and often cryptic recommendations. Indeed, the point of the assessment was to inform the IDT process by identifying the needs of the individual. The Monitoring Team encourages the Facility to closely review the recommendations produced by the completion of the FSA and examine whether or not the recommendations: 1) are consistent with findings within the assessment; 2) offer new (or question previously) identified needs; 3) offer utility in the development of new SAPs or other programming; and 4) are viewed as helpful to the IDT.	

#	Summary of Provision	Assessment of Status	Compliance
		As noted in the Monitoring Team's previous reports, slow progress had been noted in the area of vocational assessments, including the use of situational assessment opportunities. However, concerns were noted, including inconsistencies in format, lack of individualization, recommendations that did not reflect future vocational visions, use of graphic displays that were difficult to interpret, and the use of unstructured and on-campus situational assessments. In general, the primary finding was that previous vocational assessments were limited in nature due to the primary completion of on-campus situational assessments. That is, for individuals already working on-campus, the use of assessments targeting the same or similar job experiences appeared to limit the range and diversity of potential employment visions. Indeed, even for individuals who have not worked, the Facility was currently limited in the diversity of work it had to offer. In an effort to review the adequacy of vocational assessments, 12 individuals with ISP meetings held since the Monitoring Team's previous visit were selected and their vocational assessments were reviewed. This sample was the same sample as described above. Currently, only seven (58%) vocational assessments were available for the 12 individuals sampled. It was unclear to the Monitoring Team why these missing assessments were not provided as requested. That is, verbal reports while on site indicated that all individuals with ISPs within the past six months would have completed vocational assessments. Of the seven available vocational assessments, all (100%) were completed within the last 12 months and all (100%) were completed prior to the most recent ISP. In addition, although in-text summaries described a number of previous vocational explorations and job introductions, for most individuals sampled, documentation evidenced supplemental assessments for only five (71%). Of these five individuals, four (80%) appeared to have one or more situational assessments and/or job explorations completed within the last year. More specifically, four (57%) of the seven evidenced situational assessment(s) within the last 12 months; and two (29%) of the seven evidenced job exploration assessments. The exception was Individual #315 who had a "job introduction" in September 2010. The vocational assessments for two of the sampled individuals indicated that situational assessments were not conducted due to the preference, contentment, and/or insistence of the individual (i.e., Individual #295 and Individual #167). This is despite the fact that the vocational assessment for Individual #167 acknowledged that "… [individual]'s vocational goal may be limited due to limited exposure to community jobs." Overall, none (0%) of the more formal situational assessment were conducting in the community. It was unclear to the Monitoring Team why criteria for revision included yearly updates for those actively employed in vocational programming and revision every three years for those not actively working. It would appear that more robust and ongoing assessment would be necessary for those individuals not working.	

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		Consistent with findings reported in the Monitoring Team's previous reports, all of the reported situational assessments were conducted on campus targeting existing employment activities. At times, the situational assessments appeared to be related to the currently identified vision (e.g., Individual #184 and Individual #172), and for others, the situational assessments did not appear consistent with the identified vision (e.g., Individual #275 and Individual #95). Overall, situational assessments might have been more meaningful and functional, at least for some of the individuals, if they had been completed in community-based settings. That is, because situational assessments primarily appeared to be completed on campus, the range and diversity of employment visions continued to be potentially limited. Job exploration assessments, however, were all conducted off-campus and reflected progress in exploring additional community-based settings that were likely to offer more diverse opportunities and, hopefully, a wider range of meaningful employment positions, as well. The Facility should consider adding more specification to the Situational Assessment Summary as well as within the vocational exploration section of the vocational assessment. More specifically, it would appear helpful to IDT members who read the assessment if, on the form, the specific site/setting in which the assessment was conducted as well as the specific date was identified. This should include conspicuously highlighting whether or not the setting was on or off campus. In addition, the form should require the rater to identify the current vocational vision and determine whether or not it is consistent with the actual experience targeted by the situational assessment. If they were consistent, the rater would need to briefly offer how the experience is different from past or current vocational (likely on-campus work) experiences, as well as the unique or potential benefits. If they are inconsistent, the rater should be required to explain how they are different and offer a rationale as to why the experience was offered to the individual. This extra step might facilitate better understanding of the direction pursued by vocational staff, as well as demonstrate efforts at providing individuals with new experiences outside their "comfort zone" or beyond that typically offered on campus. In addition, all assessments should clearly provide specific dates on which situational assessments were completed. Lastly, in some cases, individuals appeared resistant or uninterested in exploring new options through situational assessments. In these cases, the Facility should consider clearly documenting the detailed efforts made in encouraging these next experiences. These efforts should demonstrate strategies beyond verbal encouragement, and include documented rationales beyond, for example, the individual's preference or resistance to change. Vocational staff should be vigilant with regard to old adage "you don't know what you don't know" which, in some cases, can be accurately applied to individuals with restricted vocational experiences. Data displayed within currently provided summary documentation appeared to reflect a decrease in the number of on-campus and off-campus situational assessments over the	

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		past four and three months, respectively. It appeared that higher rates completed in February and March could not be sustained. However, the overall rates of Job Explorations appeared to reflect an increasing trend over the past six months (with the exception of March). The Monitoring Team strongly encourages the Facility to continue with these assessments, and looks forward to a greater emphasis on the completion of community-based situational assessments. As noted in many of the Monitoring Team's previous reports, the utility of the vocational assessment will continue to improve as its findings are based on meaningful situational assessments, including a greater diversity of experiences potentially available in community-based off-campus settings. Their value also will improve as the results are linked directly to functional skill acquisition programs related to achieving individualized employment visions. The Monitoring Team recognized the efforts at utilizing (or at preparing to utilize) other standardized and structured assessments (e.g., the Educational and Training Assessment, the ABLLS-R, etc.) in an attempt to better support individuals in educational settings. Indeed, initial efforts to more broadly utilize more evidence-based assessments and skill training curricula appeared promising (as discussed with regard to Section K.8). The Monitoring Team looks forward to continued review of these initial and ongoing efforts of the Facility. Due to the continued inadequacy and concerns as noted above, the Facility remained out of compliance with this provision of the Settlement Agreement.	
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	Some progress was noted regarding the development, training, and monitoring of individualized, practical and functional skill acquisition plans. However, serious concerns remained regarding the quality of these developed SAPs, their procedural integrity, and their ongoing monitoring and review. The Monitoring Team's previous reports noted that a weekly peer review process, entitled the Skill Acquisition Review Committee, had been initiated to examine developed skill plans and to provide feedback and ongoing coaching, and refinement. According to verbal reports and onsite observation, this committee continued to meet weekly to	Noncompliance

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		review developed plans. Over time, this committee had received technical support from one of the contracted BCBAs, the Clinical Psychologist, and Chief Psychologist. Based on findings from the current review (as discussed with regard to Section S.1), robust clinical and technical support continued to be necessary. Indeed, based on verbal reports during the Monitoring Team's most recent visit, it appeared evident that available on-campus resources, including those cited above, were insufficient or unavailable to provide the support necessary to make the needed qualitative changes to the development, implementation, and monitoring of SAPs. In an effort to examine whether or not SAPs effectively addressed the individuals' needs for services and supports, randomly selected SAPs were examined in a sample of individuals with ISP meetings held since the Monitoring Team's last visit (this was the same sample as described with regard to Section S.1 of the Settlement Agreement). More specifically, SAPs were reviewed to determine if targeted needs were identified by currently completed assessments. As previously reported with regard to Section S.1, although rationales were found for all 12 (100%) of the individuals, concerns were noted with regard to the assessments cited within these rationales. Overall, the rationale listed in one (8%) of the sampled SAPs appeared incomplete (i.e., Individual #58). The rationale of approximately eight (67%) sampled SAPs included references to specific needs as identified within completed assessments (e.g., FSA, ISPA, Psychological Evaluation), and 10 (83%) cited discussion at the ISP as the rationale for the need (although, technically, the Monitoring Team did not view this as a formal assessment). The Monitoring Team could only confirm agreement in two (29%) of the seven SAPs that cited a specific assessment as the basis of the identified need (i.e., Individual #295 and Individual #275). That is, in the majority of cases, the Monitoring Team could not identify the targeted need within the assessment cited with the SAP. In fact, in several cases, the need identified within the SAP appeared counter to information found within the cited assessment (e.g., the PFA for Individual #236 and Individual #95). In addition, the needs addressed by the SAPs could only be confirmed in 10 (83%) of the ISPs. Lastly, some identified assessments were not available to the Monitoring Team (i.e., the PALS for Individual #236 and the ISPA for Individual #315). In an effort to examine whether or not SAPs were practical and functional in the most integrated setting, the prescribed settings of current SAPs were examined. As described in Section S.3.b of the Settlement Agreement, all (100%) of the individuals currently sampled had at least one SAP identified for completion in a residential setting. Indeed, the majority of SAPs reviewed across all sampled individuals were set within the residential setting. However, all (100%) of the individuals sampled had at least one SAP identified for completion in a community setting, and 10 (83%) had SAPs identified for either vocational/work settings and/or classroom /day program settings. Upon review of the twelve sampled SAPs, it appeared that eight (67%) clearly had SAPs that were	

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		practical and functional. More specifically, it was unclear whether or not four of the sampled SAPs would ever be effective or promote a successful skill in the most integrated setting or ultimately effectively serve a purpose. These findings are described below: ▪ The SAP for Individual #236 targeted teaching two signs of being happy and content in a community setting. It was unclear how staff would ultimately know whether or not she was truly happy or content. And, although staff could bring her to a place where she is likely to be happy or content, these selected responses of emotion cannot necessarily be prompted or accurately measured. ▪ The SAP for Individual #275 did not appear practical, because her level of supervision and community restrictions limited her access to the community significantly. That is, she had not been able to work on this objective for the past three (or more) months due to community restrictions contingent upon maladaptive behavior. ▪ The SAP for Individual #58 targeted the skill of choosing and engaging in a sensory activity. It was unclear how staff might effectively identify or measure whether or not he "engaged" in a sensory activity (anything that stimulates the senses). Although experiencing sun on your face or the smell of ocean air can be a pleasurable and rewarding activity, it was unclear to the Monitoring Team how the Facility would teach this as a skill (i.e., using objective and measureable responses). ▪ The SAP for Individual #153 targeted improving his exposure by teaching him the "Ability to ride in the van off campus." Although increasing the diversity of experiences for individuals is laudable, it was unclear how the Facility might determine if riding in the van "enriches his life experiences," or served a measurable purpose. Since the Monitoring Team's last review, substantial efforts to provide competency-based training (CBT) on skill acquisition plans (SAP) to CCSSLC staff were evident. That is, according to summary documentation, the Active Treatment Department conducted CBT targeting SAPs to over 560 CCSSLC professional and direct support professionals in April and May 2012. In addition, verbal reports as well as documentation indicated that skill acquisition training curriculum had been integrated into the New Employee Orientation (NEO). However, it was difficult for the Monitoring Team to determine if this content was significantly different from content found in previous training curriculum. That is, the formats used within NEO continued to appear outdated compared to expectations based on verbal reports regarding changes to SAP formats, including changes to operational definitions as well as changes to the maintenance and generalization sections. Currently, based on the NEO materials provided, it appeared that the curriculum continued to be inadequate. More specifically, materials identified an operational definition section, but operational definitions were rarely found in reviewed	

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		SAPs (as discussed with regard to Section S.1). In addition, the materials did not adequately address chaining (including the different types), differential reinforcement, or the use of the prompt hierarchy. The training needed to be more robust with regard to determining how to identify the prompt level targeted, when to use a more intrusive level of prompt, how to limit the use of prompts (i.e., fading to avoid prompt dependency), mastery criteria involved in changing prompt levels, etc. The Facility still did not submit any training content on differential reinforcement (e.g., how/when to use reinforcers following correcting/incorrect responding) or types of chaining. The SAP example included in the training was of a "whole" task, but it was only one step, which is not typically seen as an adequate task analysis. The Facility appeared to utilize data obtained through "Integrity Treatment Checklists" as one method to assess staff competency in implementing SAPs. That is, summary documentation reported that the effectiveness of the CBT (in implementing SAPs) would be assessed through the use of Integrity Treatment Checklists (ITC). It was unclear to the Monitoring Team why scores obtained during the actual training were not utilized (or provided for review). However, summary documentation suggested that high rates of competency were obtained in April (89.4%) and May (95.5%). These estimates should be reviewed with caution, because they appeared to be based on insufficient data. More specifically, the score for April was only based on data collected across seven (58%) of the programs, and, on average, approximately four checks per residence. In addition, similar concerns were noted for May data. Although the score for May was based on data collected across 12 (100%) of the programs, this estimate was based, on average, on only four checks per residence as well. Consequently, the Facility should ensure that an adequate sample of integrity checks had been completed (with sufficient IOA between raters) prior to reporting integrity estimates. As reported in previous Monitoring reports, reported integrity scores, in some cases, had likely overestimated the level of actual implementation integrity. And, as found during the Monitoring Team's review, concerns regarding the adequacy of integrity checks were noted during direct observation of integrity checks. More specifically, the Monitoring Team's previous report described inadequacies following direct observation of two active treatment staff conducting SAP integrity treatment checks. At that time, several concerns were noted regarding the adequacy of these integrity checks, and it was recommended that active treatment staff receive more training and support in accurately completing these checks as well as completing IOA estimates across raters. During the Monitoring Team's most recent visit, similar concerns were noted following direct observation of several integrity checks completed. That is, during the integrity treatment checks, direct support professionals appeared to be coached or prompted at times by the raters, raters often discussed the SAP and/or related scoring during the integrity check, and raters often had difficulty correctly scoring the rubric during the sessions. At times,	

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		raters also had difficulty accurately describing the SAP, including how to appropriately prompt incorrect responding and explaining generalization. Indeed, on several occasions, raters failed to demonstrate independent scoring. Review of the actual integrity checks revealed that raters did not fully score the rubric. Overall, concerns remained regarding the actual integrity of the integrity checks. Consistent with previous observations, currently reviewed integrity check sessions reflected the need for ongoing support and training for active treatment staff who conduct these sessions. The Monitoring Team recognizes that completing integrity checks with a high degree of fidelity and reliability is challenging and, like other challenging skills, requires sufficient support to master. It was evident that the Facility recently had re-trained those individuals completing these checks (dated 6/5/12). These efforts should continue. In addition, documentation revealed ongoing revision of the rubric (most recently on 4/10/12) utilized during these checks. The Facility should consider further revision over time, when necessary. For example, the current review noted concern with using adequate task analyses and specific criteria targeting task analyses were not included within the rubric. In addition, current findings demonstrated continued confusion with the method of chaining, but this was not conspicuously included in the rubric. Also, it was not always clear when training was prescribed. Perhaps clearer instructions on Item 5 (of the current rubric) would facilitate more conspicuous identification of the prescribed training schedule. In addition, operational definitions and behavioral objectives were almost always combined in SAPs (based on the sample), and yet each component had its own section on this rubric. Perhaps highlighting that these were discrete components would be helpful. Relatedly, attempts to more clearly discriminate between generalization and maintenance procedures might be effective if these were clearly discrete within the rubric. Lastly, the rubric appeared to be missing reference to other important components (i.e., prompting hierarchy and methods, method of instruction, and mastery criteria). Consistent with previous reviews, mixed findings were observed during onsite visits when direct support professionals were asked simple questions about behavioral and skill acquisition programming. That is, as discussed with regard to Section K.11 of the Settlement Agreement, inconsistent findings with regard to staff knowledge of PBSPs and Skill Acquisition Plans continued to be observed during onsite visits. A small sample of staff members was interviewed about selected individuals and their programming in an effort to estimate staff knowledge about individuals. Overall, although many staff appeared knowledgeable of plans and skill programs of randomly selected individuals, many staff still were unable to answer basic questions about behavioral or skill programming for some individuals. For example, a direct support professional was able to provide accurate information in response to questions about Individual #167, but was unable to locate the Individual Notebook to describe data collection. Staff correctly answered questions regarding target behaviors and prescribed consequence-based	

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		interventions for Individual #58 and was able to generally describe the plan for Individual #22. However, when asked, staff needed to confirm whether or not some individuals had a PBSP (e.g., Individual #310). In some cases, staff reported that an individual (Individual #254) had a PBSP when that was not the case. In one case, staff described a target behavior of PICA and related preventative strategies that were not listed in Individual #315's PBSP. Brief onsite reviews also evidenced somewhat mixed findings with regard to the adequacy of data collection. In most cases, however, data collection was not adequate. Brief record reviews examining the collection of behavioral data indicated that 91%, 29%, 63%, and 70% of the data appeared adequately collected for Individual #275, Individual #353, Individual #315, and Individual #254, respectively. Brief reviews of skill acquisition plan data indicated that 53%, 46%, 67%, and 40% of the data appeared adequately collected for Individual #7, Individual #353, Individual #310, and individual #254, respectively. These estimates were consistent with verbal reports at the Skill Plan Review Committee that suggested that the biggest obstacle was ensuring adequate procedural integrity of skill plan implementation and data collection. During the Monitoring Team's previous review, it was noted that the Facility had implemented weekly checks examining the quality of data collection for SAPs. That is, a checklist was created to assess the adequacy of data collection for each skill plan across all individuals in a residence. This ongoing evaluation of data collection appeared to offer an effective although indirect way to more regularly and systematically monitor the adequacy of data collection, as well as prompt feedback or initiate further examination when inadequate data collection was observed. Direct observations by the Monitoring Team during the most recent onsite visit evidenced the continued use of these checks. Indeed, according to summary documentation, on July 1, 2012, a revised standardized weekly SAP checklist was implemented. Like the previous rubric, this checklist was used to examine and document the percentage of data collected per week. Review of documentation did not evidence a summary of the data collected during these checks. As previously recommended, the Facility should consider revision to the checklist to determine an overall score (per person or per residence) that would allow monitoring of adequate data collection over time. At the previous review, data collection procedures associated with SAPs, including ISP Monthly Reviews, were not examined because at that time it was anticipated that these methods were likely to change with the inclusion of the Murdoch skill program library and data collection system. According to verbal reports and documentation provided at that time, the Murdoch library (a commercially available skill teaching and monitoring format) was being piloted at the Pacific and Coral Sea Homes. Unfortunately, according to verbal reports at the Monitoring Team's most recent onsite visit, the Murdoch data	

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		collection system had been discontinued. Indeed, verbal reports and discussion during the recently observed Skill Plan Review Committee meeting, on 7/10/12, revealed a previous consensus and decision not to implement this form of data collection, but to utilize a revised version in its place. In addition, verbal reports voiced during the meeting indicated support of this decision by the State Consultant during a recent review of skill programming. That is, the feedback indicated that the current Facility's format was a close enough approximation to the format likely to be supported by the State Office. The Monitoring Team believed that the Murdoch data collection system offered many advantages over the previous and current monitoring approach reviewed here. The current findings are reported below. Review of both selected SAPs as well as ISP monthly reviews (for the last three months as requested) evidenced concerns. It should be noted that the same sample of individuals (including the same selected SAPs and related ISP monthly progress notes) described in Section S.1 was utilized here. Overall, the current review found none (0%) of the ISP monthly reviews for selected SAPs adequate. The following quantifies the results of the most recent Monitoring Team's review and clarifies reasons why these were found to be inadequate: ▪ None of the 12 (0%) of those sampled utilized graphic displays that were adequate and/or interpretable; ▪ Of those sampled, four (33%) had complete data and had data that was clearly accurate for the month reviewed. An example of problems noted was that June data was displayed in a May monthly note for Individual #236; ▪ Of those sampled, nine (75%) had behavioral objectives that matched the objective on the SAP. The remaining three listed behavioral objectives that did not match the objective on the SAP (Individual 295, Individual #58 and Individual #236); ▪ Of those sampled, nine (75%) were signed and dated. Those that were not included Individual #236, Individual #95, and Individual #315. For these, the Monitoring Team could not determine whether or not the reviews were completed in a timely fashion. ▪ Of those sampled, two were clearly not reviewed in a timely manner. That is, some appeared to be updated concurrent with the Monitoring Team's current onsite review (i.e., Individual #275 and Individual #58). Overall, the Monitoring Team found the graphic displays difficult to understand and interpret. In addition, the Monitoring Team found the data collection system, at times, redundant and not informative. Also, it was unclear why graphic displays were found in both the SAP and ISP monthly reviews. That is, the display did not appear to provide necessary or helpful information relative to the implementation of the SAP. In all cases, graphs did not include meaningful titles and/or labels (on the Y axis). The metric used	

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		on the Y-axis as well as the information found in tables attached to graphs was often meaningless. The point of using graphic display is to facilitate efficient and effective monitoring of data. It was a challenge to efficiently understand or effectively interpret any of the sampled graphs give the insufficient information provided. The interpretation and usefulness of SAP data was limited in a number of ways. First, prompting levels were not always consistently recorded in reviewed SAPs or ISP monthly reviews. Relatedly, the nature of prompting (i.e., if it was used and, if it was, what level of prompting was required) could not be determined from current graphic displays. Secondly, graphic displays presented data across months (on the X axis). This monthly data point was primarily the average of four (or less) trials or, as found in many cases (i.e., 25% in the current sample), was based on a single trial. This is clearly insufficient to monitor and adjust skill acquisition programming over time. In addition, there were multiple data codes, in addition to "+" correct and "-" incorrect, that direct support professionals could utilize to describe performance. These included "A" (absent) and "R" (refusal) in addition to prompt level, in some cases. Review of documentation reflected the frequent use of these additional data codes. However, these were not reflected in monthly graphic displays. Consequently, graphic displays did not adequately reflect performance. That is, three data points of zeros could reflect three incorrect trials, one incorrect trial and two refusals, or two incorrect trials and one refusal. It became more complicated with the inclusion of more data codes (one or more absences, for example), as well as more than one trial as the basis of the monthly data point (i.e., some monthly data points were averaged across four trials). The Facility continued to need an ongoing data collection and monitoring system that addressed the above concerns. The Facility should review all of the Monitoring Team's previous and current findings and recommendations related to data collection, data display (i.e., including standards of graphic display) and ongoing performance monitoring. The findings and recommendations related to PBSPs are just as relevant to SAPs. Lastly, emphasis should be placed on implementing a data collection system that would efficiently identify the type of chaining strategy utilized, which step(s) of the task analysis is currently targeted, and what prompting level is currently being utilized. This would allow staff to more efficiently run trials as well as determine if mastery criteria had been met. In addition, this system should support the implementation of more frequent teaching trials and related ongoing data collection (i.e., prompt level, correct/incorrect responding), as well as easily accommodate data collection on significantly more trials over time. Serious consideration should be given to collecting data on every teaching trial conducted. Given the above concerns regarding the development, training, and monitoring of SAPs, the Facility remained in noncompliance with this provision of the Settlement Agreement.	

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	(b) Include to the degree practicable training opportunities in community settings.	Continued progress was noted in supporting skill acquisition programming within the community, including the procurement of off-campus employment. The Monitoring Team's previous reports noted progress in the number of individuals with formal opportunities to engage in skill acquisition programs within the community. Documentation from the Monitoring Team's previous reviews indicated an increasing progression of approximately 8%, 30%, 68%, and 95% of individuals at CCSSLC with SAPs designed for implementation in community settings as of July 2010, January 2011, July 2011 and January 2012, respectively. Based upon the Monitoring Team's current review of sampled SAPs, it appeared that individuals had approximately five to eight SAPs across an array of individualized content areas. However, general themes of SAPs emerged as all (100%) individuals sampled had SAPs targeting money management and medication skills (or identified pre-requisite skills for medication). In addition, occasional SPOs were evident as well. These were found to be in place for five (42%) of individuals sampled. It was unclear to the Monitoring Team why these SPOs continued to be utilized. That is, verbal reports during the Monitoring Team's previous visits indicated that the SPOs would be phased out and replaced by SAPs. In addition, all (100%) of the individuals sampled had a SAP identified for completion in a community setting and 10 (83%) had SAPs identified for either vocational/work settings and/or classroom or day program settings. Concerns with regard to the quality of these goals are discussed in further detail with regard to Section S.1 and F.2.a.1. One of the consistently reported challenges to community integration identified during previous visits was the limited availability of transportation. In response, three new vans were purchased and available (in November 2010) to support community integration and supported employment. At the Monitoring Team's last review, verbal reports as well as documentation indicated that six new vans were to be purchased in July 2011. At the time of the Monitoring Team's previous and current onsite review, these vans have not yet been purchased. Due to the continued inadequacy and concerns related to the quality of the plans developed to support community training opportunities, the Facility remained out of compliance with this provision of the Settlement Agreement.	Noncompliance

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

1. The State Office should assist the Facility in identifying or providing staff with expertise in skill acquisition as well as writing and monitoring skill acquisition programming. This likely will require involvement of Behavioral Services and/or Special Education staff that have competency in these areas. Using such resources, robust competency-based training and re-training should be provided to the staff currently developing,

monitoring and training the implementation of SAPs. This should include developing multiple exemplars (e.g., SAPs, data collection methods, monthly monitoring/review notes) that could be used by staff to address needs typical to individuals in residential settings. Staff should then use these exemplars as a foundation to individualize subsequent SAPs. Ongoing on-site critical review, training, and support by expert staff should occur on a weekly or monthly basis. (Section S.1 and S.2)

2. The Facility should ensure that assessments listed as part of the rationale provide clear evidence of the link between the identified need and the skill targeted within the skill plan. Ensuring specific citation of items and/or sections of assessments within rationales might improve the accuracy with which these rationales are identified. (Section S.1)
3. The Facility should ensure that SAPs are based on identified needs as found in assessments. That is, needs should not be identified through task analyses. (Section S.1)
4. A process should be developed and implemented to describe how preferences that are identified within the PFA or CFA are incorporated into skill programs. (Section S.1)
5. The Facility should expand its use of the "test trial" for developed (or selected) task analysis 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. The planning and validating of each task analysis should occur prior to training and staff should expect that adjustments likely will be necessary. (Section S.1)
6. As previously recommended, the identification of specific prompt levels should be eliminated within behavioral objectives, because this appears to necessitate more frequent revisions of the program or, if including reference to a prompt level is desired, an "independent level" of responding could be stated (following the initial instruction) when writing most behavioral objectives. In addition, criteria for mastery (moving up a step in the task analysis) should not be included in the behavioral objective, but rather in the instructions section. Consideration should be given to standardizing the mastery criteria, when appropriate (Section S.1)
7. Skill Plans should utilize a more generalized discriminative stimulus that does not include specific steps of the task analysis. This instruction should cue completion of the entire task analysis and should reduce the amount of necessary revision as the individual makes progress. (Section S.1)
8. Redundancy of information across sections in the skill acquisition plans should be avoided. Instructions, discriminative stimuli, error correction, reinforcement procedures, and data collection procedures, for example, are not necessary under the methodology section, if they are sufficiently described in other sections. (Section S.1)
9. 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), or does not have sufficient detail to ensure identification of a correct response(s). They should be complete, detailed, and accurate. (Section S.1)
10. More training should be provided on behavior chains, including task analysis, discriminative stimuli, differential reinforcement, and the collection of data appropriate to the type of chaining procedure prescribed. That is, total (whole) task presentation provides training to the individual on each step of the task analysis during every session. (Section S.1)
11. 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 or setting. (Section S.1)
12. Programming for maintenance should include more specification, including when maintenance probes would be conducted once the entire skill is learned, and be distinct of generalization strategies. (Section S.1)
13. 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)
14. Plan authors should ensure the prompt sequences in skill plans are appropriate, especially when primarily targeting verbal responses. (Section S.1)
15. 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 might

be difficult to access on a daily schedule. (Section S.1)

16. The error correction procedures should be standardized across all skill acquisition plans, when appropriate. This should not include data collection procedures, but rather descriptions of how staff respond to errors (i.e., avoid provision of reinforcers). Additional staff instructions (e.g., explanations, second chances, specific prompting sequences) should be avoided and not included in this section. (Section S.1)
17. Consideration should be given to standardizing when staff members evaluate performance on a SAP. That is, the authors of SAPs should consider determining performance (correct or incorrect responding) on the first trial. Some SAPs provide a second chance (to get the trial correct), which leads to inconsistency and perhaps less efficient learning. (Section S.1)
18. 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. Staff instructions should avoid the use of supplemental verbal responses from staff, because this is likely counterproductive and inconsistent with the prompting hierarchy (Section S.1)
19. 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)
20. Reinforcement procedures should be part of every skill acquisition plan and reinforcers should be individualized, when appropriate. (Section S.1)
21. 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)
22. The Facility should examine the usefulness of the current data sheet used for SAPs and consider adopting a data form that allows the collection of data during each learning trial. This could include the identified step of the task analysis and prompt level. This type of system would be responsive to individuals who proceed quickly through a task analysis. (Section S.1)
23. The IDTs of individuals currently not attending a day or vocational program away from their residential unit should continue to meet to identify the barriers to their participation and problem-solve to assist, as appropriate, individuals in overcoming such obstacles. IDTs should review such reasons and justifications regularly and document these in the ISP, as well as progress made in assisting individuals to overcome such obstacles. (Section S.1)
24. As appropriate, behavioral supports should be developed for individuals to support their participation in meaningful day and vocational programs. (Section S.1)
25. Although some data is collected to track program attendance (e.g., vocational, work, class, etc.), if not already available, data should be displayed to monitor ongoing performance of individuals or programs over time. This would facilitate the identification of individual improvement or decline, and allow closer examination of the effectiveness of current supports. (Section S.1)
26. Generally accepted graphing conventions still should be used when displaying data across all assessment and monthly review (specific recommendations regarding graphing are offered with regard to Section K). (Section S.1)
27. 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 psychology and active treatment as teams work to develop skill acquisition programs. (Section S.1)
28. The Facility should ensure that all assessments are adequately completed, including summary and recommendation sections of the PFA and FSA, prior to the ISP meeting. (Section S.2)
29. When monitoring vocational data, the Facility should clearly indicate whether or not situational assessments were completed in on- or off-campus settings for each individual listed. (Section S.2)
30. Situational assessments on-campus should continue, but with the understanding that these still potentially limit the vocational visions of some individuals. Community-based vocational assessments should be pursued as well, because these might offered more diverse vocational

opportunities. (Section S.2)

31. The Skill Acquisition Review Committee should pursue consistent and ongoing collaboration with the State Level Consultants and the Psychology Department for technical support when developing, implementing, and monitoring skill acquisition programs. (Section S.3.a).
32. Further training of active treatment staff on completing skill plan integrity checks should be completed. This includes training on completing IOA probes. (Section S.3.a)
33. Data should continue to be collected and summarized to allow monthly examination of integrity checks of skill plans across programs. (Section S.3.a)
34. 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 plans. (Section S.3.a)
35. Necessary equipment (e.g., vans) should be purchased to support the integration of individuals into the community. (Section S.3.b)
36. Community outing data should include monthly summaries and graphic display that allow monitoring over time. This might 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. The quality of the community outing also should be rated in terms of meeting individuals' preferences and offering opportunities for community integration. (Section S.3.b)

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

1. As recommended previously, a spreadsheet should be created that tracks community-based supported employment and that would allow ongoing assessment of trends over time. 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 S.1)

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o In response to request for description of how the Facility assesses individuals for community transition, a copy of the Living Options Discussion Record template, undated; o Community Placement Report for period between 11/16/11 and 5/31/12, dated 6/5/12; o List of individuals assessed for placement between 6/1/11 and 5/31/12, dated 6/5/12; o List of individuals currently referred for community placement, dated 6/1/12; o List of individuals who have had a Community Living Discharge Plan (CLDP) developed since the last review, undated; o List of individuals who have requested community placement, but have not been referred, dated 6/1/12; o List of those individuals who would be referred by the IDT 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, undated; o List of individuals that prefer community transition, but not referred due to LAR preference, dated 6/4/12; o Annual Report: "Obstacles to Transition Statewide Summary, Fiscal Year 2011, data as of 8/31/11; o List of individuals transitioned to community settings, from 12/1/11 through 5/31/12; o List of training/educational opportunities provided to individuals, families, and LARs to enable them to make informed choices related to community transition for past 12 months, including to sign-in sheets; o List of all training and educational opportunities that address community living, including but not limited to provider fairs, community living option in-services, and/or onsite visits to community homes and resources provided to Facility staff, undated; o Facility and Local Authority staff training curricula related to community living, transition and discharge, including any training materials; o Corpus State Supported Living Center Tour Activity, dated 6/13/12; o List of staff attending community tours, from 8/5/11 through 5/18/12; o Living Options Discussion for the PSP, undated; o Living Options Addendum template, undated; o Inclusion of the Designated Local Authority during Living Options Discussions; o Community Living Discharge Plans (CLDPs), including individuals' most recent ISP and related assessments for Individual #30, Individual #338, Individual #151, Individual #114, Individual #41, Individual #277, and Individual #364; o Blank template for Essential/Nonessential Supports, and Support Spreadsheet; o In response to request for State Office review of CLDPs, the statement: "No Evidence;" o Post Move Monitoring Schedule, dated 6/1/12;

	○ List of alternate discharges, dated 6/1/12; ○ List of individuals transferred to other SSLCs, dated 6/1/12; ○ List of alleged offenders, dated 6/1/12; ○ Discharge Packet for Individual #264 for whom an alternate discharge was completed; ○ Obstacles to Moving to a Community Setting: Obstacle Collection Form, dated 8/2/11; ○ Obstacles to Community Setting Reporting Period monthly reports, for the months of December 2011 through May 2012; ○ Obstacles to Community Setting Reporting period 12/1/11 through 2/29/11; ○ Obstacles to Community Setting Reporting period 3/1/12 through 5/31/12; ○ For the last one-year period, a list of individuals who have transitioned to the community indicating whether or not since their transition, 1) had police contact, and if so the reason why, the date, and an indication of whether or not they were arrested or otherwise detained; 2) had a psychiatric hospitalization, including the date on which they were hospitalized and the length of stay; 3) had an ER visit or unexpected medical hospitalization, including the reason; 4) had an unauthorized departure, including the date and length of departure; 5) been transferred to different setting from which he/she originally transitioned, including both addresses and reason for transfer; 6) died, including the date of death and cause; and/or 7) returned to the Facility, including the date of individual's transition to the community, date of return, and reason, undated; ○ Individual Support Plans, Sign-in Sheets, and Assessments for the following: Individual #290, Individual #363, Individual #184, Individual #268, Individual #282, Individual #336, Individual #26, Individual #250, Individual #228, and Individual #63; ○ Pre-Move and Post-Move Monitoring documentation for the following: Individual #151, Individual #30, Individual #114, Individual #277, Individual #364, Individual #41, and Individual #338; ○ Inter-Rater Reliability for T – Sub Section I: Planning for Movement, Transition, and Discharge, for 3/12 through 5/12; ○ Last 10 monitoring tools completed by: a) Admissions Placement Coordinator; and b) Quality Assurance Department staff, various dates; ○ Settlement Agreement Compliance Report for Section T – Sub Section I: Planning for Movement, Transition, and Discharge for 3/12 through 5/12; ○ CCSSLC Self-Assessment, updated 6/25/12; ○ CCSSLC Action Plans, updated 6/25/12; ○ CCSSLC Provision Action Information, undated; and ○ Presentation Book for Section T. ▪ **Interviews with**: ○ Dora Flores, former Admissions Director, and current Transition Specialist; ○ Esmerelda Vogt, Admissions Director; ○ Sandra Vera, Post-Move Monitor (PMM); ○ Nelda Gonzalez, Program Compliance Monitor; and ○ Rachel Martinez, QDDP Coordinator.

	▪ **Observations of**: o ISP meeting for Individual #341; and o Post-Move Monitoring visit for Individual #30.
	Facility Self-Assessment: Based on a review of the Facility's Self-Assessment with regard to Section T of the Settlement Agreement, the Facility found that it was in compliance with the following subsections: T.1.c, which is an overarching provision encompassing a number of different provisions; T.1.c.3, which requires teams to review CLDPs with individuals and their LARs; T.1.d, which requires the Facility to provide individuals transitioning to the community with "current comprehensive assessment of needs ad supports within 45 days prior to the individual's leaving; T.1.e, which requires the development of a CLDP that includes adequate essential and nonessential supports, and that the essential supports are confirmed to be in place prior to the individual's transition; T.1.g, which requires the collection and analysis of data regarding obstacles to placement, as well as efforts on DADS part to overcome such obstacles; T.1.h, which requires the Facility to provide a Community Placement Report; and T.2.a, related to post-move monitoring. Not all of these findings were consistent with the Monitoring Team's findings. Specifically, the Monitoring Team did not find the Facility in compliance with T.1.c, T.1.d, T.1.e, T.1.g, or T.2.a for the reasons discussed in the sections of the report that follow. The Monitoring Team did find the Facility in compliance with T.1.c.2 (with which the Facility did not find itself to be in compliance), T.1.c.3, and T.1.h. In its Self-Assessment, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating using the information cited in the section on results. Although a number of concerns continued to exist with the Facility's self assessment process, over time, this format should be helpful in substantiating the Facility's findings with regard to compliance. Since the last review, a number of new indicators had been added to the Self-Assessment. Many of these appeared to have merit in assisting the Facility to identify where it was doing well, and where it needed to focus its improvement efforts. However, a number of concerns were noted, including, for example: ▪ The Facility's Self-Assessment did not define how the samples were selected, or give a sense of whether they were representative samples. ▪ It was often unclear what criteria the Facility had used in its assessments, and, at times appeared that the presence of an item versus its quality was assessed. For example, the quality of assessments used in developing CLDPs is essential to compliance with Section T.1.d, but in finding itself in compliance, the Facility did not appear to take quality into consideration, just timeliness. ▪ In addition, not all requirements of the Settlement Agreement had been reviewed. For example, nowhere in the Self-Assessment did it appear that the Facility had assessed the quality of the essential and non-essential supports in the CLDPs. ▪ At times, the Self-Assessment included potential key indicators or outcome measures. For example, for Section T.1.b, which addresses education about community options, the Facility had included numbers of individuals that participated in community tours, numbers of individuals and families participating in the Provider Fair, etc. This was valuable information. However, in order for it to be meaningful, it needed to be put into the context of a measurable outcome indicator. This would need to be accomplished by identifying baselines, and then setting a goal for what would be considered an acceptable or desirable level of participation.

	▪ At time, items that were being measured did not equate to compliance. For example, for Section T.1.b.3, the State Office requirement for assessment for appropriateness for placement required a number of steps as detailed in the Monitoring Team's report. However, the Self-Assessment did not address these steps, but rather broadly referenced the Living Options discussion. ▪ For the various monitoring/audit tools, inter-rater reliability needed to be established with the QA and programmatic staff (e.g., QDDP Coordinator) responsible for conducting audits. ▪ As discussed during the last review, the need still existed 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). ▪ The data presented clearly identified areas of need. However, the Facility Self-Assessment did not yet provide any analysis of the information, identifying, for example, potential causes for the issues, or connecting the findings to portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings. In its last report, the Monitoring Team recommended that the Facility Self-Assessment present the findings as the rate of compliance versus noncompliance. This change had been made, and it facilitated the reader's understanding of the findings. Overall, the Facility had demonstrated increasing use of the data it had collected. Efforts to ensure the validity and reliability of the data will be important next steps, as will using the data to identify areas in which focused attention is needed. Particularly given the number of discrepancies between the Facility' s findings and the Monitoring Team's findings, the Facility should carefully review the differences to determine factors that might be leading to findings of substantial compliance when the Facility is not yet in compliance. The Facility's progress in developing a quality assurance process for Section T is discussed in further detail below with regard to Section T.1.f.
	Summary of Monitor's Assessment: Individuals' ISPs 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 ISPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports, and services, and that, as appropriate, these be transitioned to the community through the community living discharge plans. As noted in previous reports, one issue that appeared to delay individuals' referral to the community at times was a Local Authority representative not being at a meeting at which the team decided a referral should be made. New rules had been put in place to resolve this issue. The rules set forth the parameters for ensuring LA representatives were invited to meetings, notifications of the Admissions/Placement Coordinator of referrals made during meetings, informing the LA of referrals made in their absence, and holding an additional meeting should the LA have any questions or concerns about the referral. It was positive that with these new rules, an LA representative's inability to attend a meeting would not delay a potential referral.

	An increasing number of assessments prepared for annual ISP meetings had begun to include the assessor's recommendation regarding transition to the community. However, individuals' ISPs generally still did not include a summary or conclusion of 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. The Facility submitted monthly and quarterly aggregate totals of the obstacle categories State Office had identified. Based on interview, Facility staff indicated that education of individuals and their guardians had been identified as an area of need. However, they stated that formal analysis of all of the data was still in process. The Facility would soon be submitting its second annual report to the State, which should include an analysis of data collected thus far. Although the Facility had made some progress, Community Living Discharge Plans continued to inadequately define the necessary protections, support, and services to ensure the individual's health and safety. Many of the issues identified in the Monitoring Team's previous reports regarding deficiencies with the CLDPs had not yet been rectified. As a result, individuals transitioning to the community were potentially at risk due to the lack of adequately planned and implemented protections, services, and supports. 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 generally provided a thorough description of the methods used to evaluate the item and the findings (e.g., interviews, document reviews and observations). This was further confirmed through an observation of a post-move monitoring review. During the course of the review, the Post-Move Monitor identified some serious issues. The Post-Move Monitor handled these issues professionally with community provider staff, and took appropriate steps to ensure the safety of the individual. The post-move monitoring activities identified some issues with regard to the provision of services at the community sites. In addition, one of the individuals who had transitioned to the community had experienced serious events, such as police contact. However, IDTs at CCSSLC did not document thorough follow-up or attempts to ensure that the individuals had the protections, services, and supports they needed.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for	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	Noncompliance

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	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.	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 ISP. During future reviews, the Monitoring Team will continue to evaluate the State and the Facility's implementation of this policy. With regard to the availability for funding 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. At the time of the review, at CCSSLC, 11 individuals had been referred for community transition. Six of these 11 individuals had exceeded the 180-day timeframe. Generally, these individuals had significant behavioral concerns and/or medical concerns that required careful planning, and identification of a community provider who could offer supports to ensure the individuals' health and safety, as well as their growth and development. For one individual that had been on the list for a little over a year (i.e., Individual #213), he had experienced medical issues requiring hospitalization and ongoing revisions to his medical plan of care. Although his referral had not been rescinded, his team wanted him to be more medically stable before a transition occurred. For another individual that had been on the list for approximately a year (i.e., Individual #26), although at times it was unclear whether or not she wanted to transition to the community, her team continued to meet and attempt to identify options that would support her behavioral and mental health needs. As is discussed in further detail with regard to Section T.1.g, although obstacles to individuals' transition to community settings had not been fully identified and analyzed on a systemic level, anecdotally, the availability of community providers who could support individuals with complex behavioral and/or medical needs appeared to be an issue. The Monitoring Team agrees wholeheartedly with the teams' decisions not to transition individuals until an appropriate configuration of supports and services was	

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		identified. However, this likely is an area in which more systemic attention is needed from DADS State Office. As noted in previous reports, one issue that appeared to delay individuals' referral to the community at times was a Local Authority representative not being at a meeting at which the team decided a referral should be made. Based on documentation the Facility provided (i.e., the Community Placement Report), two individuals had not been referred to the community due to the LA not being present at their annual meeting. Of these, one individual had since been referred to the community. It was unclear whether or not a meeting had been held for the remaining individual whose original meeting was held in May 2012. However, as discussed with regard to Section F, new rules had been put in place to resolve this issue. The rules were summarized in a document entitled: "Inclusion of the Designated Local Authority during Living Options Discussions." More specifically, the rules had been modified to allow a referral to be made without the LA present. The rules also set forth the parameters for ensuring LA representatives were invited to meetings, notifications of the Admissions/Placement Coordinator of referrals made during meetings, informing the LA of referrals made in their absence, and holding an additional meeting should the LA have any questions or concerns about the referral. It was positive that with these new rules, an LA representative's inability to attend a meeting would not delay a potential referral. At the time of the review, assessments prepared for annual ISP meetings increasingly included the assessor's recommendation regarding transition to the community. Of the 10 ISPs reviewed, all of the assessments for one individual (10%) (i.e., Individual #228) included the applicable statement/recommendation. For four of individuals most of the assessments included such a statement (i.e., Individual #63, Individual #250, Individual #336, and Individual #290). However, individuals' ISPs still often did not include a summary or conclusion of the professional team members' determination with regard to whether or not community placement was appropriate. Of the 10 ISPs reviewed, one individual (i.e., Individual #26) had been referred for transition to the community a few months previously, and the team agreed to continue the referral. For the remaining nine individuals, two individuals' ISPs (22%) included an independent recommendation from the professionals on the team to the individual and LAR (i.e., Individual #184, and Individual #282). 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. This is discussed in further detail with	

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		regard to Section T.1.b.3. In reviewing CLDPs and ISPs of those individuals that were referred, none of them had opposed transition to the community. The Facility remained out of compliance with this overarching provision of Section T of the Settlement Agreement.	
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 Monitoring Team's previous review, the Facility had maintained its set of 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 that likely would require modifications to be made to Facility policies. As noted in previous reports, the three Monitoring Teams had a number of concerns related to the DADS draft policy, and on 5/16/11, had submitted comments for the State's consideration. It was anticipated that the State would address the Monitoring Teams' concerns in the revised version of the policy. At parties' meetings in July 2012, the parties agreed that the Monitors would rate T.1.b as just the development of an adequate policy. The sections T.1.b.1 through T.1.b.3 would be considered stand-alone provisions that require implementation independent of T.1.b or any of the other cells under T.1.b. Due to the fact that the State and Facility had not yet finalized an adequate policy related to transition and discharge processes, the Facility remained out of compliance with this provision.	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 will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs	As noted above with regard to Section F of the Settlement Agreement, CCSSLC had continued to make efforts to improve ISPs. The ISP format was in the process of changing, but the ISPs reviewed for this review included a section for discussion about the individual's living options. This section included discussion regarding the individual's and his/her LAR's awareness of community options, their preferences for a specific living option, and team members' recommendations related to the individual's transition to the community. A section of the plan also captured the team's Living Option Recommendation, and any reasons/obstacles for not referring an individual to the community. The draft DADS Policy 004.1 – Individual Support Plan Process stated: "The purpose of this policy is to establish procedures to develop an integrated Individual Support Plan (ISP) that is both beneficial and effective for individuals *regardless of the setting in which services are provided*" (emphasis added). The other sections of the revised ISP Meeting Guide were designed to elicit from the team a comprehensive set of protections, services, and supports.	Noncompliance

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	and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	A review was conducted of a sample of 10 ISPs. 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 ISP 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 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. <u>Identification in ISPs of Needed Protections, Services, and Supports</u> As was discussed with regard to Section F of the Settlement Agreement, individuals' ISPs did not 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, services and supports not being adequately integrated with one another, and/or adequate plans not being developed to address individuals' preferences, strengths and needs. As has been reiterated since the baseline review, it is essential, as teams plan for individuals to move to community settings, that ISPs 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 ISP 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. When all of the necessary protections, supports, and services are not outlined in the ISP, it is much more difficult to ensure the individual's safe transition. Based on a review of 10 ISPs, none of the plans reviewed (0%) included a comprehensive list of the protections, supports, and services needed to support the individual. As has been stated in previous reports, 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. PBSPs, PNMTs, health care plans, psychiatric treatment plans, communication plans,	

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		etc.) continued to result in incomplete ISPs. Previous reports have provided detailed examples of concerns related to ISPs. 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 ISPs and CLDPs. <u>Identification of and Plans to Overcome Obstacles to Transition to Community</u> As noted above, the ISP format included a section on obstacles the IDT identified. The new format incorporated the State Office's standardized list of obstacles/barriers to community transition to assist in the analysis of information collected from IDTs throughout the SSLC system. These were obstacles teams would potentially identify during the consideration for referral process. Reportedly, a more detailed list of obstacles would be maintained should issues arise as teams made efforts to transition individuals to the community. In reviewing the sample of 10 ISPs, teams generally had identified some obstacles. Of the 10 ISPs reviewed, nine should have had obstacles defined. The remaining individual had been referred for transition to the community (i.e., Individual #26). Of the nine remaining plans, none (0%) included an adequate list of obstacles. The problems associated with the remaining lists of obstacles included the following: ▪ When guardians or individuals objected, adequate inquiry did not occur with regard to specifically what their concerns were (e.g., Individual #63, although the narrative included some information, none of the boxes were checked to identify the guardian's specific concerns; Individual #184; Individual #282; Individual #336; and Individual #268, although the narrative indicated the guardian was concerned about the individual's behavioral needs being met); ▪ At times, the team did not identify any obstacles, but the individual was not referred for transition (e.g., Individual #290, although the narrative indicated "preferences for a home site have not been determined;" and Individual #363); and ▪ Some were not adequately justified (e.g., Individual #228 for whom the team identified that lack of understanding of living options. However, her PSI indicated in response to the question about where she would want to live: "She is nonverbal and therefore, unable to give us this information." In addition, her reactions on two community home tours were described as "alert, looking around with interest, and smiling." Moreover, the team indicated she could not make decisions on her own, making the team the body that would make referral decisions, absent a guardian. Similarly, for Individual #250, although the standard list of obstacles was not included in the ISP, the narrative indicated the obstacle was that the individual's preference had not been determined. However, due to the difficulty the individual had in communicating her	

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		preferences, it appeared that the mother's concerns about placement were more at issue, even though she was not the guardian). Moreover, action plans to overcome the obstacles identified generally were not adequate. Of the nine ISPs, six (67%) included an action plan to overcome obstacles identified (i.e., Individual #363, Individual #184, Individual #336, Individual #228, Individual #63, and Individual #250). Of these seven, none (0%) were adequate. The plans were not adequately individualized or measurable (e.g., many indicated that the individual would participate in community tours, but the number or tours, the types of programs that would be visited, or the specific timeframes in which this would occur were not stated), and a number only addressed the individual, when the obstacle related to a guardian's or family member's reluctance. As has been noted previously, when a guardian is reluctant, to the extent possible, the related action plans should address the specific issues about which the guardian is concerned. For example, if the guardian were concerned about the behavioral supports available in the community, then more education or research about the individual's options for being properly supported would be appropriate topics for an action plan. Sometimes, the action plans will involve staff action as opposed to guardian action. Based on interviews, Facility staff recognized that this was an area that continued to need improvement. 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. Although some limited progress had been made in teams' awareness of the need to identify obstacles, CCSSLC remained at the beginning stages of adequately identifying obstacles to community transition, and developing plans to overcome such obstacles. This deficiency, in addition to ISPs 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: ▪ **Annual provider fair**: On November 9, 2011, 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. A questionnaire had been used to assist individuals and the staff accompanying them to ask relevant questions of community providers. Data had been collected regarding attendance of individuals, families and staff. Satisfaction surveys also	Noncompliance

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		had been distributed to: a) providers that participated; and b) individuals, families, and staff that attended. The Facility provided a summary of the information. Reportedly, some of this information was being used to make changes for future fairs. Plans were underway for the next provider fair. One of the new Transition Specialists was had begun to contact providers and was working with the Self-Advocacy group to design fliers. ▪ **Community Living Options Information Process (CLOIP):** Individuals and their guardians also were provided information through the Local Authority CLOIP process. Based on tracking sheets provided, it appeared that this occurred regularly as part of the individual planning process. However, it did not appear that outcomes/measures had been determined and/or data collected regarding the number of individuals, and families/LARs who agree to take new or additional actions regarding exploring community options, or the number of individuals and families/LARs who refuse to participate in the CLOIP process. Collection and review of such data would allow the State to evaluate the effects of the process and make changes made to future CLOIP activities. ▪ **Tours of community providers**: Since January 2011 through the present, visits to community group homes and day programs continued to occur every Friday with assistance from the Active Treatment Department and Nueces County Local 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. Facility staff reported that they attempted to give everyone a chance to participate in these visits. Some IDTs had made specific referrals for individuals to attend. However, it was unclear if data had been analyzed to ensure that: a) all individuals have the opportunity to go on a tour (except those individuals and/or their LARs who state that they do not want to participate in tours); b) places chosen to visit are based on individual's specific preferences, needs, etc.; and 3) the individual's response to the tour is assessed. As noted in previous reports, 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. ▪ **A plan for staff to learn more about community options**: Although CCSSLC	

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		had not provided a formal plan to address education on community living options to management staff, clinical staff, and direct support professionals, they had continued to take a number of steps to provide educational opportunities. However, this should be formalized in a plan. As noted in the previous report, they had partnered with the Local Authority to provide training to each team on campus. This had continued, and on July 12, 2012, the Local Authority's Annual HCS Educational Presentation was offered. In addition, the Facility was tracking the staff, including their titles that participated in the community tours, as well as the provider fair. Based on review of the list, the staff that attended community tours were largely direct support professionals, QDDPs, and active treatment staff. ▪ The following were areas that the Facility had not yet addressed fully: o Providing opportunities for individuals to visit friends who live in community; o If aggregate data, which was not yet being analyzed, showed that families and guardians had similar concerns, then using mechanisms to provide information on specific topics could be used. For example, including articles in newsletters or offering specific educational seminars might be useful. The Facility had not yet engaged in these types of activities. o Providing education at: Self-advocacy meetings, as offered and invited; house meetings for the individuals; and family association meetings. The most challenging area with regard to education of individuals and LARs/families is individualizing this process, and documenting that individuals and their guardians are making informed decisions. In reviewing 10 recently completed ISPs, one individual had been referred for placement (i.e., Individual #26). For the remaining nine, seven (78%) had a plan that addressed education about community options. However, none of these (0%) were adequate. The following concerns were noted: ▪ None of the plans were individualized to address the individual and/or the LAR's particular needs or concerns. The plans for the following individuals were not individualized: Individual #290, Individual #363, Individual #184, Individual #336, Individual #228, Individual #63, and Individual #250. For example, some individuals had specific needs that a community provider would have to address and they or their families expressed concerns about the ability of community providers to address these needs (e.g., behavioral or medical supports). However, the action plans developed did not, for example, target specific types of providers for community tours, identify research that the team would do to answer the individuals or their guardians' questions, include visits to peers with similar needs that had moved to the community, etc. ▪ None of the plans were measurable, or provided for the team's follow-up to	

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		determine the individual's reaction to the activities offered. Many of the plans involved participation in community tours, but did not say how many or when these would occur. No methodologies were included to ensure that the individual and/or guardian's questions were answered (e.g., helping them write a list of questions specific to them, or a staff person assisting with asking questions). The action plans generally provided for the team to provide "ongoing" monitoring, but no specific strategies were included to obtain the individual's reaction at the time or shortly after an educational opportunity. Often, when the individual's LAR or family was reluctant, no specific strategies were included in the action plan to address the family or guardian's concerns or questions. Rather, the action plans were targeted towards the individual (e.g., Individual #363, Individual #63, and Individual #250). As the Monitoring Team discussed with staff during the onsite review, it is essential that these be individualized using the information that the team is able to gather about the reasons for the family member or LAR's reluctance. For example, if he/she has questions about the specific supports available in the community, identifying providers with expertise in providing such supports and introducing the LAR or family member to such providers would be important. For some, talking to another guardian or family that has experienced a transition to the community might be helpful. At the time of the review, this had not yet occurred. Creative ideas and brainstorming within CCSSLC and with other SSLCs will be necessary to identify the best ways to provide effective educational opportunities. ▪ None of the plans indicated whether or not there was a plan the previous year and/or if it was completed. ▪ The following individuals had no plan: Individual #268, Individual #282. Although the Facility was continuing to complete some of the basic activities related to education and some progress had been made in expanding these opportunities, minimal progress had been made since the last review in individualizing the process. Although more individuals had a plan in their ISP, the plans were not individualized or measurable. The individualization of this process is key to ensuring that individuals and their guardians are 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 individuals for placement pursuant to its new or revised policies, procedures,	As is discussed above with regard to Section T.1.a of the Settlement Agreement, the individuals' ISPs reviewed did not consistently 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. The Facility had begun to implement the State Office's plan to have each professional member of the IDT document his/her recommendation regarding the individual's ability	Noncompliance

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	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.	to transition to the community in the assessments completed prior to annual ISP meetings. These assessments also were to identify supports that the individual would need in a community setting. In addition, at the ISP meeting, the professional members of the team needed to make a recommendation to the individual/guardian. Based on the review of 10 ISPs: ▪ Some assessments included the required statements/recommendation, and others did not. However, this was an area in which improvement was seen. Of the 10 ISPs reviewed, all of the assessments for one individual (10%) (i.e., Individual #228) included the applicable statement/recommendation. For four of individuals most of the assessments included such a statement (i.e., Individual #63, Individual #250, Individual #336, and Individual #290). ▪ Of the 10 ISPs reviewed, one individual (i.e., Individual #26) had been referred for transition to the community a few months previously, and the team agreed to continue the referral. For the remaining nine individuals, two individuals' ISPs (22%) included an independent recommendation from the professionals on the team to the individual and LAR (i.e., Individual #184, and Individual #282). The following problems were noted for the other individuals: o For two individuals (22%), the assessments and/or ISP narrative included statements showing disagreement amongst the team regarding the individual's appropriateness for community transition (i.e., Individual #290, and Individual #63). For both of these individuals, the team recommendation was that the individual remain at the Facility. However, it was not clear how the team disagreement about this had been resolved. o For one individual (11%) (i.e., Individual #228), all team members had included statements in their assessments indicating the individual could be supported in a less restrictive setting. In the ISP narrative, the team indicated: "All the disciplines who work with [Individual #228] agreed in their assessments that community placement would be appropriate if the proper supports were in place to meet her special needs. She is in good health and adapts well to new situations." Individual #228 did not have a guardian or active family involvement. In other portions of the ISP, the team concluded that she required a guardian for all aspects of decision-making. However, the team "determined that [the Individual] would not benefit from moving to a less restrictive environment at this time." The reason given was that: "She needs additional education about community living options." The team did not provide adequate justification for its conclusion. In addition to the fact that the team indicated the individual could not make her own decisions, she also had been on two community tours the previous year, and appeared to be "alert, looking around with interest, and smiling." Moreover, her PSI	

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		indicated in response to the question about where she would want to live: "She is nonverbal and therefore, unable to give us this information." It was unclear if the team did not have enough information about community options (given that in lieu of a guardian, the team was responsible for this decision), or if the team believed there was another obstacle to transition that they did not identify. o For four individuals (44%), based on the assessments and sometimes the narratives in the ISPs, the team members stated that the individual could be supported in a less restrictive setting. However, a specific recommendation to the individual and/or LAR was not made (i.e., Individual #363, Individual #268, Individual #336, and Individual #250). The Facility remained out of compliance with this provision. Although progress was noted with regard to the inclusion of recommendations in individuals' assessments related to their appropriateness for transition to the community, this was not consistently seen in all assessments. In addition, frequently, professional members of the team were not making and/or documenting in the ISP a consensus recommendation to the individual and/or his/her guardian.	
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:	Since the last review, some progress had been made with regard to CCSSLC teams' development of CLDPs. Teams had expanded the scope of the essential and non-essential supports included in the plans. However, unfortunately, none of the CLDPs were yet adequate to ensure individuals had appropriate protections, supports, and services to meet their needs once they transitioned to the community. The CLDPs continued to need improvement. Community Living Discharge Plans were reviewed for six of the seven individuals who had transitioned from the Facility to the community since the Monitoring Team's last onsite review, representing 86% of this group of individuals. These included the CLDPs plans for Individual #277, Individual #114, Individual #364, Individual #151, Individual #338 and Individual #30. With regard to the timeliness of the Community Living Discharge Plans, five of the six (83%) included documentation to show that they were developed sufficiently prior to the individual's transition. The plan that did not include such documentation (Individual #151) appeared to have been developed only two weeks prior to the individual's transition. However, the documentation in the body of the CLDP indicated that some planning, including visits to providers had occurred over four months prior to the CLDP meeting date. It was unclear, though, what had happened in the intervening months. The Facility had added information to the face sheet of the CLDP to identify when the	Noncompliance

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		plan first was initiated, and each date on which it was revised. Dates documented on the top of the first page for this individual did not show much prior planning. For the remaining plans, the initiation dates were generally close to the referral date, and many revision dates were noted. This was a positive development. 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. Very similarly to the last review, some examples of the general concerns noted across all plans included: ▪ Many of the plans identified the need for training for community provider staff. However, none of them adequately 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). In some cases (e.g., Individual #364, and Individual #277), the staff requiring training were defined in general terms such as residential and day staff. This was insufficient to ensure that the individual received the supports he required. ▪ 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 ISPs 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. ▪ Missing from most 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. In a couple of the plans reviewed, action steps were included for the CCSSLC nurse to meet with the community provider nurse. This was positive, however, not necessarily well defined. However, for other clinicians, such as the psychologist/behavior analyst, psychiatrist, physician, habilitation therapists, etc., no such action steps were included. ▪ Similarly, no coordination was specified as needing to occur between current and future residential or day/vocational staff.	Noncompliance

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		▪ 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). ▪ 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, 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. ▪ The monitoring activities were identified in the CLDPs, including the role of the IDD Local Authority, as well as the role of Facility staff in the post-move monitoring and follow-up process. However, no action steps were designed to ensure that the Post-Move Monitor worked together with the Local Authority Service Coordinator to pass on important information or ensure monitoring continued to occur of essential and non-essential supports. As is described in further detail in the section of this report that addresses Section T.1.e of the Settlement Agreement, the CLDPs also did not consistently identify the essential supports required by the individuals. The Facility remained out of compliance with this provision.	
	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. Teams also had continued to consistently identify the specific person(s) responsible by name and/or position for action steps included in CLDPs for which Facility staff or others were responsible. Such details were found in all six of the plans reviewed (100%). The Facility was found to be in substantial compliance with this provision. As noted in the last report, in order to remain in compliance, the Facility is cautioned to ensure that as the supports included in CLDPs expand that adequate timeframes and persons responsible are assigned. For example, implementation of plans, such as PNMPs, health care plans, and PBSPs, will require a start date, and then a frequency to be stated for a number of different aspects of plan implementation (e.g., daily implementation and documentation, monthly review by a clinician, at least annual review or as needed modifications to the plan, etc.). This will require a lot more detail regarding both	Substantial Compliance

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		timeframes and persons responsible.	
	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 IDTs with adequate information with which to develop an appropriate CLDP or to offer community providers 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.1, and M.2 of the Settlement Agreement. The following information is repeated here from Section M and exemplifies the issues related to inadequate assessment processes for individuals transitioning to the community. Regarding the nursing documentation for discharges/individuals transitioning to the community, a review of the Nursing Discharge Summaries for six individuals including: Individual #41, Individual #364, Individual #277, Individual #151, Individual #30, and Individual #114 found the following: ▪ None (0%) of the Nursing Discharge Summaries adequately addressed the health/mental issues of the individuals. ▪ There was adequate information contained in none (0%) of the Nursing Discharge Summaries that would guide the community staff in providing the needed nursing care to the individual. ▪ A current nursing assessment was conducted for none (0%) of the individuals prior to discharge/transferring the individual to the community. ▪ There was adequate documentation identifying specific nursing interventions needed for all health/mental issues in none (0%) of the cases reviewed. With regard to tracking the availability, timeliness, and quality of assessments: ▪ For none of the six CLDPs reviewed (0%) were all assessments provided in a timely manner. Timeliness was an area where some improvements were seen. More assessments were updated and submitted to allow for review by both the IDT developing the CLDP and the community provider staff. However, for all six individuals, one or more assessment was submitted after the final community	Noncompliance

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		living discharge plan was developed. Some were dated the day of the individual's transition to the community. It was unclear what, if anything happened to update the CLDP with the assessment information, or make needed changes to essential or nonessential supports. The Facility had begun to track the timeliness of assessments, and provided the Monitoring Team with a printout of the grid showing the dates each assessment was submitted for each of the individuals that had transitioned. However, the data was very confusing. It included a summary date, which appeared to be the dated each assessment summary was completed; a "Calculated 45 day" date, which was different for most assessments, and appeared to be the date that resulted when 45 days was added to the assessment date; and the transition date. The purpose of the assessments being updated prior to the individual leaving is to ensure that the individual's CLDP accurately reflects the individual's current strengths, needs, and preferences. Therefore, the date should be calculated so it is no more than 45 prior to when the individual transitions to the community, but also is available for the team's review at the "final" CLDP meeting. ▪ In addition, the quality of these assessments was lacking. None of the six CLDPs reviewed (0%) were based on adequate assessments. In particular: o Most of the assessment formats were not designed to provide a summary of relevant facts related to individuals' stays at the Facility. Although it is understandable that an individual's full history cannot be included in a discharge summary, it is important that the Facility provide community providers with a summary of, for example, treatments or plans that have particularly successful or unsuccessful, and important milestones during the individual's stay at the Facility. Such a summary should contain an analysis of information, not merely a listing of dates, times, occurrences/lab results, etc. o In addition, assessments frequently were inadequate to assist teams in developing a comprehensive list of protections, supports, and services in a community setting. They did not describe or recommend the protections, treatments, and supports that needed to be provided (e.g., implementation of plans, staffing supports, training for staff, specific staff qualifications, etc.), and/or the specific clinical supports required (i.e., qualifications of clinical staff, the frequency and level of their involvement, etc.). o Moreover, assessments did not identify supports that might need to be provided differently or modified in a community setting, and/or make specific recommendations about how to account for these differences. For example, nursing assessments for individuals who had nursing	

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		care/health management plans at the Facility should include recommendations about their continuation and/or any modifications that need to be made to accommodate community settings that might not have nurses available at all times. Similarly, psychology/behavioral assessments should identify differences (e.g., environmental, staffing, training of staff on protective holds, etc.) that could impact the implementation of the PBSP in place at the Facility, and/or make recommendations about needed modifications. o In addition to specific issues related to transition, as is discussed in other sections of this report, the underlying assessments were not of adequate quality. o Finally, as has been recommended in previous reports, a process should be considered, particularly with regard to the transition of medical and other clinical information, for a summary to be developed, including but not limited to the individual's current status, any outstanding issues (e.g., tests due, issues for which resolution has not been reached), as well as any critical information about the individual's treatment (e.g., allergies, past history of medication use, etc.). This would result in a document that could be provided to community medical care providers that would facilitate the transition of this information. 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. The Facility remained out of compliance with this provision.	
T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the	The CLDPs reviewed included essential and non-essential supports. Since the last review, some progress had been made in expanding the scope of protections, supports, and services identified in the CLDPs. However, the Facility recognized that this was an area requiring further development. On a positive note, across the State, changes were being made to ISPs. 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 the full array of supports after the individual was referred for transition made it more difficult due to the generally short timeframes from referral to transition. The Facility and State Office recognized that the essential and non-essential supports required improvement. One effort to assist teams with this process included the State Office's development of a Support Spreadsheet and an Essential/Non-Essential Supports outline. The outline provided some of the items that the teams needed to consider, particularly related to training for staff, as well as a format for teams to use to help identify the various supports and related training that should be provided as the	Noncompliance

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	implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	individual transitioned to the community. It also emphasized the need to identify the evidence that would be needed to determine implementation. The spreadsheet identified four areas of supports for teams to consider, including general supports, environmental supports, personal supports or "deal breakers," and restrictive practices. Each had a brief definition. At CCSSLC, at the time of the review, two teams had used these tools as they had begun the process of developing the lists of essential and non-essential supports. According to staff, the tools significantly assisted teams in thinking about and outlining a fuller set of protections, supports, and services. However, at the time of the current review, teams did not consistently identify all the essential or non-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. 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. Similarly to the last report, the following summarizes the general concerns noted: ▪ 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 ISPs, 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 by reviewing current assessments, which, as noted above, 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. ▪ Although clinical services (e.g., nursing, psychology, therapy, etc.) were sometimes now referenced in the CLDPs, they still often were missing. In addition, the intensity of the supports was not identified, nor were the qualifications or the roles clearly defined. Supports defined as "be seen by a psychologist to monitor BSP and behaviors," or "see a dietician within 45 days" 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. ▪ In addition, clinical supports that CCSSLC was providing, based on assessment	

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		information, were not included in the CLDPs, and no justification was provided for not identifying a functionally equivalent support. For example, nursing care/health management plans often were not referenced in the CLDPs reviewed, or were simply referenced as something the CCSSLC nurse would review with community provider staff, not as plans that required implementation. Likewise, individuals who were receiving habilitation therapies supports at CCSSLC did not have functionally equivalent supports identified in their CLDPs. ▪ Of significant concern, for individuals who had been identified as being at risk through the Facility's at-risk screening process, the risk action plans that the Facility had begun to develop, albeit still inadequate, were not adequately reflected in action plans included in the CLDPs. As is discussed with regard to Section I of the Settlement Agreement, plans for individuals whose teams identify them as being at-risk should be of adequate clinical intensity to address the level of risk. Similarly, the action plans included in CLDPs for such individuals should include supports and services of adequate intensity to ensure the individuals' wellbeing to the extent possible. Based on this most recent review, CLDPs included some of the action steps, but none of the CLDPs reflected even all of what was in the CCSSLC inadequate risk action plans. Often multiple steps related to the multiple risks that each of the six individuals had were not transferred into the CLDPs. ▪ 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, for individuals with health management plans at the Facility, their discontinuation would need to be justified, or an alternate support provided. Similarly, if individuals receive supports from Habilitation Therapies or Dietary at CCSSLC, these services should be included in the CLDP, unless justification is provided for not including them, or an equivalent community service is identified. ▪ 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 Behavior Support Plan that uses campus bucks as a reinforcer moves to the community, plans need to be put into place to transition the individual to a different reinforcer. ▪ 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, as well as the scope of staff trained. ▪ In addition, few, if any, plans identified an essential or nonessential support for the full set of plans implemented at the Facility (e.g., nursing care plans, health management plans, PNMPs, and PBSPs) to be implemented in the community. Although this was improving, most of the CLDPs were missing specific,	

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		measurable action steps for some such plans. ▪ 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. With the most recent plans, more action steps were seen for monitoring some of these indicators, but consistently not all were identified, and when they were, no parameters for notification or next steps were identified. ▪ Only one of the applicable plans (i.e., for Individual #30) identified the need to develop a crisis intervention plans. However, even for this individual, it was unclear what the plan needed to include, who would review it, and/or how the current methods for dealing with crises at the Facility needed to be modified in a community setting. ▪ Direct support staffing ratios and requirements (i.e., supervision level) generally were not specified. In specifying staffing supports, teams should identify specifically the individual's staffing needs in relation to others supported in the home or day/vocational program (e.g., if an individual requires line-of-sight supervision, and other individuals live in the home, the team should consider this in describing an appropriate ratio), as well as in different situations (e.g., in the home, in the community, at a day or work site, at night, etc.), as well as the qualifications of staff (e.g., specific training requirements for staff, competencies or certifications needed, etc.). For the couple of plans that did mention staffing, concerns were noted. For example, for Individual #364, he had one-to-one supervision for community activities while at CCSSLC. The CLDP downgraded this to "eyesight" level of supervision without explanation or justification. ▪ In reviewing assessments, albeit incomplete, many recommendations were not specifically addressed in CLDPs (e.g., specific medical follow-up, adherence to weight reduction programs, etc.). ▪ Generally, day and vocational supports were not well defined. ▪ 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. ▪ Issues continued to be noted with regard to the measurability of supports identified. Although this had improved significantly, the issue was not completely resolved. ▪ It appeared that teams often were identifying due dates for critical supports that were not reflective of what the individual needed, but rather dependent on issues related to the conversion of individuals' Medicaid from institutional to community Medicaid. Not having such supports available at the time of transition, or shortly, thereafter potentially compromised individuals' successful	

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		transition. Of the six individuals who had transitioned to the community in 2012, two had experienced negative outcomes. One had been to the ER twice, and eventually had open heart surgery. The other had been to the ER twice, including once as a result of behaviors that caused an injury, and had police contact based on a threat to kill himself as well as related behaviors. The Monitoring Team only reviewed the post-move monitoring information for the second individual, because the first had moved to an area for which another Facility provided the monitoring services. However, for the second individual, concerns were noted with regard to the transition plan, 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 previously discussed in some detail while at the Facility, good transition planning requires the commitment of the entire IDT, 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. With regard to Monitoring by the Local Authority or other means to ensure essential supports are in place prior to an individual's transition, the Local Authority'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 Local Authority 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 Local Authority representatives had actually confirmed that the individualized essential supports were in place. However, the Facility was 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 four individuals' pre-move site visit documentation (i.e., Individual #30,	

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		Individual #114, Individual #277, and Individual #151). All three (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, a couple of days prior to 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. 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 Monitoring Team's previous review, the Facility was 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 conducted reviews of the Living Options component of Section T. Since the Monitoring Team's last review, little had changed with regard to monitoring, and quality assurance efforts. Areas in which progress had been sustained included: ▪ Validity checks were being conducted between the QA Department auditor, and the Post-Move Monitor. This was a good attempt to ensure inter-rater reliability. 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. ▪ The Facility 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. ▪ The audits completed of the Living Options component identified significant issues related to, for example, the teams' identification of adequate, individualized supports and services. 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.	Noncompliance

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		▪ The Facility had continued to incorporate the data into its self-assessment. Areas in which continued efforts needed to be made included: ▪ As noted above, inter-rater reliability had not yet been established, nor had the accuracy of the monitoring data. ▪ 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. Facility staff recognized this and indicated that they were working on new/additional instructions for the tools. ▪ Analysis of the data, and development of appropriate corrective action plans had not yet occurred to the extent necessary. Although progress continued to be made in this area, the Facility recognized the need to fully 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 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	Activities at the Facility and State levels demonstrated progress towards substantial compliance with this provision item. The State issued the Annual Report: Obstacles to Transition Statewide Summary, Fiscal Year 2011, with data current as of 8/31/11. As noted in the Monitoring Team's previous report, based on review of the annual report, the Facility was beginning to gather data on the obstacles. However, this remained limited: ▪ Data for five fiscal years, 2007 through 2011, were reported in the new annual report. Data included number individuals who moved to the community, deaths, and discharges to other placements. Data also was provided for these timeframes on numbers of individuals referred for community placements, the number of rescinded referrals, community transitions, and numbers of individuals who returned from community transitions. ▪ Very limited data were included in the report regarding the types of obstacles identified (even though the data collection system was noted to be flawed), and the concerns of LARs and individuals that led to their preference to not be	Noncompliance

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	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.	referred. ▪ The data system only allowed one obstacle to be recorded per individual. This confounded the data. ▪ The data on the 69 individuals indicated that 27 (39%) were not referred due to LAR preference. The data system, however, did not indicate if this was the sole reason for non-referral, or if it was one of a number of obstacles. The CCSSLC report did not yet include an analysis of the overall data included in the report. ▪ As noted, data accuracy and validity needed to be improved. ▪ Assistance from the QA Department and State Office might be helpful in analyzing data once it is collected. ▪ For example, graphs of the data could be trended over successive months, and analysis could be completed. Facility staff's knowledge of the underlying issues could be helpful in identifying potential solutions to existing obstacles. The Facility's assessment report that was included in the State's overall report outlined the major concerns, and the Facility's initial plans to address each. These included: ▪ Questions regarding the reliability of the data collection were to be addressed through additional training of IDTs, as well as revision to the data form to assist in understanding, and facilitate data entry. ▪ A high level of individual and LAR reluctance was to be addressed through individualized action plans is ISPs, initiatives to improve the CLOIP process, and additional educational supports to individuals, families, and friends. ▪ The lack of Local Authority participation in individuals' meetings was to be addressed through further training of the QDDPs on how to address this issue. DADS took steps to overcome or reduce these obstacles. ▪ DADS created a report summarizing obstacles across the state, and included the Facility's report as an addendum/attachment to the report. The statewide report was dated October 2011. ▪ The statewide report listed the 13 obstacle areas used in FY11. DADS will be improving the way it categorizes and collects (and the way it has the Facilities collect) data regarding obstacles. ▪ DADS indicated actions that it would take to overcome or reduce these obstacles: o Eleven numbered items were listed. Five were related to the IDT process and upcoming changes to this process, three were related to working with local authorities and local agencies, two were related to improving provider capacity and competence, and two were related to funding initiatives regarding slot availability and the new community living	

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		specialist positions. In general, these were descriptions of the early steps of activities related to addressing obstacles to each individual living in the most integrated setting. o DADS did not, but should, include a description as to whether it determined it to be necessary, appropriate, and feasible to seek assistance from other state agencies (e.g., DARS). Since the last review, the Facility had continued to gather data related to obstacles. As discussed in detail with regard to Section T.1.b.1, concerns continued to exist with teams' accurate identification of obstacles. The Facility had developed its own data collection tool entitled: "Obstacles to Moving to a Community Setting." It set forth the various obstacle categories and subcategories in an easy-to-use format. However, based on review of individuals' ISPs, teams continued to struggle with understanding the potential obstacles, and selecting the appropriate ones, particularly the subcategories. As a result, the validity of the data was questionable. For example, in reviewing aggregate data for the quarters between 12/1/11 and 2/29/11, and 3/1/12 and 5/31/12, the "individual's lack of understanding of community living options" was the obstacle with the highest count. Based on a review of a limited number of reviews, it appeared that at times, teams identified this obstacle, even when for example, an individual's understanding of living options could not be and likely never could be assessed. As noted above, the Facility submitted monthly and quarterly aggregate totals of the obstacle categories State Office had identified. Based on interview, Facility staff indicated that education of individuals and their guardians had been identified as an area of need. However, they stated that formal analysis of all of the data was still in process. The Facility would soon be submitting its annual report to the State, which should include an analysis of data collected thus far. Improvements in data collection and analysis, implementation of new ISP processes, and actualization of the planned activities to overcome or reduce obstacles will be necessary for substantial compliance to be obtained.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the	In response to a document request, the Facility submitted to the Monitoring Team a Community Placement Report. For the time period between 11/16/11 and 5/31/12, the report listed: ▪ Current Referrals: Twelve individuals were included on this list, but one of these individuals had transitioned to the community since the report was issued. ▪ Community Placements: Six individuals were included on this list. As noted above, and additional person had transitioned in the weeks prior to the review. ▪ Rescinded Referrals: One individual was included on this list. The reason was	Substantial Compliance

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	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.	IDT decision: behavioral/psychiatric. 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 11/16/11 and 5/31/12, the report listed: ▪ Individual Prefers Community, Not Referred – LAR Choice: This list included seven individuals. ▪ Individual Prefers Community, Not Referred – Other Reasons: This list included nine individuals. One of these individuals had since been referred to the community. For the remaining eight individuals, for one, the LA was not present, which is a requirement for a referral being made (although this recently had changed as discussed with regard to Section T.1.a). In these cases, the teams reportedly were required to reconvene a meeting at which the LA could be present. It was unclear if this had occurred. For one other individual, the reason listed was "exploring community options. For one individual, citizenship/funding issue was the reason listed. For five individuals, behavior/psychiatric issues were listed. The Monitoring Panel asked that a final category be added that included 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. The Facility provided a separate list of two individuals that fell into this category. However, as noted above with regard to Section 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. This was not yet happening consistently. Therefore, it was unlikely that this data was yet reliable.	
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	<u>Timeliness of the Checklists</u> Post-move monitoring documentation was reviewed for four individuals (i.e., Individual #30, Individual #114, Individual #277, and Individual #151). 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 four individuals, 10 reviews should have been completed since the previous review. Of the 10 required visits, all (100%) had been	Noncompliance

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	three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool, consistent with the sample tool attached at Appendix C. Should the Facility monitoring indicate a deficiency in the provision of any support, the Facility shall use its best efforts to ensure such support is implemented, including, if indicated, notifying the appropriate MRA or regulatory agency.	documented as having been completed on time. In addition, monitoring visits were conducted at the various sites at which supports were provided. As applicable, the Post-Move Monitor appeared to have consistently visited individuals at their residential as well as their day/vocational sites. <u>Content of Checklists</u>: Since the last review, all of the post-move monitoring reports used the updated format, which was consistent with the format the Settlement Agreement required. In fact, the new format included some additional items from those included on the sample tool provided in Appendix C of the Settlement Agreement. The Post-Move Monitor reported and the Monitoring Team agrees that these additions enhanced the tool, and appeared to assist the Post-Move Monitor in reviewing important elements of the protections, supports, and services the community providers offered to individuals that had transitioned. The Facility continued to ensure that the methodology being used to confirm the existence of necessary protections, supports, and services was stated. The checklists reviewed generally were completed very thoroughly. At times, issues were noted that required follow-up. Some of these involved supports that had not been fully provided and/or issues that had arisen since the transition. Similar to the last review, the Monitoring Team's overall concern was the lack of adequate follow-up by teams at CCSSLC. Although the Post-Move Monitor appeared to identify issues and take action with provider agencies to remedy issues found, individuals' teams also were supposed to meet, review the reports, and take action or make recommendations, as appropriate. This piece did not appear to be solidly in place. In some instances, serious issues had occurred for individuals (e.g., Individual #114's call to the police threatening to kill himself), or the post-move monitoring activities identified potential misunderstandings on the part of the new home of the need to consistently provide identified supports (e.g., Individual #277 who required alarms on the doors for his and others' safety). As part of its document request, the Monitoring Team asked for any follow-up ISPAs or CLDP follow-up documentation. For Individual #114, the team met, but the team's response was not adequate. It did not appear that the team reviewed in any methodical way the behaviors, their functions, or whether or not the provider was implementing the SSLC BSP. Moreover, the provider had not obtained the required psychology review of the BSP, but the team did not appear to emphasize with the provider the importance of obtaining this support as soon as possible. For Individual #277, no evidence was submitted that the team had met. Certainly, the Facility had not used "its best efforts to ensure" supports were provided. Although progress continued to be made with regard to the post-move monitoring	

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		process, follow-up to the monitoring visits remained the biggest challenge for the Facility. This will require the efforts of individuals' IDTs, as well as the Admissions and Placement Office. The Facility remained out of compliance with this provision.	
T2b	The Monitor may review the accuracy of the Facility's monitoring of community placements by accompanying Facility staff during post-move monitoring visits of approximately 10% of the individuals who have moved into the community within the preceding 90-day period. The Monitor's reviews shall be solely for the purpose of evaluating the accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.	During the week of the onsite review, a member of the Monitoring Team accompanied the Post-Move Monitor on a post-move monitoring visit for Individual #30, including to his day program and home, as well as to an emergency relocation site. The Monitoring Team appreciates the Post-Move Monitor finalizing the report from the visit, because this provided the opportunity to compare the observations of the visit with the written report. As has been noted in the past, the Post-Move Monitor systematically reviewed the supports included in Individual #30's CLDP. She asked many good questions, conducted observations, and reviewed relevant documentation. During the course of the review, the Post-Move Monitor identified some serious issues, including that the water had been turned off in the home in which the individual was living due to nonpayment of the bill. The individual and his housemate had to move temporarily to a hotel. In order to ensure his safety, in addition to notifying the Local Authority's support coordination unit and DFPS, the Post-Move Monitor made an additional visit to the hotel that the provider identified as the emergency relocation site. Moreover, in addition to requesting an emergency meeting with the team at CCSSLC, the Post-Move Monitor made an additional visit to the individual's home the following day to confirm that the water had been restored. The Post-Move Monitor handled these issues professionally with community provider staff. These issues also were reflected in the written report. The report was thorough, and included a complete description of the evidence that the Post-Move Monitor had reviewed to draw her conclusions. Her conclusions appeared to be sound, and she documented the follow-up that would occur to address the outstanding issues identified. Due to the thorough and accurate post-move monitoring observed, the Facility has been found in substantial compliance with this provision. As has been discussed, maintaining substantial compliance will require the Post-Move Monitor to keep pace with the expanded responsibilities for monitoring that will occur once CLDPs are improved.	Substantial Compliance
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		

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	competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
T4	**Alternate Discharges -**		
	Notwithstanding the foregoing provisions of this Section T, the Facility will comply with CMS-required discharge planning procedures, rather than the provisions of Section T.1(c),(d), and (e), and T.2, for the following individuals: (a) individuals who move out of state; (b) individuals discharged at the expiration of an emergency admission; (c) individuals discharged at the expiration of an order for protective custody when no commitment hearing was held during the required 20-day timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order	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, one individual had transferred another SSLCs (i.e., Individual #264). Based on a review of the discharge summary completed for Individual #264, it 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, this summary did not "accurately describe the individual, including his/her strengths, needs, required services, social relationships and preferences" as required by the CMS guidelines [42 Code of Federal Regulations (CFR) §483.440(b)(5)(i), and W203]. In addition, the discharge plan 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." Each of the requirements of the CMS-required discharge planning process is discussed below: ▪ If an individual is either transferred or discharged, the Facility has documentation in the individual's record that the individual was transferred or discharged for good cause: Based on the information provided, in one out of one records reviewed (100%), good cause was identified in the discharge summaries (i.e., team's agreement, including his guardians, that he required a more structured environment, which the other Facility could offer). ▪ The Facility provided a reasonable time to prepare the individual and his or her parents or guardian for the transfer or discharge (except in emergencies): Based on the information provided, for none out of one individuals (0%), reasonable time was given to prepare. For the one individual, it was not clear from the	Noncompliance

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	vacating the commitment order.	information provided how much time was provided. ▪ At the time of the discharge, the Facility develops a final summary of the individual's developmental, behavioral, social, health and nutritional status: Although the final summary included each of these components, for none of the one individuals (0%) was the information adequate. Concerns included: o Adequate summaries were not provided of the individual's overall stay at CCSSLC. In fact, much of the information related to his prior placements, as opposed to a summary of what had occurred while he was at the Facility. o Incomplete historical and current status information was provided (e.g., significant lapses in information with regard to psychiatric information). o Generally, little information was provided about the supports the individual was receiving, and little analysis was provided regarding what supports had assisted the individual versus those that had not been effective to assist the receiving facility to develop an appropriate treatment plan. o The individual had significant psychiatric issues. A list was provided of his current medications and diagnoses. However, the summary provided inadequate information about attempts at CCSSLC to modify his medications, review his diagnoses, etc., and/or determine if the current psychiatric treatment was effective. ▪ With the consent of the individual, parents (if the client is a minor) or legal guardian, provides a copy to authorized persons and agencies: For none of the one individual (0%), CCSSLC provided documentation to show that a copy of the discharge summary and related assessments had been provided to the receiving Facility. ▪ The Facility provides a post-discharge plan of care that will assist the individual to adjust to the new living environment: Based on the narratives provided in the Referrals and/or Necessary Services Required in New Environment section, the IDT for none of the one individual (0%) adequately described the key supports that the individual would need in his new setting. This section of the support simply stated: "Prior to his transfer to [SSLC], [Individual] and his Guardian's (sic) were provided with an explanation of his impending transfer and an	

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		explanation of the reason for the transfer. A complete re-assessment of all needed supports/services will be conducted by the [SSLC] upon his arrival." The information included in the other sections of the summary was largely assessment information or narratives regarding incidents. Although some supports he was receiving were mixed into the narrative, a specific and comprehensive list was not included anywhere in the document. The Facility was not in compliance with this provision. This was 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. 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)
3. 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)
4. As teams begin to better define obstacles to movement, and begin to talk in greater depth about the options available in community settings to meet individuals' specific needs in comparison with services and supports available at the Facility, this discussion should be memorialized in the ISP to document that individuals and their families are making informed decisions with regard to an individual's living options. (Section T.1.b.1)
5. With regard to education opportunities:
    a. For the CLOIP process, outcomes/measures should be determined and/or data collected regarding the number of individuals, and families/LARs who agree to take new or additional actions regarding exploring community options, and the number of individuals and families/LARs who refuse to participate in the CLOIP process. Collection and review of such data should be completed to allow the State to evaluate the effects of the process and make changes made to future CLOIP activities.
    b. With regard to community tours, data should be analyzed to ensure that: a) all individuals have the opportunity to go on a tour (except those individuals and/or their LARs who state that they do not want to participate in tours); b) places chosen to visit are based on individual's specific preferences, needs, etc.; and 3) the individual's response to the tour is assessed.
    c. The Facility should develop a formal plan to address education on community living options to management staff, clinical staff, and direct support professionals.

d. The Facility should provide opportunities for individuals to visit friends who live in community;
e. If the analysis of aggregate data showed that families and guardians had similar concerns, then using mechanisms to provide information on specific topics should be used. For example, including articles in newsletters or offering specific educational seminars might be useful.
f. The Facility should provide education at: Self-advocacy meetings, as offered and invited; house meetings for the individuals; and family association meetings.
g. The Facility should add creative and individualized educational activities to meet the needs of various individuals and families/guardians, including action plans in individuals' ISPs designed to meet their specific needs. (Section T.1.b.2)

6. 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)
7. Essential and non-essential supports should be better defined in Community Living Discharge Plans. More specifically:
    a. The role of the Facility and community provider staff in the transition and discharge process should be defined better. This should include, but not be limited to defining:
        i. Which community provider staff need to complete which training (e.g., direct support professionals, management staff, clinicians, day and vocational staff, etc.), and/or for each component of training, what level of mastery of the information is required (e.g., demonstration of competence);
        ii. 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 PBSP, PNMP, etc. For some individuals, specific components of their ISPs should be targeted for more intensive training of community provider staff prior to the individual's transition (i.e., an essential support), or, at a minimum, evidence that the community provider staff have the competencies necessary to safely support the individual;
        iii. Collaboration between the Facility clinicians currently working with the individual and the community clinicians who will assume responsibility for supporting the individual (e.g., medical staff, nurses, therapists, psychologists, etc.);
        iv. Coordination between current and future residential or day/vocational staff;
        v. 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, Behavioral Services 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); and
        vi. The role CCSSLC staff or community provider staff might play in assisting the individual to make the transition;
    b. Due to the current inadequacies of the ISPs, teams should start at the beginning, and describe the full array of supports the individual needs and prefers. Once these are listed, the CLDPs should identify how the necessary supports will be provided in the community, by whom, when, with what frequency, and for how long. This can be accomplished by reviewing current assessments, which, as noted above, were inadequate, and then asking each team member what they do for the individual hourly, daily, weekly, monthly, quarterly, and annually. Based on this knowledge, the foundation for the CLDP could be built;
    c. With regard to clinical services, the CLDPs should define the intensity of the supports, as well as the qualifications, and the roles of clinicians;
    d. Clinical supports that CCSSLC is providing should be included in the CLDPs, or adequate justification for not identifying a functionally equivalent support should be documented in the CLDP;
    e. For individuals whose teams identify them as being at-risk, CLDPs should be of adequate clinical intensity to address the level of risk. Specifically, the action plans included in CLDPs for such individuals should include supports and services of adequate intensity to ensure the individuals' wellbeing to the extent possible;

f. In removing any support that the individual utilized at the Facility from the array of supports that will be provided in the community, teams should justify why the support is not needed in the community;
g. Teams should factor in modifications that need to be made to current programs or plans, and write such modifications into the essential or nonessential supports;
h. As appropriate, teams should identify as an essential or nonessential support the implementation of current plans (e.g., nursing care plans, health management plans, PNMPs, diets, exercise programs, etc.). As necessary, modifications might need to be made to the methodology for providing these supports, with the end result being the individual's need for the support being met;
i. For individuals who have specific health care indicators that require monitoring (e.g., seizures, weight, aspiration triggers, etc.), teams should include supports in the CLDPs to ensure that specific staff are responsible for monitoring such indicators, and when specific criteria were met, reporting these to health care staff;
j. As appropriate, crisis intervention plans should be developed, and/or essential and non-essential supports should define how the current methods for dealing with crises at the Facility should be modified in a community setting;
k. Direct support staffing ratios and requirements should be specified. In specifying staffing supports, teams should identify specifically the individual's staffing needs in relation to others supported in the home or day/vocational program (e.g., if an individual requires line-of-sight supervision, and other individuals live in the home, the team should consider this in describing an appropriate ratio), as well as in different situations (e.g., in the home, in the community, at a day or work site, at night, etc.), as well as the qualifications of staff (e.g., specific training requirements for staff, competencies or certifications needed, etc.);
l. Recommendations in assessments should be addressed specifically in CLDPs (e.g., SPL, and OT/PT therapy recommendations, adherence to weight reduction programs, etc.), and justification provided for any recommendation not included as an essential or non-essential support;
m. As recommended previously, CLDPs should clearly identify any action steps that have been begun at the Facility, but need to be completed once an individual transitions to the community;
n. Particular attention needs to be given to adequately defining day and vocational supports. Just like residential supports, day/vocational supports should be defined with specificity, including staffing requirements, a schedule that addresses the needs and preferences of the individual, the type of training that should be provided, identification of any ancillary supports that need to be provided at the day/vocational site, such as behavioral or other therapy supports, etc. Supports that need to be provided across day and vocational programs, as well as residential programs (e.g., nursing, psychology, therapy, etc.) should included as part of the day/vocational component;
o. For individuals with complex behavioral or medical needs, community supports adequate to meet their needs should be available upon their transition (e.g., involvement of the community psychologist, psychiatrist, neurologist, etc.), and teams should include dates that meet the individuals' needs. If the conversion of Medicaid from institutional to community is a barrier to the provision of supports, teams should identify this as an obstacle; and
p. Focused effort should be placed on ensuring each of the supports identified is measurable. (Sections T.1.c.1 and T.1.e)

8. In addition to addressing recommendations related to assessments in other sections of this report to improve the overall quality of assessments used in developing CLDPs, modifications should be made to assessments to:
   a. Provide a summary of relevant facts related to individuals' stays at the Facility. Although it is understandable that an individual's full history cannot be included in a discharge summary, it is important that the Facility provide community providers with a summary of, for example, treatments or plans that have particularly successful or unsuccessful, and important milestones during the individual's stay at the Facility;
   b. Assist teams in developing a comprehensive list of protections, supports, and services in a community setting. Assessments should describe or recommend the protections, treatments, and supports that an individual requires (e.g., implementation of plans, staffing supports, training for staff, specific staff qualifications, etc.), as well as the specific clinical supports required (i.e., qualifications of

clinical staff, the frequency and level of their involvement, etc.); and

c. Identify supports that might need to be provided differently or modified in a community setting, and/or make specific recommendations about how to account for these differences. (Section T.1.d)

9. A process should be considered, particularly with regard to the transition of medical and other clinical information, for a summary to be developed, including but not limited to the individual's current status, any outstanding issues (e.g., tests due, issues for which resolution has not been reached), as well as any critical information about the individual's treatment (e.g., allergies, past history of medication use, etc.). This should be comprehensive, and not just include general medical information, but also specialists' involvement with individuals. This would facilitate the transition of this information to community medical care providers. (Section T.1.d)
10. 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., are transferred to a mental health hospital after transitioning to the community), whose community transitions are in jeopardy, or who experience other serious negative outcomes. (Section T.1.c and T.1.e)
11. 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)
12. 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	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Presentation Book for Section U; o Copies of letters sent to primary correspondents, current Legally Authorized Representatives (LARs), and previous guardians for whom letters of guardianship had expired, dated May 1, 2012; o CCSSLC policies, including: ▪ Corpus Christi State Supported Living Center – Statewide Policy and Procedures, Policy #057 – Self-Advocacy, dated 5/30/12; ▪ Policy #UU.9 – Rights and Protection Complaint Resolution, implementation date 3/9/12; ▪ Policy UU.11 – Review of Restrictive Behavior Support Plans and Crisis Intervention Plans by the Human Rights Committee (HRC), implementation date 5/1/12; ▪ Policy UU.12 – Review of Psychotropic Medications, Pre-Sedation and Sedations for Medical Appointments by the HRC, implementation date 5/1/12; ▪ Corpus Christi State Supported Living Center – Statewide Policy and Procedures, Policy #019, – Guardianship, dated 3/7/12; o ISP Addendum template related to prioritization of the need for a guardian, undated; o Sample completed ISP Addendum related to prioritization of the need for a guardian, undated; o CCSSLC prioritized list of individuals lacking both functional capacity to render a decision, and Legally Authorized Representative (LAR) to render such a decision, undated; o List of one individual for whom an advocate had been obtained; o Consent Monthly Report for April 2012; o Report on Missing Guardianship Letters, dated 7/12/12; o Self-Assessment for Section U; o Settlement Agreement Cross Referenced with ICF/MR Standards Section U – Consent monitoring tool; o Provision Action Information for Section U; o Action Plans for Section U; o Texas Guardianship Statute - Probate Code, Chapter XIII. Guardianship, Sections 601 through 700; o Texas Health and Safety Code, Title 7. Mental Health and Mental Retardation, Subtitle D. Persons with Mental Retardation Act, Chapter 591. General Provisions, Subchapter A. General Provisions, Section 591.006. Consent; o Texas Health and Safety Code, Title 7. Mental Health and Mental Retardation, Subtitle B. State Facilities, Chapter 551. General Provisions, Subchapter C. Powers and Duties Relating to Patient Care, Section 551.041. Medical and Dental Care; and o Texas Health and Safety Code, Title 7. Mental Health and Mental Retardation, Subtitle D.

	Persons with Mental Retardation Act, Chapter 592. Rights of Persons with Mental Retardation, Subchapter A. General Provisions, Section 592.054. Duties of Superintendent or Director. ▪ **Interviews with**: o Karen Forrester, Human Rights Officer (HRO); and o Karen Ryder, Program Compliance Monitor.
	Facility Self-Assessment: In its Self-Assessment, the Facility recognized that it was not in compliance with the requirements of Section U. Since the last review, the Facility had incorporated some record reviews into its self-assessment process. However, much of the data included in the Self-Assessment related to other sections of the Settlement Agreement. For example, some of the requirements related to the Human Rights Committee's review of psychotropic medication were included in this section. These would be reported on more appropriately with regard to Section J of the Settlement Agreement. Other concerns related to the Self-Assessment included: ▪ For Section U.1, reviews reportedly were being conducted of "263 ISPAs (for all individuals) to determine if Guardianship Policy was followed insofar as Guardianship Priority determination." Although this activity had not yet been completed, it was unclear what criteria the assessors would use to determine if the policy requirements had been met. ▪ Once State Office issues procedures for formally assessing individuals and pursing guardianship or other decision-making resources, then the self-assessment process will need to be modified. For example, it will be important for the Facility to conduct audits to ensure that teams are correctly identifying individuals who might need guardians or other assistance in making decisions, that individuals are appropriately prioritized on the list, and that adequate efforts are being made to identify needed supports. ▪ For Section U.2, the assessment mainly related to reviewing letters that had been sent out to current guardians and/or involved family members. Although this was an important activity, moving forward, assessment of Section U.2 will need to be broader, including assessment of whether or not the Facility as a whole and individuals' teams are making "reasonable efforts to obtain LARs for individuals lacking LARs." Based on interviews with staff, since the last review, a Program Compliance Monitor had been assigned to Section U. The Program Compliance Monitor and Human Rights Officer had used the Settlement Agreement Cross Referenced with ICF/MR monitoring tool for Section U to conduct joint reviews in February and March. Inter-rater reliability measurements in March and April were 46% and 58%, respectively. A breakdown was provided by question. Reportedly, the two staff were now working together to develop better guidelines for the tool to help to improve inter-rater reliability. This was a positive effort. Once the consent policy is established, it should be paired with further competency-based training from State Office to ensure the validity as well as reliability of monitoring results across Facilities for Section U.
	Summary of Monitor's Assessment: At the time of the review, the State Office Guardianship Policy had been disseminated, but the policy on consent remained in the development phase. CCSSLC had adopted the

	State Office policy and had begun to implement portions of the policy. Although teams at the Facility had completed Individual Support Plan Addenda to identify individuals' priority level for obtaining a guardian, a number of concerns were noted with the process. As a threshold issue, prioritizing an individual's need for guardianship cannot be done adequately until a process is in place to screen for an individual's need for a guardian. 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. Although problems were noted with the process the Facility used, CCSSLC generated a prioritized list of individuals needing guardians. It included a total of 263 names. Of these, 167 individuals were identified as adults with no guardians, but needing guardians, including 43 at high need, 102 at medium need, and 22 at low need for a guardian. There were 96 individuals identified as having no need for a guardian. Since the last review, no guardians had been identified for individuals who needed them. CCSSLC had made efforts to identify potential guardianship resources. Since the last review, one such effort included sending letters to involved family members to inquire about their interest in pursuing guardianship, as well as current guardians to determine if they would consider becoming guardian for someone else. However, 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. On a positive note, as noted in the last report, the Facility was implementing an advocacy program. This involved the recruitment of volunteers to serve as individuals' advocates. Advocates had been identified for two individuals. This potentially provided a resource to assist individuals in decision-making that was less restrictive than guardianship. The Facility should be commended for its efforts in this regard. CCSSLC also continued to provide support to the Self-Advocacy Group. Some of their activities involved assisting individuals to learn about their rights as well as decision-making.

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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	Since the Monitoring Team's last review, DADS State Office had issued Policy #019: Guardianship, dated 3/7/12. Based on interview with Facility staff and document review, CCSSLC had adopted the State Office policy and had begun to implement portions of the policy. As is discussed in further detail below, although some concerns were noted, teams at the Facility had completed Individual Support Plan Addenda to identify individuals' priority level for obtaining a guardian. A second policy on consent reportedly was in development. Since the last review, because CCSSLC was awaiting further guidance through State Office policy, limited progress had been made with regard to consent and guardianship. The State is	Noncompliance

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	LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	encouraged to finalize the consent policy, because it should assist the Facilities in moving forward with regard to the implementation of the Section U Settlement Agreement requirements. As noted above, since the issuance of the State Office policy, CCSSLC teams had met to review all individuals the Facility supported and determine their guardianship priority level. A workgroup had developed an ISP addendum template that teams used to structure and document their discussions. The template essentially repeated in question format the criteria included in the Settlement Agreement and State policy in relation to factors that might prioritize one individual's need for a guardian over another individual's need. Based on review of documentation provided, a number of problems were noted with regard to the implementation of the process: ▪ Based on the few completed ISPAs the Facility provided, it did not appear that the full team, including the individual, was involved in the decision-making review process. For example, for Individual #283 and Individual #182, according to the sign-in sheets, only the QDDP, nurse, and psychologist were present at the meetings. For Individual #307, the sign-in sheet was blank. Given that teams reviewed 263 individuals in eight days, it was unclear how the appropriate members of individuals' teams could have been present for the discussions. ▪ A missing component from this process was the adequate screening and/or assessment of individuals "functional capacity to render a decision regarding the individual's health or welfare." The first factor the team was to consider if an individual did not have a guardian read: "Does the person have a <u>limited</u> ability to express their own wishes or make determinations regarding their own health and welfare?" However, no tool was provided to assist teams in making this determination, and limited criteria were included on the form (i.e., "consider IDD level of moderate/severe or profound, moderate to severe communication status"). Without some further guidance, teams likely will use inconsistent criteria to make their decisions. It is the Monitoring Team's understanding that the State Office policy on Consent will provide further guidance. However, until that time, teams' ability to assess individuals' functional capacity is limited. ▪ In addition, because this initial factor (i.e., an individual's "ability to express their own wishes or make determinations regarding their own health and welfare") was weighted the same as the other three factors discussed below, it appeared that an individual might have no ability to communicate his/her wishes and no ability to make a determination about his/her health or welfare, but if none of the other factors were present, he/she would not be placed on the prioritized list for guardianship. ▪ The narratives included in the ISPAs addressing each of the four questions used to assist in prioritizing an individual's need for a guardian varied considerably in	

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		detail and quality. For the questions related to restrictive programming, frequency of decision-making, and "active" family involvement, similar to what is discussed above, limited criteria or guidelines were included to assist teams in objectively quantifying their decisions. For example, active family involvement was defined as involvement once a year, but the quality of such involvement was not defined; some example of restrictive programming were included on the template, but it was not clear if this was meant to be a comprehensive list; and although "3+" was identified for the criterion for frequent decision-making, it was unclear if the list of types of decisions to be included was meant to be all-inclusive. This lack of detailed guidance appeared to confuse teams. For example, "No" was marked for Individual #307 for the question about frequency of decisions requiring consent. However, the narrative noted: "Diet, Finance, wheelchair with a seatbelt, and a bed with bedrails and bedrail padding." It was unclear if this constituted four decisions, and/or whether or not the team had considered decisions related to healthcare, routine consents that had been signed, etc. ▪ During the interview with staff as well as in reviewing the sample ISP addendum related to prioritization of the need for a guardian, it was noted that if an individual had an advocate through the Protection and Advocacy agency, they were not placed on the priority list for guardianship, even if they met the other criteria. It was not clear how this decision was made. This practice was not described in the State Office policy. In addition, the Protection and Advocacy agency has no authority to make decisions on an individual's behalf. Therefore, if an individual requires a guardian (i.e., lacks functional decision-making capacity), regardless of whether or not they have an advocate, they should be placed on the prioritized list in alignment with the other factors the Settlement Agreement details. Based on this process, CCSSLC generated a prioritized list. It included a total of 263 names. Of these, 167 individuals were identified as adults with no guardians, but needing guardians, including 43 at high need, 102 at medium need, and 22 at low need for a guardian. There were 96 individuals identified as having no need for a guardian Although the new policy set forth a process for prioritizing an individual's need for guardianship, this cannot be done adequately until a process is in place to screen for an individual's need for a guardian. As noted above, a process had not yet been set forth to screen or assess an individual's functional decision-making capacity. Once the State Office policy is finalized, CCSSLC should review and revise, as necessary, its policies as well as the prioritized list. As noted previously, this will take considerable effort. Based on the Monitoring Team's review of ISPs, although teams often identified that	

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		individuals did not have guardians and had difficulty with decision-making, the discussion appeared limited. In the ISPs reviewed, teams made no delineation of an individual's priority need for a surrogate decision-maker, and little planning appeared to occur in relation to alternatives to guardianship or identifying potential guardians. More specifically, in reviewing 10 ISPs and related addenda, which are identified in the documents reviewed section, the following was found: ▪ Six of 10 (60%) had a guardian appointed. ▪ Two of the remaining four (50%) (i.e., Individual #250 and Individual #228) had ISPs or ISPAs that included a discussion of the individual's need for a guardian. As Facility staff pointed out, although the Rights Assessments were generally being completed, little connection was found between them and the ISPs. ▪ None of four (0%) included an adequate assessment of the individual's "functional capacity to render a decision regarding the individual's health or welfare." It is important to note that the teams' discussions were not informed through the completion of a valid screening or assessment process to assist them in identifying individuals' capacity to make decisions, including different types of decisions, and/or to think through some of the supports that might increase individuals' decision-making capacity. No discussion was documented of whether or not the team would recommend limited guardianship, or if other supports could be provided to the individuals to assist them in maintaining some of all of their ability to make decisions for themselves. ▪ Two of four (50%) (i.e., Individual #250 and Individual #228) had ISPAs that included a discussion of the individual's priority factors for needing a guardian. However, even for these two, concerns were noted with regard to the adequacy of these discussions, and particularly, the objective criteria the teams used. For example, although multiple restrictive practices were noted for Individual #250, her team did not identify her as having comparatively frequent needs for decision-making." As noted while the Monitoring Team was on site, it will be important for the Facility's monitoring and self-assessment activities to evaluate the quality of teams' activities related to assessment of individuals' functional capacity, identification of viable options to assist individuals with decision-making, and prioritization of individuals' needs for guardianship. 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 he/she is able to make informed decisions as well as those areas in which he/she cannot make such decisions. Further, it is important for such assessments to	

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		identify if there are supports or resources that could enable an individual to make informed decisions, or increase their capacity to make such decisions. As noted in previous reports, the Social Supports Questionnaire the Facility had developed 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. However, it appeared use of this form had been discontinued. As noted in the Monitoring Team's previous report, the DADS Guardianship Program had provided Facility staff with training on the various guardianship options, as well as alternatives to guardianship. This had occurred in December 2011. Based on staff report, the training was helpful in educating staff about the restrictiveness of guardianship, as well as some of the alternatives. As noted in the Monitoring Team's previous report, the Facility had begun to implement an advocacy program. This involved the recruitment of volunteers to serve as individuals' advocates. Since the time the program had been operational, advocates had been identified for two individuals, and another potential match was being considered. This potentially provided a resource to assist individuals in decision-making that was less restrictive than guardianship. The Facility should be commended for its efforts in this regard. The Human Rights Officer was an advisor to the Self-Advocacy Group. Some of their activities related to expanding individuals' knowledge of their rights, as well as consent-related issues. For example, some topics included discussions of pros and cons of certain decisions, such as decisions related to diet restrictions. Such efforts to provide education should assist some individuals to expand their decision-making capacity. As discussed, it will be important to expand these efforts, and for teams to individualize them. These include, but are not limited to developing information in formats that are more easily understood, including utilizing simpler language, or formats with pictures; expanding individuals' knowledge about options available (e.g., making informed decisions about jobs or places to live might require individuals to see and experience the different options, or making a decision about inclusion of personal information in an article in the newsletter might require someone to see the newsletter and/or some of the places to which it is distributed); and identifying specific staffing supports to assist an individual to interpret information (e.g., sign interpreters, someone to read and explain information in a user-friendly manner, etc.). Although some limited progress had been made, the Facility remained out of compliance with this component of the Settlement Agreement. The Facility had a prioritized list, but an adequate standardized process for determining individuals' functional capacity to render informed decisions still was not being used. In addition, although teams were	

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		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 on consent 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 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.	Based on interviews with Facility staff and review of documentation, since the last review, no guardians had been identified for individuals who needed them. As noted in the Monitoring Team's previous reports, the Human Rights Officer had engaged in some efforts to identify potential guardianship resources, including contacting a couple of the other SSLCs to discuss their efforts in recruiting guardians, and some private entities that might have resources. 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. Since the last review, the Facility also had sent letters to all of the individuals' primary correspondents and/or guardians. For those individuals with guardians, the letter inquired about their willingness to consider becoming guardian for someone else at the Facility. For those individuals with lapsed guardianship letters, the letter requested updated documentation. For individuals without guardians, but with involved family members, the letters included some information about the importance of guardianship, and inquired about the family member's interest in pursuing guardianship. Although the letters generated a number of telephone calls, at the time of the review, they had not resulted in any new guardians for individuals. Based on samples reviewed, the Human Rights Officer was tracking all related contact through the Integrated Progress Notes. Other plans included the Human Rights Officer presenting at an upcoming Family Association Meeting. In addition, the Self-Advocacy Group and Human Rights Officer planned to have a booth at the upcoming Provider Fair. Guardianship and consent information would be provided in these venues. As indicated in the Monitoring Team's last report, the Human Rights Officer also had reinitiated her involvement with a volunteer surrogate decision-making program that offered supports to individuals living in community-based ICFs/DD that did not have guardians. Given the potential connections that such a volunteer position could offer, this was a valuable endeavor. Although it appeared from the training materials that this was a legislated process that specifically excluded individuals at SSLCs, it raised the question of whether or not it would be a valuable process to pursue for individuals at the SSLCs.	Noncompliance

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		CCSSLC had not yet implemented the portion of the State Office Guardianship policy that required development and operation of a Guardianship Committee. As discussed while the Monitoring Team was on site, this would be an important initiative to begin to develop. Such a group, if properly constituted, might be helpful in identifying resources related to alternatives to guardianship, potential guardians, as well as funding to support individuals for whom the guardianship fees prohibit them from applying to become a guardian. In addition, continued collaboration with the other SSLCs will be essential. For example, as discussed, another Facility had identified a potential funding source through the "applied income" option available for individuals eligible for Supplemental Security Income. As noted above, the current list of individuals requiring guardians included 169 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. 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 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. 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. (Section U.1)

2. Once the State policy is finalized, the State should provide key Facility staff with training on its implementation. (Section U.1)
3. Once the State policy is finalized, CCSSLC should develop and/or revise its policies related to consent to reflect the State policy. (Section U.1)
4. Once the State identifies the tools and processes to be used to assess individuals' decision-making capacity, teams should screen/assess all individuals served by the Facility. (Section U.1)
5. Based on its monitoring activities, the Facility should identify areas in which teams require further guidance regarding their responses to the questions related to prioritizing an individual's need for a guardian. As appropriate, additional guidance should be developed and provided to teams with a goal of increasing consistency between teams. (Section U.1)
6. If an individual requires a guardian (i.e., lacks functional decision-making capacity), regardless of whether or not they have an advocate, they should be placed on the prioritized list in alignment with the other factors the Settlement Agreement details. (Section U.1)
7. Efforts should be made to identify other supports that might assist individuals to make decisions. These include, but are not limited to developing information in formats that are more easily understood, including utilizing simpler language, or formats with pictures; expanding individuals' knowledge about options available (e.g., making informed decisions about jobs or places to live might require individuals to see and experience the different options, or making a decision about inclusion of personal information in an article in the newsletter might require someone to see the newsletter and/or some of the places to which it is distributed); and identifying specific staffing supports to assist an individual to interpret information (e.g., sign interpreters, someone to read and explain information in a user-friendly manner, etc.). (Section U.1)
8. As State Office policy requires, the Facility should develop a Guardianship Committee to assist it in its efforts related to developing alternatives to guardianship, identifying guardians, and securing funding for guardianship. (Section U.2)
9. 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 U.2)
10. As the processes for assessing individuals' capacities to make decisions are implemented, it will be important for the Facility to conduct audits to ensure that teams are correctly identifying individuals who might need guardians or other assistance in making decisions, that individuals are appropriately prioritized on the list, and that adequate efforts are being made to identify needed supports. In addition to providing statistics and narrative descriptions of activities, the Self-Assessment should include analyses of the audit results. (Facility Self-Assessment)
11. In addition to the Facility's efforts to develop better guidelines for the audit tool, once the consent policy is established, State Office should provide further competency-based training to ensure the validity as well as reliability of monitoring results across Facilities for Section U. (Facility Self-Assessment)

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Note related to CCSSLC Policies – Section V, related to record keeping, indicating no changes since last review; o CCSSLC Filing and Retention Schedule, revised 10/1/11; o List of Persons Responsible for Management of Records; o Description of Quality Assurance Procedures, effective March 2012; o Plans of correction resulting from record audits for last three months: "No Evidence;" o Master Record Order and Guidelines: Historical Records, revised 11/19/10; o Master Record Order and Guidelines: Inactive Records, dated 3/10/11; o Active Record Order and Guideline, revised 12/12/11; o Individual Notebook: Guidelines and Retention Schedule, revised 5/21/11; o Master Table of Contents of Policy and Procedure, dated 3/15/12; o Policy Tracking FY 2012; o Quality Assurance Checklists completed for last 10 records reviewed by Facility staff; o Samples of training materials and documentation of completion of training on recently approved policies; o For the last three months, trending reports for Section V reviewed at monthly QA meetings with Records Department staff; and o Presentation Book for Section V. ▪ **Interviews with**: o Elena Menchaca, Unified Records Coordinator; o Lily Rodriguez, Unified Records Coordinator; o Edesiri Onovughe, Medical Records Coordinator; and o Blanca Goans, Administrative Program Specialist.
	Facility Self-Assessment: Based on a review of the Facility's Self-Assessment with regard to Section V of the Settlement Agreement, the Facility found that it was out of compliance with all of the subsections. This was consistent with the Monitoring Team's findings. In its Self-Assessment, the Facility had identified: 1) activities engaged in to conduct the self-assessment; 2) the results of the self-assessment; and 3) a self-rating using the information cited in the section on results. A number of the indicators included in the Facility Self-Assessment for Section V had merit. Since the Monitoring Team's last review, the QA Department's role in auditing had been defined. This was a positive addition. Although a number of concerns continued to exist with the Facility's self assessment process, over time, this format should be helpful in substantiating the Facility's findings with regard to compliance. The following concerns were noted:

	▪ Selected results of the Facility's regular record audits should be included in Section V.1 to provide information about the adequacy of individuals' active and master records, and their individual notebooks. ▪ As the Facility identified, now that a process is available for tracking training on new policies, the Facility's Self-Assessment should review this data. ▪ With regard to Section V.3, the Facility should assess if it is completing the required record reviews, but also if analyses of the data are being used to improve the system. The Facility had added data about the individual record follow-up and correction process. This was very positive. Additional information should be provided about the systemic issues identified and addressed. ▪ With regard to Section V.4, it will be important for the Facility to incorporate the topics the parties agreed upon, and are now incorporated into the Monitoring Teams' reports. ▪ Inter-rater reliability will need to be established with the QA and programmatic staff responsible for conducting audits. ▪ The data presented clearly identified areas of need. However, the Facility Self-Assessment did not yet provide any analysis of the information, identifying, for example, potential causes for the issues, or connecting the findings to portions of the Facility's Action Plans to illustrate what actions the Facility had put in place to address the negative findings. Overall, the Facility had demonstrated that it was beginning to incorporate some of the data it had collected into its self-assessment process. Efforts to ensure the validity and reliability of the data will be important next steps, as will using the data to identify areas in which focused attention is needed. The Facility's progress in developing a quality assurance process for Section V is discussed in further detail below with regard to Section V.3.
	Summary of Monitor's Assessment: CCSSLC continued to maintain Active Records as well as Individual Notebooks. Facility staff also continued to work to convert individuals' historical files to the Master Record format State Office issued. A significant amount of historical information had been sent to an outside vendor to maintain. The Facility continued to use 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. As is discussed throughout this report, policies and procedures necessary to implement the Settlement Agreement were in various stages of development. At the time of the last review, the Facility had developed systems to track draft policies through to finalization. Since the last review, the Facility had begun to use the system it had designed to track the training of staff on new or revised policies. A pilot project to maintain copies of updated policy manuals in various program and administrative locations also had been completed and was being rolled out across campus. CCSSLC was conducting reviews of more than the required five records each month. A Program Compliance Monitor from the QA Department also had been assigned. Efforts were being made to revise

	the tools and develop guidelines to improve the reliability and validity of the monitoring results. The processes for identifying trends that needed to be addressed and putting plans in place to address problematic trends remained in the beginning stages of development. However, the Records Department continued to use its knowledge of problems with the records to work with some of the other departments on areas of need. For example, the Day Program Director was beginning to implement a plan to monitor skill acquisition data to identify missing data. The Chief Nurse Executive also had created a system to monitor nursing staff's entries into the Integrated Progress Notes.

#	Provision	Assessment of Status	Compliance
V1	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall establish and maintain a unified record for each individual consistent with the guidelines in Appendix D.	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 reports, all individuals' Active Records had been converted to the new Table of Contents. Since that time, the State Office had issued revisions to the Table of Contents, and changes had been made in the active records across campus. File Clerks continued to have responsibility for maintaining the Active Records, for the most part. However, some exceptions had been made to this. Some of these distinctions were described in the previous report. 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. The final phase of the process involved the conversion of individuals' historical files to the Master Record format State Office issued. Based on interview with staff, since the last review, progress continued to be made. The Medical Records Coordinator was overseeing the conversion of records. In addition, information that could be stored offsite had been prepared and sent to a secure warehouse from which retrieval was readily available should there be a need for the records. Similar to the previous review, from a limited review of records while on site, it was noted that very few documents were missing from the records. In the past, issues had been noted with regard to Nursing Quarterly Assessments, Nursing Annual Assessments, and Nursing Health Management Plans, but during this review, they were generally found in the records. Of note, a number of records (e.g., restraint records, PBSPs, etc.) were missing from the Monitoring Team's document requests, but it was unclear if this was due to the fact that they did not exist, or they were not filed properly. As noted in the last report, one of the mechanisms that seemed to have had a positive	Noncompliance

#	Provision	Assessment of Status	Compliance
		effect was the implementation of the Active Records Document 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. This was an electronic system, which allowed functions such as auto-populating fields, and linking references to documents to their electronic version. It also allowed tracking and trending to be completed more easily. As noted in the Monitoring Team's past two reports, 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 medical appointments or an ISP meeting. This policy addressed an essential component of maintaining control over the security of the records. 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. It will be important for the Facility to use its monitoring results to identify any areas in which the records might not meet the requirements of Appendix D of the Settlement Agreement, and take action, as appropriate, to correct them.	
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. As noted in the Monitoring Team's last report, the Facility had developed systems to track draft policies through to finalization. At that time, a process also recently had begun to track the training of staff on new or revised policies. Since then, the process had been used to track training on new and revised policies. Based on a review of a sample of policies and the related training, the tracking process seemed to capture the essential elements, included who needed to be trained, who would provide the training, who completed the training, and the curriculum used. Based on interviews with staff, the Competency Training Department was maintaining the data, so that it could be easily determined who had completed the training and who still needed to complete it. Since the Monitoring Team's last review, this process had been formalized in policy. As an attachment, Policy A.13 included a format for following and documenting the process described above. The QA/QI Committee was involved in decision-making about which staff required training. The Administrative Program Specialist was using these forms to follow-up to ensure that training identified as being necessary was provided to all staff for whom training was required. Plans also were underway to improve access to policies for all staff. By creating hyperlinks to the electronic versions of policies, the Administrative Program Specialist	Noncompliance

#	Provision	Assessment of Status	Compliance
		had made it possible for those with regular computer access to have a quick method to find specific policies. A process also had been piloted for making paper copies available in programmatic and administrative areas. The pilot had been successful, and a timeline was provided for rolling this process out across campus. The Facility was making progress in updating and/or developing policies to address the various requirements of the Settlement Agreement. However, it was not yet in compliance with this provision. In addition to continuing to develop and revise policies in concert with the issuance of State Office policies, the Facility also should continue to ensure that staff that require training on the policies complete the training adequate to facilitate the policies' implementation.	
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.	Progress had been made and/or sustained with this provision of the Settlement Agreement. Positive developments included: ▪ The Unified Records Coordinators were conducting record reviews. ▪ Based on the documentation provided, it appeared that more than five reviews were being conducted each month. Based on interview, a total of 10 record audits were done each month. ▪ Since the last review, a Program Compliance Monitor had been assigned from the QA Department. In April 2012, record reviews were conducted to try to establish inter-rater reliability. The Program Compliance Monitor and Unified Records Coordinators had begun the process of writing instructions for the tools to improve the reliability and validity of the findings. ▪ The Program Compliance Monitor had begun to select the records for review. ▪ To conduct the audits, the monitors were completing the Active Record Order Guidelines Audit Tool, and then the information collected was used to complete the monitoring tool entitled "Settlement Agreement Cross Referenced with ICF/MR Standards – Section V: Recordkeeping and General Plan Implementation, Provisions 1, 3, and 4." ▪ In addition, an individual's team for one record review each months was selected for completion of the State Office's interview tool designed to solicit information specifically about Section V.4, which requires the Facility to routinely utilize individuals' records in making care, medical treatment and training decisions. ▪ Issues identified through the monitoring process with regard to individual records were addressed with the specific File Clerks. Individualized training or technical assistance was provided. In addition, emails were sent requesting corrections, if other departments were involved. Since the Monitoring Team's last review, the Facility continued the process of checking to determine if corrections had been made. Based on interview, at times, second emails had to be sent, because requested corrections had not been made.	Noncompliance

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		Areas in which improvements should be made in order to achieve compliance, included: ▪ It is important to note that based on knowledge gained from internal auditing and surveys, as well as information that the Monitoring Team provided, the Facility had taken steps to correct issues. For example, the Day Program Director was beginning to implement a plan to monitor skill acquisition data to identify missing data. The Chief Nurse Executive also had created a system to monitor nursing staff's entries into the Integrated Progress Notes with the intention of identifying and correcting any problematic areas. However, no evidence was presented to show that the audit data had been analyzed thoroughly to identify trends and determine the other underlying issues, and/or action plans developed to address such issues. The Facility recognized that this was the next step in the process. Since the last review, the Records Department staff had begun to meet with the Program Compliance Monitor to discuss monitoring results, and had spoken to the Data Analyst to seek assistance in aggregating the data and producing reports. At the Monitoring Team's request, the Facility submitted some reports that showed the breakdown in data for Section V. The most helpful of this information was broken down by question, as opposed to the graphs that provided overall compliance scores that were difficult to interpret in any meaningful way. ▪ 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. Although the Facility continued to complete some of the tasks that required with regard to this provision of the Settlement Agreement, CCSSLC had not begun to aggregate and analyze results of monitoring data, and/or develop, and implement actions necessary to correct deficiencies identified systemically. The Facility remained out of compliance with this provision. The Facility also was still in the process of finalizing instructions for monitoring tools, and establishing inter-rater reliability.	
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	Recently, the Monitors and the parties agreed to a list of actions that the SSLCs would engage in to demonstrate substantial compliance with this provision item. CCSSLC had not incorporated this structure into their internal monitoring. The following represent the Monitoring Team's findings: ▪ **Records are accessible to staff, clinicians, and others**: Although CCSSLC was not yet self-assessing this, the Monitoring Team observed that:	Noncompliance

#	Provision	Assessment of Status	Compliance
	decisions.	o On a positive note, in an effort to ensure accessibility of certain documents that teams needed to develop ISPs and engage in related activities, Personal Folders for each individual were maintained on the shared drive. o As noted in the Monitoring Team's last report, to address issues related to the timely filing of information needed to make decisions, CCSSLC had developed a process to track the submission and timely filing of information in the Active Record. The impact of this policy and the related efforts appeared to have been significant. This process appeared to have improved the accountability for the timely filing of documents in the records. However, as the Facility's monitoring activities showed, some issues continued to exist with the timely availability of documents in Active Records. The new system was helpful in identifying where problems had occurred, increasing accountability. However, it could not be determined if missing documents from the Monitoring Teams' documentation requests were due to the documents not being completed, not being available in the active records, or inadvertently not included in the requested packets. The Facility should continue to ensure that documents are available, and filed in a timely manner in the individuals' records, so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services. o Generally, it appeared that records were available in the residences, and, as needed, at clinic appointments, in individuals' meetings, etc. ▪ **Data are documented/recorded timely on data and tracking sheets (e.g., PBSP, seizure)**: The Monitoring Team observed some problems. For example: o 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 might not have been accurately, consistently, and timely documenting data, and processes were not in place to ensure data reliability. Similarly, the Monitoring Team regularly found that nursing staff were not adequately documenting ongoing assessments and/or the results of such assessments. o As noted above, the Records Department was partnering with the Director of Day Programs to implement a plan to monitor skill acquisition data to identify missing data. The Chief Nurse Executive also had created a system to monitor nursing staff's entries into the	

#	Provision	Assessment of Status	Compliance
		Integrated Progress Notes with the intention of identifying and correcting any problematic areas. It should be noted that the Nursing Department's findings of 100 compliance with documentation in the Integrated Progress Notes was not consistent with the Monitoring Team's findings, as discussed in greater detail with regard to Section M. ▪ **Staff surveyed/asked indicate how the unified record is used as per this provision item:** The Unified Records Coordinators were asking a sample of team members to complete the questions that State Office had sent related to Section V.4. Based on discussions with Record Department staff, they did not find this tool measurable, and had revised it, and just begun use of the revised form. ▪ **Observation at meetings, including ISP meetings, indicates the unified record is used as per this provision item:** The Facility had not yet developed a process for incorporating information regarding the use of records during relevant meetings into the monitoring or database for Section V.4. As discussed in previous reports, this should include observations of a variety of meetings in which information from the records needs to be utilized (e.g., psychiatric reviews, ISP meetings, etc.). The Unified Records Coordinators might not do this, but such indicators might be distributed in other monitoring tools, and the data fed back to the Records Department. Based on the Monitoring Team's observations and record reviews: o As discussed with regard to Section F and Section I of the Settlement Agreement, although improvement was seen, ISPs and integrated health care plans continued to lack consistent evidence of teams making data-based decisions. Although progress was being made, the Facility remained out of compliance with this provision. Teams were not consistently using data to make decisions, and the quality of data and information in the records often was not adequate to allow teams to make well-informed decisions.	

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. 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)
3. 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)
4. 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)

5. Documents should be submitted and 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)
6. 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)
7. Efforts should be made to ensure that IDT 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)
8. As the Facility expands its self-assessment processes, for Section V.4, a number of different methodologies, including, for example, interviewing staff, observing meetings in which information from the records needs to be utilized (e.g., psychiatric reviews, PSP meetings, etc.), and reviewing documents such as medical consultations to ensure that key information from the record has been considered. All of these indicators might not be reviewed by the Unified Records Coordinators, but might be distributed in other monitoring tools. (Facility Self-Assessment, and Sections V.3, and V.4)
9. Further refinement of the internal auditing process should occur, including establishment of inter-rater reliability, analysis of audit results, and development and implementation of corrective action plans. (Facility Self-Assessment)

List of Acronyms

Acronym/ Symbol	Meaning
≥	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
APS	Adult Protective Services
ASHA	American Speech and Hearing Association
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
BMP	Basic Metabolic Panel
BSC	Behavior Support Committee
BSP	Behavior Support Plan
BUN	Blood Urea Nitrogen
c	With
cc	Cubic Centimeters
CCC	Competency of Clinical Certification
CBC	Complete Blood Count
CCSSLC	Corpus Christi State Supported Living Center
CD	Communication Dictionary
C-Diff	Clostridium difficile
CDC	Centers for Disease Control

CEU	Continuing Education Units
CIP	Crisis Intervention Plan
CIR	Client's Information Record
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
CME	Continuing Medical Education
CMP	Comprehensive Metabolic Panel
CMS	Centers for Medicare and Medicaid Services
CNE	Chief Nurse Executive
CNS	Central Nervous System
COPD	Chronic Obstructive Pulmonary Disease
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
DEXA	Dual-energy x-ray absorptiometry
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
DPN	Dental Progress Note
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
FSA	Functional Skills Assessment
FTE	Full-time Equivalent
GERD	Gastroesophageal Reflux Disease
GFR	Glomerular Filtration Rate
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
HMT	Health Monitoring Tools
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
IHCP	Integrated Health Care Plan
ILASD	Instructor Led Advanced Skills Development
ILSD	Instructor Led Skills Development

IM	Intramuscular
IM	Incident Management
IMC	Incident Management Coordinator
IMRT	Incident Management Review Team
IOA	Inter-observer Agreement
IPN	Integrated Progress Notes
IRRF	Integrated Risk Rating Form
ISP	Individual Support Plan
ISPA	Individual Support Plan Addendum
IT	Information Technology
ITC	Integrity Treatment Checklists
IV	Intravenous
J-tube	Jejunostomy feeding tube
LA	Local Authority
LAR	Legally Authorized Representative
LON	Level of Need
LOS	Level of Supervision
LVN	Licensed Vocational Nurse
LRA	Labor Relations Alternatives
MAR	Medication Administration Record
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
MRI	Magnetic Resonance Imaging
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
NOS	Not Otherwise Specified
NP	Nurse Practitioner
NPO	Nothing by Mouth

NSAID	Non-Steroidal Anti-Inflammatory Drugs
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
PCN	Program Compliance Nurse
PCP	Primary Care Practitioner
PECS	Picture Exchange Communication System
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
RO	Rule Out

ROM	Range of Motion
RPC	Restrictive Practices Committee
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
SLPA	Speech Language Pathology Assistant
SOAP	Subjective, Objective, Assessment, and Plan
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
UI	Unusual Incident
UIMRT	Unit Incident Management Review Team
UIR	Unusual Incident Report
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
VFS	Video Fluoroscopy Study
VNS	Vagal Nerve Stimulator
WAIS	Wechsler Adult Intelligence Scale
WBC	White Blood Count
WC	Wheel Chair