United States v. State of Texas

Monitoring Team Report

Corpus Christi State Supported Living Center

Dates of Review: January 4 through 8, 2010
January 25 through 29, 2010

Date of Report: March 10, 2010

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Introduction

I. **Background** - In 2005, the United States Department of Justice (DOJ) notified the Texas Department of Aging and Disability Services (DADS) of its intent to investigate the Texas state-operated facilities serving people with developmental disabilities (Facilities) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). The Department and DOJ entered into a Settlement Agreement, effective June 26, 2009. The Settlement Agreement covers 12 State Supported Living Centers (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. In addition to the Settlement Agreement (SA), the parties detailed their expectations with regard to the provision of health care supports in the Health Care Guidelines (HCG).

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

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

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

In order to provide a complete review and focus the expertise of the team members on the most relevant information, team members were assigned primary responsibility for specific areas of the Settlement Agreement. It is important to note that the Monitoring Team functions much like an individual interdisciplinary team to provide a coordinated and integrated report. Team members shared information as needed, and various team members lent their expertise in the review of Settlement Agreement requirements outside of their primary areas of expertise. To provide a holistic review, several team members reviewed aspects of care for some of the same individuals. When relevant, the Monitor included information provided by one team member in the report for a section for which another team member had primary

responsibility. For this baseline review of Corpus Christi SSLC, the following Monitoring Team members had primary responsibility for reviewing the following areas: Toni Richardson reviewed protection from harm, including restraints as well as abuse, neglect, and incident management, as well as quality assurance, and integrated protections, services, treatments and supports; Kenneth Weiss reviewed psychiatric care and services, and medical care; Victoria Lund reviewed nursing care, dental services, and pharmacy services and safe medication practices; Patrick Heick reviewed psychological care and services, and habilitation, training, education, and skill acquisition programs; Nancy Waglow reviewed minimum common elements of physical and nutritional supports as well as physical and occupational therapy, and communication supports; and Maria Laurence reviewed serving individuals in the most integrated setting, consent and record keeping. Input from all team members informed the reports for integrated clinical services, minimum common elements of clinical care, and at-risk individuals.

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

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

(a) **Onsite review** – During the weeks of January 4 through 8, 2010, and January 25 through 29, 2010, the Monitoring Team visited Corpus Christi State Supported Living Center. As described in further detail below, this allowed the team to meet with individuals and staff, conduct observations, review documents as well as request additional documents for off-site review.

(b) **Review of documents –** Prior to its onsite review, the Monitoring Team requested a number of documents. Many of these requests were for documents to be sent to the Monitoring Team prior to the review while other requests were for documents to be available when the Monitors arrived. This allowed the Monitoring Team to gain some basic knowledge about Facility practices prior to arriving onsite and to expand that knowledge during the week of the tour. The Monitoring Team made additional requests for documents while on site.

Throughout this report, the specific documents that were reviewed are detailed. In general, though, the Monitoring Team reviewed a wide variety of documents to assist them in understanding the expectations with regard to the delivery of protections, supports and services as well as their actual implementation. This included documents such as policies, procedures, and protocols; individual records, including but not

limited to medical records, medication administration records, assessments, Personal Support Plans (PSPs), Behavior Support Plans (BSPs), documentation of plan implementation, progress notes, community living and discharge plans, and consent forms; incident reports and investigations; restraint documentation; screening and assessment tools; staff training curricula and records, including documentation of staff competence; committee meeting documentation; licensing and other external monitoring reports; internal quality improvement monitoring tools, reports and plans of correction; and staffing reports and documentation of staff qualifications.

Samples of these various documents were selected for review. In selecting samples, a random sampling methodology was used at times, while in other instances a targeted sample was selected based on certain risk factors of individuals served by the Facility. In other instances, particularly when the Facility recently had implemented a new policy, the sampling was weighted toward reviewing the newer documents to allow the Monitoring Team the ability to better comment on the new procedures being implemented.

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

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

(e) **Other Input** - The State and the U.S. Department of Justice also scheduled calls to which interested groups could provide input to the Monitors regarding the 13 Facilities. The first of these calls occurred on Tuesday, January 5, 2010, and was focused on Corpus Christi State Supported Living Center. The second call occurred on Tuesday, January 12, 2010, and provided an opportunity for interested groups to provide input on the remaining 12 Facilities.

III. **Organization of Report –** The report is organized to provide an overall summary of the Supported Living Center's status with regard to compliance with the Settlement Agreement as well as specific information on each of the paragraphs in Sections II.C through V of the Settlement Agreement and each chapter of the Health Care Guidelines.

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

The report addresses each of the requirements in Section III.I of the SA regarding the Monitors' reports and includes some additional components which the Monitoring Panel believes will facilitate understanding and assist the Facilities to achieve compliance as quickly as possible. Specifically, for each of the substantive sections of the SA and each of the chapters of the HCG, the report includes the following sub-sections:

(a) **Steps Taken to Assess Compliance:** The steps (including documents reviewed, meetings attended, and persons interviewed) the Monitor took to assess compliance are described. This section provides detail with regard to the methodology used in conducting the reviews that is described above in general;
(b) **Summary of Monitor's Assessment:** Although not required by the SA, a summary of the Facility's status is included to facilitate the reader's understanding of the major strengths as well as areas of need that the Facility has with regard to compliance with the particular section;
(c) **Assessment of Status:** As appropriate based on the requirements of the SA, a determination is provided as to whether the relevant policies and procedures are consistent with the requirements of the Agreement. Also included in this section are detailed descriptions of the Facility's status with regard to particular components of the SA and/or HCG, including, for example, evidence of compliance or non-compliance, steps that have been taken by the Facility to move toward compliance, obstacles that appear to be impeding the Facility from achieving compliance, and specific examples of both positive and negative practices, as well as examples of positive and negative outcomes for individuals served;
(d) **Facility Self-Assessment:** A description is included of the self-assessment steps the Facility undertook to assess compliance and the results thereof. The Facilities will begin providing the Monitoring Teams with such assessments 14 days prior to each onsite review that occurs after the baseline reviews are completed. The Monitor's reports will begin to comment on the Facility self-assessments for reviews beginning in July 2010;
(e) **Compliance:** The level of compliance (i.e., "noncompliance" or "substantial compliance") is stated; and
(f) **Recommendations:** The Monitor's recommendations, if any, to facilitate or sustain compliance are provided. As stated previously, it is essential to note that the SA identifies the requirements for compliance. The Monitoring Team offers recommendations to the State for consideration as the State works to achieve compliance with the SA. However, it is in the State's discretion to adopt a recommendation or utilize other mechanisms to implement and achieve compliance with the terms of the SA.

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

IV. Executive Summary

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

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

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

Restraints

- There is a clear commitment from the top-level management at CCSSLC to prohibit the use of most mechanical restraints and to reduce the use of all restraints. CCSSLC has a plan for reducing the use of programmatic restraint. Implementation of this plan has resulted in progress as evidenced by the FY10 First Quarter Trend Analysis report. A comparison to First Quarter FY09 data shows restraint use down from 223 to 59 occurrences. The Facility should be commended for its efforts to reduce the use of restraint, and is encouraged to continue with the implementation of this plan.

Abuse, Neglect, and Incident Management

- There are processes in place to report abuse, neglect, and other incidents, and staff members appeared to know their responsibilities in this regard.

- Trends are being reported quarterly for some key issues, such as abuse allegations, incidents, and hospitalizations. Information is available to show some specific characteristics of incidents, such as where incidents are occurring, what time of day, and on which living units.

Integrated Individual Support Plans

- Some of the positive aspects of the individualized Personal Support Plans reviewed included efforts to identify the preferences and achievements of individuals served; inclusion of Legally Authorized Representatives (LARs) in team meetings, including offering options such as telephone participation; and updating PSPs at least annually.

Psychological Care and Services

- It is clear that over the past year, improvement has been made in terms of the comprehensiveness of the behavioral services evaluation process as well as more stringent criteria for the completion of the Inventory for Client and Agency Planning (ICAP) as part of the psychological assessment. Both of these recent changes have improved the potential of behavioral services staff to obtain information necessary to effectively inform treatment.

Nursing Care

- CCSSLC has 61 positions allotted for Registered Nurses (RNs) with only three (3) vacancies, and 50 positions for Licensed Vocational Nurses (LVNs) with only three (3) vacancies. Having adequate and consistent nursing staff is extremely positive to the provision of clinical care and outcomes for the individuals being served at CCSSLC.

Pharmacy Services and Safe Medication Practices

- Pharmacy staff are regularly conducting quarterly drug regimen reviews (DRRs), as well as checking new medications against individuals' current drug regimens. These reviews appear to result in the identification of potential issues that the pharmacy department forwards to physicians and nurse practioners.

Medical Care

- The Facility Audiologist has developed an Audiology Standards Manual to provide a foundation for the implementation of audiology services that supports the implementation of functional communication. An audiology database had been developed to track the status of audiology assessments and related adaptive equipment.

Habilitation, Training, Education, and Skill Acquisition Programs

- Engagement levels appeared to be quite high when visiting Facility work sites. More specifically, individuals at these sites were engaged in various work activities (i.e., paper cleaning and shredding paper, can crushing, sorting hangers, folding wash clothes, pic-pac assembly, etc.). Individuals at these sites appeared happily engaged and many reported great satisfaction in their work. Efforts are being made to identify additional off-campus vocational options and employment for individuals.

Serving Individuals in the Most Integrated Setting Appropriate to Their Needs

- CCSSLC has engaged in a number of activities to provide education about community options to individuals and their families or guardians to enable them to make informed decisions.

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

Restraints

- The Facility is at the beginning stages of developing individualized plans that include strategies to reduce the need for pre-sedation medication for medical and dental procedures. It appears that the Facility is focusing its efforts initially on individuals for whom dental care is an issue. This should be a priority as initial reviews of a sample of individuals' records reveal that many require pre-sedation for dental appointments, and are in need of dental work.

Abuse, Neglect, and Incident Management

- Facility policy should be amended to clearly identify a zero-tolerance for abuse, neglect and exploitation.
- The next step with regard to the analysis of incident and allegation trends is responding to the trends with thorough analyses of potential causes, and the development of action plans to address issues identified. Follow-up will also need to occur to ensure that actions are taken that effectively address the issues identified.

Quality Assurance

- Many of the quality enhancement activities at CCSSLC are in the initial stages of development. A Quality Enhancement Plan is not yet in place. However, the staff in the Quality Enhancement Department appear to be working intensely to develop and implement processes that will allow them to monitor the Facility's progress on the Facility Plan of Improvement designed to assist the Facility in achieving compliance with the Settlement Agreement, as well as to monitor abuse and neglect reporting, and to work on risk assessment of individuals served.

Integrated Individual Support Plans

- CCSSLC is at the beginning stages of implementing a new Personal Support Plan format that was introduced in November 2009. It appears that the new format is designed to address some of the components of the Settlement Agreement that the previous format did not address, such as the identification of barriers to individuals living in the most integrated setting appropriate to their needs and preferences, and plans to address such barriers.
- The biggest challenge for CCSSLC with regard to PSPs appears to be with regard to ensuring that team meetings include interdisciplinary discussions that result in one comprehensive, integrated treatment plan for each individual. This also includes the need to incorporate individuals' preferences and desired outcomes into the

planning process in a meaningful way. In addition, focused efforts should be made to improve the quality of assessments that are used in the developments of individuals' PSPs.

At Risk Individuals

- The Facility is at the very beginning stages of implementing the process of screening individuals to determine if they fall into an at-risk category. Once this initial screening and identification system is implemented, the Facility must identify/develop and implement appropriate assessment tools. Such tools are necessary to allow interdisciplinary teams to identify individuals' specific strengths and needs, develop plans to provide necessary services and supports for at-risk individuals, and then to respond to changes as measured by established at-risk criteria.

Psychiatric Care and Services

- At the time of the review, there were not any staff psychiatrists at CCSSLC. There were two (2) consulting psychiatrists, one who provides approximately 50 hours of service per month, and the other who provides approximately 24 hours per month. The Medical Director acknowledged that the expected complement of psychiatrists at the Facility is two (2.0) full-time equivalents (FTEs). The limited availability of psychiatry hours appears to have a negative impact on the delivery of services, particularly as it limits the ability of psychiatry and psychology staff to work in an interdisciplinary and integrated fashion to design treatment plans for individuals served.
- In terms of psychiatric diagnoses, there was a lack of clearly defined diagnostic criteria for the conditions diagnosed. There was little or no evidence that individuals being evaluated had case formulations in the record. CCSSLC's Plan of Improvement indicates that a standardized psychiatric assessment form is to be implemented that includes the necessary review and case formulation. The State and Facility need to move forward with putting these pieces in place.

Psychological Care and Services

- Positive Behavior Support Plans (PBSPs) contain many of the elements that the Settlement Agreement requires. There are areas of the process that require refinement, including the consistent development of functionally equivalent replacement behaviors, and the use of individualized reinforcers. Such reinforcement use needs to be expanded across antecedent and consequent-based intervention strategies. The processes for documenting consent prior to the implementation of the plans, and for addressing the need to eliminate to the extent possible the use of restrictive procedures need to be enhanced.
- Some Direct Care Professionals (DCPs) demonstrated knowledge and understanding of strategies outlined in randomly selected PBSPs. In addition, there were some information systems in place to ensure that DCPs had an understanding and were able to implement PBSPs. However, such systems were not systematically utilized to facilitate and ensure adequate implementation.

Nursing Care

- CCSSLC needs to develop and implement a number of Nursing monitoring tools that will accurately reflect the quality of nursing care being provided in order to quickly identify problematic trends and implement timely plans of correction. In addition, these data need to be integrated into the facility's Quality Management and Risk Management systems.
- Overall, there were a number of significant problematic issues that were found regarding complete and adequate nursing assessments of symptoms for acute changes in status. In addition, there were problems noted regarding the lack of adequate documentation of assessments prior to the transfer to an off-site medical center as well as upon return to the Facility.
- Nursing Care Plans currently generally do not include measurable objectives. As these are improved, it will be essential for nursing quarterly assessments to discuss the progress an individual is making or not making, strategies that are working or not working, and to recommend changes, if needed, in strategies, supports and services.

Pharmacy Services and Safe Medication Practices

- Whenever an individual is prescribed a new medication, a system appears to be in place to check for potential issues. However, a system needs to be developed and implemented to ensure that there is supporting documentation of the notification of a physician that the addition of a newly prescribed medication may have adverse effects in combination with the existing medication regimen. In addition, the physician's response to this notification needs to be documented.
- Likewise, a system needs to be instituted to ensure that physicians and/or nurse practitioners respond to recommendations included in the quarterly DRRs.

Physical and Nutritional Supports

- CCSSLC therapists have limited specialized training and/or experience in which they have demonstrated competency in working with individuals with complex physical and nutritional management (PNM) needs. Continuing education opportunities need to be increased for members of the Physical and Nutritional Management Team (PNMT), and be focused on providing supports to people with complex physical and nutritional support needs.
- At the time of the review, the Facility was not systematically identifying individuals with PNM concerns. There appeared to be pieces of an identification system in place, but not a comprehensive, integrated system to ensure that individuals with such needs are identified in a timely manner to allow for prompt development and implementation of plans to address their needs.
- The Facility also was not completing comprehensive assessments of individuals at risk with regard to PNM concerns, or developing comprehensive plans to address risk areas.
- It did not appear that monitoring of staff's competence with regard to the implementation of Physical and Nutritional Management Plans (PNMPs) was being evaluated regularly.

Dental Care

- Problems with regard to the provision of dental care included missing documentation regarding: 1) obtaining or attempts at obtaining dental x-rays; 2) a documented review of the individuals' medication and allergies; and 3) comprehensive treatment plans indicating what dental work the individual actually needed regarding restorations and preventative care.
- There does not appear to be a system in place to ensure that individuals are being properly monitored when receiving pre-sedation. Nursing needs to collaborate with dental to develop a monitoring system to ensure that individuals are appropriately monitored when receiving pre-sedation for medical/dental procedures.

Communication

- It appears that a number of individuals who do not currently have access to alternative and augmentative communication systems might benefit from such systems. However, they have not been properly assessed and/or plans developed to address their needs.

Habilitation, Training, Education, and Skill Acquisition Programs

- The vocational assessment format being utilized does not adequately address individuals' strengths, needs and preferences. It does not create a vocational profile based on, for example, objective data, situational assessments, and/or a thorough work history or interest inventory.
- Although many appear to be individualized, many skill acquisition programs appear to be inadequate. Several critical components necessary for learning and skill development appear lacking. In addition, skill acquisition programs seldom appear to be implemented in community settings for the majority of individuals.

Serving Individuals in the Most Integrated Setting Appropriate to Their Needs

- The Community Living Discharge Plans reviewed included essential and non-essential supports. However, it appears that the Facility is at the beginning stages of refining this process. Teams did not consistently identify all the essential supports that the individual needed to transition safely to the community, nor did teams adequately define the essential supports in measurable ways. Moreover, the plans did not consistently identify preferences of the individuals that might affect the success of the transition. This makes it difficult for thorough and meaningful monitoring to occur prior to and after the individual's transfer to the community.
- The post-move monitoring activities identified some issues with regard to the provision of services at the community sites. It would be helpful if the reviewers identified more specific action items describing the Facility's best efforts to ensure the supports are implemented. Such items might include, but not be limited to notifying the provider agency's management team of the issues identified, attempting to reach agreement with the agency on persons responsible and timeframes for the completion of needed actions, and notifying the community case manager of the need for follow-up.

In summary, the Facility already has undertaken a number of performance improvement activities that will assist it in achieving compliance with the Settlement Agreement and Health Care Guidelines. CCSSLC appears to have a strong management team who will help to lead the Facility through this change process. The management team also appears

to have the appropriate philosophy that a methodical approach to change with careful planning will result in the development of a sustainable system. The Monitoring Team looks forward to an ongoing collaborative and productive relationship with CCSSLC.

V. Status of Compliance with the Settlement Agreement

<table>
<tr><th>SECTION C: Protection from Harm-Restraints</th><th></th></tr>
<tr><td rowspan="2">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.</td><td>Steps Taken to Assess Compliance: The following activities occurred to assess compliance:
▪ Review of Following Documents:
o DADS Policy #002.1: Protection from Harm – Abuse, Neglect, and Incident Management, dated 11/06/09;
o DADS Policy #001: Use of Restraint, dated 8/31/09;
o Health Care Guidelines, dated May 2009;
o Texas Administrative Code Title 40, Part 1, Chapter 5, Subchapter H, Rule Section 5.354 General Provisions, Use of Restraint in Mental Retardation Facilities;
o CCSSLC Plan of Improvement, dated 8/28/09;
o CCSSLC Policy Section J: Behavioral Services, as of 1/25/09;
o CCSSLC Behavioral Services: Positive Behavior Support Practices, dated 7/28/09;
o Restraint Documentation Guidelines for State Supported Living Centers: November 2008;
o CCSSLC Safety Plan for Crisis Intervention;
o CCSSLC: Human Rights Committee Minutes for time period from September 9, 2009, through December 23, 2009;
o CCSSLC Facility Plan for Reduction of Restraint;
o Minutes of Restraint Reduction Team meeting for 7/22/09, 10/2/09, and 12/2/09;
o Restraint Checklist revised 12/09/08;
o Individuals Restrained from 7/1/09 through 12/31/09;
o List of Permitted Restraints;
o Restraint Reporting Form;
o Restraint Checklist (401200BR);
o Face-to-Face Assessment, Debriefing and Reviews for Crisis Intervention Restraint 11/24/08;
o Restraint documentation for the following individuals: Individual #1[1], Individual #2, Individual #3, Individual #4, Individual #5, Individual #6, and Individual #7; and
o Sample of 20 files of investigations of abuse and neglect allegations
▪ Interviews with:
o Robert C. Cramer, Director of Behavioral Services, Chief Psychologist;
o Colleen M. Gonzales, Chief Nurse Executive; and
o Various staff in homes and day programs throughout campus</td></tr>
<tr><td>Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.</td></tr>
</table>

[1] As noted in the methodology section, to protect individuals' privacy, individuals are identified in this report using a number (e.g., Individual #1). A separate numbering key will be provided to the parties in the case.

	Summary of Monitor's Assessment: There is a clear commitment from the top-level management at CCSSLC to prohibit the use of most mechanical restraints and to reduce the use of all restraints. At the time of the review, there were 18 individuals with safety plans in place for the use of restraints when other methods of supporting a person to control his/her behavior have failed and more restrictive measures are necessary to protect the person and others. Staff interviewed appeared to know that mechanical restraints are prohibited. However, during the review, a member of the Monitoring Team attended a Personal Support Plan meeting during which the Personal Support Team (PST) filled out the form for restraint use that still contained a list of mechanical restraints. The team filled out the form as if mechanical restraints were still an option. This is an example of how it will take some time to ensure that all vestiges of mechanical restraint have been removed. In order for this to be successful, there will need to be constant attention to behavioral programs, activities and environmental changes to help individuals and the staff develop less restrictive alternatives to managing behaviors that do not lead to restraint. The Facility is at the beginning stages of developing individualized plans that include strategies to reduce the need for pre-sedation medication for medical and dental procedures. It appears that the Facility is focusing its efforts initially on individuals for whom dental care is an issue. This should be a priority as initial reviews of a sample of individuals' records reveal that many require pre-sedation for dental appointments, and are in need of dental work.

#	Provision	Assessment of Status	Compliance
C1	Effective immediately, no Facility shall place any individual in prone restraint. Commencing immediately and with full implementation within one year, each Facility shall ensure that restraints may only be used: if the individual poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable, written policies, procedures, and plans governing restraint use. Only	The CCSSLC Plan of Improvement indicates that the policies and procedures prohibiting prone restraint are in place. Policies prohibiting prone restraint were found in CCSSLC policies on Behavioral Services, specifically in Section J.2., Step 3 and at J.3.01 of the manual. In addition, the Facility Director clearly stated that prone restraint and most mechanical restraints were not in use at CCSSLC. Further limitations on the use of restraint are expressed in the policy statement at the beginning of Section J of the policy manual and at J.1, Procedure 3. Further restrictions can be found at J.2, Steps 1 and 2. Based on a review of 20 restraint records involving seven (7) individuals, there was no indication of prone restraint, nor was there evidence of restraint being used for the convenience of staff or as punishment. This will continue to be reviewed during future monitoring visits. As is discussed below in the section that addresses Section K of the SA, additional improvements need to be made to Positive Behavior Support Plans to ensure that adequate programming is in place to reduce the likelihood that restraint will need to be used.	

#	Provision	Assessment of Status	Compliance
	restraint techniques approved in the Facilities' policies shall be used.		
C2	Effective immediately, restraints shall be terminated as soon as the individual is no longer a danger to him/herself or others.	The CCSSLC policy manual states in Section J.1, Procedures 3.c and at J.2, Step 12 that restraint must be terminated as soon as the person is no longer a danger to him/herself or others. A review of a sample of restraint reports indicated that restraints were used for behavioral purposes 13 times in the month of July 2009 for periods from one (1) to 28 minutes. Four (4) of the restraints exceeded 10 minutes in length. From this data it appears that individuals are being released promptly from restraint. The criterion for release is listed in code form. There is an event code with numbers and a release code. Based on the reports reviewed, staff usually entered "#7" as the event code, meaning that the person was calm, and "L" as the release code, meaning that the person was not a danger to self or others. An additional review was conducted of 20 recent incidents of restraint involving seven (7) individuals. The documentation on the Restraint Checklists indicated that all individuals were released as soon as they were noted to be calm. Overall, most of these holds lasted one minute with the lengthiest time being 20 uninterrupted minutes.	
C3	Commencing within six months of the Effective Date hereof and with full implementation as soon as practicable but no later than within one year, each Facility shall develop and implement policies governing the use of restraints. The policies shall set forth approved restraints and require that staff use only such approved restraints. A restraint used must be the least restrictive intervention necessary to manage behaviors. The policies shall require that, before working with individuals, all staff responsible for applying restraint techniques shall have successfully completed competency-based training on: approved verbal intervention and redirection techniques; approved restraint techniques; and adequate	The Department of Aging and Disability Services' (DADS) policy on restraint was completed on August 31, 2009. Review by the Monitoring Team found that the policy is congruent with and addresses relevant components of the Settlement Agreement (SA). CCSSLC's policies and procedures on the use of restraint were also reviewed, including Section J of the manual that addresses Behavioral Services, and the November 2008 guidelines on use of restraint and associated forms. The SSLC Plan of Improvement indicates that this element was in place as of June 26, 2009, and refers to the sample restraint debriefing forms and Unit Incident Management Meeting Notes as evidence of compliance. Procedures and forms were available and in use that indicate the some of the elements of this provision are being fulfilled. However, some refinements to the policies, procedures and processes are necessary. More specifically, there appeared to continue to be some lack of clarity with regard to the types of restraint and the conditions under which they could be used. For example: ▪ Restrictions on the use of mechanical restraint were spelled out in Section J of the CCSSLC Policy Manual. However, there was a list of prohibited as well as permitted mechanical restraints separate from the manual. The existence of both lists was somewhat confusing, since it was clear from the Facility Director and from quality enhancement staff that no mechanical restraints were available on campus except for wrist bands and belly ties used to prevent self-injury or to	

#	Provision	Assessment of Status	Compliance
	supervision of any individual in restraint.	promote posture. ▪ The Personal Support Plan format still included a form that listed mechanical restraints that could be considered by the team for use with the individual. ▪ Checklists on the restraint evaluation form and in the policy and procedure manual need to be amended to remove references to mechanical restraints that have been banned. ▪ The policy manual did not have information on what chemical restraints could be used. ▪ The manual had references to types of physical restraint that could be used, but there was not a clear list of the approved holds. ▪ Section J.1 of the policy manual addressed a graduated range of less restrictive measures to be tried prior to use of restraint and the form for reporting restraint use included a list of many of the less restrictive measures. However, as discussed further below, it was not clear how staff members are instructed to implement such less restrictive options. It was clear in Section J.1, Procedure 3.b that staff applying restraint must have training in the use of the restraints they apply. It was not clear that staff applying restraint must also be trained in verbal intervention and redirection techniques or approved restraint techniques generally. Nor was it clear that staff would be trained in supervision of the individual in restraint. While provisions for training may appear in a separate training manual that was not clear in Section J that specifically addresses restraint requirements.	
C4	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall limit the use of all restraints, other than medical restraints, to crisis interventions. No restraint shall be used that is prohibited by the individual's medical orders or ISP. If medical restraints are required for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for restraint.	The CCSSLC Policy Manual, Section J.2, Step 2 requires that restraint be used only in crisis situations. In addition, conversations with staff suggest that they understand that restraint is to be used only as crisis intervention. On a very positive note, CCSSLC has a plan for reducing the use of programmatic restraint. Implementation of this plan has resulted in progress as evidenced by the FY10 First Quarter Trend Analysis report. A comparison to first quarter FY09 data shows restraint use down from 223 to 59 occurrences. The Facility should be commended for its efforts to reduce the use of restraint, and is encouraged to continue with the implementation of this plan. It would be helpful if the Restraint Reduction Team meeting minutes included information regarding the analysis the team has conducted, the trends identified, clinical findings, and descriptions of the plans of correction implemented, including expected outcomes, dates of completion, and responsible persons. Particularly because it appears that the team's efforts are having a positive impact, it is important to maintain a record of the team's findings and recommendations, which action steps were successful as well as which methodologies had to be modified and which, if any, did not have the desired impact.	

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		According to the SA, authorization for the use of medical restraint must be documented in the individual's PSP and the PSP must include strategies to minimize or eliminate such use. Section J.4.01 of the policy manual sets out requirements for the use of medical restraint, but does not clearly indicate that the PSP must include strategies to minimize or eliminate its use in the future. The following provide examples of individuals for whom these requirements were not met: ▪ Individual #8's PSP contains a "Risk for Restraint" form completed on 11-13-09. The form does not include a check-off for whether restraint should or should not be used. The psychological evaluation includes references to use of a "binder" to prevent G-tube removal. This raises a question about whether the binder was authorized by the team with consideration of the risks and benefits involved. There also did not appear to be a plan to minimize or eliminate the use of the binder in the future. ▪ Individual #9's PSP, dated 12/1/09, indicates that she uses sedation for dental visits. Her annual physical recommended the use of intravenous sedation "due to poor dental rating." The only intervention that the team appears to have had in place was a relaxation objective that direct care professionals were to implement daily. It did not appear that the team had discussed an integrated set of strategies to potentially reduce her need for sedation. ▪ Individual #2's PSP, dated 12/2/09, indicates that she receives sedation for dental care. However, no plan including strategies to reduce the need for sedation was found. According to the Chief Psychologist, at the time of this review, the Psychology Department had developed a draft Desensitization Program to facilitate decreasing the use of pre-sedation/restraint for dental and medical procedures. The Chief Psychologist reported his department is working with the nursing and dental departments so that by the next review a number of these programs should be implemented for individuals requiring pre-sedation for dental appointments.	
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	With regard to the existing policies and procedures: ▪ The November 2008 restraint documentation guidelines require a face-to-face assessment of the person in restraint by a trained staff member within 15 minutes of application of the restraint, and the restraint form calls for recording of the assessment. In addition, the form for the nurse requires the nurse to check on the status of the individual in restraint at least every 30 minutes. ▪ No clear reference was found with regard to the need for physicians to document the extraordinary circumstances when they order an alternative monitoring schedule. There also was no reference found to a physician specifying the type of monitoring and schedule when a medical restraint is ordered, although Sections	

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	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.	J.4.01 and .02 appear to address these elements in part. ▪ There was no specific reference to what is required when a restraint is applied away from the facility. A review of 20 episodes of physical restraints consisting of holds to hands, legs, basket holds and finger weave holds for seven (7) individuals (Individual #1, Individual #2, Individual #3, Individual #4, Individual #5, Individual #6, and Individual #7) found that all had their vital signs documented by a nurse every 30 minutes. However, there were a few instances in which initial check of the individual's vital signs was initiated well over 30 minutes after the episode began without explanation provided for the delay. In addition, in a few episodes, the mental status section and respirations were marked as "refused" by the nurse. These areas do not require the individual's cooperation to be able to make observations and document these in the appropriate section. During upcoming monitoring visits, larger samples of restraint documentation will be reviewed.	
C6	Effective immediately, every individual in restraint shall: be checked for restraint-related injury; and receive opportunities to exercise restrained limbs, to eat as near meal times as possible, to drink fluids, and to use a toilet or bed pan. Individuals subject to medical restraint shall receive enhanced supervision (i.e., the individual is assigned supervision by a specific staff person who is able to intervene in order to minimize the risk of designated high-risk behaviors, situations, or injuries) and other individuals in restraint shall be under continuous one-to-one	CCSSLC Policies and Procedure at Section J.2, Steps 6 and 8 require that an individual in restraint be checked for injury. The November 2008 restraint guidelines also include some of the specified elements. A restraint checklist is prescribed in the policy manual at J.7, and there is a form for collecting and reporting information about the use of a restraint. A review was conducted of a small sample of three (3) restraint records to determine if they had been completed correctly. For these restraint instances, face-to-face assessment appeared to be completed correctly, and the restraint checklist appeared to be used correctly and completely. This is an area that will require further review during upcoming monitoring visits. From a nursing perspective, a review of 20 episodes of restraint for seven (7) individuals showed documentation indicating that the individual was checked for injury following the restraint episode. Appendix A of the Settlement Agreement requires that "Prior to the administration of a	

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	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.	chemical restraint, the licensed health care professional contacts the psychologist, who assesses whether less intrusive interventions are available and whether conditions for administration of a chemical restraint have been met." In one (1) episode reviewed Individual #6 received a chemical restraint. There was evidence that the individual was being monitored by a licensed staff, although Individual #6 was uncooperative with allowing some vital signs to be taken. However, no documentation was found that the psychologist was notified of the chemical restraint. The signature of the psychologist on the Restraint Checklist was dated three (3) days after the chemical restraint was administered.	
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:	The specific provisions with regard to the use of restraint with an individual more than three (3) times in a 30-day period were not found in Section J of the Facility policy and procedure manual. However, the Unit Incident Management Review Teams (IMRTs) appear to be taking the first important step in this process. Specifically, there appears to be a process in place to identify individuals who have been placed in restraint more than three times in any rolling 30-day period. The IMRT is meeting and reviewing restraint use as evidenced by their meeting logs. At the time of the review, the Facility Incident Management Team had been meeting and reviewing use of restraint and multiple uses of restraint each weekday for the past 24 hours as evidenced by their logs. From a baseline perspective, it appears that although Facility policy does not memorialize it, the Facility has developed a process to identify individuals who have experienced restraint more than three (3) times in a 30-day period, and are referring these situations back to PSTs for review. The following are a couple of examples that illustrate this: ▪ Individual #4 was reviewed as a person who experienced multiple episodes of restraint in a 30-day period. Individual #4 was restrained 10 times between 12/24/09 and 12/27/09. Nine (9) restraints were personal physical and one was chemical. All were reported on the 12/28/09 IMRT form as crisis intervention restraint and were noted under "Other Recommendations and Challenges", and scheduled for a Personal Support Plan Addendum (PSPA) meeting to be held for discussion by 12/31/09. On 1/5/10, the Incident Management Review Team reviewed progress, noting that the Personal Support Team had recommended a change in residence and had scheduled another PSPA to be held prior to the move so that the Behavior Support Plan and other applicable programs could be modified as needed and retained the issue on the log. ▪ Individual #2 experienced more than three (3) restraints in a 30-day period. She was restrained on 11/22/09 on two occasions for self-injurious behavior (SIB) and once for aggression toward staff. On 11/23/09, she was retrained for SIB. The three (3) restraints that occurred on 11/22/09 were reported to the Unit Incident Management Team on 11/23/09, as crisis intervention restraints. However, the restraint on 11/23/09 did not appear on the unit team meeting log	

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		for 11/24/09. Policies and procedures should be developed/revised to formalize the role of the Incident Management Review Team in this process, and ensure that all of the requirements of this provision of the SA are adhered to with regard to the assessment of the individual, and the development of plans, as appropriate, to address identified needs.	
	(a) review the individual's adaptive skills and biological, medical, psychosocial factors;	The assessment and BSP development process for individuals who have been placed in restraint more than three (3) times in 30 days will need to be reviewed during upcoming monitoring visits.	
	(b) review possibly contributing environmental conditions;	The assessment and BSP development process for individuals who have been placed in restraint more than three (3) times in 30 days will need to be reviewed during upcoming monitoring visits.	
	(c) review or perform structural assessments of the behavior provoking restraints;	The assessment and BSP development process for individuals who have been placed in restraint more than three (3) times in 30 days will need to be reviewed during upcoming monitoring visits.	
	(d) review or perform functional assessments of the behavior provoking restraints;	The assessment and BSP development process for individuals who have been placed in restraint more than three (3) times in 30 days will need to be reviewed during upcoming monitoring visits.	
	(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	The assessment and BSP development process for individuals who have been placed in restraint more than three (3) times in 30 days will need to be reviewed during upcoming monitoring visits.	

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	designated approved restraint situation, and the criteria for terminating the use of the restraint shall be set out in the individual's ISP;		
	(f) ensure that the individual's treatment plan is implemented with a high level of treatment integrity, i.e., that the relevant treatments and supports are provided consistently across settings and fully as written upon each occurrence of a targeted behavior; and	The assessment and BSP development process for individuals who have been placed in restraint more than three (3) times in 30 days will need to be reviewed during upcoming monitoring visits.	
	(g) as necessary, assess and revise the PBSP.	The assessment and BSP development process for individuals who have been placed in restraint more than three (3) times in 30 days will need to be reviewed during upcoming monitoring visits.	
C8	Each Facility shall review each use of restraint, other than medical restraint, and ascertain the circumstances under which such restraint was used. The review shall take place within three business days of the start of each instance of restraint, other than medical restraint. ISPs shall be revised, as appropriate.	The CCSSLC Plan of Improvement calls for this requirement to be completed on 1/30/10, after the date of this monitoring visit. However, a review was completed of 20 episodes of restraint for seven (7) individuals. A few concerns were identified with regard to the documentation of the review of the restraints. Specifically: ▪ Because the documentation for use of alternative measures prior to the restraint is a checklist, there is no way to determine if the staff used the appropriate methods and strategies that were included in the individual's Behavior Support or Safety Plans. This would make it difficult, if not impossible, to determine the overall effectiveness of the interventions in the plans, or to help clinical staff identify when interventions need to be modified. The current checklist does not lend itself to performing a critical clinical analysis. Modifying the form so that specific, individualized alternative measures could be documented would provide pertinent clinical information for review and analysis. ▪ Inconsistent documentation was noted in the progress notes regarding the restraint episodes. There were a number of episodes that did not have a description of the individual's behavior that warranted the restraint documented in the progress notes. Consequently, the only description available was the brief description noted on the Restraint Checklist forms. ▪ For Individual #6, who was administered a chemical restraint, the section of the form addressing Chemical Restraint Clinical Review was left blank indicating that no review was conducted.	

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

- The Facility's efforts to decrease the use of restraints should continue.
- The Restraint Reduction Team meeting minutes should be restructured to include information regarding the analysis the team has conducted, the trends identified, clinical findings, and descriptions of the plans of correction implemented, including expected outcomes, dates of completion, and responsible persons.
- Requirements for staff training in verbal intervention and redirection as well as approved restraint techniques and supervision should be added to Section J, or be referenced there.
- Consideration should be given to updating the policy statement that prefaces Section J of the CCSSLC Policy Manual on Behavior Supports to emphasize that behavior interventions must always begin with the least restrictive means, that restraint is used only when other methods have failed, and that only limited methods of restraint are permitted, including a clear list of permitted holds.
- Facility policy should be amended to define what chemical restraints, if any, may be used, under what circumstances, and with what protections in place.
- References to the use of mechanical restraints, that are now prohibited, should be removed from the policy manual as well as from PSP sections that still reference its use.
- Facility policy should indicate that PSPs must include strategies to minimize or eliminate a restraint that is authorized for medical purposes.
- PSPs should be monitored to ensure that if they include medical restraints, there are strategies to minimize and/or eliminate the use of the restraint, and that the team weighed the risks and benefits of the use of restraints.
- It should be established in policy that physicians document the extraordinary circumstances when they order an alternative monitoring schedule.
- It should be established in policy that the nurse must check within 30 minutes of arrival of anyone who was restrained while away from the Facility.
- Policies and procedures should be finalized with regard to the review process necessary for individuals with whom restraint has been used more than three (3) times in a 30-day period. Such policies and procedures should describe the role of the incident management staff, unit and facility-level review teams, and Personal Support Teams. Once such procedures are defined and implemented, monitoring should occur to ensure consistency and follow-through at each level.
- In order to ensure that pertinent clinical information is available for review and analysis, the section of the Restraint Checklist on alternative measures that were attempted prior to the use of restraint should be modified to require more specific information, particularly with regard to implementation of the individual's BSP or Safety Plan.
- Monitoring instruments and procedures should be developed and implemented by the Facility for review of the components of this section of the SA.

SECTION D: Protection From Harm - Abuse, Neglect, and Incident Management	
Each Facility shall protect individuals from harm consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS Policy #002.1: Protection from Harm – Abuse, Neglect, and Incident Management, dated 11/06/09; o CCSSLC Policy Section R: MAPES, as of 1/25/09; o Adult Protective Services: Investigations of Abuse, Neglect and Exploitation in MH/MR Settings: Presentation to Monitoring Teams by Ann Cortez and Karl Urban 11/16 /09; o Incident Management Review Team Meeting CCSSLC blank form; o Campus Coordinator Log-Entries, July 2009; o List of Employees terminated from employment since 2001; o CCSSLC Unit Incident Management Team Review Meeting Notes/Logs for Atlantic Unit, 11/03/09 through 12/8/09; o CCSSLC Incident Management Review Team Meeting records, 12/01/09 through 12/31/09; o Incident report forms and data on individuals who experienced incidents or abuse/neglect allegations during the six (6) months preceding the review; and o Investigation records maintained by the Facility of 20 allegations of abuse and/or neglect ▪ **Interviews with**: o Iva Benson, Director; o Cheryl Huff, Incident Management Coordinator; o Tammy Bonds, Campus Coordinator; o Polly Ramirez, Settlement Agreement Coordinator; o Gustavo Herrera, Unit Coordinator; o Sandi Gauza, Campus Coordinator; o Epi Dominquez, Unit Coordinator; o Ulyssess G., Staff Member; o Pat W., Staff Member; o Individual #23, Individual Served; and o Nora Flores, Morning Campus Coordinator ▪ **Observations of**: o Various homes and day/vocational programs throughout campus; and o Incident Management Meeting led by the Director on 1/6/10.
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.

	Summary of Monitor's Assessment: Over the last year, the Facility and the individuals it serves have faced significant challenges with regard to abuse of individuals served. In part, this appears to have been due to some of the perceived stereotypes of individuals with disabilities as well as some cultural norms that some staff, albeit a small number of staff, brought with them to the workplace. With the leadership of the Facility Director, the Management Team has implemented an action plan to create a competing culture within the CCSSLC that values people with disabilities. There are indications of progress in this direction as evidenced by efforts to improve the environment in the living units with new furniture, paint, and floor-to-ceiling walls, as well as efforts to improve the Personal Support Plans and make them more responsive to individual preferences and choices. A number of other actions have been taken, and others continue to need to be refined and/or implemented. There are processes in place to report abuse, neglect, and other incidents, and staff members appeared to know their responsibilities in this regard. As an illustration of their understanding of their responsibilities, staff consistently pointed to the back of their badges on which there is a sticker that explains how to report abuse or neglect to the Department of Family and Protective Services (DFPS). Incident reports that are submitted generally appeared to be timely. Staff also appeared to understand that the Facility Director intends to protect them from retaliation. She has demonstrated her intent by making referrals to the Inspector General on two (2) occasions to investigate allegations of retaliation. In reviewing over 20 investigations of abuse/neglect/exploitation (A/N/E), it appears that the reports are generally timely, interviews with potential witnesses are being completed, and reports include findings and conclusions. Further review of investigation reports will be completed during future monitoring reviews. Trend analysis of incidents is underway and that will produce additional data as the process evolves. One of the challenges with analyzing such data will be ensuring that issues that are identified are addressed. This is an area that will be reviewed in further detail in future reviews as the process develops.

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D1	Effective immediately, each Facility shall implement policies, procedures and practices that require a commitment that the Facility shall not tolerate abuse or neglect of individuals and that staff are required to report abuse or neglect of individuals.	The DADS policy on abuse, neglect and incident management was completed on November 6, 2009. The policy was reviewed and found to correspond in most respects to what is required under the Settlement Agreement. Any variations from the SA are noted under the corresponding sections below. The DADS abuse, neglect and exploitation rules and incident management policy state that abuse, neglect, and exploitation are prohibited. The SSLCs are required to comply with these State policies and rules. CCSSLC's policies and procedures on abuse, neglect and incident management also were	

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		reviewed. Section R of the Facility's current policy and procedure manual contains information about abuse, neglect, and incident management. There are also guidelines and forms that are in use at the Facility, and these provide the basis for some of the analysis below. Section R of the CCSSLC Policy Manual contains sub-sections on abuse/neglect of individuals served. Section R begins with a policy statement that says, "CCSS is committed to providing quality services to individuals by identifying issues, teaching and coaching and analyzing data to improve performance." Although a clear intolerance for abuse and neglect was evident when the Monitoring Team interviewed the Facility Director, this statement in the policy manual does not explicitly state that there will be zero tolerance for abuse or neglect. In speaking with staff, it was clear that staff had been trained in reporting abuse and neglect. When the reviewer inquired of staff what should be done if abuse or neglect is suspected, they consistently said they needed to protect the individual and report the abuse/neglect immediately. When the reviewer asked where they must report, staff consistently flipped over their identification badges and showed the reviewer where the instructions and phone number is always available. During an interview, the reviewer asked one staff member if he had ever reported abuse. He said that he had. When the reviewer asked the last time he made such a report, he said it was less than a week ago. This review was limited by the fact that most of the elements within the Settlement Agreement were not scheduled for completion at the Facility-level prior to the monitoring visit. At the time of the review, the Facility was at the beginning stages of implementation. Reference is made in the following sections to those action steps on the Plan of Improvement that were marked as complete.	
D2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall review, revise, as appropriate, and implement incident management policies, procedures and practices. Such policies, procedures and practices shall require:		
	(a) Staff to immediately report serious incidents, including but not limited to death, abuse, neglect, exploitation, and	According to Section R.4 of the Facility policy manual, staff are required to immediately (or within one hour) report abuse, neglect or exploitation to the Texas Department of Family and Protective Services by calling an 800 number. Reporting appears to be timely with regard to the investigation reports reviewed. Policy requires that this number be	

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	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.	posted in work areas, and each employee's ID badge carries the number as well. Policy states that other incidents such as deaths must be reported to the unit supervisor, campus coordinator and nurse, and the Director must be notified. The timeframe for this appears to be within 24 hours. During future monitoring visits, the timeliness of reporting incidents will be reviewed further. The CCSSLC Incident Management Review Team meets each weekday to discuss serious injuries and incidents, and to assure that the appropriate reporting procedures are being followed. The reviewer attended one of these meetings. The Director led the meeting. Each member had a printout of the incidents and issues being followed, and reported on any important additional information. The procedure appeared efficient and well-run. Individuals with identified issues tended generally to be followed until the issues were resolved. However, as is discussed in further detail in the section below that addresses Section E.1 of the Settlement Agreement, it was not always clear why some individuals were taken off the list prior to the identified issue being resolved, and/or why, in some cases, appropriate follow-up did not appear to occur while the person was on the list. Efforts should be made to ensure that this process continues to evolve. Standard forms are in use for the reporting of abuse, neglect, exploitation and serious injuries and incidents. According to the Plan of Improvement, staff training on abuse was scheduled to be completed by 1/30/10.	
	(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	In CCSSLC Policy in Section R.4 at page 7, it is stated that the staff member who discovers or learns about abuse/neglect/exploitation must stop the abuse/neglect/exploitation; arrange for a nurse to assess the individual for injuries, and preserve the physical evidence. In Section R.5 of the manual, the Director or her designee, must take measures to assure the safety of the alleged victim, including reassigning the alleged perpetrator away from direct contact with the alleged victim. Generally, based on the reports reviewed, it appeared that these steps were being taken. However, during the next monitoring visit, additional inquiry will occur to ensure that these steps are being implemented consistently and correctly. An Incident Management Coordinator (IMC) has been put in place to review incidents, assure that they are being addressed properly, and analyze incident reports to identify and assess series of incidents in one location for contributing factors. Several additional steps are outlined for implementation in the Plan of Improvement to enhance compliance in this area, including but not limited to: regular meetings with	

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	the investigation.	DFPS to discuss timeliness of investigations and false allegations, conduct of root cause analyses for certain series of incidents, and regular review and follow-up to ensure the safety of individuals by the IMRT. It is recommended that the Facility continue to implement these components of the Plan of Improvement.	
	(c) Competency-based training, at least yearly, for all staff on recognizing and reporting potential signs and symptoms of abuse, neglect, and exploitation, and maintaining documentation indicating completion of such training.	According to Section R.16 of the Facility Policy Manual, all staff receive an initial orientation on reporting and investigation of unusual incidents and training related to abuse, neglect and exploitation. Staff receive training on abuse, neglect and exploitation annually. While the Plan of Improvement refers to the training as "competency-based", the manual at R.16 does not. Training provided to staff will be reviewed in greater detail during the next monitoring visit.	
	(d) Notification of all staff when commencing employment and at least yearly of their obligation to report abuse, neglect, or exploitation to Facility and State officials. All staff persons who are mandatory reporters of abuse or neglect shall sign a statement that shall be kept at the Facility evidencing their recognition of their reporting obligations. The Facility shall take appropriate personnel action in response to any mandatory reporter's failure to report abuse or neglect.	Section R.4 of the CCSSLC Policy Manual at Step 4 outlines the requirements for training staff on reporting abuse, neglect and exploitation, including initial and annual training. However, the list of training topics does not specifically include the requirement that each staff member provide a written statement evidencing their reporting obligations. The Plan of Improvement specifies the maintenance of evidence of staff recognition of reporting obligations and indicates that this action step is complete, though the full implementation due date is listed as 6/26/10. A sample of staff personnel records was not reviewed during this initial review to verify the existence of the signed statements. However, this will be verified at the next monitoring review. The Plan for Improvement has a target date of 1/30/10, for the documentation of personnel actions for failure to report to be included in the unusual incident review file. This process was not fully examined during this initial review, but will be reviewed at the next monitoring visit.	
	(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	The Plan of Improvement calls for providing a training and resource guide to recognizing signs of abuse, neglect and exploitation and how to report it. It is anticipated in the Plan of Improvement that this guide will be provided at admission and annually to all individuals, primary correspondents and legally authorized representatives. The target date for this action step was 1/30/10, shortly after the initial monitoring review was completed. It will be evaluated during the next monitoring visit.	

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	unusual incidents, including allegations of abuse, neglect and exploitation.		
	(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.	At the state level, the DADS policy on abuse, neglect and exploitation did not appear to require a rights posting. At the Facility level an attractive poster called "You Have the Right" was observed in common areas in most living units. In addition to some printed information, the poster included icons to assist individuals who are not able to read in understanding their rights. In one unit (517), it was not posted at all and could not be found when requested on two (2) consecutive days. In another, it was posted where staff rather than individuals who live in the home would be likely to see it. It was also noted in some day program sites.	
	(g) Procedures for referring, as appropriate, allegations of abuse and/or neglect to law enforcement.	The Facility Policy Manual at R.1, Step 10 requires the Superintendent (now Director) to ensure that if it is determined that there is potential criminal activity that the Office of Inspector General and/or local law enforcement is notified. Section R.20 also calls for reporting suspected criminal incidents to the Office of Inspector General. The records reviewed did not include any issues that would have needed to be referred to law enforcement. This provision of the Settlement Agreement will be further reviewed during upcoming monitoring visits. The Assistant Commissioner for State Supported Living Centers has indicated that a Memorandum of Agreement/Understanding is being developed to clearly identify responsibilities in this regard.	
	(h) Mechanisms to ensure that any staff person, individual, family member or visitor who in good faith reports an allegation of abuse or neglect is not subject to retaliatory action, including but not limited to reprimands, discipline, harassment, threats or censure, except for appropriate counseling, reprimands or discipline because of an employee's failure to report an incident in an appropriate or timely	Section R.4.2 of the Facility Policy Manual provides that information about retaliation can be reported to the Director. It can also be reported to the Office of Consumer Services and Rights Protection, and/or the Office of the Attorney General. Numbers are provided for the latter two. In an interview with the Director, she made it clear that she does not condone retaliatory action, and has made referrals to the Office of Inspector General on two (2) occasions to investigate alleged retaliation. When staff were asked what they would do if they believed retaliatory action was being taken against them, they consistently indicated they would go directly to the Director to report it.	

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	manner.		
	(i) Audits, at least semi-annually, to determine whether significant resident injuries are reported for investigation.	There did not appear to be a section concerning audits in Section R of the Facility Policy Manual. However, the Plan of Improvement did include an action step to audit observation/progress notes, injury reports and shift logs to ensure that incidents are reported. The target date for this was 1/30/10, shortly after this monitoring review. However, during an interview, the Incident Management Coordinator indicated that staff were being hired to conduct these audits and the expectation was that this would be underway on schedule. This will be evaluated further during future reviews.	
D3	Commencing within six months of the Effective Date hereof and with full implementation within one year, the State shall develop and implement policies and procedures to ensure timely and thorough investigations of all abuse, neglect, exploitation, death, theft, serious injury, and other serious incidents involving Facility residents. Such policies and procedures shall:		
	(a) Provide for the conduct of all such investigations. The investigations shall be conducted by qualified investigators who have training in working with people with developmental disabilities, including persons with mental retardation, and who are not within the direct line of supervision of the alleged perpetrator.	State Policy requires both DFPS and Facility investigators to have training in investigations. However, the policy does not make it clear that both DFPS and Facility investigators must have training in working with people with developmental disabilities. It also is not clear that the investigations must be carried out by persons who are outside the direct line of supervision of the alleged perpetrator. According to the Facility's Plan of Improvement, Facility policy has been completed for this provision. However, there was no reference in Facility policy with regard to the qualifications of investigators or for the need to ensure that investigators are outside the direct line of supervision of the alleged perpetrator.	
	(b) Provide for the cooperation of Facility staff with outside entities that are conducting investigations of abuse, neglect, and exploitation.	DADS Policy Number 002.1, entitled Protection from Harm – Abuse, Neglect, and Incident Management, refers at I.D to cooperation with DFPS, and Section V.A.2.d refers to cooperation with DFPS in the conduct of investigations. Policy 002.1 at D provides for reporting to law enforcement and requires staff to abide by all instructions of the law enforcement agency. Facility policy requires employees to cooperate with Adult Protective Services (APS) investigators in all matters related to the investigation and warns employees they may	

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		be subject to disciplinary action if they fail to cooperate (see Section R.5, Step 7). Facility policy also requires cooperation with DFPS in the investigation of allegations of practices of professionals such as physicians (see Section R.5, Steps 8). Based on a preliminary review of a sample of investigations, there was no indication that CCSSLC staff had failed to cooperate with DFPS investigations.	
	(c) Ensure that investigations are coordinated with any investigations completed by law enforcement agencies so as not to interfere with such investigations.	DADS policy at Section V.D refers to reporting to law enforcement. In Facility policy, there is a reference in R.1, Step 10 that requires reporting of potential criminal activity to the Office of the Inspector General and/or local law enforcement. At R.21, the Facility policy provides for assisting the Office of Inspector General with investigations. As stated previously, the preliminary review of a sample of investigations did not identify any situations in which a referral to law enforcement should have been made, but was not.	
	(d) Provide for the safeguarding of evidence.	Section R.19 of Facility policy addresses the collection and securing of evidence. State policy references a checklist for collecting evidence that the reviewer was not able to find in the documents provided. During future visits, the state checklist will be cross-checked with the Facility policy to determine if they match, and if the checklist includes all of the necessary steps for safeguarding evidence. Based on an interview with the Incident Management Coordinator, it appeared that the Facility is following its rules for securing evidence and has a safe for that purpose. Future visits will include following the chain of evidence for selected cases.	
	(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	Facility policy at R.1, Steps 13 requires the investigation of a serious incident to commence within 24 hours, and at Step 16 requires completion of the investigation and submission of the report to the IMC within five (5) working days. The IMC then presents the final report at the next scheduled Incident Management Review Team meeting. Such meetings are scheduled each weekday morning. The policy provides for the Director to extend the time for the completion of an investigation with a signed approval at R.1, Steps 17. A written investigation report is required at R.6, Definitions and at R.6, Step 8. In reviewing 20 investigations of abuse/neglect/exploitation, it appears that the reports are generally timely, interviews with potential witnesses are being completed, and reports include findings and conclusions. Further review of investigation reports will be completed during future monitoring reviews.	

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	summary of the investigation, findings and, as appropriate, recommendations for corrective action.		
	(f) Require that the contents of the report of the investigation of a serious incident shall be sufficient to provide a clear basis for its conclusion. The report shall set forth explicitly and separately, in a standardized format: each serious incident or allegation of wrongdoing; the name(s) of all witnesses; the name(s) of all alleged victims and perpetrators; the names of all persons interviewed during the investigation; for each person interviewed, an accurate summary of topics discussed, a recording of the witness interview or a summary of questions posed, and a 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.	Section R of the Facility Policy Manual does not include a subsection addressing the content of the report of investigation of a serious incident. The Plan of Improvement includes a target date of 1/30/10, for the completion of this activity. This provision will be reviewed further during the next monitoring visit.	
	(g) Require that the written report, together with any other relevant documentation, shall be reviewed by staff	Facility policy in Section R.6, Step 7 requires that the Incident Management Coordinator review the report written by the APS investigator, and determine if further investigation is required. If it is, the IMC assigns the case to a Facility investigator and enters findings on the Final Investigation Report (FIR). It is not clear that the report is to be reviewed	

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	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.	for accuracy, completion and coherency, but the policy does specify a review by the IMC for thoroughness, prior to approving the report. Reports in the sample had been reviewed by the IMC. For one, she required additional investigation by Facility staff when she was not satisfied with the DFPS investigation. The supervisory process with regard to investigations conducted by DFPS was not reviewed during this initial monitoring visit. However, additional information regarding this process will be requested during upcoming reviews.	
	(h) Require that each Facility shall also prepare a written report, subject to the provisions of subparagraph g, for each unusual incident.	See above for discussion of FIRs. It appears that the Facility is reviewing the DFPS investigative reports, and, in two (2) instances for the sample reviewed, added recommendations to the DFPS report.	
	(i) Require that whenever disciplinary or programmatic action is necessary to correct the situation and/or prevent recurrence, the Facility shall implement such action promptly and thoroughly, and track and document such actions and the corresponding outcomes.	Section R.22 of the Facility Policy Manual addresses the immediate placement and monitoring of alleged perpetrators on temporary work assignments. It provides for removing the alleged perpetrator (AP) from contact with individuals served; obtaining a signed form from the AP indicating understanding of specific rules for conduct during temporary assignment, and warns that failure to comply may result in termination. Personnel records will be reviewed during the next monitoring visit to determine if the policy is being followed. Section R.18 addresses re-entry to the workforce after a DFPS investigation issues a finding. The employee may be directed to appear before the Facility Re-Entry to the Workforce Committee based on a specified list of conditions such as frequency of allegations, work history, etc. The committee is authorized to make recommendations to the Director who has final authority on action to be taken.	
	(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.	This is addressed in Section R.23 of the Facility Policy Manual. This section includes a description of how cases are filed, and designates the Incident Management Coordinator as the person responsible for follow-up tracking of all recommendations made as part of an unusual incident investigation. Upon interview with the IMC, it was learned that records are maintained in the Incident Management Department for the fiscal year and reportedly, on campus for 70 years. During upcoming monitoring visits, additional information will be requested from DFPS regarding how it maintains investigation records, and how investigators are using this information to inform current investigations.	
D4	Commencing within six months of	The Facility Plan of Improvement includes four (4) action steps to fully accomplish this	

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	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.	requirement and identifies the full implementation date as 6/26/10. Two (2) action steps involve collecting and analyzing data and completing monthly trend analysis. These have target dates of 1/30/10. Another action step concerns using trend analyses to determine the effectiveness of the CCSSLC system, and reporting on corrective actions to the State quarterly. The fourth refers to the State monitoring plans of correction with a target date of 10/31/09. The Facility Policy Manual contains section R.13 that was revised on 10/29/09, which is specific to incident trend analysis. This section provides for quarterly trending of incidents by type of incident, staff involved, individual(s) involved, location, day and time of incident, cause of incident, and outcomes of investigation. Trend analysis of incidents is underway and that will produce additional data as the process evolves. One of the challenges with analyzing such data will be ensuring that issues that are identified are addressed. For example, one of the trends that appears to be emerging is that less than 10 percent of the filed allegations of abuse and neglect result in the allegation being confirmed. There could be a number of reasons for this, including but not limited to problems with the investigation process; inaccurate witness statements based on fear of retaliation; misunderstanding on the part of individuals, families or staff regarding the definitions of abuse and neglect; or false allegations due to a variety factors including, for example, disputes amongst staff, or behavioral issues of individuals served. Reporting of abuse, neglect and/or exploitation should never be discouraged. However, if such a trend is confirmed through ongoing data review, not addressing it could have negative implications such as a failure to identify when abuse and neglect actually have occurred, high numbers of staff being taken out of staffing ratios while investigations are conducted, and/or a decrease in staff morale when false allegations are made. Identifying such potential trends as well as the potential causes of such trends, and developing strategies to overcome issues identified will be a challenge that the Facility will face as it refines its trend analysis processes.	
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	The State policy on Abuse, Neglect and Exploitation does not contain information on prerequisites to allowing staff or volunteers to work directly with individuals. However, Section 3000 of the DADS regulations on Volunteer Programs requires criminal background checks on volunteers at section 3200.3. The DADS Operational Handbook, Revision 09-21 Effective 10/29/09, at Part E, Section 19000 requires criminal background checks on employees. The DADS criminal history rule also contains prerequisites for allowing staff of volunteers to work directly with individuals. The Facility Plan of Improvement indicates that CCSSLC follows department rules that support this outcome. During an interview, the Incident Management Coordinator	

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	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.	indicated that potential staff members are fingerprinted prior to employment, and checked in the Federal Bureau of Investigation (FBI) system and the Client Abuse and Neglect Reporting System (CANRS) system, which tracks abuse. A secure internet check allows for identification of a person who has been confirmed to have abused individuals served. It was not clear whether volunteers at CCSSLC are always checked prior to interacting with individuals, or directly supervised if pre-volunteer investigations are not complete. Review will need to be completed of personnel and volunteer records during upcoming reviews.	

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

- Since it appears that DADS and Facility policies related to abuse, neglect and incident management were being developed simultaneously, the Facility should compare its completed or near-completed policy sections against the State polices that have been completed. This will ensure that the Facility's policies and procedures reflect the requirements set forth by the State.
- Although it seems that staff understand that abuse and neglect will not be tolerated, and the Facility policy sets out circumstances when reporting is required as well as the results of failure to report, a strong statement of commitment that abuse and/or neglect will not be tolerated should be added at the beginning of Section R.4.
- The detailed action steps in the Plan of Improvement for Section D.2.b of the SA regarding follow-up to allegations of abuse and neglect should continue to be implemented.
- The Facility Policy Manual should specifically state that staff must complete annual competency-based training on abuse and neglect.
- Specific language should be included in Section R.4 of the Facility Policy Manual requiring annual notification to staff of their obligation to report abuse, neglect or exploitation, and the requirement that each staff member provide a written statement of acknowledgement of their responsibilities to report.
- The "You Have the Right" poster should be posted in all homes and day program sites in common areas that are frequently accessed by individuals served.
- Requirements about training of investigators should be included in the DADS' policy on Abuse/Neglect/Exploitation, or if these requirements are elsewhere in State policy, reference to their location should be provided in the A/N/E policy. The DADS' policy also should include requirements that the Facility Investigator be outside the direct line of supervision of the alleged perpetrator.
- In CCSSLC policy, a section should be included on training of investigators that requires Facility investigators be trained in investigations and in working with people with developmental disabilities. The Facility policy also should include a requirement that Facility Investigators be outside the direct line of supervision of the alleged perpetrator.
- The Facility should develop and implement an investigation format that meets the requirements of Section D.3.f of the SA. This format should be included in Section R of the Facility's Policy Manual, along with an explanation of how the investigation report should be completed and a detailed description of the supervisory level review that needs to be conducted.

SECTION E: Quality Assurance	
Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall develop, or revise, and implement quality assurance procedures that enable the Facility to comply fully with this Agreement and that timely and adequately detect problems with the provision of adequate protections, services and supports, to ensure that appropriate corrective steps are implemented consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS Policy #003: Quality Enhancement, dated 11/13/09; o CCSSLC Plan of Improvement, dated 8/28/08; o CMS Statement of Deficiencies, dated 4/3/09; o CMS Statement of Deficiencies, dated 5/30/09; o CMS Statement of Deficiencies, dated 5/2/09; o CMS Statement of Deficiencies, dated 7/21/09; o Trend Analysis Report FY10 December; and o Trend Analysis for First Quarter FY10 ▪ **Interviews with**: o Daniel Dickson, Quality Enhancement Director on January 5, 2010
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: Many of the quality enhancement activities at CCSSLC are in the initial stages of development. A Quality Enhancement Plan is not yet in place. However, the staff in the Quality Enhancement Department appear to be working intensely to develop and implement processes that will allow them to monitor the Facility's progress on the Facility Plan of Improvement designed to assist the Facility in achieving compliance with the Settlement Agreement, as well as to monitor abuse and neglect reporting, and to work on risk assessment of individuals served. Trends are being reported quarterly for some key issues, such as abuse allegations, incidents, and hospitalizations. Information is available to show some specific characteristics of incidents, such as where incidents are occurring, what time of day, and on which living units. The next step, which can be a challenging one, is responding to the trends with thorough analyses of potential causes, and the development of action plans to address issues identified. Follow-up will also need to occur to ensure that actions are taken that effectively address the trends. The Quality Enhancement Plan is not yet in place, though it is in the queue for development. Some quality monitoring is underway, such as checks of Personal Support Plans for timeliness and completeness. Upcoming challenges will include checking for quality of the plan, the integration of information from the assessments, and the true individualization of supports and activities. There are a number of other areas in which the quality of supports, services and protections will need to be regularly monitored, the data analyzed, and action taken, as appropriate. As the Quality Enhancement Plan is developed, it will be important to define the roles of various staff throughout the Facility in the quality enhancement process.

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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.	The Monitoring Team's review of the State Policy with regard to quality assurance/enhancement showed that it was consistent with the requirements of the Settlement Agreement. The Facility had not yet developed quality assurance policies. The Facility's Quality Enhancement Director was interviewed, and provided helpful information about the activities of the CCSSLC quality enhancement program. At the time of the review, there were some activities, including daily Incident Management Review Team meetings, and unit meetings at which data regarding allegations and incidents, restraint, medical issues, and environmental concerns were being discussed. This process is described in further detail below. These meetings are a good basis for further review and analysis of individual as well as system-wide data. They also provide a forum from which action plans can be developed and tracked. The "Trend Analysis for First Quarter FY10" contained data and analysis for restraints, incidents, and allegations of abuse. Total restraints were analyzed as compared to a year ago; the number of restraints by residence and location within the residence; the number of allegations of abuse by residence; the number of allegations confirmed; the number of incidents involving injury and the most common type of injury. The Incident Management Review Team, led by the Facility Director, meets on weekdays to review the most recent unusual incidents, the status of pending DFPS reports, reports of individual-to-individual aggression, discovered injuries, restraint as a crisis intervention, emergency rights restrictions, and significant medical issues/admission to hospital or infirmary. Members of the team include executive staff, the medical administrator, unit directors and other key staff. They follow an agenda that includes reporting of new incidents or allegations, exchanging and updating information, designating tasks that need follow-up, and making assignments with regard to follow-up tasks. It was not always clear what progress was being made for someone who remained on the list for some time. In addition, it was not always clear if the IMRT was asking all of the critical questions necessary to resolve incidents, ensure adequate supports and services for individuals, and prevent unnecessary incidents or complications. For example: ▪ Individual #10 entered the Infirmary on 6/22/09, with "S/P Community Acquired Pneumonia." On 12/7/09, he was still in the Infirmary and on the significant medical issues list, and he remained there on 12/30/09. It is possible that at some point during his six (6) month stay at the Infirmary that the IMRT was asking questions about his progress, the care being provided to him, and steps that could be taken to prevent such illnesses in the future. However, such discussion is not reflected in the notes on the form. ▪ Likewise, Individual #5 entered the North West Behavioral Hospital on 12/4/09.	

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		On 12/21/09, the IMRT report noted a date of discharge as 12/18/09. On 12/23/09, a discharge planning date was recorded as 12/18/09. On 12/28/09, Individual #5 was no longer on the list. It might have been useful to indicate on the sheet the day that he returned to CCSSLC. It also would be important to know why there was not some notice of the discharge date so that planning for his return could take place. Each unit meets each weekday to review incidents, allegations of abuse, emergency use of restraints and restrictive procedures, injuries and significant medical issues. They review recommendations for follow-up, assign persons to be responsible for resolution and indicate due dates. They also track outstanding work orders. This kind of process, when done regularly, can be effective in keeping issues on track for resolution. The process lends itself to review by executive staff to check on whether identified issues are being resolved. It is not clear what criteria is used for a person who is being followed to be removed from the list, and whether being removed from the list means the identified issue(s) has been resolved. For example: ▪ Individual #11 appeared to have been placed on the list for "recommendations and follow-up" on 6/01/09, with a recommendation that he transfer to a unit more suited to his mobility and activity levels. He was removed from the list on 12/4/09. However, the report for 12/03/09 still showed him with a pending due date, and no indication that a move was scheduled. There are a number of areas in which data is either just beginning to be collected, or it is anticipated will be collected. For example, the Quality Enhancement (QE) Department has just begun to review individuals' records, and will be collecting and aggregating data on this. Likewise, the QE Department will be developing review tools for Settlement Agreement items such as PSPs, and Community Living and Discharge Plans (CLDPs). These reviews will result in the collection of data that will need to be aggregated and analyzed, trends identified and action plans developed, as needed and appropriate.	
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	Although the Settlement Agreement does not anticipate full compliance with this provision until 6/26/12, according to the CCSLC Plan of Improvement, some data are already being analyzed regularly. For example, data on restraints are trended by quarter, showing a dramatic decrease in use of restraints from 223 times in the first quarter of FY 2009 to 59 in the first quarter of FY 2010. The Trend Analysis Report for the first quarter of FY 2010 shows restraints being used most often in apartments 518, 517 and 511, and most incidents occurring in the living room, hallway or bedroom. Allegations of abuse had been analyzed, showing that Tropical and Atlantic made up 75 percent of the	

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	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.	allegations in the first quarter. Only nine (9) percent of allegations were confirmed. Self-injurious behavior and aggression were identified as the most frequent causes of injuries. Injuries also were analyzed showing that of the 670 injuries reported in the first quarter, 10 were serious. The most common injury by type was "scratch" (146.) The second most frequent was "other" at 105. Most injuries occurred in apartments 511, 514 and 522A. The trending of data is off to a good start and should continue to be refined as additional data are collected. The next important step will be developing and implementing corrective action plans to address identified problems. For example, the data reveals significant issues with apartment 511. It is the location of many restraint uses, and the location of the most injury reports. This suggests that some further investigation and corrective action is needed to reduce such occurrences in that apartment. One way that data analyses can be used productively is to identify the areas where several issues occur simultaneously, and where concentrated action might produce the largest positive results. One corrective action plan that the Facility Director shared with the Monitoring Team was a plan that was put in place to address some significant allegations of abuse that were confirmed. The plan described by the Facility Director appeared to be thoughtful, measurable, and identified specific people responsible for implementation. The plan included a number of action steps designed to shape the culture within the Facility to be one of respect for the individuals served; ensure that there was consistent supervision provided to staff on a 24-hour-a-day, seven-day-a-week basis; improve the quality of supervision provided to staff; and ensure that staff were aware of their responsibilities and had the knowledge to do their jobs. One of the results of the implementation of this plan was the development and implementation of a teaching tool that the Monitoring Team viewed as exceptional in its conception and in its potential for making a difference. The "CCSSLC Active Treatment Monitoring – Coaching Guide", dated 12/18/09 was in use by night shift supervisors as a prompt during their rounds, and as a tool to promote learning by the staff under their supervision. It included 24 questions and was designed for use with one staff member at a time to help ensure that staff members understand their responsibilities. This tool provides structure to the supervisory process, a regular mechanism for one-to-one interaction and training of direct support staff by supervisors, and a method for management to collect data that can be analyzed to identify gaps in knowledge on an individual staff level and/or systemic level. When the reviewers visited homes during the overnight shift, this tool was clearly in use. Supervisors reported that it assisted them in structuring their time, and ensuring that staff had the knowledge they needed to do their jobs. This is a good example of how careful development and implementation of corrective action plans can have a positive impact.	

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E3	Disseminate corrective action plans to all entities responsible for their implementation.	According to the CCSSLC Plan of Improvement, this step was not scheduled to begin until 12/26/09, with full implementation in 6/26/12. At the time of this review, steps were already under way to establish this practice. This will be reviewed further during the next monitoring visit.	
E4	Monitor and document corrective action plans to ensure that they are implemented fully and in a timely manner, to meet the desired outcome of remedying or reducing the problems originally identified.	According to the CCSSLC Plan of Improvement, this step was not scheduled to begin until 12/26/09, with full implementation in 6/26/12. This will be reviewed further during the next monitoring visit.	
E5	Modify corrective action plans, as necessary, to ensure their effectiveness.	According to the CCSSLC Plan of Improvement, this step was not scheduled to begin until 12/26/09, with full implementation in 6/26/12. This will be reviewed further during the next monitoring visit.	

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

- The Facility should continue to conduct daily Incident Management Review Team meetings as well as unit meetings. The processes used by these committees should be refined to ensure that critical questions are asked and answered, and follow-up is tracked to completion. In addition, clear criteria should be developed to determine which individuals and incidents the team should review, and when an individual or topic should be closed or removed from the list.
- The CCSSLC QE Department should finalize the development of the Quality Enhancement Plan, including the development of review tools that will be used, schedules for monitoring, processes for analyzing data, identifying trends, and developing, implementing and monitoring corrective action plans. The roles of other departments and staff in the QE monitoring process as well as the implementation of corrective action plans should be defined.
- As problematic trends and/or individual issues are identified, the Facility should develop, implement and monitor corrective action plans. It might be useful to begin this process by identifying an apartment, such as 511, for which there appears to be a spike(s) in trend data, analyze the data, identify potential causes for such trends, and develop a plan of action to address the associated issues. Apartment 511 shows up as one of the places restraint is used most often as well as one where injuries occur most frequently.

SECTION F: Integrated Protections, Services, Treatments, and Supports	
Each Facility shall implement an integrated ISP for each individual that ensures that individualized protections, services, supports, and treatments are provided, consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o CCSSLC Policy Section F: Person Supported Planning and Active Treatment, as of 1/25/09; o CCSSLC Active Treatment Monitoring-Coaching Guide, dated 12/18/09; o PSPs, Evaluations and Specific Program Objectives (SPOs) for the following individuals: Individual #2, Individual #3, Individual #5, Individual #8, Individual #9, Individual #10, Individual #12, Individual #13, Individual #14, Individual #15, Individual #16, Individual #17, Individual #18, Individual #19, Individual #20, Individual #21, Individual #22, Individual #23, Individual #24, and Individual #25 ▪ **Interviews with**: o Daniel Dickson, Director of Quality Enhancement; o Henry G., Active Treatment Specialist (ATS); o Qualified Mental Retardation Professionals (QMRPs); and o Individual #23, Individual Served ▪ **Observations of**: o PSP Staffing meeting for Individual #23; and o PSP Staffing meeting for Individual #26
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: CCSSLC is at the beginning stages of implementing a new Personal Support Plan format that was introduced in November 2009. It appears that the new format is designed to address some of the components of the Settlement Agreement that the previous format did not address. Because very few teams had utilized the new format at the time of the review, the sample of PSPs reviewed generally used the old format. Some of the positive aspects of the plans reviewed included efforts to identify the preferences and achievements of individuals served; inclusion of Legally Authorized Representatives in team meetings, including offering options such as telephone participation; and updating PSPs at least annually. The biggest challenge for CCSSLC with regard to PSPs appears to be with regard to ensuring that team meetings include interdisciplinary discussions that result in one comprehensive, integrated treatment plan for each individual. This also includes the need to incorporate individuals' preferences and desired outcomes into the planning process in a meaningful way. As is noted in other sections of this report, issues with regard to adequate assessments impact teams' ability to identify strengths as well as needs of individuals. As assessment processes improve, teams will have better tools on which to base their

	discussions and the resulting integrated plans. Quality Enhancement activities with regard to PSPs are in the initial stages of development and implementation. As this process proceeds, it will be important to ensure that there is a focus on the integration of all needed supports and services into one comprehensive plan.

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F1	**Interdisciplinary Teams -** Commencing within six months of the Effective Date hereof and with full implementation within two years, the IDT for each individual shall:	The DADS policy for this section had not been developed at the time of this review, and so it was not reviewed. The CCSSLC Policy Manual, Section F addresses person supported planning and active treatment. Since the DADS policy, which is anticipated to include changes, was not available to the Facility, a comprehensive review of the Facility policy was not completed during this review. However, CCSSLC's Plan of Improvement was examined to determine the status of updating policy sections. Only three (3) items on the Plan of Improvement for this section were noted as "complete." A general review of the policy manual section revealed that it is under development, for example, pages were out of order, mis-numbered, or missing when compared to the table of contents. The 20 PSPs that were reviewed were chosen from among those people who appeared on abuse reports, incident reports, at risk lists and restraint lists.	
F1a	Be facilitated by one person from the team who shall ensure that members of the team participate in assessing each individual, and in developing, monitoring, and revising treatments, services, and supports.	The CCSSLC Plan of Improvement noted this subsection as "complete." According to the Table of Contents for Section F, dated 6/20/09, Subsection F.3 is entitled "Participating in the Annual Planning Meeting", and appeared to be the likely location for information about which team member is the team facilitator. However, that section was not included in the materials the Facility provided. Reviews of PSPs suggest that the QMRP is the team leader and responsible for ensuring team participation, but this is not clearly set forth in the policies and procedures examined. In the interview with the QMRPs, it was not clear that all of those attending understood their role as facilitator of the PSP, and, particularly, for assuring that team members participated and supplied required information. Many of the QMRPs present indicated they were newly employed in this role, and that may explain lack of clarity about responsibilities. The following provides some information related to the specific meetings which members of the Monitoring Team attended: ▪ At the PSP meetings attended by the reviewer for Individual #23, the QMRP was clearly taking a lead role in the conduct of the meeting, assuring that all	

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		paperwork was present, and that the individual and all team members fully participated. This QMRP, however, was the most senior of the group of QMRPs interviewed. ▪ At the PSP meeting for Individual #26, the QMRP provided leadership with regard to ensuring the agenda of the meeting moved forward. However, the QMRP missed opportunities to involve the individual in the meeting, as well as to encourage team interaction to ensure that an interdisciplinary process was used to problem-solve and solicit input from team members with various expertise. For example, the team identified that Individual #26 has dental issues, and that he refuses dental care. A team member indicated that psychology was working on a desensitization plan. However, the QMRP did not provide leadership to solicit from the team a plan to address the immediate dental concerns that Individual #26 was experiencing.	
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.	A policy to this effect was not found in the current Facility Policy Manual. However, the Plan of Improvement indicated that there is a "Person Directed Planning tracking system, QSO database", which should make it possible to track whether staff connected to the person and his/her interests are participating in plans. At the team meetings attended, this did appear to be happening. Efforts were made, for example, to include the Legally Authorized Representative (LAR) by telephone, if he/she could not attend in person. In reviews of PSPs, QMRPs were present at the annual meetings. Others participating included nurses, direct care professionals, Legally Authorized Representatives, psychologists, Occupational Therapists (OTs), Physical Therapists (PTs), and other disciplines, depending on the individual's circumstances. Vocational staff or day program staff were not always in attendance, however, as noted for Individual #8, for example. This provision will continue to be reviewed during upcoming monitoring visits.	
F1c	Conduct comprehensive assessments, routinely and in response to significant changes in the individual's life, of sufficient quality to reliably identify the individual's strengths, preferences and needs.	Most of the PSPs reviewed contained assessments of health, residential living [often Positive Adaptive Living Skills (PALS)], behavior including psychological evaluations, speech, OT/PT, nutrition, self-administration of medication, audiological screening, dental, community living options, and other assessments based on specific needs. Vocational evaluations were in most, but not all, files. Sometimes Vocational information was included in the PALS, but not always. Plans included a "Personal Focus Worksheet" (PFW) that gathered information on the individual's preferences. Some plans included the DADS-authorized assessment forms for various potential risks such as aspiration, weight, nursing risks, and polypharmacy. This Facility's Plan of Improvement Indicated that this was an area in which work was still underway. As noted in a number of other sections of this report, the Monitoring Team found the	

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		quality of assessments to be an area needing improvement. In order for adequate protections, supports and services to be included in individuals' PSPs, it is essential that adequate assessments be completed that identify individuals' preferences, strengths, and needs. This provision of the SA will continue to be reviewed during upcoming monitoring visits.	
F1d	Ensure assessment results are used to develop, implement, and revise as necessary, an ISP that outlines the protections, services, and supports to be provided to the individual.	The connection between the assessment results and the PSP are not always clear. For example, on Individual #2's personal focus worksheet, it says she does not like to swim. But in her PSP, going swimming is listed at one of the things most important to her. Smoking cigarettes was important to her on both lists, as was contact with her boyfriend. On the worksheet, a private bathroom and a quiet, calm environment seemed important, yet those do not appear on her PSP's most important list. Behavioral services include sex education, yet she clearly said she did not want to participate in such education on the worksheet, and the PSP does not offer an explanation regarding how the team reconciled this. Crafting connections between what an individual likes or what interests them to how the person's services and supports are configured can be challenging, but the results can be positive. Conversely, if an individual's preferences are not adequately considered, the provision of adequate treatment may be difficult to attain. In addition, there appear to be two (2) major factors negatively impacting the Facility's ability to ensure that assessment results are used to develop, implement, and revise, as necessary, an ISP that outlines the protections, services and supports provided to the individual. These are: 1) as is noted above in the section of this report that addresses Section F.1.a of the SA, there is a lack of consistent interdisciplinary discussion and coordination in the development of PSPs. This limits 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 are inadequate. Examples of this include inadequate nursing assessments, vocational assessments, psychiatric assessments, and assessments of individuals' physical and nutritional management support needs. The Facility needs to address these two (2) issues to ensure that appropriate assessment information is available, and that teams use such information in an integrated fashion to develop the comprehensive, individualized plans required by the SA.	
F1e	Develop each ISP in accordance with the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132 et seq., and the United States Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581	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.	

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	(1999).		
F2	**Integrated ISPs -** Each Facility shall review, revise as appropriate, and implement policies and procedures that provide for the development of integrated ISPs for each individual as set forth below:		
F2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, an ISP shall be developed and implemented for each individual that:	According to the interview with the QMRPs, in approximately November 2009, QMRPs underwent training, and a new PSP format was introduced statewide. At the time of this review, not all QMRPs had used the new format yet, and many of plans for the PSP staffing meetings at which it had been used were still in the drafting/production stage. As a result, the Monitoring Team could not conduct a thorough review of the new format and its implementation. Therefore, a review of a sample of mostly the older format PSPs was conducted, and some commentary is provided below. However, at upcoming reviews, samples of the new format PSPs will be reviewed. Based on information provided by the QMRPs, it appears that the newer format includes some of the components required by the Settlement Agreement that the older format did not include. As stated previously, the DADS policy on Integrated PSPs had not been completed at the time of the review. The Monitoring Team looks forward to reviewing the DADS policy once it is completed, as well as the Facility's implementation of PSPs in accordance with the new policy and new PSP format.	
	1. Addresses, in a manner building on the individual's preferences and strengths, each individual's prioritized needs, provides an explanation for any need or barrier that is not addressed, identifies the supports that are needed, and encourages community participation;	PSPs reviewed generally included some information regarding the individual's preferences and strengths. However, clear prioritization of the individual's needs or careful delineation of barriers to addressing needs was not found. The integration of individuals' preferences to address needs or barriers also was not consistently seen. For example: ▪ Individual #2 wanted to move to a community setting to live near a specific friend. The plan did not address whether the team agreed and, if so, how the team was going to support the individual to attain this goal, or, if not, how the individual would be educated about the risks and benefits of living near this friend. ▪ Individual #2 also wanted a small dog. Again, there was no plan to assist the person in realizing this goal or explanation of why it was not possible. If it was not possible immediately, there was no explanation of how the individual would be educated about the requirements for owning a dog, or a plan to provide the individual with other options for interacting with dogs, such as a volunteer opportunity. ▪ According to Individual #19's PSP, he has a number of health issues and is losing weight. His PSP includes a health management plan to address his undesired	

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		weight loss. His psychological evaluation notes his reluctance to eat and the difficulty staff have assisting him to eat because of constant head turning. The evaluation says that he sometimes eats everything offered to him. However, no integrated team discussion regarding these various pieces of information was documented. For example, has the team noted what is being served and who is feeding him when he eats everything? Is there a medical or behavioral reason for the constant head turning? Discussion by the team of these kinds of questions could lead to possible solutions to overcoming challenges. Community participation was included in some individual's plans, but it was not a focus such that it could be termed "encouragement." Barriers to community participation were not always identified and addressed. For example: ▪ Individual #22's PSP indicated that he wanted to go to a Catholic church. Some sexually inappropriate behaviors may make that challenging, but nothing was said about how a program might be implemented that could lead to off-grounds church participation. The lack of goals and objectives designed to encourage community integration is discussed in further detail in the section of this report that addresses Section S of the SA.	
	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;	PSPs generally included some individualized and measurable goals/objectives, treatment strategies and supports. However, as is discussed in further detail throughout this report, improvement is needed in this area. For example, nursing plans, that should be incorporated into the overall PSP, do not generally contain individualized measurable goals/objectives. This is further detailed in the section of this report that addresses Section M of the Settlement Agreement. Likewise, as is discussed below with regard to Sections O and P of the SA, measurable functional outcomes are not being identified for individuals in need of physical and nutritional management support. At this juncture, behavior support plans and psychiatric treatment plans do not contain all of the measurable goals and/or objectives that they should. What also is not consistently clear is whether or how these goals and objectives are related to individuals' preferences, or are designed to overcome barriers to living in the most integrated setting.	
	3. Integrates all protections, services and supports, treatment plans, clinical care plans, and other interventions provided for the individual;	PSPs appear to integrate some, but not all protections, services and supports that individuals require. For example, the health services portion of the plan frequently still stands apart, as does the PBSP. As is discussed in greater detail below with regard to Section J of the SA, another striking example of the lack of integration is between psychiatric and behavioral services. Without a fully functioning Physical and Nutritional Management Team, the integration of such services to address the needs of individuals is	

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		lacking, as is discussed in further detail in the section that addresses Section O 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, methods, timeframes and staff responsible were identified.	
	5. Provides interventions, strategies, and supports that effectively address the individual's needs for services and supports and are practical and functional at the Facility and in community settings; and	As identified in other sections of this report, not all of the interventions, strategies and supports offered to individuals at CCSSLC effectively address individuals' needs, and not all are practical and functional at the Facility and/or in community settings.	
	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 data collection, and the person(s) responsible for the data review.	Generally, PSPs and the resulting Specific Program Objectives contain data collection methods, frequency with which data should be collected, and identify a person(s) responsible. CCSSLC Policy Manual contains Section F.41 that covers team participation in PSP Monthly reviews, and specifies reporting formats for the QMRP, the Medical and the behavioral supports reviews. These reviews lead to team meetings, and a template to record the results is identified. While this process is useful, it is not clear that the team is required to review objective data, nor does the Facility policy place a single person in charge of the overall process. The QMRP clearly coordinates the process, but whether the QMRP has authority to insist on compliance from other team members is not clear. Again, as is discussed in other sections of this report, not all components of individuals' PSPs identify the data to be collected, the frequency, and/or the persons responsible for such data collection. For example, some of these elements are missing from the nursing care plans, as well as psychiatric services such as the monitoring of symptoms that medications are prescribed to reduce.	
F2b	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall ensure that goals, objectives, anticipated outcomes, services, supports, and treatments are coordinated in the ISP.	As noted above, there are issues with regard to the integration and coordination of outcomes, services and supports in individuals' PSPs. This will continue to be evaluated as the new policy and format for PSPs is implemented.	
F2c	Commencing within six months of	At present the PSP is located on the residential unit, but locked in a cabinet for security	

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	the Effective Date hereof and with full implementation within two years, the Facility shall ensure that each ISP is accessible and comprehensible to the staff responsible for implementing it.	reasons. Given privacy and security requirements, this is appropriate. It appeared that if staff needed access to the locked records, a key was easily available. The SPOs are located on the unit and accessible to staff, usually in folders or notebooks. As the new format for the PSPs is implemented, the Monitoring Team will review whether it is comprehensible to staff responsible for its implementation.	
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.	Section F.41 of the Facility Policy Manual provides for monthly reviews of the PSP, monthly meetings of the key plan participants and reporting of needed changes. The QMRP is authorized to call a meeting within five (5) working days to review any recommendations and to complete a PSP amendment. As noted above, while this process is useful, it is not clear that the team is required to review objective data, nor does the Facility policy place a single person in charge of the overall process. The QMRP clearly coordinates the process, but whether the QMRP has authority to insist on compliance from other team members is not clear. During future monitoring visits, monthly team meetings will be reviewed in further detail.	
F2e	No later than 18 months from the Effective Date hereof, the Facility shall require all staff responsible for the development of individuals' ISPs to successfully complete related competency-based training. Once this initial training is completed, the Facility shall require such staff to successfully complete related competency-based training, commensurate with their duties. Such training shall occur upon staff's initial employment, on an as-needed basis, and on a refresher basis at least every 12 months thereafter.	According to the Facility Plan of Improvement, the Facility target date for implementing this provision is 9/30/10. This provision will be reviewed during future monitoring reviews.	

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	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.		
F2f	Commencing within six months of the Effective Date hereof and with full implementation within one year, the Facility shall prepare an ISP for each individual within thirty days of admission. The ISP shall be revised annually and more often as needed, and shall be put into effect within thirty days of its preparation, unless, because of extraordinary circumstances, the Facility Superintendent grants a written extension.	Since July 1, 2009, no individuals have been admitted to the Facility. Based on the sample of PSPs reviewed of individuals currently residing at the Facility, all had been updated within the last year. The Monitoring Team also reviewed some addenda to PSPs that were completed due to the changing needs of individuals. A more systematic review will be completed during upcoming monitoring reviews to ensure that annual reviews are being completed for all individuals at the Facility.	
F2g	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement quality assurance processes that identify and remediate problems to ensure that the ISPs are developed and implemented consistent with the provisions of this section.	According to discussions with the Quality Enhancement Division Director, planning for this provision is underway. The QE Department currently is monitoring a sample of plans for timeliness and completeness. Their review does not currently include a review of all of the indicators required by the Settlement Agreement, but the QE Department reportedly is moving in this direction. During upcoming reviews, the Monitoring Team will review the tools being developed by the QE Department to address this provision, as well as the results of monitoring, and any actions to address issues identified.	

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

- Section F of the Facility Policy Manual should be modified to address changes in DADS policy once it is finalized. Facility policy should include subsections that:
    - Explain the role and authority of the QMRP with regard to the team process, or identify an alternative team leader. Such a statement might be included as part of the policy statement at the beginning of Section F; and
    - Emphasize the need for individuals' teams to include clinical and direct support staff, dictated by the preferences and needs of the individual. This should include vocational and/or day program staff, whenever appropriate.

- QMRPs and/or others with responsibility for facilitating team meetings should be provided with competency-based training on group facilitation, particularly as is relates to the interdisciplinary team process.
- As teams are trained on the new PSP policy and format, a focus should be on all team members' role in the interdisciplinary process, including the integration of information and development of strategies to address individuals' preferences and needs, and to identify and overcome barriers.
- As indicated in other sections of this report, focused efforts should be made to improve the quality of assessments that are used in the development of individuals' PSPs.
- The Facility's QE processes with regard to PSPs should include reviews to ensure that all of the components of the Settlement Agreement with regard to PSPs are addressed, including but not limited to assessment to ensure that:
  - Team composition includes the individual, the LAR, the QMRP, staff who regularly provide direct supports to the individual, and others that reflect the individual's preferences, needs and strengths;
  - Comprehensive assessments are completed, and the results integrated into the PSP;
  - Assessments are completed to identify the preferences of the individual and his/her LAR, and that this information is used meaningfully by the team in developing supports and services for the individual. Teams should constantly challenge themselves to discover creative ways to deliver what is needed in ways that are positive for the individual, and help move her/him farther toward her/his goals.
  - Team meetings include interdisciplinary discussion that utilizes the team's knowledge of the individual and his/her strengths, preferences, desired outcomes and needs to develop one comprehensive, integrated plan for each individual.
  - Interventions, strategies and supports are functional at the Facility and in the community.
  - Community integration is encouraged.

SECTION G: Integrated Clinical Services	
Each Facility shall provide integrated clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below.	**Steps Taken to Assess Compliance:** Information gathered as a result of activities undertaken to assess clinical services discussed throughout this report was analyzed to make determinations with regard to the Facility's progress with these provisions of the Settlement Agreement.
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: As is discussed in other sections of this report, at the time of this initial review, there were a number of gaps with regard to the integration of clinical services. It appears that the Facility is working on methodologies to ensure that recommendations from non-Facility clinicians are reviewed, considered, and documentation maintained justifying decisions.

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G1	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall provide integrated clinical services (i.e., general medicine, psychology, psychiatry, nursing, dentistry, pharmacy, physical therapy, speech therapy, dietary, and occupational therapy) to ensure that individuals receive the clinical services they need.	As is discussed in other sections of this report, at the time of this initial review, there were a number of gaps with regard to the integration of clinical services. Some of the most striking include the need for greater integration between psychiatric and behavioral support; dental/medical and behavioral/psychology; nursing and dental; and between the disciplines responsible for the provision of physical and nutritional supports to individuals served. These are all discussed in further detail in the sections of this report that address these various disciplines.	
G2	Commencing within six months of the Effective Date hereof and with full implementation within two years, the appropriate clinician shall review recommendations from non-Facility clinicians. The review and documentation shall include whether or not to adopt the recommendations or whether to refer the recommendations to the IDT for integration with existing	It appears that the Facility is working on methodologies to ensure that recommendations from non-Facility clinicians are reviewed, considered, and documentation maintained justifying decisions. According to the Facility's Plan of Improvement, processes were being put in place for this beginning on 12/26/09, shortly before this review, with a target date for completion of 1/20/11. During upcoming monitoring visits, this will be reviewed.	

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	supports and services.		

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

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

SECTION H: Minimum Common Elements of Clinical Care	
Each Facility shall provide clinical services to individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** Information gathered as a result of activities undertaken to assess clinical services discussed throughout this report was analyzed to make determinations with regard to the Facility's progress with these provisions of the Settlement Agreement.
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: According to the Facility's Plan of Improvement, the Facility is in the process of developing policies and procedures to implement these provisions of the Settlement Agreement. The target date for most of these activities is 1/30/11. As is illustrated throughout this report, different clinical disciplines are at different stages of ensuring that assessments and evaluations are completed as required or needed, treatment plans are developed and implemented, monitoring systems are in place to measure compliance with and the efficacy of treatment plans, and treatments and interventions are modified as needed.

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H1	Commencing within six months of the Effective Date hereof and with full implementation within two years, assessments or evaluations shall be performed on a regular basis and in response to developments or changes in an individual's status to ensure the timely detection of individuals' needs.	As is illustrated throughout other sections of this report, there are issues with regard to assessments and evaluations being completed regularly, and performed in response to development or changes in an individual's status. Some examples of this include nursing assessments, particularly with regard to individuals who experience acute illness; individuals who may benefit from communication systems; individuals being considered for enteral nutrition; and individuals requiring restorative dental care.	
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	As is illustrated, particularly with regard to psychiatric services, the assessment processes used to determine diagnoses are not always consistent with DSM criteria or generally accepted standards of practice.	

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	Related Health Problems.		
H3	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be timely and clinically appropriate based upon assessments and diagnoses.	As is referenced in the section above with regard to Section H.1 of the Settlement Agreement, without timely and thorough evaluations and assessment, the planning of treatments and interventions is hindered. For example, for individuals for whom communication needs are not properly assessed, adequate treatments and interventions cannot be developed, and implemented. Likewise, if psychiatric diagnoses are not accurate and/or if psychiatric services are not integrated with behavior supports, then proper treatment likely will not be provided.	
H4	Commencing within six months of the Effective Date hereof and with full implementation within two years, clinical indicators of the efficacy of treatments and interventions shall be determined in a clinically justified manner.	As is illustrated in various sections of this report, clinical indicators often are not identified. For example, when psychiatric medications are prescribed, the target symptoms are generally not clearly identified, and tracked to assist in determining the efficacy of the treatment. Likewise nursing plans do not identify what clinical indicators will be tracked, by whom, or when. Physical and nutritional management plans also do not identify the functional outcomes to be measured, and behavior support plans frequently do not identify measurable goals for the decrease of challenging behavior.	
H5	Commencing within six months of the Effective Date hereof and with full implementation within two years, a system shall be established and maintained to effectively monitor the health status of individuals.	Again, as is illustrated, for example, in the nursing and physical and nutritional support sections of this report, there are not systems in place to effectively monitor the health status of individuals.	
H6	Commencing within six months of the Effective Date hereof and with full implementation within two years, treatments and interventions shall be modified in response to clinical indicators.	Until accurate clinical indicators are developed and monitored/measured, this will continue to be an indicator on which the Facility needs to work.	
H7	Commencing within six months of the Effective Date hereof and with full implementation within three years, the Facility shall establish and implement integrated clinical services policies, procedures, and guidelines to implement the provisions of Section H.	According to the Facility's Plan of Improvement, such policies are anticipated to be completed beginning at the end of December 2009, with a target date of 1/30/12. This will be further assessed during upcoming visits.	

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

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

SECTION I: At-Risk Individuals	
Each Facility shall provide services with respect to at-risk individuals consistent with current, generally accepted professional standards of care, as set forth below:	**Steps Taken to Assess Compliance:** The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o DADS Policy #006: At Risk Individuals, dated 10-15-09; o DADS Risk Assessment Tools, dated 8-31-09; o Health Risk Assessment Tool-Nursing; o Braden Scale; and o CCSSLC's lists of individuals with clinical risks ▪ **Interviews with**: o Colleen M. Gonzales, BSHS, Chief Nurse Executive; o Rhonda Lynn Warner, RN, QA; o Shelly Scott, RN, Nursing Operations Officer; o Teresa Irvine, RN, MSN, Director Employee Health/Infection Control (IC); o Julie Graves Moy, MD, MPH, Medical Director, State Office; o Della Cross, RN, Nurse Educator; o Daniel Dickson, Director of Quality Enhancement; o Nutritional Management Team (NMT) Chairperson; o Physical therapists, occupational therapists, and speech-language pathologists, as well as other professionals, and direct support professional during observations; and o Dr. Robert Cramer, Director of Behavioral Services and Chief Psychologist
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: DADS completed the "At Risk Individuals" policy on 10/5/09. DADS also provided the Facilities with a set of risk screening tools that cover health risks, challenging behaviors, injuries and polypharmacy. According to the CCSSLC Plan of Improvement, work on the at-risk screening section did not begin until 12/26/09. Discussions with the Quality Enhancement Director revealed that some work has been done around at-risk individuals, but the Facility is at the beginning stages of implementing this process. Once this initial screening and identification system is implemented, the Facility must identify/develop and implement appropriate assessment tools. Such tools are necessary to allow interdisciplinary teams to identify individuals' specific strengths and needs, develop plans to provide necessary services and supports for at-risk individuals, and then to respond to changes as measured by established at-risk criteria.

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I1	Commencing within six months of the Effective Date hereof and with	DADS completed the "At Risk Individuals" policy on 10/5/09. DADS also provided the Facilities with a set of risk screening tools that cover health risks, challenging behaviors,	

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	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.	injuries and polypharmacy. The CCSSLC Policy Manual contains Section D, entitled "Safety and Risk Management." However, it contains information about dealing with hurricanes, fires and other safety issues, but does not address at-risk individuals. Section F.12, revised on 1/13/09, provides for a High Risk Oversight Committee. According to the CCSSLC Plan of Improvement, work on the at-risk screening section began on 12/26/09. Discussions with the Quality Enhancement Director revealed that some work has been done around at-risk individuals, but the Facility is at the beginning stages of implementing this process. From a quality assurance perspective, the Facility has some processes in place that could assist in identifying individuals at risk. For example, as part of managing quality and monitoring trends, there are lists of individuals at risk due to a swallowing incidents, diagnoses of pneumonia, hospital admissions or emergency room (ER) admissions. While the individuals' risks are not measured using a screening tool, this is one method of identifying people who might be at risk, and elevating the attention paid to preventing recurrences. However, such information does not appear to be used consistently to identify individuals at risk, and develop plans to address them. For example: ▪ Individual #24 was hospitalized for psychiatric treatment on two (2) occasions in October 2009. The "Health Status Team Review" section of her May 2009 PSP identified her as at risk for challenging behaviors, specifically aggression, and the need for sedation to undergo dental care. Her evaluations indicate that she was refusing dental care for at least a year while complaining of tooth pain. Her PSP action plan does not address her refusal of dental care, although it indicates she has a Behavior Support Plan. Her behavior services evaluation indicates that her seizure disorder may affect her behavior, but does not mention dental problems, or any plan to address them. Meanwhile her behavior problems increased. In September 2009, her dentist was finally able to examine her and indicated she needed major dental work under anesthesia. In October 2009, she was hospitalized for psychotic behavior and hallucinations. Three (3) questions arise, including: 1) were her dental problems addressed prior to her October psychiatric hospitalizations; 2) did the dental problems and the pain that she reported experiencing exacerbate her behavior problems and/or psychiatric hospitalization; and 3) have the dental issues been resolved? At a minimum, identified risks need to be reviewed in an interdisciplinary fashion to determine if there could be connections and to resolve any issues uncovered.	

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		From a nursing perspective, the Facility was not able to accurately identify individuals with clinical risks. Currently, CCSSLC is using the Health Risk Assessment Tool-Nursing as the tool for the identification of clinical risk indicators for individuals. However, this tool is simply scored either "yes" or "no" for items in areas regarding Cardiac, Constipation, Dehydration, Diabetes, gastrointestinal (GI) concerns, Hypothermia, Medical Concerns (other), Osteoporosis, Respiratory, Seizures, Skin Integrity, Urinary Tract Infection (UTI), and Aspiration/Choking. The tool is not an adequate comprehensive risk assessment for any of the areas mentioned, and does not result in the appropriate identification of clinical risk indicators. The Facility is using an appropriate standardized tool, the Braden Scale, to assess skin integrity issues. Standardized statewide tools should be used by all the Facilities in assessing and documenting clinical indicators of risk to ensure that individuals who have clinical risks are appropriately identified, and proactive interventions are put in place to address these risks in a timely manner. Once this system is implemented and individuals' risks are appropriately identified, the PSTs need to regularly address these issues at the integrated team reviews.	
I2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall perform an interdisciplinary assessment of services and supports after an individual is identified as at risk and in response to changes in an at-risk individual's condition, as measured by established at- risk criteria. In each instance, the IDT will start the assessment process as soon as possible but within five working days of the individual being identified as at risk.	As noted above, from a nursing perspective, the current risk tool that CCSSLC is using is inadequate in identifying individuals' clinical risks indicators. With regard to other risk categories, the Facility reported being at the very beginning stages of screening individuals to determine if they are at risk. Without an adequate system to screen individuals for risk indicators, at-risk individuals cannot be accurately identified, and the appropriate assessments cannot be completed. Once this initial screening and identification system is developed and implemented, the Facility must identify/develop and implement appropriate assessment tools. Such tools are necessary to allow interdisciplinary teams to identify individuals' specific strengths and needs, develop plans to provide necessary services and supports for at-risk individuals, and then to respond to changes as measured by established at-risk criteria.	
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	As stated previously, the Facility does not have the underlying screening and assessment processes in places that are necessary for implementation of this provision.	

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	meet needs identified by the interdisciplinary assessment, including preventive interventions to minimize the condition of risk, except that the Facility shall take more immediate action when the risk to the individual warrants. Such plans shall be integrated into the ISP and shall include the clinical indicators to be monitored and the frequency of monitoring.		

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

- There is a variety of information available from which to identify individuals who are potentially at risk. The policies and procedures for a risk management system should draw together the various risk assessment instruments and procedures into one process that can reliably identify individuals whose health or well-being place them at risk, and to address their needs.
- Standardized statewide tools should be used by all the Facilities in screening and assessing individuals, and documenting clinical indicators of risk.
- The Facility also needs to develop/identify the tools and/or processes that will be used to conduct an interdisciplinary assessment of services and supports after an individual is identified as at risk, and in response to changes in an individual's at-risk condition, as measured by established at-risk criteria.
- Using information from such an assessment process, PSTs need to develop individualized plans for addressing such needs in an integrated manner, within the timeframes established by the SA. Such plans need to include the clinical indicators to be monitored, and the frequency of monitoring.

<table>
<tr><th>SECTION J: Psychiatric Care and Services</th><th></th></tr>
<tr><td rowspan="3">Each Facility shall provide psychiatric care and services to individuals consistent with current, generally accepted professional standards of care, as set forth below:</td><td>Steps Taken to Assess Compliance: The following activities occurred to assess compliance:
▪ Review of Following Documents:
o Credentials for Dr. Hernandez;
o REISS Information;
o List of individuals prescribed psychotropic medications;
o Minutes from Polypharmacy Case Review Committee Meeting Minutes for October and December 2009;
o Monitoring of Side Effects Scale (MOSES) and Dyskinesia Identification System: Condensed User Scale (DISCUS) forms; and
o Clinical records for the following individuals: Individual #3, Individual #6, Individual #13, Individual #14, Individual #23, Individual #25, Individual #27, Individual #28, Individual #29, Individual #30, Individual #31, Individual #32, Individual #33, Individual #34, Individual #35, Individual #36, Individual #37, and Individual #40
▪ Interviews with:
o Dr. Michael Hernandez, Consulting Psychiatrist;
o Dr. Sandra Rodrigues, Medical Director;
o Robert Sartin, Pharmacist;
o Linda Taylor, RN;
o Brenda Fuller, RN; and
o Dr. Julie Moy, DADS Medical Director
▪ Observations of:
o On 01/05/10, Psychiatric Consultation meetings for Individual #14, Individual #38, and Individual #39; and
o Tour of Facility, including day/vocational programs and residential units, as well as the infirmary and rehabilitation areas</td></tr>
<tr><td>Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.</td></tr>
<tr><td>Summary of Monitor's Assessment: In reviewing quarterly review documentation regarding the provision of psychiatric services, there appeared to be little meaningful input evident from the psychology staff. In addition, there was documentation of medication changes, but the detailed rationale for them was often absent. This lack of integration of medical/psychiatric services with psychological services makes it difficult to determine if the treatment plans generated by the psychiatric department are clinically justifiable.

In terms of psychiatric diagnoses, there was a lack of clearly defined diagnostic criteria for the conditions diagnosed. There was little or no evidence that individuals being evaluated had case formulations in their</td></tr>
</table>

	records. CCSSLC's Plan of Improvement indicated that a standardized psychiatric assessment form was to be implemented that includes the necessary review and case formulation. The State and Facility need to move forward with putting these pieces in place. At the time of the review, there were not any staff psychiatrists at CCSSLC. There were two (2) consulting psychiatrists, one who provides approximately 50 hours of service per month, and the other who provides approximately 24 hours per month. The Medical Director acknowledged that the expected complement of psychiatrists at the Facility is two (2.0) FTEs. She has contacted employment services and has reached out to academic medical centers. As is indicated in other subsections of this report, the limited availability of psychiatry hours appears to have a negative impact on the delivery of services, particularly as it limits the ability of psychiatry and psychology staff to work in an interdisciplinary and integrated fashion to design treatment plans for individuals served. The Polypharmacy Case Review Committee has been meeting to review individuals for whom polypharmacy is prescribed. It appears that the Committee is reviewing individuals, and looking at a number of factors to assist in decision-making regarding either justification for continuing the polypharmacy, or changes that need to be made. This activity incorporates multiple types of staff and evidences a thoughtful approach to the clinical issues.

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J1	Effective immediately, each Facility shall provide psychiatric services only by persons who are qualified professionals.	Dr. Hernandez is a fully trained psychiatrist, certified by the American Board of Psychiatry and Neurology. As a general psychiatrist with experience in the treatment of individuals with intellectual disability, he is qualified to provide service for the population served. During the next monitoring visit, additional review will be conducted with regard to the credentials of the other contract psychiatrist and nurses who work in the psychiatry department.	
J2	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall ensure that no individual shall receive psychotropic medication without having been evaluated and diagnosed, in a clinically justifiable manner, by a board-certified or board-eligible psychiatrist.	The Consulting Psychiatrist explained that psychiatric service are provided as a result of two (2) factors: consultation requests generated by staff with regard to behavioral changes, and chart review of all individuals on psychotropic medications. At the time of the review, because the Consulting Psychiatrist is not a member of the medical staff, the Medical Director was cosigning all orders. Nurses and psychiatric assistants staff the psychiatry department. The Consulting Psychiatrist personally examines individuals on the consultation list. For routine chart review, the Consulting Psychiatrist runs "clinics," in which all individuals on the caseload are reviewed approximately monthly. According to the Consulting Psychiatrist, all individuals on psychotropic medications have a personal examination on a quarterly	

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		basis. At the time of the review, approximately 170 individuals were prescribed psychotropic medication. According to the Medical Director, psychiatric consultant services each month consist of approximately 50 hours by the Consulting Psychiatrist and an additional 24 hours by a weekend consultant. By rough calculation, this amounts to approximately one fifth of the two (2.0) FTE psychiatric staff that are included in the budget. On January 5, 2010, during the psychiatric consultation rounds, three (3) individuals were seen. In all cases, the psychiatrist attempted personal examinations. In the case of a young woman, Individual #14, she communicated verbally and was able to interact with the Consulting Psychiatrist. The problem had been her aggression, specifically, she had thrown a rock through a car window, and threw herself onto the floor. The Consulting Psychiatrist found that the individual had gained significant weight, though it was left ambiguous as to whether the use of antipsychotic medication was implicated versus the individual's repeated use of the canteen. The Consulting Psychiatrist was following the effects of a psychotropic medication that had recently been instituted for hyperactivity. In the second instance, Individual #38 was discussed at the housing unit. She had been showing aggressive behavior, but the last episode of it had been about one year earlier. Approximately one month before, the antipsychotic medication, Clozaril, had been reduced. About two (2) weeks thereafter, there was an episode of aggression. At the same time, the nursing staff had been monitoring the individual's heart rate. The Consulting Psychiatrist made a decision to substitute another antipsychotic medication, Zyprexa, at a low dosage. The third consultation was a young man, Individual #39, with microcephaly and profound intellectual disability. There had been some question regarding a change in his behavior, though the genesis of the consultation request was not determined at the time of the visit. There did not appear to be a threshold for psychiatric intervention. Available staff in the housing units of the individuals visited attended the consultations. Although reports of behaviors are integrated into the consultations, there seemed to be no organized attempt to discuss the overall approach to the behaviors in question with regard to the relative contributions of psychological and psychopharmacological approaches. Additional individuals were reviewed on paper via Quarterly Psychiatric Review and Psychiatric Consultation Flow Sheets. On the positive side, the documentation of the quarterly reviews showed that often a number of the PST members were present (e.g., nursing, psychology, psychiatry, etc.), and the various treatment changes were reasonably documented. On the other hand, there was little meaningful input evident from the psychology staff. Similarly with the Flow Sheets, there was documentation of	

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		medication changes, but the detailed rationale for them was often absent. This gives the impression that the psychiatric clinic and consultations were being done in a vacuum; that is, not integrated with other support services. This lack of integration of medical/psychiatric services with psychological services makes it difficult to determine if the treatment plans generated by the psychiatric department are clinically justifiable. In terms of psychiatric diagnoses, there was a lack of clearly defined diagnostic criteria for the conditions diagnosed. Thus, an individual displaying agitation could have various labels applied; for example, *psychosis*, *mood disorder*, *hyperactivity disorder*. Though this would be consistent with good clinical practice and documentation, it sometimes leads to negative consequences for the individual. The best example of this would be the unnecessary prescribing of antipsychotic medications for behaviors that do not seem to respond to this class of drug. This is part of the broader problem of placing too much weight on psychotropic drugs in the SSLC setting. Thus, while certain challenging behaviors might be addressed through the prescription of medications, there may be instances in which managing reinforcement contingencies or redirection would be more fitting. This again underlines the importance of the integration of psychology/behavioral services with psychiatric services. The following provide examples of individuals for whom the clinical justification for psychiatric diagnoses could not be found in their records: ▪ Individual #25 was admitted to CCSSLC in December 2003. According to his records, Individual #25's behavior deteriorated after his mother died. He lived with his sister for a period, but she accused him of sexually abusing children. On that basis, he was admitted to San Angelo SSLC. This is an example of an individual showing various behaviors, for example running away, destroying property, temper tantrums, low frustration tolerance, and oppositional behavior, that have been elevated to psychiatric diagnoses, including generalized anxiety, major depression, psychosis, and pedophilia. It is not clear whether these labels are being used to justify various medication trials versus following Diagnostic Statistical Manual (DSM) criteria. This individual's most recent medications included Celexa for depression, Keppra for intermittent explosive disorder, Ativan for insomnia, and Geodon for intermittent explosive disorder. An earlier psychiatric evaluation dated 6/6/01, characterized Individual #25's behaviors as an effort to "obtain what he wants," whereas there was no evidence of psychosis. This was echoed to a degree by the Consulting Psychiatrist on 1/30/08, when he wrote: "He does get upset when redirected as far as his diet or redirected from smoking… At that point he is prone to agitation and aggression." On 3/25/08, because Individual #25's blood sugar was rising, the antipsychotic medication was switched from one second-generation antipsychotic (SGA), Invega, to another, Geodon. On an undated Quarterly Medication Review	

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		Worksheet, it was noted that there was no indication for Geodon, and that target symptoms were not identified. An antismoking aid, Chantix, was added on 5/20/08. Then after manipulations of dosage of an antiepileptic medication, Keppra, on 3/31/09, another SGA was prescribed, Zyprexa, due to increased agitation noted on 3/18/09, despite the fact that this drug raised blood sugar before. It was discontinued a few weeks later. It appears from the documentation that Individual #25's behaviors are based on his ability to manipulate staff for his basic needs or addictions (smoking). Instead of a program to manage these contingencies behaviorally, the psychiatrist is prescribing potentially hazardous and dubiously effective drugs to stop the behaviors. On the positive side, clinicians are identifying the behaviors. However, an integrated approach to care is needed to effectively diagnose and treat the behavioral symptoms. ▪ Individual #23 provides another example in which it appears behaviors have been deconstructed and treated as separate psychiatric syndromes. On the Annual Medical Assessment completed on 8/19/09, historical diagnoses were listed as mild mental retardation (MR), speech disorder, deafness, obsessive-compulsive disorder (OCD) and temporal lobe atrophy. The current medications and indications were: Tegretol for psychosis due to congenital brain defect, Effexor XR for OCD, Ativan for generalized anxiety and Abilify for psychotic disorder. The psychiatric evaluation on 11/15/08, listed the target behaviors as agitation, cursing, yelling, crying, shooting the finger, name-calling, aggression, inappropriate sexual behavior, hoarding, and hand washing. Individual #23 was diagnosed with OCD and mild MR, and psychotic disorder was noted without justification. Antipsychotic medications were ordered, as was Tegretol, an antiepileptic, entirely without indication. In April 2009, the Consulting Psychiatrist made an observation that could have led to a more appropriate style of intervention. Specifically, the psychiatrist noted that Individual #23 spends her money on soda and then does not have it for cigarettes. This, in turn, makes her irritable and she turns on others, going as far as throwing rocks. Individual #23's compulsive behaviors may be appropriately addressed through the use of Effexor. Beyond that, it appears that behavioral strategies, not psychotropic medications, need to be employed to attempt to address the behavioral symptoms present. There is a process in place for fielding requests for consultations and integrating the clinical work into the limited hours of the Consulting Psychiatrist. However, at this point, it is not clear if individuals who are in need of psychiatric consultation are referred consistently to psychiatry. This will be further reviewed during the next monitoring visit.	

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J3	Commencing within six months of the Effective Date hereof and with full implementation within one year, psychotropic medications shall not be used as a substitute for a treatment program; in the absence of a psychiatric diagnosis, neuropsychiatric diagnosis, or specific behavioral-pharmacological hypothesis; or for the convenience of staff, and effective immediately, psychotropic medications shall not be used as punishment.	According to the Consulting Psychiatrist, CCSSLC has been using individualized medical treatment planning since 2006. They use the Texas Implementation of Medical Algorithms (TIMA), referring to the Texas Medical Algorithm Project (TMAP). It is important to note that any algorithm for schizophrenia, depression or bipolar disorder is based on an adult population that does not have developmental disabilities. That being said, if the TIMA is in use, then documentation should be present reflecting such use. If the use is implicit, then the documentation of decisions about psychotropic drugs should be transparent within the medical record. At the time of this review, this was not the case. The following provide some examples: ▪ On admission, Individual #14 had three (3) Axis I diagnoses: schizophrenia, chronic undifferentiated type; binge eating; and insomnia; and two (2) Axis II diagnoses: mild mental retardation (MR), and borderline personality disorder. The physician who reviewed these labels for the Annual Medical Assessment in 2009, listed the Axis I disorders as schizoaffective disorder, bipolar type; and disruptive behavior disorder. The individual also has a seizure disorder by history on Axis III. In the Consulting Psychiatrist's consultation on 1/5/10, after which there was a slight increase in lithium, the following were the clinical conditions medicated and their corresponding treatments: psychosis, Seroquel; binge eating, Zoloft; mood lability, lithium; psychosis, Klonopin; insomnia, Sinequan; psychosis, Geodon; aggression, Intuniv; and appetite suppression, amantadine. In late 2009, the progress notes indicated erratic upsets, but no sustained mood episodes, or aggression. The Consulting Psychiatrist wrote "Poor treatment response to her medications despite multiple interventions." This is an instance of polypharmacy that does not follow an algorithm. Instead, the pattern is to deconstruct the syndrome, and treat each component as if it were a separate, cognizable condition. ▪ Individual #3 was admitted to CCSSLC from San Antonio State Hospital. She is an individual who functions at a relatively high level [Intelligent Quotient (IQ) is 66], with clear concurrent mental illness and adaptive deficits. Diagnoses included personality change due to peri-natal brain damage and schizoaffective disorder on Axis I; and mild MR and borderline personality disorder on Axis II. The psychological evaluation on 3/27/09, noted behaviors such as aggression, departures, SIB, and property destruction. In addition to her SIB, other individuals had hit her. As of January 2010, Individual #3 was on five (5) psychotropic medications: Depakene for schizoaffective disorder; Klonopin for generalized anxiety; Zyprexa for mood stabilization; Zoloft for depression; and Topamax for mood stabilization. The condition of Type-2 diabetes was noted in 2009, but it does not appear that it was connected to treatment with Zyprexa. Instead, the Consulting Psychiatrist was concerned about her eating habits (also appropriate). Also in 2009, there were some medication adverse effects: a lithium-induced tremor and a rising thyroid stimulating hormone (TSH) level,	

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		also likely associated with lithium. Accordingly, lithium was discontinued on 9/9/09. This is an example of ongoing attempts to bring an individual's behaviors under control. However, medications that are not producing clear results should not be maintained. There is obvious attention to medication side effects, such as those with lithium. However, one could say that, in individuals with Type-2 diabetes, the use of second-generation antipsychotics such as Zyprexa is questionable. ▪ The Annual Medical Review in 2007 for Individual #6 documented four (4) Axis I diagnoses: schizoaffective disorder, generalized anxiety, major depression, and insomnia; and mild MR and seizures were listed on Axes II and III, respectively. Depakote had been prescribed, with a blood level done on 8/13/08. Subsequent blood levels could not be found. Current medications and indications included: Ativan for generalized anxiety; Depakote ER for mood/schizoaffective disorder; Haldol for psychosis/schizoaffective disorder; chlorpromazine for psychosis/schizoaffective disorder; bupropion for major depression; and Cymbalta for depression. A Drug Regimen Review on 4/8/07, said, "Lipid profile needs to be done yearly or every 6 months"; but glycated hemoglobin (HgbA1c) was not done. Then on 10/20/08, it was noted that there had been a 40-pound weight gain in the month following an increase in the antidepressant mirtazapine. That drug was discontinued and replaced with Abilify. The psychiatric evaluation by the Consulting Psychiatrist on 2/25/09, noted SIB, what appears to be depression, and aggression. He notes, "He has been talking to himself and it is unclear as to whether or not this represents psychosis." The treatment used at that point was to add an antidepressant, Cymbalta. This appears to be haphazard use of psychotropic medications, with unclear indications and diagnostic labels. Individual #6's serious weight gain is a good example of a potentially health-threatening problem that must be addressed.	
J4	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, if pre-treatment sedation is to be used for routine medical or dental care for an individual, the ISP for that individual shall include treatments or strategies to minimize or eliminate the need for pre-treatment sedation. The pre-treatment sedation shall be coordinated with other medications, supports and services	The Facility appears to be at the beginning stages of developing individualized strategies to minimize or eliminate the need for pre-treatment sedation. For example: ▪ At the PSP staffing meeting for Individual #19, his team discussed ongoing dental issues that he was experiencing and his refusal to cooperate. His plan indicated the need for sedation. The team indicated that the psychology department had just begun to develop desensitization plans to address the needs of individuals such as Individual #19. ▪ See additional examples in the section of this report that addresses Section C.4 of the Settlement Agreement.	

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	including as appropriate psychiatric, pharmacy and medical services, and shall be monitored and assessed, including for side effects.		
J5	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall employ or contract with a sufficient number of full-time equivalent board certified or board eligible psychiatrists to ensure the provision of services necessary for implementation of this section of the Agreement.	At the time of the review, there were not any staff psychiatrists at CCSSLC. There were two (2) consulting psychiatrists, one who provides approximately 50 hours of service per month, and the other who provides approximately 24 hours per month. The Medical Director acknowledged that the expected complement of psychiatrists at the Facility is two (2.0) FTEs. She has contacted employment services, and has reached out to academic medical centers. As is indicated in other subsections of this report, the limited availability of psychiatry hours appears to have a negative impact on the delivery of services, particularly as it limits the ability of psychiatry and psychology staff to work in an interdisciplinary and integrated fashion to design treatment plans for individuals served.	
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.	With regard to psychiatric assessment, diagnosis and case formulations, the Consulting Psychiatrist, with the few hours he has, conducts limited psychiatric assessment and makes diagnoses based on a “best-fit" model. However, there was little or no evidence that individuals being evaluated had case formulations in their records. This is a serious deficiency that could be remedied in part by requesting that the Consulting Psychiatrist dictate a paragraph justifying a psychiatric diagnosis, and the way in which psychotropic drug interventions have been integrated into an overall treatment plan. As it is, prescriptions for psychotropic drugs are issued and the results followed, but little attention is given to the importance of psychological and environmental interventions. The need for an increase in the completeness, detail and overall robustness of psychiatric assessments underlines the need for additional psychiatry staff. The DADS Medical Director, who was present for the interviews, stated that DADS is moving towards unified policies affecting psychiatric care. The immediate plan was to explore the policies and procedures at the Mexia SSCLC in February 2010. The next step, she suggested, would be to convene psychiatrists within the system for the purpose of developing unified policies and procedures, including those related to assessment. The CCSSLC’s Plan of Improvement indicated that a standardized psychiatric assessment form was to be implemented that includes the necessary review and case formulation. The State and Facility need to move forward with putting these pieces in place.	
J7	Commencing within six months of the Effective Date hereof and with full implementation within two	Not all individuals served by CCSSLC are seen and/or assessed by a psychiatrist. Instead, the Reiss screening tool is used, which, in turn, generates clinical information that may give rise to a psychiatric consultation. The Consulting Psychiatrist and nurse indicated	

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	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.	that they believed that Reiss assessments were done for everyone not under psychiatric care. A document requested during the visit to CCSSLC, entitled "REISS Information", provided a list of individuals, and the date of either a psychiatric examination or the date and score of the Reiss screening tool. Most individuals had one or the other, and the dates were largely in 2008 or 2009. This is an area that requires further review by the Monitoring team. During upcoming reviews, samples of individuals for whom it is indicated have been screened using the tool will be reviewed to determine if the tool was completed appropriately and by a qualified person, and the results responded to, as necessary and appropriate.	
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.	At the time of the review, pharmacological treatments at CCSSLC were not integrated with behavioral and other interventions through combined assessments and case formulation. This appeared to be a function of the lack of adequate psychiatric resources. At this point, individuals have behavioral programs and medication management running in parallel, but not in an integrated fashion. There is evidence from individual records that "case formulation" has been attempted, but it is doubtful that anything emerges from it that would be considered an interdisciplinary approach. Additional details regarding these concerns are discussed above in the subsections addressing Sections J.2, J.3, J.5, and J.6 of the Settlement Agreement.	
J9	Commencing within six months of the Effective Date hereof and with full implementation within two years, before a proposed PBSP for individuals receiving psychiatric care and services is implemented, the IDT, including the psychiatrist, shall determine the least intrusive and most positive interventions to treat the behavioral or psychiatric	Once again, the predominant theme is that the behavioral specialists and the psychiatrist are working in parallel, rather than in actual collaboration. It appears that the psychiatric nurses bridge some of the gap by providing a communication mechanism between psychiatry and psychology. However, the quality as well as the quantity of the communication between the two (2) disciplines needs to be improved.	

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	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.		
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.	Although it appears that psychotropic medications are being prescribed with a risk-benefit analysis implied, if not stated, the lack of interdisciplinary activity with regard to the provision of psychiatric services, including the prescription of medication, is problematic. Thus, for example, the idea that alternate treatments could replace medications could only arise in a setting in which there is discussion, measurement of behavior, and a step-wise analysis of interventions. As it is, there may be a request for psychiatric consultation on an individual showing agitation at a certain time of day. If the psychiatrist is called and determines that there is "mood lability", then the individual may have a mood-stabilizing medication prescribed, for example, Depakote. This medication could be beneficial; yet, it could result in little of no meaningful benefit, and expose the individual to liver toxicity or unnecessary weight gain. It could turn out that the mood lability could be related to a staffing pattern or a nutritional dynamic, but it could go undetected if there is no interdisciplinary approach. According to the Facility's Plan of Improvement, beginning on 12/26/09, shortly before this review occurred, individuals' Personal Support Teams (PSTs) were scheduled to begin discussing and considering the risks and alternative treatment strategies when developing Behavior Support Plans that include psychotropic medications. Teams were also to begin documenting whether the harmful effects of alternative treatment outweigh the risks of the psychiatric medication. It is not stated, but teams also need to review and document if the harmful effects of the individual's mental illness outweigh the possible harmful effects of the medication. During upcoming reviews, individuals' plans will be reviewed to determine if this process is being fully implemented, and if the appropriate outcomes are being achieved for individuals.	
J11	Commencing within six months of	The Polypharmacy Case Review Committee minutes were impressive and well done.	

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	the Effective Date hereof and with full implementation within one year, each Facility shall develop and implement a Facility- level review system to monitor at least monthly the prescriptions of two or more psychotropic medications from the same general class (e.g., two antipsychotics) to the same individual, and the prescription of three or more psychotropic medications, regardless of class, to the same individual, to ensure that the use of such medications is clinically justified, and that medications that are not clinically justified are eliminated.	Nurses facilitated the meetings. In attendance were the Consulting Psychiatrist, one or more physicians or nurse practitioner, other nurses and/or psychiatric assistants, and a pharmacist. Section J.11 of the SA is quoted in the minutes. At the October session, eight (8) individuals were reviewed under "old business" and nine (9) under "new business." In the former case, seven (7) of the eight (8) individuals had either reductions in dosage or discontinuation of a drug. In two (2) of the cases, it was a matter of substituting one antipsychotic drug for another. In the latter case, individuals with five (5) or more psychotropic medications were considered for reduction or justification. At the December session, there was a similar pattern, whereby there were nine (9) individuals previously identified and six (6) newly identified. The newly identified individuals were listed, and there was a description of each containing clinical examples relevant to the situation as well as rationales for why changes were or were not made. This activity deserves praise. Not only is it respectful of the SA, it also incorporates multiple types of staff and evidences a thoughtful approach to the clinical issues. This is a good model for other types of committee activities.	
J12	Within six months of the Effective Date hereof, each Facility shall develop and implement a system, using standard assessment tools such as MOSES and DISCUS, for monitoring, detecting, reporting, and responding to side effects of psychotropic medication, based on the individual's current status and/or changing needs, but at least quarterly.	The individual records reviewed generally contained the side effect monitoring forms. At times, the assessments had been completed less than quarterly. Often in such cases, there was a notation indicating that the assessment was "x" numbers of months late. It is unclear if there is a system for tracking when the quarterly assessments are due. If such a system is not in place, it is recommended that one be initiated. An example of an individual for whom consistent side effect monitoring was not completed is: ▪ Individual #34's medications include Tegretol for seizures, Abilify for intermittent explosive disorder, and Effexor for Post Traumatic Stress Disorder (PTSD). MOSES assessments were not consistently completed on a quarterly basis. Dates of MOSES assessments over the past two (2) years included: 1/14/08, 3/14/08, 9/8/08, and 3/10/09. DISCUS exams completed on 2/2/08, 3/24/08, 7/2/08, 9/17/08, 12/5/08, and 3/10/09, also were not consistently completed quarterly, particularly in 2009. As of 1/7/10, 137 individuals were prescribed atypical antipsychotic medications (second-generation antipsychotics or SGAs). The most common was quetiapine (Seroquel). Although Section N.3 of the SA addresses the need for monitoring to occur with regard to the metabolic and endocrine risks associated with the use of SGAs, the HCG does not provided guidelines for the pre-testing and ongoing testing of individuals on SGAs for "metabolic syndrome." However, the Consulting Psychiatrist appeared to be well aware of the risks involved. Since the preponderance of individuals on antipsychotics at CCSSLC were prescribed SGAs, DADS and the Facility should have a	

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		policy and procedure for safe use of them. The following provides an example of the risks associated with SGAs: ▪ For Individual #25, there have been concerns about medication adverse effects. For example, Individual #25 is diagnosed with diabetes. His glycated hemoglobin (HgbA1c) was high on 1/2/08, and 10/21/09. He was on the second generation antipsychotic, Geodon. The Drug Regimen Review on 5/21/08, noted that SGAs can cause hyperglycemia; noted the same again on 9/8/08; and on 10/31/08, noted that Individual #25's blood sugar was not well-controlled; and in 4/09, noted that the dosing of Geodon was being split on account of the issues related to blood sugar. On an undated Quarterly Medication Review Worksheet, it was noted that there was no indication for Geodon, and that target symptoms were not identified. This individual's most recent medications included Celexa for depression, Keppra for intermittent explosive disorder, Ativan for insomnia and Geodon for intermittent explosive disorder. Then after manipulations of dosage of an antiepileptic medication, Keppra, on 3/31/09, another SGA was prescribed, Zyprexa, due to increased agitation noted on 3/18/09, despite the fact that this drug raised blood sugar before. It was discontinued a few weeks later.	
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 CCSSLC Plan of Improvement indicates that beginning on 12/26/09, shortly before this review, PSTs were to begin ensuring that PSPs included input from the psychiatrist concerning psychotropic medication. According to the Plan, beginning on 12/26/09, Behavior Support Plans would begin to include symptoms to monitor effectiveness of psychotropic medications and other psychiatric treatment. During upcoming reviews, this will be reviewed in further detail. To provide a baseline review, PSPs and PBSPs completed prior to 12/26/09, were reviewed, however, the Monitoring Team recognizes that these may not reflect recent changes. The following provides some examples of what was found with regard to these requirements: ▪ Individual #2's 12/2/09 PSP indicates that she is prescribed Geodon and Depakote to address intermittent explosive disorder and aggression. Her PSP does not identify symptoms to monitor the effectiveness of the medication, by whom, when and/or how. ▪ Individual #40's 8/12/09 PSP and 9/14/09 PBSP indicate that she was prescribed Depakote for mood stabilization, Seroquel for agitation and aggression, Lexapro for Obsessive Compulsive Disorder, and Invega for self-injurious behavior. However, her PSP does not identify the symptoms to be monitored, by whom, when and how.	

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	the treatment plan, as often as necessary, based on the individual's current status and/or changing needs, but no less often than quarterly.		
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.	As is discussed in further detail below with regard to Section U of the SA that addresses consent, many individuals at CCSSLC do not have Legally Authorized Representatives. For individuals who do not have LARs and who are not able to provide informed consent, state regulation includes provisions for the Facility Director to provide consent. Although efforts are beginning to ensure that individuals who need LARs have them, this process will take some time. In the meantime, the Facility Director will continue to be asked to provide consent with regard to the use of psychotropic medications for a segment of the individuals residing at CCSSLC. During future reviews, additional information will be reviewed related to the information that is provided to the Director to assist her in making such decisions, including information related to how clinicians have come to the decision to use medication to treat the individual, any discussion of least restrictive alternative, and any guidance the Director has received in reaching her decision.	
J15	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that the neurologist and psychiatrist coordinate the use of medications, through the IDT process, when they are prescribed to treat both seizures and a mental health disorder.	The review of individual records indicated that the neurologist and psychiatrist, both who are consultants to the Medical Director, were cognizant of each others' prescriptions. However, it was not apparent that there was any real collaboration. This is likely due to the fact that both the neurologist and psychiatrist are part-time consultants to the Medical Director. In interviewing the Consulting Psychiatrist, it appeared that he took into account the psychotropic actions of antiepileptic drugs (AEDs), for example, in the service of mood stabilization and anxiety reduction. However, there needs to be a system to ensure that neurologist and psychiatrist are collaborating in the use of such medications, and that this collaboration is documented as part of the IDT process. CCSSLC's Plan of Improvement indicates that beginning on 12/26/09, the "psychiatrist provides information and input to the neurologist to coordinate medications and receives information from the neurology appointments." This action step does not describe a specific process for this to occur. It would be beneficial if the logistics of how this communication and collaboration will occur were further defined.	

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

- As indicated by the DADS Medical Director, DADS should proceed with the development of statewide policies regarding the provision of

psychiatric care. Such policies should be comprehensive, and address all relevant components of the Settlement Agreement as well as the Health Care Guidelines.

- Staff and consultants responsible for the provision of psychiatric services to individuals at CCSSLC should have ongoing continuing education in the area of psychopharmacology, as well as specifically psychiatric treatment of individuals with intellectual disabilities.
- Psychiatry staffing should be increased to the two (2.0) full-time equivalent positions currently budgeted for CCSSLC. The Facility should continue to advertise to fill its psychiatry positions. If this has not been done, national advertising for DADS-wide positions could be placed in *Psychiatric News*, a publication of the American Psychiatric Association.
- Behavioral and psychiatric services need to be integrated to ensure that individuals are receiving appropriate services. Methodologies need to be developed and implemented to ensure that psychiatric decision-making is fully informed by and integrated with behavioral as well as other clinical and programmatic services. Consideration should be given to developing a prioritized list of individuals who are most at risk from a behavioral and/or psychiatric perspective, and implementing an integrated planning format for them as soon as possible. For example, individuals who have had frequent medication changes due to behavioral instability could be identified, and meetings held at which the focus would be true collaboration between psychiatry and psychology, as well as all other members of the team.
- The Facility should establish and implement a policy and procedure for documenting target behaviors in such a way as to identify which behaviors are best treated behaviorally versus in combination with psychotropic medications.
- CCSSLC would benefit from using medication algorithms that are integrated with behavioral programming.
- The Consulting Psychiatrist(s) should begin to dictate and/or include case formulations in each individual's record.
- The Polypharmacy Committee should continue to meet, and review a prioritized list of individuals. Consideration should be given to including psychology representatives on the Committee.
- If there is no centralized scheduling and/or tracking system for MOSES and DISCUS assessments, such a system should be initiated to ensure their timely completion and review by the psychiatrist to ensure that necessary follow-up is completed in a timely manner.
- DADS and the Facility should have a policy and procedure for safe use of SGAs. At a minimum, the policy should include pretesting for diabetes, hyperlipidemia and a body-mass index (BMI); clear rationale for the use of an antipsychotic in contrast, for example, with another class of sedative; timelines for monitoring of metabolic syndrome, sedation, weight gain, etc.; and procedures for dosage optimization.
- Policies, procedures and specific practices need to be developed/revised and implemented to ensure that there is collaboration between the neurologist and psychiatrist when medications are prescribed to treat both seizures and mental health disorders.

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 Following Documents**: o Individual degree certificates of behavioral services staff members, and summary data included in document entitled "Survey Staffing Review for ICF-MR Facilities"; o CCSSLC Behavioral Services Program Flow Chart, as well as the new Structural and Functional Behavior Assessment (SFBA) format; o Behavior Support Committee (BSC) Meeting handouts; o Document entitled "CCSSLC Behavior Support Committee"; o Recently revised "Behavior Services Monthly Tracking Log"; o Brief on-site individual chart reviews were conducted on the following individuals: Individual #41 (on 1/5/10), Individual #7 (on 01/06/10), Individual #40 (on 01/06/10), Individual #42 (on 01/06/10), Individual #43 (on 01/07/10), and Individual #44 (on 01/07/10). Items targeted on the chart reviews included PBSPs, safety plans, personal support plans, and/or skill acquisition/maintenance programs [i.e., skill acquisition objectives (SAOs), SPOs, and staff service objectives (SSOs)]. In addition, review of current and past behavior and/or skill acquisition/maintenance was completed, if available. Often during these visits, direct observations of and/or discussions with staff members were completed as well; o Off-site documentation reviews, including examination of the items listed above, were completed on a sample of requested documents for the following individuals: Individual #7, Individual #14, Individual #22, Individual #40, Individual #41, Individual #42, Individual #44, Individual #45, Individual #46, Individual #47, Individual #48, Individual #49, Individual #50, Individual #51, and Individual #52; o Individuals' PBSPs, psychological evaluations or Behavioral Services Evaluation (BSE), and monthly PSP Meeting Reviews, where available, for the following individuals: Individual #7, Individual #14, Individual #22, Individual #40, Individual #41, Individual #42, Individual #44, Individual #48, Individual #49, Individual #50, Individual #51, Individual #52; and o Psychological evaluations for the following individuals: Individual #7, Individual #14, Individual #22, Individual #40, Individual #41, Individual #42, Individual #45, Individual #46, Individual #47, Individual #48, Individual #49, Individual #50, Individual #51, Individual #52. Note: unfortunately, the sample did not include a psychological evaluation in the newest format (i.e., Structural and Functional Behavior Assessment) ▪ **Interviews with**: o Dr. Robert Cramer, Director of Behavioral Service and Chief Psychologist, on 01/07/10 and 01/08/10; o Bruce Boswell, Director of Active Treatment, on 01/07/10; o Large group interview with 12 of the 14 current Associate Psychologists, including Lloyd Halliburton, Amy Flores, Samantha Mendoza, Marie Rangel-Gomez, Sandra Vera, Dorothy

Montelongo, Gina Hawkins, Debbie Taylor, Everett Bush, John Guerra, Daniel Rivera, and Rochella Thomas, and all seven (7) of the current Psychologist Assistants, Tiffany Carranza, Christina Martinez, Erica Pedraza, Patricia Sprencel, Melissa Perez, Laura Maldonado, and Erin Tetreault;
    - A large group interview with 11 of the current residential Qualified Mental Retardation Professionals (QMRPs); and
    - Dr. Michael Hernandez, Consulting Psychiatrist
- **Observations of**:
    - An initial tour of the Facility conducted on 01/04/10, including the following sites: Coral Sea Unit (Seahorse and Sand Dollar residences), Pacific Unit (Ribbonfish 3), Tropical Unit (Angelfish and Pompano residences), Habilitative Therapies Building, Vocational Building, Adult Life Skills Building, Gym, Hurricane Ally, and the Atlantic Unit (Starbright and Kingfish residences);
    - Observation and discussion with staff members at the Behavior Support Committee meeting on 01/05/10;
    - Personal Support Team (PST) meeting held for Individual #6 on 01/05/10;
    - On 01/05/10, Psychiatric Consultation meetings for Individual #14, Individual #38, and Individual #39;
    - Site visits to residential programs, including direct observation, chart reviews, data reviews, and/or discussions with psychologists, direct care professionals (DCP), active treatment specialists, and/or site QMRPs were conducted at the following sites: Angelfish (on 01/05/10), Pompano (on 01/06/10), Kingfish #1 and #4 (on 01/06/10), Adult Life Skills (on 01/06/10), Habilitation/Annex Building (on 01/06/10), and Ribbonfish #4 (on 01/07/10)

Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.

Summary of Monitor's Assessment: Overall, the Facility does not currently employ staff with Board Certified Behavior Analyst (BCBA) certification or with demonstrated competence in applied behavior analysis (ABA). However, it appears that there are some efforts underway to increase psychology staff's competence with regard to ABA. The Facility employs a Director of Behavioral Services who is licensed and has experience working with individuals with intellectual or developmental disabilities. In addition, there is evidence that the Director of Behavioral Services has the support of the behavioral services staff, and is actively pursuing additional educational and experiential competencies in ABA with the intent of obtaining his BCBA.

The Facility conducts regular review of PBSPs through an inter-disciplinary Behavior Support Committee (BSC), and there is a revised system in place to ensure annual review. However, authors of PBSPs and those that supervise implementation of plans are not consistently in attendance, and the group's competency in ABA as well as insufficient data collection/display limits the depth and comprehensiveness of the review. Supplemental review by an independent Human Rights Committee (HRC) and external peer

	review is also currently lacking. In general, the data collection system is not reflective of a generally accepted practice. However, there is evidence that substantial changes within the system have recently been initiated. These improvements are likely to have a positive influence on data collection and progress monitoring. It is clear that over the past year, improvement has been made in terms of the comprehensiveness of the behavioral services evaluation process as well as more stringent criteria for the completion of the ICAP as part of the psychological assessment. Both of these recent changes have improved the potential of behavioral services staff to obtain information necessary to effectively inform treatment. The newly revised Structural and Functional Behavior Assessment format was just initiated in December 2009. Consequently, evaluations using this new format were unavailable and, therefore, not examined at the time of this review. This will be assessed during the next monitoring visit. PBSPs contain many of the elements that the Settlement Agreement requires. There are areas of the process that require refinement, including the consistent development of functionally equivalent replacement behaviors, and the use of individualized reinforcers. Such reinforcement use needs to be expanded across antecedent and consequent-based intervention strategies. The processes for documenting consent prior to the implementation of the plans, and for addressing the need to eliminate to the extent possible the use of restrictive procedures need to be enhanced. Some DCPs demonstrated knowledge and understanding of strategies outlined in randomly selected PBSPs. In addition, there were some information systems in place to ensure that DCPs had an understanding and were able to implement PBSPs. However such systems were not systematically utilized to facilitate and ensure adequate implementation.

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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	All Associate Psychologists currently have at least a Master's degree. The degree areas appear to be within General Psychology, Counseling, Counseling Education, or Chemical Dependency. Four (4) of the 14 Associate Psychologists are licensed, and two (2) are currently enrolled in a doctoral program at a local university. Currently, however, none of the Associate Psychologists are Board Certified Behavior Analysts. Subsequently, none of the PBSPs currently implemented at the Facility were developed by a BCBA or developed under the supervision of a professional with a BCBA. However, three (3) behavioral services staff members just recently enrolled in the first of a series of online courses offered by the University of North Texas that are required toward certification in ABA. However, none of these staff members are currently receiving the necessary supervision (i.e., by a professional with a BCBA). Verbal reports from the Associate Psychologists indicated that the administration is very	

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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.	supportive of current behavioral services staff members pursuing further educational competencies and professional development opportunities. Indeed, weekly and/or and monthly group study sessions are held to support the development of knowledge base in Applied Behavior Analysis. In addition, the Director of Behavioral Services verbally reported active efforts to recruit a professional with a BCBA. At the time of the interview, however, there was no formal written plan or policy to increase the number of professionals who possess board certification in ABA.	
K2	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall maintain a qualified director of psychology who is responsible for maintaining a consistent level of psychological care throughout the Facility.	The Facility currently employs a Director of Behavioral Services and Chief Psychologist. He has a Doctor of Psychology (Psy.D.) degree in Child and Family Therapy. He reported being employed in his current position for four (4) and a half years, and that he has no advanced degree or training in ABA. However, he is currently enrolled in the first of a series of courses designed to meet the educational requirements for certification as a board certified behavior analyst. Verbal reports during group meetings with psychology staff, including psychologists and psychology assistants, consistently reflected positive reviews of the Director of Behavioral Services, including his interactions and professional support.	
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.	At the time of the review, it appeared that the Behavior Support Committee, along with initial review of behavioral programming by the Director of Behavioral Services, was the current process of internal review. There is a two (2)-page description of the membership and processes of the BSC, and a standardized form to be completed for each PBSP or safety plan review. Annual review of PBSPs and safety plans is tracked via the Behavior Services Monthly Tracking Log. The BSC meets on a weekly basis and consists of an inter-disciplinary membership (e.g., speech-language, day services, quality assurance, psychiatry, and nursing). However, attendance by Associate Psychologists is often inconsistent and, when they are in attendance, they reported feeling that the meeting is inadequate to sufficiently review submitted plans. More importantly, however, is the committee's limited ability to provide adequate review due to the memberships' limited educational competencies and specialized training in ABA. In addition, comprehensive review is also limited by the absence of adequate information to support data-based decision making. More specifically, although current data was available for the PBSP review for Individual #99, there was no data on replacement behaviors. The data available for the PBSP review for Individual #41 did not include any data on target or replacement behaviors from over the past year. Both reviews presented data in table format only. Reports indicate that graphic display of data has been initiated only recently (since December 2009) at the Facility.	

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		In addition, regular representation by staff members (other than Psychologists) responsible for monitoring the integrity of plan implementation (i.e., Psychology Assistants and Residential Coordinators) does not occur and is not currently expected. The Director of Behavioral Services does not currently supervise the Associate Psychologists or the Psychology Assistants, limiting his ability to require such staff's attendance at meetings. As is recommended below, the Facility should assess and take whatever action is necessary to ensure that Psychology Assistants and Residential Coordinators attend and participate in such meetings regularly. In assessing this, it is recommended that the Facility consider whether or not the current line of supervision is adequate to address the psychology/behavioral needs of the individuals served by the Facility. Reports also indicated that a substantial number of plans (PBSPs, safety plans, and desensitization plans), in addition to regular business, are reviewed at each meeting. This has the potential to limit the BSC's ability to thoroughly review each plan. As is recommended below, consideration should be given to establishing a process that ensures sufficient time for adequate review. More specifically, consideration should be given to developing a hierarchy for behavior plans (perhaps based on restrictiveness, intrusiveness, severity of target behaviors, etc.) that would prescribe more or less time or, perhaps, comprehensiveness or frequency of review dependent upon where the plan falls on this hierarchy. Moreover, review of HRC meeting minutes and verbal reports indicated that HRC membership appears to include a number of professionals employed by CCSSLC. Currently, there is no external peer review policy or process in place to review PBSPs, particularly plans that include restrictive procedures.	
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	In general, expectations regarding the timeliness of data collection for PBSPs were inconsistent across staff members. When asked when data collection should occur, several randomly selected staff (i.e., DCPs and an Active Treatment Specialist) indicated that data collection was typically completed at the end of the shift. Alternatively, discussions with Associate Psychologists and Psychology Assistants as well as one (1) DCP at Angelfish (on 01/04/10), clearly indicated that data collection should occur immediately following the observation of a target behavior. Direct observation conducted over the course of the week by the reviewer, including observations of multiple target behaviors demonstrated by several individuals, did not reflect one (1) occurrence of immediate or timely data recording by staff. Indeed, daily data collection systems were not obvious or readily available. When inquires were made, data collection systems appeared to be stored in offices, cabinets or bins. In some cases, they could not be located (e.g., inquiry to DCPs regarding Individual #40 on 01/06/10;	

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	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.	and inquiry to DCP, QMRP, and Associate Psychologist regarding Individual #43 on 01/07/10). In addition, on-site chart reviews indicated that data was at times inconsistently recorded (e.g., several missing days of data on monthly data sheets for Individual #7, and Individual #44). Some cases where data collection was consistently recorded were observed. However, the timeliness of the collected data could not be verified. Data in table format was typically found in each individual's PBSP as well as psychological evaluation; however, the data summary was often incomplete (i.e., missing data, data on replacement behaviors not reported, etc.). In addition, the current data collection systems reflect a "one-size-fits-all" approach across settings. Specifically, most appear to be predominantly frequency-based. Data reliability in not currently assessed, and target and replacement behaviors are not typically graphed to allow for sufficient decision-making. However, a new emphasis on graphing data is clearly evident from discussion with psychology staff members and has been implemented on a limited basis, as evidenced in some PBSPs. At the time of the review, however, graphed data was not typically being reviewed monthly. There is an electronic database that is being used to manage data collection and display data (as well as other variables), and appears to be utilized by some Psychology Assistants. Reports indicated that accessing the database is often restricted due to limited computer access. It was reported that in the future, all Psychology Assistants would be expected to graph target and replacement behaviors for all individuals with PBSPs at least on a monthly basis. Indeed, the recent creation of new positions and infusion of staff (e.g., active treatment specialists and psychologist assistants) will undoubtedly provide resources that have the potential to facilitate improved accuracy and fidelity of data collection.	
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.	It is evident that the standard practice of psychological assessment at CCSSLC has undergone significant changes over the past two years. Prior to 2008, a single psychological assessment was completed on an annual basis. Throughout 2008 and 2009, two (2) assessments including a psychological assessment and a behavior assessment were completed on an annual basis. In December 2009, changes within both the psychological assessment and behavior assessment processes occurred. More specifically, in regard to the psychological assessment, criteria were changed to ensure that an ICAP is completed at least every three (3) years. In addition, the format of the behavior assessment was significantly revised. The new assessment process, outlined in the SFBA, is much more structured and comprehensive compared to the previous format. According to review of this new format and discussions with behavioral services staff, the SFBA will likely enhance the development and effectiveness of PBSPs as well as Safety Plans for Crisis Intervention (SPCI). At the current time, verbal reports indicate that only a few recently completed assessments conform to this new assessment format.	

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		Unfortunately, the sample of assessments reviewed did not include one in the new format. During upcoming monitoring visits, the use of the new format will be reviewed in detail. In general, review of sampled assessments, including five (5) of the older format (i.e., "psychological assessments"), and five (5) of the subsequent generation of report formats (i.e., "behavioral services evaluations") revealed that all reports included a summary and/or review of scores from previously conducted standardized tests of intelligence and adaptive ability. There was one (1) exception where the results from standardized assessments of intelligence were not reported, specifically the behavioral services evaluation for Individual #42. All evaluations reported ICAP scores, with only one (1) exception. Specifically, no ICAP score was reported for Individual #47. In addition, one (1) of the ICAP evaluations appeared to be somewhat dated. Specifically, Individual #51's ICAP was conducted in June 2004. Additional information provided in the revised behavioral services evaluations appeared to increase the reports' treatment utility. For example, inclusion of graphs and behavioral objectives targeting behaviors for reduction appeared to support data-based decision-making when judging response to intervention strategies. However, not all behavior services evaluations included data on behaviors targeted for reduction. In general, individuals with PBSPs had a psychological assessment that incorporated information collected as part of a functional behavior assessment. Many of the evaluations reported comprehensive data. However, there was one (1) evaluation that did not report any functional behavior assessment data even though the individual had a PBSP and a SPCI, specifically, Individual #7's psychological evaluation. In addition, those evaluations that included functional behavior assessment data appeared to utilize acceptable indirect and direct methods of assessment as well as offer important insight regarding the occurrence (or non-occurrence) of target behaviors, including the identification of setting events, antecedents and/or consequences relevant to the undesired behavior. However, one recurrent issue was the lack of identifying functionally equivalent replacement behaviors. For example, the replacement behavior of "participation in activities" described in Individual #44's PBSP did not appear to functionally replace the identified function of SIB (i.e., communication). Similar inconsistencies between replacement behaviors and identified functions were also evident for Individual #14, and Individual #49. Specifically, for each of them, an identified function of escape or attention was identified, with replacements targeting emotional expression or identification. In addition, there was evidence that psychological assessments were completed following requests of PSP teams due to apparent changes in behavioral status (e.g.,	

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		Individual #14). This is a desirable practice and reflects responsiveness by the team to individual changes in need or status beyond that of the typical annual review.	
K6	Commencing within six months of the Effective Date hereof and with full implementation in one year, each Facility shall ensure that psychological assessments are based on current, accurate, and complete clinical and behavioral data.	As of December 2009, it was reported that behavioral services staff would complete an ICAP for each individual served, as part of their psychological assessment, at least every three (3) years. It is currently unclear what the expectation is regarding how often intelligence tests (e.g., Slosson, Leitter, Wechsler, etc). need to be completed. As reported above, in general, most psychological assessments provided a summary and/or review of scores from previously conducted standardized tests of intelligence and adaptive ability. There was one (1) exception in which results from standardized assessments of intelligence were not reported, specifically in the behavior services evaluation for Individual #42. Most evaluations reported summarized scores from the ICAP, and these evaluations were completed, on average, within 24 to 48 months of the date on the psychological evaluation. Two (2) of the reports, however, reported ICAP scores that were three (3) or more years old, specifically the reports for Individual #51 and Individual #45. In addition, one (1) report was missing an ICAP score summary, specifically the psychological evaluation for Individual #47. Monitoring of behavioral functioning was typically assessed by collecting, displaying (in tables for most plans), and reviewing data on challenging behaviors and identified replacement behaviors. It appeared that behavioral data was included in the psychological assessment for most of the sampled individuals with PBSPs. However, data was not displayed or current data was not included in the behavioral services evaluations of a few individuals reviewed, for example, Individual #50 and Individual #52. The infusion of new Psychology Assistants is likely to increase the integrity and timeliness of data collection. Therefore, more complete and current data is likely to be available for inclusion in psychological reports.	
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.	Discussions with behavioral services staff indicated a previous expectation that psychological assessments be completed at least annually. This includes reviewing summary scores of previous ICAP evaluations on an annual basis and conducting a re-evaluation using the ICAP at least every three (3) years. In general, review of a sample of records suggested that with one exception (i.e., psychological evaluation dated November 2008 for Individual #22), a psychological evaluation had been completed within the last year for each sampled individual. Review of documents of the most recent individual admitted to CCSSLC, Individual #42 on 02/11/09, revealed that a behavioral services evaluation was completed within 30 days of his arrival. This document, however, did not present scores on any standardized assessments of intellectual or cognitive ability.	

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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.	Currently, there are two (2) consultants hired through behavioral services to provide counseling services to individuals identified as needing counseling. It is currently unclear if data is being collected on individualized goals and objectives to examine the potential outcomes or therapeutic effects. The Monitoring Team will further evaluate this in upcoming reviews. In addition to these counseling services, several other types of therapeutic services were described and observed during onsite tours and visits. These included sensory rooms where individuals were offered opportunities to experience different sensory stimulation across many modalities (visual, tactile, olfactory, etc.). Indeed, it appeared that most residential programs and other settings offer access to these multi-sensory environments. Some DCPs and others described the utilization of these multi-sensory settings as opportunities for relaxation and recreation, as well as potential therapy or treatment for individuals with challenging behaviors. These rationales were also offered for other, similar environments (e.g., "Snoezelen" room, "Comfort Zone") found within the Facility. It is currently unclear if these environments are being utilized as part of formal skill acquisition programs, behavioral programming, and/or any other form of therapeutic intervention. It also is unclear whether or not data is being collected to assess their potential effectiveness in assisting individuals in achieving identified outcomes. If such settings are designed to assist in providing individuals with therapy or treatment, then it is recommended that specific outcomes be identified for each individual, and data collected and reviewed to determine the therapy's effectiveness on an individualized basis.	
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	Review of the sampled PBSPs revealed that most plans utilized generally accepted functional behavior assessment methods when developing potential hypotheses regarding the function of behavior. In general, all sampled PBSPs had sections devoted to functional assessment, although, the title of the sections varied. Plans utilized a variety of methods of assessment. Common methods included the Motivation Assessment Scale and the Functional Analysis Interview. However, assessment methods included in the plans were primarily indirect methods of assessment. It is unclear whether or not information from more direct methods of assessment (e.g., direct observation) was included in the plans. Verbal report certainly indicated that the daily onsite presence of Associate Psychologists and Psychology Assistants facilitated ongoing direct observation leading to more informed evaluation and monitoring of behavioral services. This, however, was not evident in the sampled PBSPs. Some examples of problems identified with regard to the integration of information gained from the completion of functional assessments included: ▪ The PBSP of Individual #48 indicated potential function of SIB as automatic (sensory stimulation), and escape. The plan, however, only addressed the primary	

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	timeframes, the Facility Superintendent may grant a written extension based on extraordinary circumstances.	function and not the latter, through outlined replacement strategies. ▪ Functional assessment results for Individual #44 indicated that the primary function of his SIB was "communication", yet the replacement behavior identified as "participation in activities" does not appear to be functional communicative response. The replacement behavior in this example does not appear to be functionally equivalent to the target behavior. ▪ Similar findings were evident for Individual #14 and Individual #49. Specifically, their plans identified a function of escape or attention, and included a replacement behavior targeting only emotional identification and expression. ▪ In addition, in some plans, for example, plans for Individual #52 and Individual #42, consequent-based procedures appear counter-productive given the identified function of targeted behavior. More specifically, staff are directed to verbally interact and encourage Individual #52's participation in activities immediately following his challenging behaviors, even though an indentified function of "attention seeking" was identified in his behavioral services evaluation. Similarly, staff are directed to encourage verbal and physical interaction with Individual #42 following inappropriate sexual behavior with an indentified function of attention seeking. Review of sampled plans also led to questions regarding prior intervention strategies and related outcomes, as well as the rationale for selected interventions. That is, it was not obvious if plans contained strategies that have been revised over time and whether or not they had been effective, or if they were newly implemented strategies. In addition, the format of the reviewed plans was inconsistent. In some plans, for example, functional assessment information was provided prior to interventions; in other plans, this information followed intervention strategies. This information may be more helpful if presented prior to descriptions of intervention strategies. Target behaviors for decrease (i.e., challenging behaviors) were typically operationally defined in the sampled PBSPs. These definitions, however, were limited by the lack of clear and comprehensive examples and non-examples. Providing objective examples of what the behavior is and is not, may facilitate better discrimination and more accurate data collection. In addition, many plans identified multiple target behaviors for decrease, but only included data on a single behavior (e.g., Individual #52's PBSP). Also, definitions and data were collected on multiple challenging behaviors in the behavioral services evaluation, but not targeted by specific intervention strategies in the PBSP (e.g., Individual #42). Operational definitions of replacement behaviors (SAOs) were not readily apparent in most plans. In addition, many PBSPs included behavioral objectives primarily targeting replacement behavior objectives (RBOs) as opposed to objectives related to the decrease	

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		of challenging behaviors that were identified in behavioral services evaluations. Data was typically displayed in tables within the majority of sampled PBSPs. However, there were exceptions to this as graphs have been included in more recently revised plans (e.g., plans for Individual #40 and Individual #50). Targeted behaviors for decrease were typically included in the table as well as data collected on the use of emergency medications, restraints, and medication dosages. For some plans, tables included target behaviors that were not identified or operationally defined in PBSPs (e.g., Individual #49's and Individual #42's PBSPs). In addition, tables often did not include data or reported insufficient data on replacement behavior objectives (i.e., SAOs or RBOs). This was surprising given that most plans focused primarily on only the replacement behaviors and not the challenging behavior, when stating behavioral objectives. At times, multiple replacement behaviors were identified, but only one (1) was displayed on the table, for example, Individual #7's or Individual #40's PBSPs. All sampled plans utilized some form of positive reinforcement. In many plans, the use of "campus bucks" was identified as the primary positive reinforcer. This is interesting as many authors described a great variety of items, people, places and/or activities that were highly preferred for each individual. Given the emphasis on individualization in identifying potential reinforcers, it was unusual that so many plans would predominately utilize "campus bucks" as the primary reinforcer. Notable exceptions were the individualized reinforcers identified as part of Individual #14's behavior contact (as outlined in her PBSP), and Individual #40's PBSP. More specifically, Individual #14's contract utilized a variety of reinforcers including hugs, stickers, choice of beverages, Compact Discs (CDs), and clothing. In addition, the provision of reinforcers was typically prescribed during formal SAOs, but not always highlighted as part of prevention (antecedent) or response (consequence-based) interventions. Within Individual #49's PBSP, for example, verbal praise and a "campus buck" are utilized within formal teaching sessions, but not prescribed for delivery upon successful coping within proactive (prevention) or consequence (responding) interventions. Most "Plan for Reducing Restrictions" sections of sampled PBSPs mentioned reduction of medications, which appears to be appropriate. Some plans sampled, however, did not indicate specific plans for the potential reduction of behavioral programming, including those with restrictive interventions as outlined in safety plans. Notable exceptions included the plan to reduce the amount of time Individual #44 wore his helmet, and the discontinuation of restraint interventions for Individual #14 and Individual #40. Generally, in the plans reviewed, this section was somewhat vague, and did not provide objective criteria for when less intrusive programming would be considered and/or	

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		restrictive procedures discontinued. Notable exceptions to this were the criteria described in Individual #41's and Individual #22's PBSPs. For example, in Individual #41's PBSP, objective criteria [i.e., 18 out of 20 trials per month for six (6) consecutive months] were established as a goal to reconvene the PST to discuss potential revisions to restrictive programming. It is unclear, at the current time, if PBSPs and safety plans were implemented only after necessary consents and approvals were obtained. Verbal reports from behavioral services staff suggest that plans are only implemented following receipt of consents. This verbal report appears to be consistent with consent and implementation dates recorded on sampled PBSPs. However, the copies provided do not contain actual signatures of staff or guardians. In addition, some of the copied plans (e.g., for Individual #52 and Individual #41) did not have consent dates recorded within the text. Signature sheets from a limited number of PBSPs were reviewed during onsite visits and evidence was mixed. More specifically, although all signatures were obtained for Individual #44, one or more signatures were missing from Individual #43's, Individual #40's and Individual #42's PBSP at the time of the onsite review.	
K10	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, documentation regarding the PBSP's implementation shall be gathered and maintained in such a way that progress can be measured to determine the efficacy of treatment. Documentation shall be maintained to permit clinical review of medical conditions, psychiatric treatment, and use and impact of psychotropic medications.	Inter-observer agreement is not collected at the current time. As a result, the accuracy of the data cannot be assured. As is discussed above in the section that address Section K.4 of the Settlement Agreement, there are significant concerns related to the collection of data. Timely and accurate data is essential to ensure that teams and clinical staff are making decisions that are data-based. According to staff verbal report and document review, PSP monthly review meetings are held to discuss each individual's progress. Data at these meetings are typically provided in table format. Although target behaviors, restraint data, and information on medication dosages are present, data on replacement behaviors is often missing. This finding is consistent with verbal reports of psychology staff who emphasized that qualitative changes in the data collection systems (i.e., monthly graphing of data) had just recently been initiated in November 2009. Indeed, the one (1) graph discovered during document review of PSP monthly reviews was found in a recent November review for Individual #40. This trend is consistent with the finding that very few of the PBSPs reviewed actually contain data graphs; that is, only three (3) of the 12 plans reviewed had graphs incorporated into the text. And, when graphs were included, some basic elements, including labels/descriptors of X and/or Y-axis, phase change lines, etc., that would be helpful for interpretation were missing. For example, it was difficult to know what metric was the dependent variable on the Y-axis for Individual #49, and what year was represented by the current data for Individual #50. In addition, based on direct observation during psychiatric consultation and follow-up	

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		conversation with staff, it appeared that primarily monthly data sheets (i.e., raw data from 11/09 and 12/09) were utilized to describe Individual #38's current functioning and the basis for potential psychotropic medication changes.	
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.	Onsite discussion with DCPs, QMRPs, and Associate Psychologists in regard to strategies outlined in specific PBSPs produced mixed results. For example, one (1) recently hired DCP at the Angelfish home was able to correctly answer questions regarding the replacement behaviors outlined in Individual #41's PBSP. In addition, several staff members in the Comfort Zone and ALS classrooms appeared very knowledgeable about individuals' programming. However, questions regarding strategies used in either Individual #43's PBSP or SPOs were answered incorrectly by an experienced DCP at the Ribbonfish home. Indeed, even more senior staff members at this program initially reported that Individual #43 did not have a PBSP or any formal data collection. Similar observations reflecting uncertainty about skill training programs or PBSPs strategies were evidenced in an ALS classroom setting regarding Individual #42, and the Annex vocational setting regarding Individual #40. One consistent finding across many observation settings is that, when questioned about programming, staff members who were unsure of the correct answer appeared to know where to look and were willing to actively find the answer. It is currently unclear if there is a consistent or systematic system utilized by professionals within behavioral services to directly monitor and ensure adequate implementation integrity of PBSPs. Onsite discussions with one Associate Psychologist indicated that he developed his own quizzes that were individualized for each individual, and he used these to facilitate training of staff and identify those who required additional training. However, it does not appear that this system is available or utilized for each individual with a PBSP. Review of PBSPs indicated an average length of 11 pages with a range from six (6) to 19 pages in length. It is important to note that these estimates do not include safety plans that are typically an additional two (2) pages. The format across several PBSPs, although consistent for the majority of plans, appeared to vary as well. These factors make it less likely that staff who need to implement the plans will easily understand them. Discussions with psychology staff indicated that a revised format is being developed by DADS, and is likely to be introduced in the near future.	
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	Requests were made to review training logs (described as "ITPOs") during the onsite visit as well as through onsite Monitoring Team requests. Unfortunately, training logs were consistently unavailable during the onsite visit, and were not delivered following several onsite Monitoring Team requests.	

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	supervisors successfully complete competency-based training on the overall purpose and objectives of the specific PBSPs for which they are responsible and on the implementation of those plans.	Verbal reports indicated that Associate Psychologists primarily conduct staff training on PBSPs (i.e., they are responsible for developing the PBSP). Psychology Assistants reported that if minor changes were made to behavioral programming that they, the treatment team leaders or the active treatment specialists would train residential staff members. Verbal reports also indicated that QMRPs or newly created Active Treatment Specialists are responsible for the development and training of staff on some skill acquisition (SPOs) and maintenance (SSOs) programs. Due to the lack of documentation, it is currently unclear if present staff members, as well as other pulled and relief DCPs were trained on specific PBSPs, or other skill programs at the time of the on-site visit. The dates of competency-based training are, however, tracked on the revised Behavior Services Monthly Tracking Log. This system should assist in ensuring that DCPs are trained at least on an annual basis on each PBSP. This is consistent with expectations voiced by staff within behavioral services. There does not appear to be a formal system utilized by professionals within behavioral services to directly monitor and ensure adequate implementation integrity of PBSPs across all settings. However, there are a number of positive practices in place. For example, psychology staff report utilizing individualized quizzes that are completed immediately following and approximately one (1) to two (2) weeks after training. The quizzes are designed to measure how well DCPs recall relevant information and to determine if retraining is necessary. Although this process might estimate whether or not staff understand and remember the PBSP, it may not accurately reflect proper implementation of prescribed strategies (i.e., changes in staff behavior). In addition, although direct observation of actual staff training was not observed, discussions highlighted a strong expectancy that trainings incorporate active learning strategies (e.g., modeling, rehearsal, repeated practice). Also, it appears that the proximity of the offices of Associate Psychologists and Psychology Assistants to the residential and day programs is likely to facilitate implementation of integrity checks of data collection systems and PBSPs. Having such staff located within the programs means they are readily available to model, prompt and provide corrective feedback. Further review of formal and informal systems designed to ensure that DCPs are competent in implementing PBSPs across settings will be reviewed further during upcoming monitoring visits.	
K13	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall maintain an average 1:30 ratio of professionals described in Section K.1 and maintain one psychology	At the time of the review, CCSSLC served 310 individuals and employed 14 Associate Psychologists and seven (7) Psychology Assistants. Based on these numbers, each Associate Psychologist would be responsible for, on average, approximately 18 individuals (i.e., if caseloads were perfectly equivalent, which is likely unrealistic). Current verbal reports, however, indicate an approximate range of 84 to 11 individuals per Associate Psychologist, with the greatest ratio reported at Coral Sea. The significant ratio at Coral Sea is atypical compared to other ratios reported by the remaining	

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	assistant for every two such professionals.	Associate Psychologists, and appears a bit misleading as there are only approximately 18 individuals requiring behavioral programming at Coral Sea. With this exception taken into consideration, the typical ratio appears to range from 32 to 11 individuals per Associate Psychologist. It is likely in the future that these ratios may decrease with the hiring of an additional Psychologist. There is currently one vacant Psychologist II position. In addition, support of the Associate Psychologists is likely to improve as the Facility hires additional Psychology Assistants for the two (2) positions currently vacant.	

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

- A written policy or plan should be developed that includes strategies to develop, recruit, and/or retain BCBA and, if possible, BCABA-level behavior analysts. This should include the immediate recruitment of at least one BCBA-level behavior analyst that can provide necessary supervision to current staff enrolled in related coursework. Once written, this plan should be actively implemented and its effectiveness monitored.
- Once hired, a process should be developed to regularly audit the credentials of staff that has board certification in applied behavior analysis.
- Consideration should be given to hiring an external BCBA-level consultant with competencies in developing, implementing and monitoring behavioral programming and skill training for adults with developmental disabilities, as well as experience in supervising professionals pursuing board certification. This consultant could provide necessary supervision to the current Director of Behavioral Services, and other staff as they pursue board certification within their current positions.
- A more comprehensive policy should be developed for internal peer review that ensures reasonably accepted practice for peer review of PBSPs and safety plans. This policy should include a prescribed criterion for a minimum number of Associate Psychologists in attendance as well as professionals from other disciplines that would reflect a sufficient quorum for adequate peer review. Ideally, the plan's author as well as professionals responsible for monitoring the plan's implementation should be present at the review.
- Annual peer reviews should include graphed data for both target and replacement behaviors. This is generally accepted practice as it facilitates data-based decision-making.
- With the current administrative/supervisory structure, the Director of Behavioral Services does not have supervisory responsibility over the Facility's Associate Psychologists or Psychology Assistants, limiting his ability, for example, to require attendance at BSC meetings. The Facility should assess and take whatever action is necessary to ensure that Psychology Assistants and Residential Coordinators attend and participate in such meetings regularly. In assessing this, it is recommended that the Facility consider whether or not the current line of supervision is adequate to address the psychology/behavioral needs of the individuals served by the Facility.
- Given the significant number of plans that require annual (at a minimum) review, consideration should be given to establishing a process that ensures sufficient time for adequate review. That is, consideration should be given to developing a hierarchy for behavior plans (perhaps based on restrictiveness, intrusiveness, severity of target behaviors, etc.) that would prescribe more or less time or, perhaps, comprehensiveness or frequency of review dependent upon where the plan falls on this hierarchy.
- A supplemental external peer review committee should be established that is comprised of professionals not employed by CCSSLC. Membership of this committee should include professionals who are board certified in behavior analysis. This committee would potentially meet less often than the BSC, but would likely offer alternative perspectives, evaluations, and feedback on perhaps more restrictive or intrusive behavioral programming.
- Membership of the current human rights committee should be revised to include a majority of members that are not employees of CCSSLC.
- Facility staff should collect, summarize and graph data on at least a monthly basis, or more frequently, if necessary. This should include the

- A system should be developed to ensure monthly monitoring of graphed data. This should include recording modifications or changes to programming as well as judgments on whether or not the current interventions and strategies are effective.
- Graphed data should be incorporated into psychiatric consultations, monthly PSP reviews, annual PSP, and BSC meetings.
- Consideration should be given to individualizing raw data collection systems. A review of the nature of target and replacement behaviors should be completed, and consideration given as to whether or not an alternative or supplemental data collection methodology may be more appropriate and/or would provide more meaningful data (i.e., scatter plot, A-B-C data, partial interval, duration recording, measure of intensity, etc.). Changes to the system should be weighed against potential negative effects of multiple or increasingly diverse data collection systems, as well as the systems' acceptability and feasibility as judged by those collecting the data.
- Adequate computer access should be provided to professional responsible for collecting, summarizing and displaying data.
- Dates of most recent psychological evaluations (i.e., psychological assessment, most recently completed ICAP, and structural and functional behavior assessment) should be closely monitored on the Behavior Services Monthly Tracking Log to ensure that assessments due to exceed their time limit are updated.
- All Associate Psychologists should adhere to the new format of psychological evaluations.
- At upcoming annual PSP meetings or sooner, Associate Psychologists are encouraged to review previously completed behavioral services evaluations or psychological assessments, and examine whether or not the identified replacement behaviors are likely to be functionally equivalent (i.e., have the potential to serve the same function) to the targeted behaviors they are intended to replace.
- Graphic displays of data on challenging and replacement behaviors should be included in psychological assessments and/or new Structural and Functional Behavioral Assessments.
- Similar to behavioral programming, data should be collected on the use of any intervention conceptualized, described or utilized as therapeutic or therapy. This data should include goals with measurable objectives and treatment expectations. This would allow behavioral services staff to determine whether or not the time and resources spent on these therapies are effective.
- Consideration should be given to reviewing the empirical support for these alternative therapies, and how it may relate to the current individuals who receive or are proposed to utilize these therapies. In addition, consideration should be given to whether or not other evidenced-based practices (e.g., functional communication training, picture exchange communication system, etc.) might be a better match to address the underlying needs of those identified.
- A systematic format should be developed and followed when developing and/or revising PBSPs. Consideration should be given to placing functional assessment data before information on interventions so the link between assessment and intervention is more apparent. This information could be very brief (perhaps just the identified function of each target behavior), especially if this information is reliably available in psychological assessment documentation. A brief section on history of previous interventions should be included. In addition, true baseline data (e.g., the average monthly frequency of a targeted response prior to plan implementation) should be provided in addition to the data from the previous year. Note: It may have been the case that several authors reviewed were between changes in the currently accepted PBSP rubric.
- Consideration should be given to developing a very short [one- (1) or two- (2) page] "abbreviated PBSP" that can be utilized as a training document or ongoing quick reference (i.e., "cheat sheet") for direct support professionals. This should contain the most critical data collection and intervention strategies, including operational definitions of targets and replacement behaviors.
- Consideration should be given to standardizing the format and process for the collection and monitoring of required signatures on psychological assessments, PBSPs and SPCIs. For example, a column should be included on the Behavior Services Monthly Tracking Log that reflects the date when the last required signature was obtained for PBSPs or other documents requiring signatures. A central depository should be considered for original signature pages.
- With regard to reinforcers:
    - Consideration should be given to enhancing the use of positive reinforcement across antecedent and consequent-based intervention strategies;

- Reinforcers should be as individualized as possible; and
- Consideration should be given to using differential reinforcement during formal teaching (SAO) programs. That is, provision of reinforcer (and/or quality of reinforcer) should be dependent upon the accuracy of responding.

- The section on reducing restrictiveness of interventions found in PBSPs should contain specific criteria (clear objectives) of behavioral progress (or deterioration) that would identify when team reviews or PBSPs revisions would be considered.
- Replacement behaviors should be a functional equivalent to the target behaviors they are intended to replace.
- A system should be developed for assessing and monitoring inter-observer agreement for PBSP data.
- The recent emphasis should be continued on graphic display of target and replacement behaviors as well as other important variables (e.g., changes in medication and/or doses) that are currently included in table format. However, consideration should be given to changing the way in which replacement behaviors are tracked; that is, true replacement behaviors should be measured as they occur in the natural environment and not only during formal teaching programs.
- Appropriate graphic conventions should be followed when displaying data to facilitate accurate visual analysis. For example, clear labels/descriptors of X and/or Y-axis, and phase change lines should be included consistently.
- A formal system should be developed and implemented to monitor the implementation integrity of PBSPs beyond estimating changes in knowledge based on quiz performance. This may include regular direct observation of DCPs by psychology staff using written rubrics to assess, for example, if appropriate antecedent and/or consequence-based procedures were implemented for a specific individual as prescribed in his or her PBSP.
- Consideration should be given to reviewing the current PBSP format (or implementing a new format), and eliminating sections of the plan that are not directly related to behavioral programming. Also, consideration should be given to changing the current structure to include an "if, then" table format. This may promote a more streamlined format and facilitate greater ease of understanding and use of behavioral strategies.
- A training log should be developed/revised, maintained and stored at each residential program that allows supervisory staff to determine quickly if pulled or relief DCPs have the necessary training to work at the site, and/or with specific individuals.
- Consideration should be given to developing, implementing and monitoring facility-wide trainings in ABA. Professionals within Behavior Services currently enrolled in graduate ABA coursework could take a leadership role in developing and training this curriculum.

SECTION L: Medical Care	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Clinical records for the following individuals: Individual #3, Individual #6, Individual #13, Individual #14, Individual #23, Individual #25, Individual #27, Individual #28, Individual #29, Individual #30, Individual #31, Individual #32, Individual #33, Individual #34, Individual #35, Individual #36 and Individual #37; o Clinical Death Committee Reports; and o Medical Emergency Drills Checklists from 12/08 to 11/09 ▪ **Interviews with**: o Dr. Sandra Rodrigues, Medical Director; o Robert Sartin, Pharmacist; o Dr. Julie Moy, DADS Medical Director; o Colleen M. Gonzales, BSHS, Chief Nurse Executive; o Rhonda Lynn Warner, RN, QA; o Shelly Scott, RN, Nursing Operations Officer; o Teresa Irvine, RN, MSN, Director Employee Health/Infection Control; and o Della Cross, RN, Nurse Educator ▪ **Observations of**: o Attendance at morning medical staff meeting; and o Tour of Facility, including day/vocational programs and residential units, as well as the infirmary and rehabilitation areas
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: There is a full-time Medical Director of CCSSLC, and two (2) other full-time physicians and one (1) full-time nurse practitioner. The consulting neurologist is on site at the Facility approximately once a month, and the consulting orthopedist about once every one (1) to three (3) months. CCSSLC's Plan of Improvement includes a number of actions steps that the Facility intends to take to address this provision of the Settlement Agreement. Some of these, such as the daily medical debriefings are underway. Many of the actions steps appear to be in the very initial stages of development, with a goal of completion in January 2011. For example, although some policies exist with regard to the provision of health care services and supports, one of the action steps is to have policies and procedures that support the outcome of providing adequate routine, preventative and emergency medical care to individuals served at CCSSLC. A medical review system consisting of non-Facility physician review was not yet in place at CCSSLC.

	According to the Facility's Plan of Improvement, DADS State Office was developing a review process that would include an annual review of CCSSLC with the goal of assisting and improving the quality of medical care. During future reviews, the Monitoring Team will review the process, results and any actions taken by the Facility to address issues identified. The Facility is conducting emergency response drills. However, from the documentation provided, it does not appear that physicians participate in such drills. In addition, the drills are limited in the scenarios they cover. Analyses of the information gained from the drills also did not appear to have been completed, and/or actions plans developed to address issues identified. From a practical standpoint, there appeared to be some issues with regard to nursing staff's knowledge and familiarity with emergency medical equipment.

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L1	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall ensure that the individuals it serves receive routine, preventive, and emergency medical care consistent with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	There is a full-time Medical Director of CCSSLC, and two (2) other full-time physicians and one (1) full-time nurse practitioner. Each of the four (4) residential units has a case manager and a physician/nurse practitioner (NP) assigned. During the morning medical meeting that the reviewer observed, the two (2) physicians and nurse practitioner reported issues to the Medical Director. The consulting neurologist is on site at the Facility approximately once a month, and the consulting orthopedist about once every one (1) to three (3) months. The medical staff order all medications including anticonvulsants, but not psychotropic medications. The latter are initiated by the psychiatrist, but countersigned by the staff physician. The Medical Director noted that sometimes the doctor's orders are not put into effect. There are clinic days in each dormitory. A nurse organizes the paperwork, as far as who is to be reviewed. Nursing staff schedule annual physical examinations. It was not made explicit how this was done. Similarly, nursing staff schedule follow-up laboratory tests, for example, lipid profiles. Specimens are sent to Austin, and are reviewed the next day. For emergencies requiring an ambulance, there is a nearby paramedic service. For cases of status epilepticus, the neurologist is called in to determine if medication changes are needed. CCSSLC's Plan of Improvement includes a number of actions steps that the Facility intends to take to address this provision of the Settlement Agreement. Some of these, such as the daily medical debriefings mentioned above are underway. Many of the actions steps appear to be in the very initial stages of development, with a goal of completion in January 2011. For example, although some policies exist with regard to the provision of health care services and supports, one of the action steps is to have policies and procedures that	

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		support the outcome of providing adequate routine, preventative and emergency medical care to individuals served at CCSSLC. The Monitoring Team agrees that this is an important action step for the Facility to achieve, and looks forward to reviewing such policies and procedures during future reviews. Likewise, as is seen in other sections of this report, it is of paramount importance that individuals who are at risk due to a variety of factors be identified and action plans developed to address their areas of risk. One (1) of the Plan of Improvement action steps is for Health status teams to identify individuals at high risk for adverse outcomes. Identification of individuals with such risks is an important first step, but development of integrated treatment plans is a key component to reducing their risk to the extent possible. The Plan of Improvement also includes a number of action steps related to death reviews that will occur at a number of levels, including the Facility and the State Office, and through a peer review process. Some such reviews were available for review during this initial baseline review. As indicated in the Plan of Improvement, it will be important for the Facility to follow up on recommendations resulting from such reviews, and for the tracking and trending envisioned by the Plan of Improvement to result in critical review, and the development of action plans, as necessary. For example, the five (5) individuals who died at CCSSLC between 8/23/09 and 11/27/09, all had some type of pneumonia listed as a cause of death. These included: ▪ A 46-year old man who died on 8/23/09, at hospice. The causes of death listed included aspiration pneumonia, and contributing factor of H1N1 viral infection. ▪ A 69-year-old man who died on 9/20/09, at a local hospital. The causes of death listed included aspiration pneumonia, sepsis, renal failure, and metabolic acidosis; ▪ A 56-year-old woman who died on 10/23/09, at a local hospital. The causes of death listed included pneumonia and sepsis; ▪ A woman who died on 11/18/09. The causes of death included pseudonionas pneumonia and respiratory failure; and ▪ A man who died on 11/27/09. The causes of death included pneumonia bacterial, sepsis, and hepatitis. This is a potential trend that the Facility should examine further. From review of CCSSLC's Medical Emergency Drills Checklists, the Facility appeared to be conducting drills on a monthly basis with a majority of the drills being conducted on night and day shifts. However, there was a significant gap in time from January 2009 to August 2009, when no drills were conducted. Although this may have been a misunderstanding of the documents requested, the Facility needs to ensure that that	

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		Medical Emergency Drills are conducted on every unit, on every shift, every quarter. The current procedure for conducting Medical Emergency Drills includes the use of only three (3) scenarios, specifically: respiratory distress, cardiac arrest and foreign body airway obstruction. These need to be expanded to include other scenarios that would warrant the demonstration of emergency procedures. From review of the comments documented on the drill checklist form, there were a number of drills that had no comments or recommendations listed. It would stand to reason that there would be some additional recommendations regarding the review of the drill procedures. In addition, there were a number of comments on other drill checklists that indicated there had been some issue with either equipment or staff performance. However, there is no system currently in place to document that these issues were timely and appropriately addressed. In addition, no analysis by Facility staff of the drills was found to identify trends, or generate corrective actions, as appropriate. For example, there were a number of the drills that indicated that staff members were not taking the procedure seriously. However, there was no indication that this issue had been addressed. The purpose of conducting regular medical emergency drills is to identify strengths and weaknesses with regard to the Facility's response to emergencies by continuously assessing the process as well as the staffs' knowledge and competency executing emergency procedures. Although training documents indicated that the Facility had been providing training regarding the use of emergency equipment, while on-site, the reviewer asked one of the nurses to demonstrate the use of the emergency equipment. The nurse was unfamiliar with how to turn on the oxygen. The Facility needs to implement a system whereby nurses are regularly observed checking the emergency equipment to ensure they are familiar with the use of the equipment. It is imperative that all licensed staff receive competency-based training regarding emergency procedures and equipment use. Observations of these skills should be conducted at least quarterly. In addition, the Facility does not incorporate the actual use of the crash cart in the competency-based emergency training and drills. This is essential to ensure that when an emergency arises, the nurse will be familiar with the equipment and any medications that would be used. From conversations with nurses on the units, there were several nurses who had not actually been inside the crash carts for a number of years. In the midst of an emergency, nurses should already have a working knowledge of the equipment's use, know exactly what supplies are needed, and where these supplies are kept in the emergency carts to avoid delays in treatment during an actual Code Blue. In addition, there was no indication that physicians were involved in attending the Medical Emergency Drills. This is a significant oversight that needs to be addressed. The physician knowing his or her role in a Code Blue medical emergency as well as knowing	

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		the emergency systems and staff's knowledge of emergency procedures is essential. As CCSSLC moves forward with the implementation of the Plan of Improvement, the Monitoring Team will review these efforts and their impact on the provision of routine, preventative and emergency medical care for individuals served.	
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.	This process was not yet in place at CCSSLC. According to the Facility's Plan of Improvement, DADS State Office was developing a review process that would include an annual review of CCSSLC with the goal of assisting and improving the quality of medical care. During future reviews, the Monitoring Team will review the process, results and any actions taken by the Facility to address issues identified.	
L3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain a medical quality improvement process that collects data relating to the quality of medical services; assesses these data for trends; initiates outcome-related inquiries; identifies and initiates corrective action; and monitors to ensure that remedies are achieved.	This process was not yet operational at CCSSLC. The Facility's Plan of Improvement indicated that the Facility would be initiating use of a medical quality improvement process that was being developed by the State Office Medical Director. It was anticipated that CCSSLC would begin using such a system at the end of December 2009. If this system is operation during the next monitoring visit, the Monitoring Team will review it.	
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	As noted above, development of a set of policies to ensure provision of medical care is included in CCSSLC's Plan of Improvement. It appears that the target date for completion is 7/30/10. Policies and their implementation will be reviewed during upcoming monitoring visits.	

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

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

- As indicated in the Facility's Plan of Improvement, policies, procedures and protocols should be developed to guide the provision of medical care.
- As also indicated in the Facility's Plan of Improvement, a medical review system that consists of non-Facility physician case review needs to be developed and implemented at CCSSLC.
- The Facility and/or DADS State Office should further review the five (5) deaths all of which included various types of pneumonia as a cause to determine if there are any issues of concern, and, if so, to develop actions to address any identified issues.
- The Facility's Medical Director's concern with regard to physician orders not always being followed should be further explored, and corrective action taken, as appropriate.
- The Facility's policy should require that Medical Emergency Drills are conducted at least quarterly, on every unit, and every shift and include the use of the Crash Cart.
- A policy/procedure should be developed and implemented outlining the levels of committee review for Medical Emergency Drills, actual Code Blues and emergency procedures.
- A system should be developed and implemented to ensure that Medical Emergency Drills and actual Code Blues are critically analyzed, and plans of correction developed and implemented to address problematic issues.
- Competency-based training should be implemented regarding emergency procedures that include the use of a crash cart.
- Competency-based training should be provided to all licensed staff regarding the appropriate procedures for checking emergency equipment.
- A monitoring system should be developed and implemented requiring nurses to demonstrate the use of the emergency equipment when checking it to ensure that it is in good working condition.
- Physicians should be involved in all Medical Emergency Drills.

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 Health Risk Assessment Tool-Nursing; o Quality Assurance (QA) Nursing Audits from August-November 2009 and compliance data; o Guidelines for Comprehensive Nursing Assessment; o CCSSLC's Nursing policies and procedures; o Medication Passes Assessment tool audits (68); o Current medication records for Infirmary and Sandollar; o Medical records for the following individuals: Individual #1, Individual #3, Individual #4, Individual #5, Individual #6, Individual #7, Individual #10, Individual #15, Individual #30, Individual #32, Individual #46, Individual #53, Individual #54, Individual #55, Individual #56, Individual #57, Individual #58, Individual #59, Individual #60, Individual #61, Individual #62, Individual #63, Individual #64, Individual #65, Individual #66, Individual #67, Individual #68, Individual #69; Individual #70, Individual #71, Individual #72, Individual #73, Individual #74, Individual #75, Individual #76, Individual #77, Individual #78, Individual #79, Individual #80, Individual #81, Individual #82, and Individual #83; o Nursing Staffing levels; o Minutes of Infection Control Committee Meetings from August to December 2009; o Corpus Christi's Infection Control computerized surveillance data; o The following Infection Control Policies: Care and Cleaning of Food, Medicine, and Blood and Specimen Refrigerators; Cleaning Up Blood Spills; Cleaning the Dining Room Table Between Uses; Cleaning the Bathing Trolley and/or Showers Between Use; Cleaning and Care of Mop Heads; Decontamination of CPR Manikins in CPR Training; Employee Health; Services; Tuberculosis Screening Questionnaire For Patients With A Reactive Mantoux (PPD) Skin Test; Management of Accidental Exposure to Blood/Body Substance; Hepatitis B Vaccination Declination/Acceptance/Update; Texas Department of Mental Health and Mental Retardation Release for Liability for Anti-HCV and HIV; Hepatitis C Surveillance Issues and Answers; Hepatitis A Fact Sheet; Hepatitis B Fact Sheet; Hepatitis C Fact Sheet; Reportable Diseases of Texas; Procedure for Notification for Infectious Diseases in Texas; Support Services-Dental Services, Food Services, Housekeeping, Laboratory Services, Laundry Services, Maintenance, Pharmacy, Rehabilitation Personnel, and Recreation; Infection Control Checklist; Pinworm Control Protocol; Lice Control Protocol (Pediculosis); MRSA Protocol; Scabies Protocol; Acute Bacterial Conjunctivitis; VRE Protocol; Communicable Diseases in the Employee; and, C-Diff (Clostridium Difficile) Protocol; o Novel Influenza Virus Guidelines for Congregate Facilities (April 27, 2009); o HHS Executive Memorandum regarding Waiver of HHS Policy Regarding Required Sick Leave Documentation dated 11/10/09; o Corpus Christi's Table of Organization;

	- Infection Control course description for initial and refresher training; - Training rosters for Orientation from 8/09 to 12/09; - Recommended Adult Immunization Schedule by vaccine and age group from Center for Disease Control; - Facility list of individuals with Methicillin-resistant Staphylococcus aureus (MRSA); Hepatitis A, B, and C; human immunodeficiency virus (HIV); positive Purified Protein Derivative (PPD); converters; Clostridium difficile (C-Diff); H1N1; and sexually transmitted diseases (STDs); and - Infection Control Environmental Checklist form ▪ **Interviews with**: - Colleen M. Gonzales, BSHS, Chief Nurse Executive; - Rhonda Lynn Warner, RN, QA; - Shelly Scott, RN,C Nursing Operations Officer; - Teresa Irvine, RN, MSN, Director Employee Health/Infection Control; - Julie Graves Moy, MD, MPH, Medical Director, State Office; - Della Cross, RN, Nurse Educator; and - Jeffrey W. Schmidt, Attorney, Corpus Christi State Supportive Living Center ▪ **Observations of**: - Medication administration at Sand Dollar
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: CCSSLC has 61 positions allotted for RNs with only three (3) vacancies, and 50 positions for LVNs with only three (3) vacancies. Having adequate and consistent nursing staff is extremely positive to the provision of clinical care and outcomes to the individuals being served at CCSSLC. CCSSLC needs to develop and implement a number of Nursing monitoring tools that will accurately reflect the quality of nursing care being provided in order to quickly identify problematic trends and implement timely plans of correction. In addition, these data need to be integrated into the Facility's Quality Management and Risk Management systems. Overall, there were a number of significant problematic issues that were found regarding complete and adequate nursing assessments of symptoms for acute changes in status. In addition, there were problems noted regarding the lack of adequate documentation of assessments prior to the transfer to an off-site medical center and as well as upon return to the Facility. However, the documentation provided by the hospital liaison nurse who visits the individuals while hospitalized was consistently exceptional. Nursing Care Plans currently generally do not include measurable objectives. As these are improved, it will be essential for nursing quarterly assessments to discuss the progress an individual is making or not making, strategies that are working or not working, and to recommend changes, if needed, in strategies,

	supports and services. In addition, documentation of the implementation of the interventions listed in the Nursing Care Plans was not found in the progress notes. The tool currently being used to monitor medication administration is not comprehensive, and needs to be revised to include all the basic elements of medication administration orally, by injection or via tube. In addition, the current practice of observing nurses annually during medication administration is too infrequent to ensure that appropriate medication administration practices are being followed consistently.

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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.	CCSSLC's Registered Nurse (RN) and Licensed Vocational Nurse (LVN) staffing data at the time of the review showed that they have adequate staffing of nurses at the Facility. They have 61 positions allotted for RNs with only three (3) vacancies, and 50 positions for LVNs with only three (3) vacancies. The Chief Nurse Executive reported that two (2) years ago the State added 45 RN positions to the staffing levels, and since they have a number of nursing schools in the area, maintaining adequate nursing staffing levels has not been a significant issue for the Facility. Due to adequate nursing coverage, the Facility has not needed to utilize the services of agencies to augment nursing staffing coverage. The Facility regularly has nursing students from the local nursing schools for clinical training, and has had good success in recruiting new nursing graduates. Having adequate and consistent nursing staff is extremely positive to the provision of clinical care and outcomes to the individuals being served at CCSSLC. The Facility should continue its efforts in recruiting and maintaining a stable nursing staff. At the Facility, two (2) residential buildings have 24-hour nursing care, specifically the Infirmary and Sand Dollar. The Facility has a Campus Nurse that makes rounds and covers the rest of the Facility during the night shift. From review of CCSSLC's nursing staffing assignments, the Facility has five (5) Nurse Managers, a group home manager, and two (2) Psychiatric Nurses who manage the Psychiatric Clinic. The Chief Nurse Executive directly supervises the Hospital Nurse Liaison, Nurse Educator, the Infection Control Nurse, the Nurse Operations Officer, an Administrative Assistant, Medical Appointment Secretary, the Lab Technician, and the Transporter. In reviewing the minimum staffing requirements, it appears that they are based on a fixed number of nursing staff (RN and LVN) per specific unit, but can be modified based on the census of individuals served, the acuity levels of individuals served, and staff workload related to individual or staff activities. Even though the Facility reported that it has not fallen below minimum staffing levels, since the Facility does not have a tool to assess for acuity, additional issues to consider regarding modification to staffing include the following: ▪ The education and experience of the nurses; ▪ The number of nurses in orientation; ▪ The number of temporary/agency staff assigned to the unit;	

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		▪ The particular shift and required activities and duties; ▪ The physical layout of the unit; ▪ Other Facility resources; ▪ Available technology used on the unit such as computers; ▪ Unit volatility that includes admissions, transfers and discharges (although CCSSLC was not taking admissions at the time of the review); ▪ The number of high risk individuals on a unit; and ▪ A method to assess unit acuity. At the time of this review, the Facility had few monitoring system in place to assess nursing care and clinical outcomes. CCSSLC has a Quality Assurance (QA) nurse that conducts a 22- to 26-item QA Nursing Audit on a various number of charts per month. For example in August 2009, 12 charts were reviewed; in September 2009, 14 were reviewed; in October 2009, 20 were reviewed; and in November 2009, four (4) were reviewed. The QA nurse then generates compliance data for each item. However, the items on the audit tool only address completion of a task such as the presence or absence of documentation rather than addressing the quality of the documentation. For example, one of the items on the tool asks if a nursing assessment was completed within two (2) hours upon return to the Facility from the hospital. However, there is no item that addresses the appropriateness of that assessment related to the condition that warranted the hospitalization. Consequently, the compliance scores do not accurately reflect the quality of the nursing care and/or documentation being maintained. A number of items addressing quality need to be integrated into this tool so that it accurately reflects nursing clinical practice. In addition, CCSSLC's data regarding compliance cannot accurately be interpreted since it does not include the total population being reviewed (N), and the sample of that population audited (n) to yield a percent sample to indicate the relevance of the compliance scores. Usually, compliance scores for under 20 percent of the relevant population cannot be applied to the total population. Without this information, CCSSLC's nursing quality data cannot be accurately interpreted, analyzed, or accepted as valid reflections of the practices being measured. Also, there was no documented analysis of problematic trends identified in the QA nursing audits. A review of Nursing Meeting minutes demonstrated that there was some mention of issues found from the audits, however, no documentation was found that included the identification of the problematic issue, a summary of an analysis, dates of actions implemented to correct the issue, and/or subsequent monitoring data indicating if interventions were effective. As nursing develops and implements additional monitoring tools and generates additional clinical data, the Nursing Meeting minutes could be modified to include these specific elements so that this information is included in one succinct document, and is reviewed regularly by the nursing team.	

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		CCSSLC needs to develop and implement a number of nursing monitoring tools that will accurately reflect the quality of nursing care being provided in order to quickly identify problematic trends and implement timely plans of correction. In addition, these data need to be integrated into the Facility's Quality Management and Risk Management systems. In developing these monitoring systems to meet compliance with the SA, the Nursing Department needs to evaluate its current allocation of positions since it currently has only one (1) QA nurse assigned for auditing. A review of 10 individuals' medical records (Individual #53, Individual #54, Individual #55, Individual #56, Individual #57, Individual #58, Individual #59, Individual #60, Individual #61, and Individual #62), who had been transferred to a community hospital or emergency room, found that there were significant problems in the documentation regarding the nurses' assessment in the following areas: ▪ A lack of documentation regarding the status and appropriate assessment of the individual at the time of onset of the symptoms; ▪ A lack of documentation regarding the individual's status and assessment at the time of transfer to hospital or emergency room; ▪ No documentation indicating that a transfer packet was sent to the receiving hospital at the time the individual was transferred; ▪ Inconsistent documentation that the nurse or physician notified the receiving facility of the individual's transfer; ▪ Inconsistent documentation of the time, date, and/or method of transfer to the receiving facility in the progress notes; ▪ Lack of a complete nursing assessment upon return to the Facility; ▪ Lack of an updated Nursing Care Plan to reflect changes in status and new interventions; ▪ A lack of adequate descriptions of the site of injuries; ▪ A lack of lung sounds assessed and documented for respiratory issues; ▪ A lack of neurological checks documented for individuals with a significant change in mental status; ▪ Some progress notes were illegible; and ▪ A lack of assessment of bowel sounds and abdomen for individuals with constipation. Overall, there were a number of significant problematic issues that were found regarding complete and adequate nursing assessments of symptoms for acute changes in status. In addition, there were problems noted regarding the lack of adequate documentation of assessments prior to the transfer to an off-site medical center and as well as upon return to the Facility. However, the documentation provided by the hospital liaison nurse who visits the individuals while hospitalized was consistently exceptional.	

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		As an example of some of the problems noted: ▪ In the case of Individual #53, there was no documentation included in the medical record indicating that she had a system assessment documenting her current status prior to being transferred to the hospital. In addition, the time and how she was transferred (ambulance or facility van), or why she transferred to the hospital was not included in the notes. Consequently, there is no way to determine what her signs and symptoms were, and/or her current status at the time she left the Facility. In reviewing these records onsite, it was noted that a number of documents had to be obtained from the units since they were not timely filed in the charts. This appeared to be a significant issue throughout the review when looking for specific documents. The Facility needs to ensure that documents are filed in a timely manner in the medical records so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services. From review of CCSSLC Nursing Procedures/Protocols, there is no protocol addressing change of health status. Also, a review of the Nursing policy entitled "Acute Illness/Injuries" found the timeframes for the assessment by an LVN of within four (4) hours, by the RN within four (4) hours, and by the physician within 24 hours to be inconsistent with current standards of practice. The timeliness of a nursing assessment must be based on the acuity of the illness/injury. Currently, CCSSLC procedures do not include timeframes that would adequately address conditions that would warrant immediate assessment. Four (4) hours is too long of a time lapse for the level of acuity to be determined. In addition, there were not specific instructions included that defined the essential elements that should be contained in the documentation of the assessment. At the time of this review, there was no system in place for monitoring nursing care and documentation for individuals who experienced an acute change in health status to ensure appropriate nursing practices are being implemented. This area should be viewed as a priority when developing and implementing a monitoring system to ensure that adequate nursing practices are being conducted. During the interview with the Chief Nurse Executive, she reported that there used to be a system in place for inter-facility peer review for nursing. However, this has not been in place for at least the past year. Currently, there is no internal nursing peer review being conducted at CCSSLC. Case reviews of individuals who have had to be transferred to the hospital would be a clinically relevant area to target for resuming nursing peer reviews. Although the Facility has an extensive policy addressing Nursing Peer Review, the	

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		process described in the policy is more investigational than educational. Regular nursing peer reviews should be focused on the identification of strengths and weaknesses of the Facility's nursing practices, and include critical analyses of nursing practices, identification of problematic trends with plans of correction generated for problematic areas found, and monitoring for improved clinical outcomes as a result of the corrective actions. At the time of the review, the Facility had a registered nurse with public health experience from the State's Infection Control Office in the position as the Director of the Infection Control/Employee Health Department. She has been in this position for the past two (2) years. There are no other clerical or clinical employees in the department. Review of the Facility's Infection Control (IC) program revealed that the basic areas regarding the surveillance of MRSA; Hepatitis A, B, and C; positive Tuberculin Skin Tests (TSTs); HIV; Syphilis; immunizations; vaccines; and antibiotic use is being regularly tracked on a computerized database. However, there is no system in place to ensure the reliability of the Facility's IC data. The Facility has a policy, H.2, entitled "Procedure for Notification for Infectious Diseases in Texas", that specifies who should be notified in cases of confirmed infectious diseases, but it does not include specific timeframes for notification. There is no system in place that ensures that the units are accurately reporting these issues. Without ensuring that the IC data is reliable, the Facility cannot accurately identify its trends, or where corrective interventions may be needed. The overall documentation of the activities of the IC Department is contained in both the IC Committee Meeting minutes and in the Pharmacy and Therapeutics Committee Meeting minutes. The Facility uses the IC Committee to address issues that pertain mainly to the direct care professionals, and the Pharmacy and Therapeutics Committee for some limited clinical IC issues. Although the IC Committee minutes and the Pharmacy and Therapeutics Committee Meeting minutes included some raw data related to IC issues, no comprehensive analyses was found regarding the Facility's basic surveillance data. In addition, no report or committee meeting minutes were found that comprehensively analyzed and addressed the trends in the data, inquires into problematic trends, corrective actions addressing any problematic trends, or monitoring of outcomes in relation to the activities and interventions of the Infection Control Department in conjunction with the practices on the units. None of the documentation reviewed from the Infection Control Department included any narrative descriptions of the meaning of the data related to clinical issues. Consequently, the department's data only represent raw numbers rather than clinical outcome indicators for the Facility's infection control practices. By limiting the issues discussed at the IC Committee meetings, the Facility has no forum to address the significant essential issues that define an Infection Control Program.	

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		From review of the IC Committee Meeting minutes and Infection Control Report, there was little to no information contained in these minutes to demonstrate that the Facility was addressing issues related to Infection Control practices. The Facility needs to modify the format of these minutes in order for them to contain pertinent information regarding issues discussed; corrective actions; dates, timeframes and assigned responsibility of action steps; outcomes; and how the implementation efforts will be monitored to ensure the desired clinical outcome is achieved. At the time of this review, there were no IC audits being conducted to ensure that appropriate treatment practices were being implemented regarding infection control issues. For example, there was no monitoring system in place to ensure that individuals with Hepatitis C were screened for immunizations for Hepatitis A and B, and, if needed, had received them, or that individuals with MRSA had received the appropriate antibiotic. In addition, no tracking was found of individuals who refused treatments such as immunizations or PPDs indicating that their treatment teams were addressing the refusals and implementing interventions. In addition, based on the interview with the Director of Infection Control, there does not appear to be any Infection Control information that is part of key indicator data for Quality Management. As the Facility continues to develop their Quality Management System, Infection Control information should be integrated into this system as well as integrated into the other disciplines within the Facility. There was little clinical connection between the activities of the Infection Control Department and interventions provided by the unit staff to individuals who had an infectious disease. During an interview with the Director of Infection Control, she reported that there was no review of the Nursing Care Plans for individuals with infectious diseases to ensure that they are clinically appropriate, and that the interventions are actually being implemented. As is discussed in further detail in the portion of this report that addresses Section M.3 of the Settlement Agreement, of 17 records reviewed, only one (1) individual had a Nursing Care Plan that addressed identified infectious diseases. The one plan that did exist was inadequate. The annual screenings for individuals who are Purified Protein Derivative (PPD) positive were found to be completed inconsistently. More specifically, some individuals had these screenings in their record, and others did not. It was unclear if the tests had not been completed, or if this was a problem with regard to timely filing of information. Also, the Nursing Summaries for the individuals reviewed did not consistently mention the infectious disease and in some cases, the nurse reported the wrong disease by citing that the individual had Hepatitis A, when lab reports indicated that the person had Hepatitis	

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		B. From review of the Facility's Infection Control policies, many had not been reviewed or updated since 2002, and there were several policies that needed to be revised to include generally accepted standards of practice for Infection Control. In addition, no policies were found that addressed the operations, duties and responsibilities of the Department. Based on the interview with the Director of Infection Control, there are many informal systems in place that need to be formalized into policies and procedures to ensure consistency. Also, there was a significant deficit regarding policies addressing Infection Control treatments and practices for infectious diseases. In addition, only one (1) housekeeping policy was found, and it did not adequately address specific housekeeping procedures that are required for environmental issues related to communicable diseases. A review of the Infection Control Environmental Checklist form noted it was very basic, and was to be completed monthly by the Unit Supervisors. There was no indication that problems identified were actually tracked to resolution, or that there was a comprehensive analysis of findings that led to any type of proactive interventions being implemented. In addition, having the checklist completed by the supervisor of the unit being reviewed may not facilitate a thorough review of the environment. This checklist should be rotated to staff who do not work on the units being audited, as they may identify issues that those who work on the unit each day would not see. A review of the Facility's Infection Control course description for orientation and annual refresher classes demonstrated that hand-washing and Standard Precautions were included in the curriculum and in the post-test. However, there was no system in place to randomly audit the actual practices on the units. It was evident from the lack of Nursing Care Plans addressing infectious diseases that additional and on-going competency-based training is warranted for the Nursing staff. As noted above, the Facility has a computerized database that includes individuals' names and dates of their immunizations/vaccines. However, because the database does not include information that verifies that vaccines were administered in a timely manner and according to Centers for Disease Control (CDC) guidelines, it is not useful in assisting the Facility to ensure the appropriate administration of vaccines. The Director of the Infection Control Department has experience and background in Infection Control. However, additional expertise and staffing is needed to implement systems to effectively operationalize the Infection Control Department in alignment with the Health Care Guidelines and the Settlement Agreement.	
M2	Commencing within six months of	Fifteen (15) individuals' records were reviewed, including: Individual #1, Individual #3,	

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	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.	Individual #4, Individual #5, Individual #6, Individual #7, Individual #30, Individual #32, Individual #63, Individual #64, Individual #65, Individual #66, Individual #67, Individual #68, and Individual #69. All of the individuals had quarterly nursing assessments completed. However, the quality of these assessments requires significant improvement. The current assessment form uses checkmarks for most of the sections with little to no additional information added. The narrative section for all of the 15 quarterly assessments reviewed contained mainly raw data without any mention of whether the individuals were doing better or worse than the last quarter. For example, the assessments for individuals who had lab work during the quarter only noted the current values without mention of a comparison to the previous lab values. Overall, nursing needs to include an assessment of the quarter rather than just listing lab values and appointment dates. Quarterly assessments also should reflect progress or lack thereof on measurable objectives, and service and/or supports that are included in individuals' Nursing Care Plans. As is discussed in further detail below, Nursing Care Plans currently generally do not include measurable objectives. However, as these are improved, it will be essential for nursing quarterly assessments to discuss the progress an individual is making or not making, strategies that are working or not working, and to recommend changes, if needed, in strategies, supports and services.	
M3	Commencing within six months of the Effective Date hereof and with full implementation in two years, the Facility shall develop nursing interventions annually to address each individual's health care needs, including needs associated with high-risk or at-risk health conditions to which the individual is subject, with review and necessary revision on a quarterly basis, and more often as indicated by the individual's health status. Nursing interventions shall be implemented promptly after they are developed or revised.	Fifteen (15) individuals' records were reviewed, including: Individual #1, Individual #3, Individual #4, Individual #5, Individual #6, Individual #7, Individual #30, Individual #32, Individual #63, Individual #64, Individual #65, Individual #66, Individual #67, Individual #68, and Individual #69. All of the Nursing Care Plans were weak and basically generic in nature. Many had identical interventions listed on the treatment plans that included items such as: "administer medication as ordered", "vital sign monitoring", and "monitor for effectiveness of prescribed medications and treatments." These interventions are basically services that have to be provided to all individuals. The lack of individual-specific interventions based on individualized needs in the Nursing Care Plans render them meaningless in providing staff direction for caring for individuals, and being able to measure individuals' progress toward their goals. Although some of the objectives/goals contained in the Nursing Care Plans were noted to be measurable, behavioral and/or observable, most were not. In addition, documentation of the implementation of the interventions listed in the Nursing Care Plans was not found in the progress notes. None of the nursing interventions reviewed indicated who would implement the intervention, how often they were to be implemented, where they were to be documented, how often they would be reviewed and/or when they should be considered for modification. For example: ▪ The Nursing Care Plan for Individual #1 indicated that she would be oriented to	

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		person, place, time and day daily. However, there was no indication on the Care Plan which staff would measure this, on which shift it would occur, how progress would be evaluated, when it would be considered complete and/or need to be modified, and/or where this information would be documented. ▪ In the case of Individual #30, his Nursing Care Plan notes he has skin break down and infection issues. One (1) of the interventions in the Care Plan indicates that nursing "will monitor" for signs and symptoms of potential or actual skin damage, but does not include any specifics about who will monitor this, how often it will be assessed, and/or where it will be documented. Consequently, it appears that the only monitoring that is happening is when Individual #30 actually has a skin break down. In addition, this Nursing Care Plan includes no interventions addressing prevention of skin break down. In addition, no proactive interventions were listed for individuals with specific risk factors. For example: ▪ The care plan for Individual #64 identified him as at risk for pneumonia, and listed interventions for the direct care professionals that were only reactive strategies. The plan stated that: "When pneumonia is diagnosed," nursing will then initiate a host of interventions to address this issue. There were no proactive nursing interventions included in the plan addressing the prevention of pneumonia. All interventions found in the Nursing Care Plans only addressed reactive care. An additional sample of individuals' records was reviewed to determine if individuals with infectious diseases had appropriate care plans to address their needs in this regard. Specifically, a review was completed of 17 Nursing Care Plans for individuals diagnosed with a variety of infectious diseases (from a total of 44), including: Individual #10, Individual #15, Individual #46, Individual #70, Individual #71, Individual #72, Individual #73, Individual #74, Individual #75, Individual #76, Individual #77, Individual #78, Individual #79, Individual #80, Individual #81, Individual #82, and Individual #83. Of the 17 individuals, 16 had no Nursing Care Plans for these issues, and the one (1) Nursing Care Plan for MRSA for Individual #76 was clinically inadequate. Specifically, the Nursing Care Plan did not address any of the essential elements for a contagious illness, including the need for precautions to be used when taking care of the individual, teaching the individual and staff to prevent the spread and transmission of the infection, environmental issues such as the washing and cleaning of contaminated articles, and/or the regular documentation of the status of the lesion/site. Based on this review, there is no system in place that ensures that individuals with infectious diseases are being provided the appropriate infection control procedures, or that clinically appropriate interventions to prevent the spread of infection are being consistently implemented.	

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		At the time of this review, CCSSLC did not have an adequate monitoring instrument addressing the quality and implementation of Nursing Care Plans. The current Nursing Care Plans do not provide an adequate and appropriate guide regarding the specific needs of the individuals. In addition, there is no evidence that the interventions listed in the Nursing Care Plans are actually being implemented. There needs to be a monitoring system in place ensuring that appropriate nursing interventions are being implemented.	
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.	From review of CCSSLC's Nursing policies and procedures, there are a number of these that have not been reviewed/revised since 2002. For example, as is discussed in further detail above, the current nursing assessment procedures are not adequate and should be revised. In addition, a number of nursing protocols did not include specific criteria for what should be included in the progress notes documentation, and/or other specifics such as timeframes for initiating and completing tasks, and when to notify the physician of certain critical information. Nursing needs to review all existing policies and protocols for appropriate revisions and to develop additional policies and procedures addressing nursing care. The Nursing Department also needs to ensure that all policies, procedures and protocols are in alignment with generally accepted standards of nursing practice and requirements of the SA and Health Care Guidelines. Once that is accomplished, the department then needs to develop and implement a number of associated monitoring instruments with established inter-rater reliability at 85% or above to ensure that these practices are being consistently adhered to.	
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.	Currently, CCSSLC is using the Health Risk Assessment Tool-Nursing as the tool for the identification of clinical risk indicators for individuals. However, this tool is simply scored either "yes" or "no" for items in areas regarding Cardiac, Constipation, Dehydration, Diabetes, GI concerns, Hypothermia, Medical Concerns (other), Osteoporosis, Respiratory, Seizures, Skin Integrity, Urinary Tract Infection, and Aspiration/Choking. The tool is not an adequate comprehensive risk assessment for any of the areas mentioned and does not result in the appropriate identification of clinical risk indicators. The Facility is using an appropriate standardized tool, the Braden Scale, to assess skin integrity issues. Standardized statewide tools should be used by all the Facilities in assessing and documenting clinical indicators of risk. As is discussed in the section above regarding individuals at risk, CCSSLC reported being at the initial stages of this process. Once this system is implemented and individuals' risks are appropriately identified, the PSTs need to conduct integrated team reviews, and develop plans to address identified areas of risk.	
M6	Commencing within six months of the Effective Date hereof and with	From interviews with Nursing staff and review of 68 Medication Pass Assessment tool audits completed between April and December 2009, there has been some supervision	

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	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.	provided for licensed nurses in the administration, monitoring, and recording of the administration of medications. However, the tool currently being used to monitor medication administration is not comprehensive, and needs to be revised to include all the basic elements of medication administration orally, by injection or via tube. For example, the tool should include items such as reviewing the medications with the Medication Administration Record (MARs) three (3) times while administering medication, washing hands between individuals, signing the MAR directly after administering an individual's medications, and providing education to the individual while administering his or her medications. In addition, the current procedure at CCSSLC for the Nurse Competency-Based Training Curriculum indicates that nurses are observed during medication administration annually which is too infrequent to ensure that appropriate medication administration practices are being consistently followed. Nurses should be observed administering medication at least on a quarterly basis. The Facility will need to develop and implement a tracking system to ensure that each nurse is observed at least quarterly. When observing medication administration while on site for individuals who received their mediations via tube, the following significant issues were identified. Specifically, the nurse did not: ▪ Check tube placement prior to administering the medications; ▪ Provide privacy to individuals during medication administration; ▪ Wash her hands in between individuals; ▪ Obtain the proper assistance when needing to move an individual in bed prior to administering a suppository, placing the individual at risk for injury; ▪ Provide information to the individual prior to medication administration; ▪ Consistently flush the tube with water before and after medication administration; ▪ Ensure the individual was in the proper positioning prior to medication administration; and ▪ Address individuals in a respectful manner. On the positive side, during the observation, the Nurse Educator who conducts many of the medication administration observation audits accompanied the reviewer. The Nurse Educator provided appropriate real time correction to the staff nurse who was being observed. While CCSSLC's monitoring criteria for their medication administration tool is not in alignment with appropriate practices, their data for the time period between April and December 2009, reflected 100 percent compliance for most monitoring items. This is not	

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		realistic nor was it verified during the reviewer's on-site medication administration observations. There were a number of comments written on the tools that reflected more detailed issues. However, no indication was found that issues documented on the tools were formally analyzed for trends and/or corrective actions implemented.	

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

- Nursing Assessment forms and processes should be revised to ensure that a comprehensive nursing assessment is conducted. The current form consists of a checklist that does not set the expectation for a comprehensive analysis of information. As noted above, the current format for nursing assessments results in raw data being reported, but not analyzed.
- Nurses and any other staff responsible should be required to complete competency-based training on:
  - Nursing Assessments;
  - Writing and monitoring Nursing Care Plans; and
  - The proper administration and documentation of medication.
- Regular Nursing peer review should be completed.
- Nursing Care Plans should be revised to include specific goals/objectives that are objective and measurable, as well as interventions that identify who is responsible for implementing the interventions, how often they are to be implemented, where they are to be documented, how often they are reviewed, and when they should be modified.
- A monitoring system should be developed and implemented to ensure:
  - Completion, quality and timeliness of Nursing Assessments;
  - Nursing Care Plans are individual-specific and meet professional standards of care;
  - Interventions listed in Nursing Care Plans are proactive, are being timely and appropriately implemented, and are modified in response to the individuals' progress;
  - Individuals who experience changes of status are reviewed, including reviews of individuals who were sent to community hospitals and Emergency Rooms;
  - All nurses who administer medications are appropriately supervised in the administration, monitoring, and recording of the administration of medications and any errors. Such review should occur at least quarterly to be consistent with generally accepted professional standards. The current medication administration monitoring tool should be modified to reflect appropriate standards of practice.
- Inter-rater reliability for all monitoring tools should be established at 85 percent or better.
- The current allocation of nursing positions should be evaluated to meet requirements for developing departmental monitoring activities.
- The role of nursing in the interdisciplinary treatment team process should be expanded to ensure that treatment plans are derived from an integration of the individual disciplines' assessments, and that goals and interventions are consistent with clinical assessments.
- Nursing Procedures/Protocols should be revised and/or developed and implemented to ensure that:
  - The appropriate assessments and documentation requirements are in alignment with generally accepted standards of practice, and the requirements of the SA and Health Care Guidelines; and
  - Address acute change in status.
- Documents should be filed in a timely manner in the medical records so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services.
- Currently successful efforts in recruiting and maintaining a stable nursing staff should continue.

- Consideration should be given to securing the services of an expert in the area of Infection Control to provide consultation to the State and the Facilities.
- The need for additional staff for the Infection Control Department at CCSSLC should be evaluated.
- The IC policies and procedures should be revised as needed to reflect current standard of practices and requirements outlined in the Settlement Agreement/Health Care Guidelines.
- A departmental monitoring system should be developed and implemented in alignment with IC standards of practice and Facility policies.
- Statewide IC monitoring instruments should be developed and implemented to ensure that individuals with infectious diseases are adequately treated, protected from additional infections or re-infection, and that other individuals who live in the same buildings as well as staff and visitors are appropriately protected from transmission of infections.
- Systems should be developed and implemented to ensure reliability of IC data.
- The structure of the IC minutes should be revised to include a systematic review of data trends for individuals and employees that include an analyses, an inquiry into the issue, a plan of action that includes the name of the person responsible for follow-up and the date when it will be implemented, and updates on the desired outcomes.
- The Director of Infection Control should collaborate with nursing regarding the development and implementation of individualized–specific, appropriate Nursing Care Plans for IC issues.
- The Director of Infection Control should collaborate with nursing to ensure that unit staff receive appropriate on-going competency-based IC training.
- Infection Control Environmental Checklist audits should accurately reflect the environmental conditions, and corrective actions should be taken and documented.
- IC data should be integrated into the Facility's Quality Management system.

<table>
<tr><th>SECTION N: Pharmacy Services and Safe Medication Practices</th><th></th></tr>
<tr><td rowspan="3">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:</td><td>Steps Taken to Assess Compliance: The following activities occurred to assess compliance:
▪ Review of Following Documents:
o CCSSLC Pharmacy Manual-November 23, 2009;
o Drug Regimen Reviews for the following individuals: Individual #4, Individual #5, Individual #6, Individual #10, Individual #13, Individual #25, Individual #41, Individual #81, Individual #84, Individual #85, Individual #86, Individual #87, Individual #88, Individual #89, Individual #90, Individual #91, Individual #92, Individual #93, Individual #94, Individual #95, Individual #96, Individual #97, Individual #98, Individual #99, Individual #100, Individual #101, Individual #102, and Individual #103;
o Side effect monitoring information for the following individuals: Individual #15, Individual #34, Individual #44, Individual #104, and Individual #105;
o Quarterly Medication Review Worksheets;
o Draft of Guidance for Anticonvulsant Monitoring;
o Draft of Policy # 011, Pharmacy Services and Safe Medication Practices;
o CCSSLC's medication error data and graphs for 2008 and 2009; and
o Medication administration records for the Infirmary and Sand Dollar
▪ Interviews with:
o Robert Denny Sartin, M.Sci., R.Ph., Chief Pharmacist;
o Julie Graves Moy, MD, MPH, Medical Director, State Office;
o Eric Vinson, Attorney, Office of Attorney General;
o Colleen M. Gonzales, BSHS, Chief Nurse Executive;
o Shelly Scott, RN, Nursing Operations Officer; and
o Sandra Rodrigues, MD, Medical Director</td></tr>
<tr><td>Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.</td></tr>
<tr><td>Summary of Monitor's Assessment: Whenever an individual is prescribed a new medication, a system appears to be in place to check for potential issues. However, a system needs to be developed and implemented to ensure that there is supporting documentation of the notification of a physician that the addition of a newly prescribed medication may have adverse effects in combination with the existing medication regimen. In addition, the physician's response to this notification needs to be documented. Likewise, a system needs to be instituted to ensure that physicians and/or nurse practitioners respond to recommendations included in the quarterly Drug Regimen Reviews.

There appears to be significant underreporting of medication errors. For example, while onsite, the reviewer identified a number of potential errors, but nursing staff did not consistently agree that such errors needed to be reported. Since medication error reporting is not yet reliable, a spot check system</td></tr>
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	should be initiated. The spot check system needs to include a review of the MARS and narcotics log at some time during the shift. The spot checker (auditor) should make sure that the MAR has been completed appropriately and that both the on-coming and off-going nurse has signed the narcotics log.

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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 Facility currently has a policy in place in alignment with the requirements of the Settlement Agreement. The Chief of Pharmacy indicated that when a new medication is ordered for an individual, the pharmacist receives a fax of the order, and enters it into the WORx software system which does an automatic review of the new medication, reviewing for appropriate dosing, listed allergies, and potential interactions with the individual's current medication regimen. If a problem is identified, the physician is notified. However, from the interview with the Chief Pharmacist, this notification may at times be informal without supporting documentation. A system needs to be developed and implemented to ensure that there is supporting documentation of the notification of a physician that the addition of a newly prescribed medication may have adverse effects in combination with the existing medication regimen. In addition, the physician's response to this notification needs to be documented.	
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 review of the Quarterly Drug Regimen Reviews (DRRs) was completed for 28 individuals, including: Individual #4, Individual #5, Individual #6, Individual #10, Individual #13, Individual #25, Individual #41, Individual #81, Individual #84, Individual #85, Individual #86, Individual #87, Individual #88, Individual #89, Individual #90, Individual #91, Individual #92, Individual #93, Individual #94, Individual #95, Individual #96, Individual #97, Individual #98, Individual #99, Individual #100, Individual #101, Individual #102, and Individual #103 All had comprehensive comments from the pharmacist addressing labs, the need for MOSES or DISCUS reviews, potential side effects, suggestions for tapers, recommendations for alternative medications related to absorption, and consistency on indications for medications. However, on most of the DRRs, the section indicating agreement/disagreement with the pharmacist's recommendations was either not addressed or inadequately addressed by the physician/nurse practitioner. For example, a number of the DRRs noted that a different type of calcium supplement might be a better choice due to absorption properties.	

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		However, there was no response from the primary physician/nurse practitioner addressing these recommendations. On a number of the DRRs, the psychiatrist indicated that the pharmacist's recommendations would be deferred to the individual's primary physician. However, there was no follow-up determination documenting that the deferment had been addressed.	
N3	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, prescribing medical practitioners and the pharmacist shall collaborate: in monitoring the use of "Stat" (i.e., emergency) medications and chemical restraints to ensure that medications are used in a clinically justifiable manner, and not as a substitute for long-term treatment; in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy, to ensure clinical justifications and attention to associated risks; and in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.	From review of the CCSSLC's Pharmacy Manual, no policy was found addressing this requirement. At the time of the review, the Pharmacy and Therapeutics Committee and the Polypharmacy Review Committee were only addressing the issue of polypharmacy. From discussions with the Chief Pharmacist and Medical Director, the Facility is aware and in process of developing systems to address these requirements. A number of emails verified that the Facility in conjunction with the State is in process of developing systems to address the requirements in this section of the Settlement Agreement. At the time of this review, a draft of a comprehensive policy regarding Pharmacy Services and Safe Medication Practices had been developed, and was in the process of being approved. It should be completed by the next monitoring visit at which time the Monitoring Team will review it as well as any related implementation efforts.	
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.	As noted in the section above that addresses Section N.2 of the SA, on most of the DRRs, the section indicating agreement/disagreement with the pharmacist's recommendations was either not addressed or inadequately addressed by the physician/nurse practitioner. On a number of the DRRs, the psychiatrist indicated that the pharmacist's recommendations would be deferred to the individual's primary physician. However, there was no follow-up determination documenting that the deferment had been addressed.	
N5	Within six months of the Effective Date hereof, the Facility shall ensure quarterly monitoring, and more	CCSSLC's has a current policy in place addressing this requirement. In addition, a number of the DRRs reviewed noted if a MOSES or DISCUS was needed. It is the role of the Psychiatric Nurses at the Psychiatric Clinic to conduct the quarterly MOSES and	

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	often as clinically indicated using a validated rating instrument (such as MOSES or DISCUS), of tardive dyskinesia.	DISCUS. For four (4) individuals (Individual #15, Individual #44, Individual #104, and Individual #105), review of their records indicated that all had a current MOSES and DISCUS completed. However, for Individual #34, MOSES assessments were not consistently completed on a quarterly basis. For this individual, dates of MOSES assessments over the past two (2) years included: 1/14/08, 3/14/08, 9/8/08, and 3/10/09. DISCUS exams completed on 2/2/08, 3/24/08, 7/2/08, 9/17/08, 12/5/08, and 3/10/09, also were not consistently completed quarterly, particularly in 2009. There is no monitoring system in place to ensure that this requirement is consistently addressed. In addition, no Nursing Care Plans were found addressing side effects of psychotropic medications, or the need to conduct quarterly MOSES and DISCUS monitoring. These issues need to be included in the Nursing Care Plans.	
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.	At the time of this review, CCSSLC had an Adverse Drug Reactions policy in place that was revised 7/20/09, in alignment with this requirement of the Settlement Agreement. From the report of the Chief Pharmacist, there have been no reported Adverse Drug Reactions reported to the Food and Drug Administration in the past year.	
N7	Commencing within six months of the Effective Date hereof and with full implementation within 18 months, the Facility shall ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care. The Parties shall jointly identify the applicable standards to be used by the Monitor in assessing compliance with current, generally accepted professional standards of care with regard to this provision in a separate monitoring plan.	At the time of this review, the Facility was in process of developing and implementing a system addressing drug utilization evaluations (DUE). The State's Medical Director has been working on this requirement with all the SSLCs in deciding on which medications to review as well as developing the process in alignment with the SA and Health Care Guidelines. Thus far, CCSSLC has not conducted a DUE, but anticipates beginning the process by the next review. During upcoming monitoring visits, this requirement will be further reviewed.	
N8	Commencing within six months of the Effective Date hereof and with	At the time of this review, CCSSLC had been utilizing a medication error system in accordance with the Medication Errors/Incidents procedure. From review of the	

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	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.	Facility's medication error data for 2008 and 2009, there appears to be a significant issue with the under-reporting of medication errors based on the census and the number of medications given on a daily basis. From the reviewer's discussion with the Chief Nurse Executive, the Facility only recently changed its policy regarding medication errors in an attempt to make a self-reporting system non-punitive. From review of the medication administration records in the Infirmary and for Sand Dollar, a number of missing initials were found indicating that either the individuals did not receive their medications, or the nurse did not use the appropriate procedure when administrating and documenting medications. However, when the unit nurses were asked if these missing initials constituted a medication error, most said they did, but that they did not think that they were responsible for completing a Medication Error Report. Although it was reported that the medication administration records were regularly monitored, there is clearly a resistance to report medication errors. CCSSLC needs to develop and implement a system to ensure that MARs are regularly checked to determine that medications were given as prescribed. When issues such as missing initials on the MARs are identified, a review needs to be completed to determine whether the individual was administered the medication, or if it was a documentation error. In either instance, an error report needs to be submitted. Since medication error reporting is not yet reliable, a spot check system should be initiated. The spot check system needs to include a review of the MARS and narcotics log at some time during the shift. The spot checker (auditor) should make sure that the MAR has been completed appropriately and that both the on-coming and off-going nurse has signed the narcotics log. In addition, in reviewing the minutes from the Medication Error Committee, no comprehensive narrative analysis or plans of correction were found that included interventions and/or anticipated outcomes. The Medication Error graphs and numbers only provided the raw data regarding medication errors, but did not include any clinical analysis of the trends or needed interventions addressing prevention of medication errors.	

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

- A system should be developed and implemented to ensure that there is supporting documentation of the notification of a physician that the addition of a newly prescribed medication may have adverse effects in combination with the existing medication regimen as well as the physician's response to this notification.
- The pharmacy's current practice regarding noting and addressing, as appropriate, laboratory results, and identifying abnormal or sub-therapeutic medication values on the Quarterly Drug Regimen Reviews should continue.

- A system should be developed and implemented to ensure physicians/nurse practitioners provide adequate responses regarding pharmacy recommendations on the Quarterly Drug Regimen Reviews.
- A system should be developed and implemented to ensure that the prescribing medical practitioners and the pharmacist collaborate: 1) 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; 2) in monitoring the use of benzodiazepines, anticholinergics, and polypharmacy to ensure clinical justifications and attention to associated risks; and 3) in monitoring metabolic and endocrine risks associated with the use of new generation antipsychotic medications.
- The Facility should continue to ensure that there is timely identification, reporting, and remedial action regarding all significant or unexpected adverse drug reactions.
- State Office and the Facility should continue to develop and implement a system to ensure the performance of regular drug utilization evaluations in accordance with current, generally accepted professional standards of care, the SA and Health Care Guidelines.
- The Facility should ensure that policies regarding Medication Errors identify all failures to properly sign the Medication Administration Record and/or the Narcotics Logs as medication errors, and that appropriate follow-up occurs to prevent recurrence of such errors.
- The Facility should implement documented spot checks to ensure the MARs and Narcotic Count Logs are documented appropriately.
- Nurses should conduct counts of narcotics and document such counts in the Narcotic Log at the beginning/end of each shift, as well as when the keys are passed to another nurse for breaks and when the keys are returned to the originally assigned nurse.
- The Facility should conduct an analysis and implement a plan of correction with nursing to address the underreporting of medication errors.
- Training should be provided to all nursing staff regarding the reporting of medications errors.
- The Facility, specifically nursing, should develop and implement a monitoring system to ensure that MOSES and DISCUS are conducted quarterly, and that for individuals who require this, there is a Nursing Care Plan addressing these needs.

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 Continuing education training documentation for therapists; o State Supported Living Center Policy: Nutritional Management Team (Policy #013); o Habilitation Therapies Manual; o Physical and Nutritional Management Policy; o Nutritional Management Screening Tool; o Lists of Individuals "At Risk"; o Person Directed Planning and Active Treatment (F.15 Draft 11/21/09), Ensuring Safe Mealtime Practices; o Safe Mealtime Practices Protocol; o Dining Room Test; o Documenting Meal Monitoring and Active Treatment (F.42 Implemented 09/01/08); o Mealtime Monitoring and Coaching Report forms; o Policy C.1: CCSS Ensuring Individuals' Rights (Revised 03/25/08); o Pre-Service Training Schedule for 12/01/09; o NMT Attendance Sheets submitted for the following dates: 5/20/09, 5/27/09, 6/30/09, 7/21/09, 7/29/09, 8/24/09, 8/31/09, 9/24/09, 9/29/09, and 10/26/09; o NMT Agendas submitted for the following dates: 2/11/09, 2/18/09, 2/25/09, 3/24/09, 03/25/09, 4/22/09, 4/29/09, 5/20/09, 5/27/09, 5/27/09, 6/23/09, 6/24/09, 6/30/09, 7/21/09, 7/29/09, 8/24/09, 8/31/09, 9/24/09, 10/26/09, 10/27/09, 11/12/09, 11/19/09, 11/23/09, and 12/17/09; and o Record reviews, including assessments, PSPs, and PNMPs, for the following individuals: Individual #26, Individual #29, Individual #53, Individual #57, Individual #61, Individual #62, Individual #65, Individual #79, Individual #87, Individual #106, Individual #107, Individual #108, Individual #109, Individual #110, Individual #111, Individual #112, Individual #113, Individual #114, Individual #115, Individual #116, Individual #117, Individual #118, Individual #119, and Individual #120 ▪ **Interviews with**: o Nutritional Management Team Chairperson; o Physical therapists, occupational therapists, and speech-language pathologists, as well as other professional and direct support staff during observations; ▪ **Observations of**: o A Nutritional Management Team (NMT) Meeting; o Individual #109's PSP staffing; o A seating assessment; o Annual Refresher Training and Competency-Based Check-offs; o Webinar for Seating;

	- Mealtimes; - Alternate Positioning for several individuals in Coral Sea; and - Observations of individuals and staff in homes, day program areas, clinical and dining areas.
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: CCSSLC therapists have limited specialized training and/or experience in which they have demonstrated competency in working with individuals with complex physical and nutritional management needs. Continuing education opportunities need to be increased for members of the PNM Team, and be focused on providing supports to people with complex physical and nutritional management needs. At the time of the review, the Facility was not systematically identifying individuals with PNM concerns. There appeared to be pieces of an identification system in place, but not a comprehensive, integrated system to ensure that individuals with such needs are identified in a timely manner to allow for prompt development and implementation of plans to address their needs. The Facility also was not completing comprehensive assessments of individuals at risk with regard to PNM concerns, or developing comprehensive plans to address risk areas. Many individuals at the Facility have mealtime and/or positioning plans in place. However, many of these plans did not address all activities in which swallowing difficulties can present risk. In addition, a number of individuals with identified dental problems, did not have oral care plans to address their needs. Moreover, PNMPs did not address consistently alignment/support in wheelchairs and/or alternate positions, strategies for oral hygiene, medication administration, snacks, personal care, and/or bathing/showering. A review of Mealtime Monitoring and Coaching Report forms document that mealtime errors continue to be identified from one monitoring session to the next without resolution. In addition, these forms are not analyzed to determine the need for person-specific staff re-training, and/or to determine systemic mealtime concerns. CCSSLC policy did not provide a formalized schedule for monitoring, training/validation procedures for supervisors, identification and definition of specific monitoring indicators for PNMPs, identified compliance level expected, and/or process to be followed if PNMPs are not being implemented as written. It did not appear that monitoring of staff's competence with regard to the implementation of PNMPs was being completed regularly. At the time of the review, documentation could not be found to show that annual reviews had been conducted of individuals currently receiving enteral nutrition to determine the medical necessity of the tube.

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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,	Due to the multiple requirements included in this provision of the SA, each requirement is discussed in detail below: PNM team consists of qualified Speech and Language Pathologist (SLP), Occupational Therapist (OT), Physical Therapist (PT), Registered Dietician (RD), and, as needed, ancillary members [e.g., Medical Doctor (MD), Physician's Assistant (PA), Registered Nurse Practitioner (RNP)]: Per report of the Nutritional Management Team (NMT) Chairperson, observation at the NMT meeting, and review of NMT attendance sheets, a Physical Therapist is not a member of the Nutritional Management Team. In addition, the NMT is not a consistent group of therapists, rather the membership is driven each meeting by the individuals who are referred to the NMT for review. The therapists of the individuals being reviewed, and other related staff such as nurse case manager, QMRP, etc., make up the membership of the NMT for that meeting. The State Supported Living Center Policy: Nutritional Management Team (Policy #013) defines the composition of the Nutritional Management Team as: "physician, occupational therapist, speech language pathologist and dietitian. Other disciplines as indicated by need including but not limited to Physical Therapy, Certified Occupational Therapy Assistant, Licensed Vocational Nurse (LVN), psychologist, QMRP, home staff, and others." Nutritional Management Team Policy (#013) documented the specific roles of team members as primary care provider, occupational therapist, speech language pathologist, registered nurse, registered dietitian, and qualified mental retardation professional, but did not identify the role of a physical therapist. With regard to the NMT's membership consisting of the therapists of the individuals being reviewed, this presents challenges with regard to the qualifications of the team members and their ability to develop comprehensive PNMPs for individuals with the most complex health, physical and nutritional needs. The Settlement Agreement appears to contemplate one (1) physical and nutritional management team with the required level of expertise. Such a team should obtain input from and work with the individual and his/her IDT. Specifically, the SA states: "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… All members of the team should	

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	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.	have specialized training or experience demonstrating competence in working with individuals with complex physical and nutritional management needs" (emphasis added). It is difficult in a large facility to expect that all therapists will have the necessary expertise to assess and develop comprehensive PNMPs for people with the most complex health, physical and nutritional needs. In addition, it is important that individuals with the most complex needs be seen quickly. It will take a long time to ensure that all team members have the required expertise. Although all teams should be able to assess and implement interventions to minimize risk for individuals with the most complex needs, at this time, there is a sense of urgency with regard to the need for individuals at highest risk to be seen quickly. Having one (1) team that has the expertise to do this would help to ensure that this urgent need is met, with the long-term goal of training and expanding the expertise of all relevant team members. <u>There is documentation that Physical Nutritional Management Team (PNMT) members have specialized training or experience in which they have demonstrated competence in working with individuals with complex physical and nutritional management needs</u>: CCSSLC therapists have limited specialized training and/or experience in which they have demonstrated competence in working with individuals with complex physical and nutritional management needs. Continuing education opportunities need to be increased for members of the PNM Team, and be focused on providing supports to people with complex physical and nutritional management needs. <u>PNM team meets regularly to address change in status, assessments, clinical data, and monitoring results (HCG VIII.C.9)</u>: Per review of the NMT Meeting agendas, the NMT meets one (1) to three (3) times per month. The NMT agenda includes topics for discussion, individual nutritional concerns with the individual's identified risk level (1 - High, 2 - Medium, or 3 - Low), discussion of individuals' weights, and general topics. The NMT meeting on 01/26/10, observed by the reviewer, addressed person-specific concerns for individuals experiencing weight loss or gain, but did not discuss other health related concerns of individuals that were presented during the meeting, or present recommendations for those individuals to minimize the risk of such health conditions. The members of the NMT at this meeting were the NMT Chairperson (SLP), Nurse Case Managers (4), Advanced Registered Nurse Practitioner (ARNP) (1), SLP (1), OTR (1), Dietitian (1), PNM Coordinator (1), and QMRP (1). The members of the NMT discussed each individual, the reason for the review, and recommendations to address the identified concerns. The results of the meeting were recorded by the NMT Chairperson and documented in the NM Client Master List data tracking system. <u>PNM plans are incorporated into individuals' Personal Support Plans (PSPs)</u>: The review of PSPs submitted incorporated the person's PNMP into the PSP. PNMP information	

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		could be located under OT, PT, SLP, Nutrition, and PNMP Sections. However, a review of person-specific records submitted identified a number of concerns related to the delivery of physical and nutritional supports in the areas of identification, assessment, interventions, monitoring and training. For example, concerns were noted for the following people: ▪ Individual #106's PNMP was incorporated into his PSP, but per Nutritional Management Team Policy (#013) NMT activities, the reason for review, recommendations and current status were not summarized and presented in his PSP. ▪ Individual #107's Nursing Assessment, dated 02/21/09, documented "he has had one infirmary admission this past year in March 2008 for pneumonia." Individual #107 was reviewed by the NMT on 9/8/08, 12/17/08, 02/25/09, 03/25/09, 05/27/09, 07/29/09, 09/29/09, and11/23/09. It was noted that he was in hospital for pneumonia then in the infirmary, that he continues to have multiple health problems (5/09), and was again in the infirmary for respiratory distress (11/09). Discussions and recommendations were related to weight gain. For example, recommendations included: continue to monitor and remain at Risk Level 2, formula has been decreased to facilitate gradual weight loss and down grade to Risk Level 1 on 11/09. The NMT did not initiate a comprehensive assessment to address his complex medical needs, including the repeated hospitalizations, and/or respiratory issues. ▪ Individual #108 was reviewed by the NMT on 10/29/08 and 02/25/09, related to weight gain/loss and spillage of food. The recommendations were: "pureed texture with pudding thick liquids." The documentation shows that she was being provided three (3) helpings, and she was identified as Risk Level 3 (10/08 and 02/09). There were no recommendations to deal with spillage of food. This reviewer observed Individual #108 at dinner, and her food spillage was extensive during the meal. Individual #108's Nutritional Evaluation, dated 05/18/09, documented that she is at the low end of her Ideal Body Weight Range (IBWR). Individual #108's PSP identifies her at risk for aspiration, constipation and dehydration. The NMT recommendations did not request an assessment of her current mealtime skills to address mealtime interventions to minimize loss of food/fluid during mealtimes and snacks, which has an impact on her ability to maintain her weight. They also did not address her risk for aspiration, constipation, and/or dehydration. ▪ Individual #109 was reviewed by the NMT on 02/25/09, with "no significant problems." She is a Risk Level 3, or low risk, but there was no justification for this risk level. It is unclear why she was reviewed by the NMT. ▪ Individual #61 was reviewed by the NMT on 9/3/08, 2/11/09, 6/23/09, and 8/24/09. The reasons for review and NM problems documented included: "diagnosed aspiration pneumonia. Frequent respiratory illnesses requiring	

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		treatment/pneumonia." She was hospitalized twice, and had one (1) infirmary visit. NMT discussion and recommendations discuss hospitalizations and transition from Risk Level 2, but did not recommend a comprehensive assessment to identify interventions to minimize or reduce her risk of aspiration. ▪ Individual #110 was reviewed by the NMT on 7/30/08, 10/29/08, 12/17/08, 2/5/09, 7/29/09, and 9/29/09. The NMT recommended that "staff need to ensure that he is hydrated", but this recommendation was not on his PNMP or Dining Plan. The Occupational Therapy Screening, dated 02/09/09, documented that "his fluid consistency be changed to nectar consistency as he has better control the thickened fluid in the oral state resulting in decreased anterior spillage and consult has been sent to nursing." Individual #110's PNMP indicates that his fluid consistency is nectar, but his Dining Plan identifies his fluid consistency as regular, which places him at risk during mealtimes. ▪ Individual #79 was reviewed by the NMT on 10/29/08, 2/25/09, 3/25/09, and 7/29/09. The reason for reviews included: "mild silent aspiration of liquids on MBSS [Modified Barium Swallow Study] in 07, down .6 lb., inconsistent in eating, refusing fluids and meds periodically, some staff reporting problems with swallowing, coughing and refusing meals, losing weight, but this was intended." NMT recommendations were that liquids be thickened to nectar consistency, staff to push fluids with medications, MBSS requested in 03/09, and she was to remain at Risk Level 3. Staff were to schedule a MBSS due to Individual #79's coughing. There were no documented OT consultations to address Individual #79's reported problems with swallowing, coughing and refusing meals. Her PMMP, that was revised 10/16/09, did not document NMT recommendation to "push fluids with meds." PNMP mealtime instructions stated: "If needed staff may provide gentle physical prompting to place head on headrest by placing open hand on her forehead. Introduce spoon at midline and gently press down on tongue to decrease tongue thrust. She is to be fed at a slow rate of speed allowing time to swallow one food or drink at a time." These presentation techniques were not transferred to her Dining Plan. ▪ Individual #111 was reviewed by the NMT on 9/3/08, 2/11/09, and 8/24/09. He was reviewed for being above his weight range. Recommendations were to continue on current regimen, prune juice was reinstated, and continue at Risk Level 3. Individual #111's Nursing Assessment, dated 01/06/10, documented an ER visit on 04/21/09, for low oxygen saturation rates; and on 9/30/09, for respiratory distress and abdominal distension; and hospitalizations for hypothermia and pneumonia on 07/01/09; possible bowel obstruction on 08/22/09; and possible pneumonia on 10/31/09; and infirmary visits for pneumonia, hypothermia, ileus, and asymptomatic bradycardia on 07/24/09; care for post hospitalization on 09/01/09; status post sigmoid colectomy/colostomy on 10/16/09; and UTI status post hospitalization on 11/09/09. There were no NMT and/or OT interventions to	

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		address his health concerns. ▪ Individual #65's PSP dated 01/13/09, documented that he was hospitalized twice for pneumonia on 03/26/08, and 11/8/08. His Nursing Assessment, dated 12/16/09, documented a hospitalization for aspiration pneumonia on 04/16/09, and two (2) infirmary admissions for aspiration pneumonia on 05/18/09, and 11/09/09. The NMT reviewed Individual #65 on 9/3/08, 2/11/09, 6/23/09, and 8/24/09. NMT recommendations were to remain at Risk Level 1. His PNMP did not have revision dates. There was no comprehensive assessment completed by the NMT and/or OT/PT to address his risk of aspiration pneumonia, and/or the development of interventions added to his PNMP to address his medical concerns. ▪ Individual #53's Nursing Assessment, dated 03/04/09, documented that she was admitted to the hospital two (2) times this past year due to pneumonia, including on 01/09/09, and 02/17/09. She was in the infirmary three (3) times for emesis, and two (2) times for pneumonia. Individual #53 was reviewed by the NMT on 9/3/08, 2/11/09, 5/20/09, 7/21/09, and 9/24/09. She was reviewed for "shear injury to back, has had some respiratory distress, has recent emesis, wt. stable, still having lots of emesis." Recommendations were "started Juven, vitamin C and Zinc per dietary consult." "She can be positioned on right sidelyer in bed for 2 of 4 feedings, wheelchair put together wrong and has been corrected and continue at Risk Level 2." There was no comprehensive assessment completed by the NMT, and/or OT/PT to address her risk of aspiration pneumonia.	
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	<u>A process is in place that identifies individuals with PNM concerns</u>: At the time of the review, the Facility was not systematically identifying individuals with PNM concerns. There appeared to be pieces of an identification system in place, but not a comprehensive, integrated system to ensure that individuals with such needs are identified in a timely manner to allow for prompt development and implementation of plans to address their needs. The Habilitation Therapies Manual, Section VII. Nutritional Management, described the Discovery/Referral Phase of the NMT as: "All individuals residing at the facility will be screened for risk factors and assigned a risk level. Risk levels are 1-High Risk, 2-Medium Risk, 3-Low Risk." The Nutritional Management Screening Tool lists risk factors, including Level 1 (High Risk) will be seen by the next scheduled NMT, Level 2 (Medium Risk) will be seen in 30 days to one (1) year, and Level 1 (Low Risk) is seen as needed (PRN). Per interview with the NMT Chairperson, individuals have been assigned a risk level, but the Nutritional Management Screening Tool had not been utilized. As an example, the following person received a gastrostomy tube, but was not reviewed by the NMT team: ▪ Individual #26's PSP, dated 01/07/10, did not contain the Risk Tracking Record.	

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	physical and nutritional management problems to identify the causes of such problems.	Individual #26 received a gastrostomy tube on December 10, 2009. A review of the NMT data tracking system did not document that Individual #26 had been reviewed by the NMT. His Dining Plan, dated 01/07/10, did not reflect that Individual #26 has a gastrostomy tube and is supposed to receive supplemental feedings, if he refuses to eat orally, or take medications and/or fluids. <u>Process includes levels of risk based upon physical and nutritional history, current status and includes specific criteria for guiding placement of individuals in specific risk levels (HCG VI.C.2 and VI.C.3)</u>: Submitted documentation formally identified individuals at risk within identified categories (at risk for aspiration, choking, falls, weight gain/loss, skin breakdown, impaction, dehydration, etc.). However, through record review, the reviewer identified numerous individuals who appeared to be at risk in the preceding categories, but who were not on the submitted lists. The following individuals were identified by the Facility as at risk for aspiration per submitted documentation: Individual #61, Individual #63, Individual #64, Individual #65, Individual #66, Individual #127, Individual #128, and Individual #129. The following individuals per submitted documentation also appear to be at risk for aspiration but were not identified on the submitted list: ▪ Individual #106's Risk Tracking Record, dated 04/01/09, documented Individual #106 is at risk of aspiration. ▪ Individual #108's PSP, dated 05/19/09, identified her at risk of aspiration. ▪ Individual #116's PSP, dated 04/14/09, identified her at risk of aspiration. ▪ Individual #120's PSP, dated 09/11/09, and PNMP, dated 12/22/09, documented that he was at risk for aspiration. ▪ Individual #107's PSP, dated 02/26/09, documented a history of chronic aspiration. ▪ Individual #114's PSP, dated 01/29/09, documented his risk for aspiration/choking. ▪ Individual #113's PSP, dated 05/19/09, documented her as at risk for aspiration/choking. ▪ Individual #115's Nursing Assessment, dated 07/13/09, states: "[Individual #115] has been in poor health this past year. He required admission to MMC 04/25/09, then was transferred to Corpus Christi Hospital, then returned to infirmary 06/24/09. He required treatment for aspiration pneumonia, small bowel obstruction requiring exploratory laparotomy, viral respiratory infection (VRI) in urine, swollen lymph nodes, and renal failure requiring dialysis. All problems resolved. He remains in the Infirmary at the present time." The NMT reviewed Individual #115 on 9/13/08, 2/11/09, 6/23/09, and 08/24/09. Individual #115's Occupational/Physical Therapy Screening was completed on 07/03/08, and his PNMP was revised on 12/01/09, and 1/6/10.	

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		▪ Individual #110's PSP, dated 03/10/09, documented that he is at risk of aspiration/choking. The following person was identified at risk for choking: Individual #61. The following individuals per submitted documentation appear to be at risk for choking, but were not identified on the submitted list: ▪ Individual #114's PSP, dated 01/29/09, documented his risk for aspiration/choking. ▪ Individual #113's PSP, dated 05/19/09, documented her risk for aspiration/choking. ▪ Individual #110's PSP, dated 03/10/09, documented that he is at risk of aspiration/choking. ▪ Individual #29 had two (2) documented choking incidents: choking on a biscuit on 05/25/09, and the Abdominal Thrust Maneuver was performed after she choked on a sandwich that was served as her afternoon snack while at home on 07/14/09. Individual #29 has one-to-one level of supervision per the HRC. Her diet texture is ground with cubed breads. It is unclear why Individual #29 was served a sandwich, as it is not within her prescribed diet texture. Individual #29 was reviewed by the NMT on 7/8/08, 9/24/08, 12/17/08, 2/25/09, 3/25/09, 5/27/09, 7/29/09, 9/29/09, and 11/23/09. The NMT recommended that Individual #29 be given liquids prior to eating, biscuits have been discontinued with substitute of Texas toast, she is to be monitored during meals, redirected when talking when eating, she can have seconds of some foods if she likes, and distractions are to be reduced during meals. Individual #29's Dining Plan and Diet Request did not incorporate the recommendations of the food substitution or the instructions to give liquids before eating. Per her PNMP, revised 01/04/10, if she refuses to eat or take her medications or consumes less than 50 percent of her meal, she will receive Ensure through her gastrostomy tube. The NMT review documented that Individual #29's family wants a regular diet texture for her. NMT members expressed their concerns to the reviewer as there were no established procedures for the NMT and/or therapists to follow if a family member and/or guardian requests a diet texture that is not safe for an individual, or gives that person food/fluid that is not prescribed which places that person at risk. Individuals identified by the Facility as at risk for falls were: Individual #32, Individual #57, Individual #68, and Individual #69. The following individuals per submitted documentation appear to be at risk for falls/fractures, but were not submitted on the list: ▪ Individual #113's PSP, dated 05/19/09, documented "has had slips, trips or falls in the past year." Orthopedic Clinic Evaluation, dated 03/19/08, documented "she has sustained an avulsion fracture at the base of the first distal phalanx of	

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		the left foot." ▪ Individual #112' Physical Therapy Screening, dated 05/20/09, documented "there were no recorded falls this year, though [Individual #112] has a history of throwing herself out of her wheelchair." ▪ Individual #87's Orthopedic Clinic Evaluation, dated 09/19/09, documented that: "He sustained an injury to the proximal tibia on the left side. The area showed an impacted fracture of the proximal tibia." ▪ Individual #119's Orthopedic Clinic Evaluation, dated 10/15/08, documented that "[Individual #119] was seen back in follow up for her left proximal tibia injury." ▪ Individual #115's Occupational/Physical Therapy Screening, dated 07/03/08, documented "PMP Focus: Prevent fractures from brittle bones and to prevent further joint contractures." ▪ Individual #57's Nursing Assessment documented Orthopedic consults on 03/05/09, and 04/15/09, to follow up on right hip fracture. PT was to follow up on gait training, ambulation and rolling walker use. ▪ Individual #121's Orthopedic Clinic Evaluation, dated 10/21/09, documented follow-up of the left fifth metatarsal base. It was recommended that his ambulation program be reinstituted. ▪ Individual #118's Orthopedic Clinic Evaluation, dated 10/21/09, documented an injury to her right hand long finger proximal phalanx. Occupational/Physical Therapy Screening, completed 09/22/09, documented that Individual #118 fell at her home on 09/26/09, and required stitches to her head. Individuals identified by the Facility as at risk for weight gain/loss were: Individual #68, Individual #70, and Individual #126. The following individuals per submitted documentation appear to be at risk for weight gain/loss, but were not identified on the submitted list: ▪ Individual #108 has a history of weight loss per her Nutrition Evaluation, dated 05/18/09, and PSP, dated 05/19/09. ▪ Individual #120's PSP, dated 09/11/09, identified him at risk of weight loss. Individual #120 was reviewed by the NMT on 7/30/08, 09/24/08, 12/17/08, 2/25/09, 3/25/09, 7/29/09, 9/29/09, 11/23/09, and 01/26/09, for a history of falling asleep at meals and episodes of coughing at meals. The NMT did not complete a comprehensive assessment to address these concerns. An Occupational/Physical Therapy Evaluation, dated 07/27/09, provides a consultation addressing coughing at mealtime and re-evaluation of his diet texture. ▪ Individual #118's Dietary Consultation Report, dated 05/07/09, documented a weight loss over the past 16 months. She is currently at the low end of her IBWR at 89.6 pounds. Individual #118 was reviewed by the NMT on 02/25/09, for	

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		losing weight. The recommendation was to monitor diarrhea, and she is Risk Level 3. ▪ Individual #54's Dietary Consultation Report, dated 09/24/09, documented: "he is currently 131 lbs. or 11.5% below his IBWR of 145-165." Individual #54 was reviewed by the NMT on 2/25/09, 3/25/09, 5/27/09, 7/29/09, 9/29/09, and 11/23/09. The data tracking system stated: "has gained 8lbs. since Sept and is getting near his IBW." Recommendations were to continue current regimen and remain at Risk Level 2. Individuals identified by the Facility as at risk for skin breakdown/decubitus ulcer were: Individual #35, Individual #79, and Individual #112. The following individuals per submitted documentation appeared to be at risk for skin breakdown/decubitus, but were not identified on the submitted list: ▪ Individual #87 was not included on this risk list even though his PSP, dated 06/18/09, documented that he has "a history of skin breakdown including a history of vacuum assisted closure of decubitus and a decubitus ulcer to left gluteus that was repaired with a skin flap, which healed on second attempt." ▪ Individual #65's Nursing Assessment, dated 12/16/09, documented "[Individual #65] is at risk for pressure sores as evidenced by a Braden score of 11." ▪ Individual #62's Dietary Consultation Report, dated 10/8/09, documented a request to evaluate her nutritional needs, due to three (3) small Stage II decubitus to her buttocks. She was recuperating from an open reduction internal fixation (ORIF) to the left foot/ankle in August 2009. Individual #62 was seen by the NMT on 02/25/09, with no significant problems noted. Documentation indicated she had experienced weight loss and needed to be on weight maintenance. She is identified as at Risk Level 3. ▪ Individual #54's Nursing Assessment stated that Individual #54 is at "risk for impaired skin integrity related to absence of sphincter at stoma and chemical irritant from bowel contents, reaction to product adhesive, and improperly fitting appliance." ▪ Nursing Assessments submitted reported Braden Scale for Predicting Pressure Ulcer Risk scores for the following people: 15-16 Low Risk for Individual #79 (15), Individual #116 (16), Individual #29 (16), and Individual #106 (16); 13-14 Moderate Risk for Individual #53 (13), Individual #115 (13), Individual #119 (13), Individual #117 (14); 12 or less High Risk for Individual #65 (11), Individual #111 (11) and Individual #61 (12). Individuals identified by the Facility as at risk for impaction/bowel obstruction/constipation were: Individual #64, Individual #79, Individual #108, Individual #122, Individual #123, Individual #124, Individual #125, and Individual #130. The following individual per submitted documentation appears to be at risk for	

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		impaction/bowel obstruction/constipation, but was not identified on the submitted list: ▪ Individual #116 is at risk for constipation per her PSP, dated 04/14/09, and has required five (5) interventions this past year for constipation. Individuals identified by the Facility as at risk for dehydration were: Individual #79 and Individual #123. Based on the documentation provided, the following individuals appear to be at risk for dehydration, but were not identified on the submitted list: ▪ Individual #87 was not identified at risk for dehydration although his PSP, dated 06/18/09, documented that: "He had 3 UTIs this past year. Encourage [Individual #87] to drink more water." This recommendation is not incorporated into his PNMP. ▪ Individual #108 is at risk for dehydration per her PSP, dated 05/19/09. ▪ Individual #116 is at risk for dehydration per her PSP, dated 04/14/09. ▪ Individual #113's PSP, dated 05/19/09, documented her risk of dehydration. ▪ Individual #110's PSP, dated 03/10/09, documented his risk of dehydration. Current lists of people "at risk" for GERD (gastroesophageal reflux disease), dysphagia, osteopenia/osteoporosis, mealtime assistance, contractures, non-ambulatory or assisted ambulation were requested, but documentation submitted stated "no individuals currently on at risk list" within the preceding categories. However, it was noted that numerous individuals reviewed were identified at risk within these categories in the Risk Tracking Record of the PSP. Individuals identified as being at an increased risk level are provided with a comprehensive assessment that focuses on nutritional health status, oral care, medication administration, mealtime strategies, proper alignment, positioning during the course of the day and during nutritional intake by the PNM team (HCG VIII.C.1; HCG VI.B.1): Based on interview and review of submitted documentation, the Nutritional Management Team currently does not complete a comprehensive assessment of individuals at risk with regard to physical and nutritional issues. The Nutritional Management Team policy (#013) documents the Evaluation Phase as: "Appropriate assessments are completed by the physician, therapists, nurses or consultants to address identified problems. Evaluation procedures may include mealtime evaluations, videoesophagrams or other radiological procedures, esophagogaastroduodenoscopies (EGDs), colonoscopies, lab work and others." The following people were identified at an increased risk level, but did not receive a comprehensive assessment by the NMT: ▪ Individual #106's PSP Risk Tracking Record, dated 04/02/09, identified him at risk for aspiration, constipation, and seizures. He has a diagnosis of GERD. He was reviewed by the NMT on 02/25/09, to discuss weight gain and he is	

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		within his IBWR. His Risk Level of 2-Medium Risk was lowered to Risk Level 3-Low Risk. He was reviewed again on 3/24/09, for "six pounds over his IBW, but losing weight." He remained at a Risk Level 3. The primary focus of the review by the NMT was related to weight gain/loss. The NMT did not discuss strategies to reduce his risk of aspiration, symptoms of GERD, his admissions to the infirmary seven (7) times over the last 12 months, and/or a "very poor" dental exam. Individual #106 did not have a comprehensive assessment completed by the NMT. In addition, as required by policy, the NMT did not present a summary of their activities in Individual #106's PSP. ▪ Individual #108 is identified at risk for aspiration, constipation and dehydration according to her PSP, dated 05/19/09. She has a history of weight loss. Individual #108 was reviewed by the NMT on 10/29/08, and 2/25/09, for weight gain/loss. The NMT did not complete a comprehensive assessment to address her nutritional health status related to spillage of food/fluid, dehydration, "very poor" oral hygiene status (according to her Annual Dental Summary completed on 10/07/09), and/or medication administration. Comprehensive assessments are not being completed at this time. As a result, individuals' physical and nutritional issues are not being assessed, nor are interventions being developed to include measurable, functional outcomes in PNM support plans.	
O3	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall maintain and implement adequate mealtime, oral hygiene, and oral medication administration plans ("mealtime and positioning plans") for individuals having physical or nutritional management problems. These plans shall address feeding and mealtime techniques, and positioning of the individual during mealtimes and other activities that are likely to provoke swallowing difficulties.	<u>All persons identified as being at risk (requiring PNM supports) are provided with a comprehensive Physical and Nutritional Management Plan (PNMP) (HCG VIII.B.1)</u>: Many individuals at the Facility have mealtime and/or positioning plans in place. However, many of these plans did not address all activities in which swallowing difficulties can present risk. In addition, a number of individuals with identified dental problems, did not have oral care plans to address their needs. For example, the following individuals did not have a comprehensive PNMP to address their identified risk levels: ▪ Individual #106 had a PNMP, dated 04/02/09. Although his PSP, dated 04/02/09, documented the following risk factors/medical conditions: aspiration, GERD, constipation, seizures, fixed contractures or scoliosis, and hospitalizations during the past year, these risk factors were not addressed in his PNMP. His PNMP did not address strategies to reduce his risk of aspiration for personal care, oral hygiene, bathing and water safety. ▪ Individual #108's PNMP Feeding/Nutritional Instructions, dated 12/15/09, were not successful in minimizing loss of food and fluid as observed by the reviewer during a mealtime. Individual #108 receives third helpings on all foods on first tray she is provided. The strategy to increase the amount of	

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		food presented to Individual #108 has not solved the problem of her significant food loss at mealtimes. Her Annual Dental Summary, dated 07/08/08, documented her oral hygiene rating as very poor. The following year's dental summary, dated 10/07/09, documented that she had three (3) scheduled appointments with two (2) "no shows", and one (1) appointment missed due to her having a fever. Her PNMP did not address strategies for oral hygiene. The Facility's response to the document request stated that no individuals were currently at risk for poor dental status. However, based on other documents reviewed, additional people who were identified as having poor oral hygiene status on their Annual Dental Summary, but who did not have oral hygiene strategies on their PNMPs include: Individual #26, Individual #29, Individual #53, Individual #57, Individual #61, Individual #62, Individual #65, Individual #79, Individual #87, Individual #106, Individual #107, Individual #108, Individual #109, Individual #114, Individual #115, Individual #116, Individual #117, Individual #118, and Individual #120. As appropriate, PNMPs should consist of interventions/recommendations regarding: Positioning/alignment; oral intake strategies for mealtime, snacks, medication administration, and oral hygiene; food/fluid texture; adaptive equipment; transfers; bathing; personal care; in-bed positioning/alignment; general positioning (i.e., wheelchair, alternate positioning); communication; and behavioral concerns related to intake (HCG VIII.B.2-3; and HCG VIII.C.3.): A review of PNMPs submitted for review showed that they included the following headings: ▪ Focus (physical and nutritional); ▪ Assistive equipment; ▪ Communication; ▪ Special risks and considerations; ▪ Mobility; ▪ Transfer; ▪ Bathing/toileting; ▪ Positioning; ▪ Dining equipment; ▪ Dining plan (texture and fluids); and ▪ Dining instructions. The PNMP format did not consistently include information specific to alignment and support in wheelchairs and alternative positions (including in-bed positioning), oral intake strategies for snacks, medication administration, and oral hygiene. People who receive enteral nutrition and/or therapeutic/pleasure feedings are provided	

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		with PNMPs that include the components listed above: Individuals reviewed who received enteral nutrition had a PNMP. As noted above, the comprehensiveness of the PNMPs was an issue. PNMPs are developed with input from the IDT, home staff, medical and nursing staff and the physical and nutritional management team: PNMPs are reviewed annually during the PSP meeting, but it was not documented that the NMT provides input into the development of a PNMP. PNMPs are reviewed annually at the PSP meeting, and updated as needed: A review of PSPs submitted shows that PNMPs are reviewed under the Assessments/Services section. The PNMP may be discussed under a PNMP, OT/PT, SLP, Nutrition, or Nursing section. A review of individual-specific PSPs and PNMPs shows that the PNMP may not be updated to reflect recommendations from respective disciplines. For example: ▪ Individual #106's PNMP was reviewed at his annual PSP on 04/02/09, but recommendations made by Speech in a 03/09/09 assessment were not incorporated into his PNMP. PNMPs are reviewed and updated as indicated by a change in the person's status, transition (change in setting) or as dictated by monitoring results (HCG VIII.C.9.): This was not seen consistently as illustrated in the following example: ▪ Individual #26 received a gastrostomy tube on December 10, 2009. A review of the NMT data tracking system did not document that Individual #26 had been reviewed by the NMT. His Dining Plan, dated 01/07/10, did not reflect that Individual #26 had a gastrostomy tube, and was to receive supplemental feedings if he refused to eat orally, as well as be provided medications and fluids through his tube. There is congruency between Strategies, Interventions, and Recommendations contained in the PNMP and the concerns identified in the comprehensive assessment: This could not be assessed, as the NMT did not complete comprehensive assessments at the time of the review.	
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	Staff implements interventions and recommendations outlined in the PNMP and or Dining Plan, including ensuring that individuals are in proper alignment and position (HCG VIII.C.4): The reviewer observed meals in Coral Sea (lunch and dinner), Pacific (lunch and dinner), and Kingfish (dinner) dining rooms. A total of 52 individuals were observed. Dining Cards include the following information: name, home, case number, MPI number, instructions, adaptive equipment including picture(s), diet texture and fluid consistency, picture of person eating, and revision/staffing date.	

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	after meals or snacks, and during enteral feedings, medication administration, oral hygiene care, and other activities that are likely to provoke swallowing difficulties.	*Person Directed Planning & Active Treatment (F.15 Draft 11/21/09) Ensuring Safe Mealtime Practices* defines the steps to be taken during the meal by the home dining supervisor, transporter, and dining room monitor. The Safe Mealtime Practices Protocol also identifies the responsibilities of the dining room monitor, home dining supervisor, and transporter. There was also a document entitled "Dining Room Test", but it is not clear how it is utilized. *Documenting Meal Monitoring and Active Treatment (F.42 Implemented 09/01/08)* defined mealtime monitoring expectations. The policy indicated that Habilitation Therapy and Nursing Staff would monitor at least one meal in each home, a combined total of 13 observations within a seven (7) day period. Completed forms are to be provided to the Habilitation Therapies Department Administrative Assistant for data entry. However, per interview, nurses were not completing the duties of mealtime monitors. The Mealtime Monitoring and Coaching Report form was used to monitor mealtimes. There were 17 indicators that address the general mealtime environment, but the form does not address person-specific mealtime monitoring. Per interview, there was no competency-based training for the home dining supervisor and/or the mealtime monitors. A review of multiple completed *Mealtime Monitoring and Coaching Report* forms documented extensive mealtime errors, for example, incorrect staffing ratio, tables not cleaned, adaptive equipment needed not present, staff not washing their hands, staff not wearing name tags, people not positioned according to dining plans, and/or incorrect diet texture and/or fluid consistency. A review of Mealtime Monitoring and Coaching Report forms document that mealtime errors continue to be identified from one monitoring session to the next without resolution. In addition, these forms are not analyzed to determine the need for person-specific staff re-training, and/or to determine systemic mealtime concerns. The following individuals were observed during mealtime with identified mealtime errors: ▪ Individual #120's Dining Plan documented his adaptive equipment as dycem mat, plastic plate guard, spouted cup and small-bowled spoon. During his meal, Individual #120 did not have his plastic guard. Instructions were to allow him two (2) bites of food followed by fluids, and to add dry breadcrumbs to all thin watery foods. Staff were not following these instructions during the mealtime. Individual #120 was to receive "1:1 Level of Supervision (per HRC) at all times while eating/drinking", and was receiving 1:1 supervision during the observation.	

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		▪ Individual #131 was in poor alignment and support as he was leaning to the left in his wheelchair. His table was too high, and he was losing food as he ate. There was no dining card at the table. ▪ Individual #132 did not have a drink available to her during the meal. The table was too high, and she had no arm supports. Her alignment and support were poor. ▪ Individual #125's adaptive equipment prescribed in her dining plan was a high-sided plate and footstool. She did not have a high-sided plate with divisions during her meal. ▪ Individual #62's dining plan/diet texture card documented that she "dislikes ravioli. Sub: ½ c ground beef with mashed potatoes." Individual #62 was served ravioli during the meal. ▪ Individual #109 did not have a dining card at her table. The reviewer asked staff to locate it, but staff was not able to find the dining card. Staff assisted Individual #109 in a pivot transfer after the meal. The staff person was observed to use poor body mechanics (poor base of support and twisting her back), and did not provide Individual #109 the opportunity to weight bear during the pivot transfer. ▪ Individual #133 did not have a dining card on the table, and during the observation, staff did not locate the card. Staff had been instructed to provide one-to-one supervision during meals and snacks to reduce the likelihood of stealing food and/or fluids. Individual #133 did not have HRC approval for one-to-one staffing. In addition, she requires hand-over-hand assistance, at times, to slow her pace. The staff was not seated in a position to effectively slow her pace. Individual #133 is right-handed and the staff person was seated on her left. Individual #133's dining plan did not provide a photograph of the staff positioning that should be used to slow her pace. ▪ Individual #79's diet texture stated: "add dry bread crumbs to thicken meals." Dry breadcrumbs were on the table, but not added to her food. Her modified diet texture was to prevent choking per her dining plan. ▪ Individual #134's footrests were removed from his wheelchair, and staff pushed him to the dining table. His feet were not well supported without his footrests. His dining card was not on the table, and staff did not attempt to locate the card. The instructions stated "to place only small amounts of fluid in cup (¼ cup) to avoid gulping fluids. DO NOT ALLOW HIM TO GULP FLUIDS." Staff presented a cup three-quarters full, and walked away without providing supervision during his drinking. His diet texture was listed as ground with cubed breads and au jus to soften all foods. Individual #134 did not have cubed bread during his meal. He has a "modified diet texture to prevent choking and staff support." ▪ Individual #135's instructions stated: "fed by staff with food presented at a higher level." The reviewer asked staff to explain these instructions, but staff	

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		were not able to explain. ▪ Individual #136's table was too high for her, and did not provide her with proper alignment and support. ▪ Individual #56 was sacral sitting (i.e., sitting on her tailbone) in her chair. She was in poor alignment and support for her meal. There was no dining card at the table. ▪ Individual #137's table was too high for her, and did not provide proper alignment and support. It was unclear why HRC approval is needed for one-to-one staffing at mealtimes. For example, Individual #120's plan indicated that he was to receive one-to-one staffing at mealtimes per HRC approval. Policy C.1: CCSS Ensuring Individuals' Rights (Revised 03/25/08) states the *Human Rights Committee (HRC)* reviews and approves "assignments of One-to-One and Enhanced levels of supervision." However, there were other individuals observed in the dining rooms that had one-to-one supervision on their dining plans, but did not have HRC approval. Plans are properly implemented across all activities that are likely to provoke swallowing difficulties and or increased risk of aspiration: PNMPs did not address consistently alignment/support in wheelchairs and/or alternate positions, strategies for oral hygiene, medication administration, snacks, personal care, and/or bathing/showering. For example: ▪ Individual #106 is at risk for aspiration per his PSP, dated 04/02/09, but his PNMP did not address strategies for oral hygiene, bathing/showering, alignment/support in his seating system and alternate positions, the specific degree that he is to be elevated when he is positioned during the day and night, and/or water safety/swimming. Individual #106's diet request, dated 07/09/09, conflicted with the Dietary Consultation Report, dated 01/13/10. For example, the Diet Request states "no citrus fruits or juices", and the Dietary Consultation Report states "suggest 4oz. of orange juice TID with meals." Dietary information was not documented on Individual #106's PNMP. Staff understands rationale of recommendations and interventions as evidenced by verbalizing reasons for strategies outlined in the PNMP**:** Per interview with therapy staff and observations by the reviewer, therapy staff were able to articulate the reason for the PNMP. This indicator will require further review at the next on-site review.	
O5	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall ensure that	Staff are provided with general competency-based foundational training related to all aspects of PNM by the relevant clinical staff: The Pre-Service Training Schedule for 12/01/09, for new employees documented the following training courses: Physical Management [one (1) hour duration], Lifting People [two (2) hours duration], Adaptive	

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	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.	Equipment [one (1) hour duration], Dining Techniques [one (1) hour duration], Deaf Awareness [one (1) hour duration], Alternate Means of Communication [one (1) hour duration], and Wheelchair Shop [one (1) and a half hours duration]. Competency-based training focuses on the acquisition of skills or knowledge and is represented by return demonstration of skills or by pre/post test, which may also include return demonstration as applicable**:** The reviewer observed the competency-based check-off for staff during an annual refresher training which involved staff performing a mechanical lift transfer with two (2) staff and a two- (2) person manual lift. The performance check-off was not competency-based as the trainers cued staff throughout the check-off. All foundational trainings are updated annually**:** Per interview and observation, there was an annual refresher-training course entitled *Lifting People-There Is No One Person Lift* that instructs staff on a stand pivot transfer, two- (2) person/T lift, lifting versus re-positioning, and use of the mechanical lift. Annual refresher training included Plan of Correction In-Services on seatbelts, bed rails, hospital beds, cleaning adaptive and bathing equipment, foot rests, supervision during bathing and transfer, and maintaining fluid consistency throughout the meal. Habilitation Therapies Manual PNMP Definition and Purpose (Section IV.A.1) documented that "staff is re-trained in lifting/transferring techniques upon employment, at least every two years thereafter, and as needed." Per observation and interview, staff received an annual refresher, but the manual designates every two (2) years. Staff are provided person-specific training on the PNMP by the appropriate trained personnel: In referring to staff training, the Habilitation Therapies Manual PNMP Definition and Purpose (Section IV.A.1.) indicated: "Habilitation Therapies or other designated staff provides training to responsible staff prior to implementation of the plan and when changes are made to the plan." The Physical/Nutritional Management Data sheet has a section for comments at the bottom of the form. Individual #62's PNM Data sheet dated October 2009, documented that in-service training was completed by a Physical Therapist. The form did not have a competency-based check-off with specific indicators that staff had to perform successfully. Staff are trained prior to working with individuals and retrained as changes occur with the PNMP: PNMPs have a revised date section, but PNMPs submitted and reviewed did not consistently document a revision date.	

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O6	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall monitor the implementation of mealtime and positioning plans to ensure that the staff demonstrates competence in safely and appropriately implementing such plans.	A System is in place that monitors staff implementation of the PNMPs (HCG VIII.C.7-8): The Habilitation Therapies Manual PNMP Definition and Purpose (Section IV.A.1) described PMNM monitoring as follows: ▪ "Physical management programming is monitored as scheduled by team staff, unit supervisory staff and by Habilitation Therapies; ▪ Clients with feeding programs for dysphagia or severe gastrointestinal problems are monitored as scheduled by the Nutritional Management Team; ▪ All equipment used in physical management programming (ex. Positioning and feeding equipment, wheelchairs, braces, splints, communication equipment, etc.) is monitored daily by direct contact staff for use and need for repair; and ▪ All equipment is evaluated at least annually and as needed by Habilitation Therapy staff for continued appropriateness and fit. Wheelchairs undergo routine preventative maintenance as scheduled and repaired/altered as needed by the Fabrication Shop." One of the key ways that individuals' teams, unit staff, and Habilitation Therapy staff will be able to monitor the implementation of PNMPs is by reviewing and responding to data. Based on the review of documentation provided, the following individuals had identified concerns with data collection and/or the implementation of their PNMPs. However, from the documentation provided, it does not appear that teams or therapy staff identified and responded to the issues: ▪ For the month of October 2009, Individual #107's Physical/Nutritional Management Data sheets for ambulation revealed gaps in data collection. Individual #107's PNMP, not dated, documented that: "he is to ambulate with the rolling walker as desired when not connected to the feeding pump. This should occur after feeding sometime between 7:00-11:00, 11:00-4:00 and 4:00-7:00." The instructions did identify the frequency of ambulation. There was no data sheet submitted for November. The December data sheet documented an increase in the number of times that he ambulated. ▪ For October, November and December 2009, Individual #115's PNM Data Sheets for implementation of supine positioning (6 a.m. to 2 p.m. shift), sidelying positioning (6 a.m. to 2 p.m. shift), oral stimulation (6 a.m. to 2 p.m. shift), supine (2 p.m. to 10 p.m. shift), sidelying positioning (2 p.m. to 10 p.m. shift), oral stimulation (2 p.m. to 10 p.m. shift) revealed gaps in data collection. His PNMP, revised on 1/6/10, documented: "utilize bed positioner as per nursing schedule." The bed positioner had been discontinued on 12/01/09, but data continued to be taken for sidelying for the month of December. Therapy and PNM Coordinator progress notes were requested for October, November and December, but were not submitted. ▪ Individual #57's PNMP, revised 11/30/09, indicated: "she is ambulating	

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		to/from dining room for all meals with a platform walker with saddle strap secured and orthopedic shoes." PNM Coordinator data sheets were not submitted for October, November, and December 2009 to document PNMP activities. ▪ Individual #61's PNM data for supine/sidelying positioning (6 a.m. to 2 p.m., and 2 p.m. to 10 p.m. shift), oral stimulation (6 a.m. to 2 p.m., and 2 p.m. to 10 p.m. shift), and Range of Motion (ROM) (2 p.m. to 10 p.m. shift), and joint movement exercises by PNM Coordinator(s) was inconsistent based on the data reviewed. Therapy and PNM Coordinator progress notes were requested for October, November and December 2009, but were not submitted for review. ▪ Individual #111's PNM Data sheets for supine/sidelying positioning (6 a.m. to 2 p.m., and 2 p.m. to 10 p.m. shift), oral stimulation (6 a.m. to 2 p.m., and 2 p.m. to 10 p.m. shift), Passive Range of Motion (PROM) Hand Splints (6 a.m. to 2 p.m., and 2 p.m. to 10 p.m. shift) were reviewed for October, November and December. The October data sheet was blank with inconsistent documentation for November and December 2009. Therapy and PNM Coordinator progress notes were requested for October, November and December 2009, but were not submitted for review. ▪ Individual #65's PNM data sheets for supine/sidelying positioning (6 a.m. to 2 p.m., and 2 p.m. to 10 p.m. shift), oral stimulation (6 a.m. to 2 p.m., and 2 p.m. to 10 p.m. shift), Range of Motion (ROM) (6 a.m. to 2 p.m., and 2 p.m. to 10 p.m. shift), oral stimulation (6 a.m. to 2 p.m., and 2 p.m. to 10 p.m. shift), and Positioner (6 a.m. to 2 p.m. shift) were reviewed for October, November and December 2009. There were check marks to document that positioning and oral stimulation was completed. Therapy and PNM Coordinator progress notes were requested for October, November and December 2009, but were not submitted for review. ▪ Individual #62's PNMP did not provide complete instructions to staff for her ambulation program as evidenced by a question mark and multiple blank spaces. There were PNM Data sheets for sitting up in her wheelchair with both legs elevated and front and rear seat belt buckled for a maximum of three (3) hours as tolerated (breakfast, lunch and dinner), and ambulation as tolerated four (4) times per week. There were multiple blanks on the data sheets. Therapy and PNM Coordinator progress notes were requested for October, November and December 2009, but were not submitted for review. ▪ Recommendations for Individual #121's PNMP included in his Occupational/Physical Therapy Evaluation, dated 11/13/08, were not incorporated into his PNMP. The following are examples of recommendations not included: continue use of gait belt for all transfers, continue use of home's shower chair for safety while bathing, and bed alarm. PNM Data sheets for the	

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		standing frame or Rifton walker, sidelying positioning (6 a.m. to 2 p.m., and 2 p.m. to 10 p.m. shift) were submitted for October, November and December 2009. They indicated that PNMP Coordinators were not able to implement his programs due to active treatment responsibilities. A policy/protocol addresses the monitoring process, and provides clear direction regarding its implementation and action steps to take should issues be noted: The Physical Nutritional Management Policy, Section VI. Monitoring (#012) documents the following: ▪ "PNMPs should be monitored as scheduled and as needed by Residential supervisors, Team, Nursing, Specialized Therapy and other professional staff to assess effectiveness of plans, to ensure ongoing implementation, and to make changes as necessary. ▪ PNMPs should be monitored by supervisors for implementation and to report any problems and training needs. ▪ PNMPs should be monitored by professional staff for proper application of equipment and techniques, to ensure effectiveness of Plans and proper implementation, and to correct problems. ▪ Equipment used in physical management programming (ex. Positioning and feeding equipment, wheelchairs, braces, slings, etc.) will be monitored daily by direct contact staff for cleanliness, wear, and needed repair. ▪ All equipment will be monitored as scheduled and evaluated at least annually and as needed by Habilitation Therapy staff for continued appropriateness and fit." The policy did not provide a formalized schedule for monitoring, training/validation procedures for supervisors, identification and definition of specific monitoring indicators for PNMPs, identified compliance levels expected, and/or the process to be followed if PNMPs are not being implemented as written. At the time of the review, the process of monitoring staff for competency in implementing PNMPs did not appear to be occurring. All members of the PNM team conduct monitoring (HCG VIII.C.8): The Physical Nutritional Management Policy (#012), Section VI. Monitoring indicates: "Clients with nutritional management issues will be monitored regularly by the Nutritional Management Team." However, per interview and review of submitted documentation, at the time of the review, members of the NMT team did not conduct formal monitoring. Mechanism is in place that ensures that timely information is provided to the PNM team so that data may be aggregated, trended and assessed by the PNM team: Per interview, review of submitted documentation, and the Nutritional Management Team Policy (#13), this process was not defined.	

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O7	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop and implement a system to monitor the progress of individuals with physical or nutritional management difficulties, and revise interventions as appropriate.	A process is in place that promotes the discussion, analysis and tracking of individual status and occurrence of health indicators associated with PNM risk (HCG VIII.C.9; HCG VIII.A.1): The NMT's database documents the person's name, home, last review, next review, staffing date, reason for review and NM problems, videos (swallow studies), GI consultations, Risk Level, choking and aspiration history, and recommendations. However, there was no documentation to support an analysis of trends identified through person-specific reviews to implement systemic changes. Issues with regard to the implementation of individuals' PNMPs are discussed in further detail above in the section that addresses Section O.6 of the SA. In general, individual PNMPs did not identify the level of monitoring that needed to occur. Person-specific monitoring is conducted that focuses on plan effectiveness and how the plan addresses and minimizes PNM risk indicators (HCG VIII.C.9; VIII.A.1); and issues noted during monitoring are followed by the PNM team and will remain open until all issues have been resolved and appropriate trainings conducted (HCG VIII.A.1): Per interview with members of the Nutritional Management Team and document review, there was no formal NMT team monitoring system in place. Some of the current policies anticipate an individualized monitoring system. For example, the Nutritional Management Team Policy III.G. Review Phase (#013) indicates that during the review phase: ▪ A schedule for review is established, and follow-up services are provided as needed; ▪ The risk level is reviewed and reassigned as appropriate; and ▪ The schedule for review is established. In addition, the Physical Nutritional Management Policy, Section VI on Monitoring (#012) indicated: "Clients with nutritional management issues will be monitored regularly by the Nutritional Management Team."	
O8	Commencing within six months of the Effective Date hereof and with full implementation within 18 months or within 30 days of an individual's admission, each Facility shall evaluate each individual fed by a tube to ensure that the continued use of the tube is medically necessary. Where appropriate, the Facility shall implement a plan to	All individuals receiving enteral nutrition receive annual assessments that address the medical necessity of the tube and potential pathways to by mouth (PO) status (HCG VI.C.3.c.1.d); and the need for continued enteral nutrition is integrated into the PSP: At the time of the review, documentation could not be found to show that annual reviews had been conducted of individuals currently receiving enteral nutrition to determine the medical necessity of the tube. For example: ▪ Individual #106's PMMP (04/02/09) documented that he receives all nutrition, liquids and medication by gastrostomy tube. Per documentation submitted, there was no annual assessment to address the medical necessity of the tube and potential pathways to PO status.	

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	return the individual to oral feeding.	▪ Individual #116 receives her nutrition through a gastrostomy tube that was placed in November 1989. A review of submitted assessments (OT, PT, SLP, Nursing, Medical, and Nutrition) did not address the medical necessity of her gastrostomy tube and the potential pathways to PO status. ▪ Individual #107's Nursing Assessment, dated 02/21/09, documented that he has a gastrostomy tube for all intake, fluids and medications. He has frequent skin breakdown to the stoma from leakage. A review of submitted assessments (OT, PT, SLP, Nursing, Medical and Nutrition) did not address the medical necessity of his gastrostomy tube and the potential pathways to PO status. When it is determined that it is appropriate for an individual to return to oral feeding, a plan is in place that addresses the process to be used: Based on the record review, none of the individuals reviewed who was enterally nourished had a plan to return to oral feeding. There is evidence of discussion by the PST regarding continued need for enteral nutrition: For the individuals reviewed, teams had not documented discussion regarding the continued need for enteral nutrition. For example: ▪ Individual #106's PMMP, dated 04/02/09, documented that he receives all nutrition, liquids and medication by gastrostomy tube. The PSP did not document a discussion by the PST regarding the continued need for enteral nutrition. ▪ Individual #116's PSP, dated 04/14/09, did not document a discussion by the PST regarding the continued need for enteral nutrition. ▪ According to Individual #8's 11/24/09 PSP, she had a g-tube placed in 2002 due to "problems taking liquids by mouth and maintaining sodium at normal values." At the time of her PSP, she was eating and taking liquids by mouth, but being administered medications through her g-tube. A nursing assessment was included as part of her PSP packet, but no medical evaluation was found. The PSP did not indicate that the team evaluated/discussed the continued medical necessity of the tube. Also, of note, her PSP indicated that Individual #8 had been pulling and scratching at her g-tube, which resulted in a PBSP being developed. The PBSP was discontinued and "a reduction objective was written to eventually fade the use of the binder", which appears to be used to prevent Individual #8 from pulling at the tube. A policy exists that clearly defines the frequency and depth of evaluations (Nursing, MD, SLP or OT): Documents submitted did not contain a policy that clearly defines the evaluation process for individuals who are enterally nourished.	

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		<u>Individuals who are at an increased PNM risk are provided with interventions to promote continued oral intake</u>: It does not appear that the NMT is consistently identifying and implementing interventions to promote oral intake by individuals who are at increased PNM risk. For example: ▪ Individual #117's PNMP, revised on 12/30/09, documented that he "received a G-tube due to multiple refusals of food, fluids, and meds, consecutively (12/11/09) G-tube will be used only after 3 attempts by different staff members to assist with meals, then G-tube will be utilized to provide nutrition and meds to maintain health." Individual #117 was reviewed by the NMT on 2/11/09, 4/22/09, and 6/23/09. The reason for reviews are "still losing weight, takes 1½ hours to eat, still refusing many meals and losing weight but still in weight range, still stable, although still refusing." NMT recommendations were to continue to monitor weight, and upgrade him to Risk Level 3. An Occupational Therapy Screening on 02/19/09, does not address mealtime refusals. The NMT did not review Individual #117 before the placement of his gastrostomy tube in December 2009, and did not implement interventions to promote continued oral intake. ▪ Individual #113's Nursing Assessment, dated 05/20/09, documented that she received her gastrostomy tube on 04/18/08. The first review by the NMT was on 07/30/08, per the NMT data tracking record after Individual #113 received her gastrostomy tube.	

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

- The composition of the NMT should be reevaluated. In the short-term, participants should be identified for PNMT membership who have or can quickly obtain the expertise necessary to work with PSTs to assess individuals at highest risk, and develop and monitor appropriate PNMPs. The long-term goal should be for all team members of individuals with physical and nutritional support needs to be competent in the assessment of individuals, and in the development and monitoring of PNMPs.
- Additional opportunities should be provided for continuing education for PNMT members to support their responsibilities in working with individuals with complex physical and nutritional support needs.
- Individuals with identified physical and nutritional support needs need to have a timely comprehensive assessment, intervention(s), review, documentation, monitoring and analysis to determine the efficacy of the supports provided.
- Criteria should be defined for referral of individuals to the PNMT Committee. Those people at highest risk should be prioritized to receive a PNM comprehensive assessment and PNMP with integration into the PSP.
- Reviews of individuals at risk need to be incorporated into the Facilities' Health Status Team, Performance Improvement Council, and Quality Enhancement Department's activities.
- The State and/or Facility should consider development of a policy/procedure to address parent(s)/guardian(s) who provide an individual food and/or fluid at the Facility that is not within his/her prescribed diet texture or fluid consistency, thereby placing that individual at risk.
- PNMPs should incorporate strategies for individuals for oral intake for mealtime, snacks, medication administration, oral hygiene, as well as any

other activities that present potential risks such as bathing, or water activities.

- Dining plans should have photographs or written instructions for staff positioning during mealtime.
- All policies related to mealtime monitoring should be reviewed to ensure identified performance indicators are effective in monitoring mealtimes, as well as to ensure continued staff competency with regard to knowledge and skills acquired in competency-based physical and nutritional support foundational training. Such policies need to define "regular" monitoring as required by the Settlement Agreement.
- Consideration should be given to establishing compliance benchmarks for mealtime monitoring results. Results falling below established benchmarks should require the development and implementation of person-specific, staff re-training and/or the development of an action plan to address systemic concerns.
- Consideration should be given to the development of a reporting system that presents mealtime monitoring results, including status of action plans. This reporting system should be linked to the Facility's Quality Enhancement System.
- Consideration should be given to the development and implementation of a competency-based training for dining room supervisors including roles and responsibilities before, during, and after mealtime.
- Consideration should be given to the development and implementation of a competency-based training for mealtime monitors, as well as an on-going validation process for mealtime monitors. The goal would be to achieve accurate mealtime monitoring scoring and ensure a high-level of inter-rater reliability.
- Orientation training and annual refresher training should be reviewed to ensure the content is sufficient to provide staff with the knowledge and skills to support competency in the implementation of mealtime and positioning plans.
- Competency-based performance check-offs should not involve prompts from trainers. Staff members need to be competent in the skills when trainers are not present.
- Policies for monitoring by the PNMT should be reviewed, and PNMT procedures developed to ensure adequate monitoring of the implementation of PNMPs is completed as required by the SA.
- Policies for monitoring staff's implementation of PNMPs should be reviewed and revised, and Facility procedures should be developed to ensure adequate monitoring as required by the SA and HCG.
- Policies also should define procedures to be followed by the PNMT with regard to the development and review of an individual's PNMP, if a person is determined to be at risk of harm, such as a mealtime incident that involves choking requiring the Abdominal Thrust.
- The interval of review and monitoring of individuals at various levels of risk should be clearly established as part of each individual's PNMP. Such monitoring should be completed according to schedule, and the results reviewed to identify in a timely manner individual as well as systemic actions that need to be taken to correct deficiencies.
- A procedure should be developed to ensure that individuals at risk of receiving enteral nutrition are referred to the PNMT.
- Evaluation should be conducted of individuals who are enterally nourished to determine the appropriateness of receiving enteral nutrition, and, if not, to identify strategies to transition a person to oral intake, if appropriate.

<table>
<tr><th>SECTION P: Physical and Occupational Therapy</th><th></th></tr>
<tr><td rowspan="3">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:</td><td>Steps Taken to Assess Compliance: The following activities occurred to assess compliance:
▪ Review of Following Documents:
o Occupational/Physical Therapy Services Policy (#014);
o Habilitation Therapies Manual; and
o Record reviews, including assessments, PSPs, and PNMPs, of the following individuals: Individual #26, Individual #29, Individual #53, Individual #57, Individual #61, Individual #62, Individual #65, Individual #79, Individual #87, Individual #106, Individual #107, Individual #108, Individual #109, Individual #110, Individual #111, Individual #112, Individual #113, Individual #114, Individual #115, Individual #116, Individual #117, Individual #118, Individual #119, and Individual #120
▪ Interviews with:
o Physical therapists, occupational therapists, and speech-language pathologists, as well as other professional and direct support staff during observations
▪ Observations of:
o Individual #109's PSP staffing;
o A seating assessment;
o Annual Refresher Training and Competency-Based Check-offs;
o Webinar for Seating;
o Mealtimes;
o Alternate Positioning for several individuals in Coral Sea; and
o Observations of individuals and staff in homes, day program areas, clinical and dining areas.</td></tr>
<tr><td>Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.</td></tr>
<tr><td>Summary of Monitor's Assessment: Occupational/Physical Therapy Assessments did not consistently present an analysis of findings to provide a rationale for recommendations and intervention strategies. Recommendations did not consistently provide objective, measurable and functional outcomes. In addition, competency-based training/monitoring for person-specific positioning plans was not formalized.</td></tr>
</table>

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P1	By the later of two years of the Effective Date hereof or 30 days from an individual's admission, the Facility shall conduct occupational and physical therapy screening of	The facility provides an adequate number of physical and occupational therapists, mobility specialists, or other professionals with specialized training or experience: Per the submitted Survey Staffing Review for ICF/MR Facilities, there are three (3) Occupational Therapists and one (1) contract OTR, two (2) Certified Occupational Therapy Aides (COTA), two (2) Physical Therapists and two (2) contract PTs, one (1)	

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	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.	Physical Therapy Assistant (PTA), and three (3) Fabricators for the Wheelchair Department. The Habilitation Therapy Director is an OTR. All people have received an OT and PT screening. If newly admitted, this occurred within 30 days of admission; and all people identified with therapy needs have received a comprehensive OT and PT assessment within 30 days of identification: Occupational/Physical Therapy Services Policy (#014), Section II on Occupational and Physical Therapy Procedures, subsection A on Screenings and Assessments states: "Individuals will be screened for occupational and physical therapy needs within 30 days of admission by occupational and physical therapy staff." Since July 2009, there have been no admissions to CCSSLC. These indicators will be reviewed further during upcoming monitoring visits. If receiving services, direct or indirect, the individual is provided a comprehensive OT and/or PT assessment every three (3) years, with annual interim updates or as indicated by a change in status: The Occupational/Physical Therapy Services Policy (#014), Section II on Occupational and Physical Therapy Procedures, Subsection A on Screening and Assessments documented: ▪ Individuals identified with therapy needs must receive a comprehensive, integrated occupational and physical therapy assessment within 30 days of identification of needs. ▪ Assessments must include evaluation of functional and wheeled mobility as needed. ▪ Assessments will consider significant medical issues and health risk indicators in a clinically justified manner. ▪ Clinical data or information contained in the assessment will be analyzed and interpreted in the assessment report. Implementation of this policy will be reviewed in further detail during upcoming monitoring visits. Individuals determined via comprehensive assessment to not require direct or indirect OT and/or PT services receive subsequent comprehensive assessments as indicated by change in status or PST referral: This indicator will receive further review during the next onsite visit. Findings of comprehensive assessment drive the need for further assessment such a wheelchair/seating assessment: The Habilitation Therapies Manual, Section VI on Seating and Positioning Systems includes the following sections: ▪ Evaluation and fabrication of seating and positioning systems; ▪ Evaluation strategies for seating and positioning in individuals with	

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		developmental disabilities; ▪ Protocol to prioritize and track wheelchair needs; ▪ Wheelchair database form; ▪ Wheelchair database example; ▪ Wheelchair evaluation and work order form; ▪ Mat assessment for seating and positioning; and ▪ Procedure for daily cleaning of wheelchairs. The following people had unresolved issues related to their seating systems: ▪ Individual #106's Occupational Therapy Evaluation, dated 04/02/09, Section V on Adaptive/Supportive Devices documented that he has a: "standard wheelchair with padded wheel guards, ABS custom molded seat and back, rear anti-tippers, seatbelt, swing away padded foot rest and removable umbrella." The reviewer observed Individual #106 in his wheelchair, and he presents with poor alignment and support. Individual #106's poor alignment and support is also documented in the photograph of Individual #106 in his wheelchair attached to his PNMP. Individual #106's PSP, dated 04/02/09, under Assessments/Services documented that: "Currently he has a rash to the area around his gastrostomy site and this is being treated tid with… Rash All cream. The treatment is reviewed periodically and changed as necessary. The nurse practitioner believes he develops the rash due to his posture while in his wheelchair. The poor posture is due to his diagnosis of Thoracolumbar Scoliosis and Pectus Excavatum." The Occupational Therapy Evaluation did not recommend a comprehensive seating assessment. ▪ Individual #116's photograph for her dining plan, dated 04/19/09, presented her in poor alignment and support. Her PSP, dated 04/14/09, identified her at risk of aspiration with a diagnosis of dysphagia and a gastrostomy tube placement in November 1989. There was a Wheelchair/Mobility/Assistive Equipment Work Order, dated 04/15/09, to address "wheelchair concerns of [Individual #116] arching hips off seat and seat belt tends to loosen and pelvis is not secured in wheelchair; leans her head and trunk to the right over the edge of wheelchair extending right arm over to right of wheelchair." Corrections made by the Wheelchair Department included adding a Velcro and snap to the seat belt to hold her in place, and make a right lateral support to keep her from leaning over the right side and to keep her right arm from extending off the side of the wheelchair. The Wheelchair Department documented the completion of these modifications, but it is unclear if a new photograph was taken after these modifications were completed. ▪ Individual #53's Orthopedic Clinic Evaluation, dated 05/20/09, documented that "[Individual #53] was seen to review her seating system and review her	

<table>
<tr><th>#</th><th>Provision</th><th>Assessment of Status</th><th>Compliance</th></tr>
<tr><td></td><td></td><td>radiographs made just recently on March 13, 2009. The seating arrangements were discussed with staff. There is a plan to put a chest wall pressure on the left side avoiding the axilla and to help correct her rotation and the almost 180° curvature of the spine." Per record review, Individual #53 did not have a comprehensive seating assessment. Her PNMP Staffing on 03/09/09 stated positioning times are in the morning and afternoon for supine and sidelying. PNM Coordinator data sheets for positioning were not submitted.

<u>Evidence of communication and or collaboration is present in the OT/PT assessments</u>: Per interview and policy, occupational and physical therapy assessments and/or updates are completed collaboratively. However, during record review there were instances when there was an occupational therapy assessment/update without physical therapy collaboration. For example:
▪ Individual #110 had an Occupational Therapy Screening, dated 02/09/09, but did not have a Physical Therapy Screening. His PNMP has a physical focus to maintain good skin integrity and joint range in both legs.
▪ Individual #106's Occupational Therapy Evaluation, dated 04/02/09, did not document collaboration with a physical therapist(s).

Based on documents reviewed, it was noted that assessments, dining plans and PNMPs were not consistently signed and dated by occupational and physical therapists.</td><td></td></tr>
<tr><td>P2</td><td>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</td><td><u>Within 30 days of a comprehensive assessment, or sooner as required for health or safety, a plan has been developed as part of the PSP</u>: This indicator will receive further review at the next on-site visit.

<u>Appropriate intervention plans are: a) Integrated into the PSP; b) Individualized; c) Based on objective findings of the comprehensive assessment with effective analysis to justify identified strategies; and d) Contain objective, measurable and functional outcomes</u>: Occupational/Physical Therapy Assessments did not consistently present an analysis of findings to provide a rationale for recommendations and intervention strategies. Recommendations did not consistently provide objective, measurable and functional outcomes.

<u>Therapists provide verbal justification and functional rationale for recommended interventions</u>: This indicator will receive further review at the next on-site visit.

<u>On at least a monthly basis or more often as needed, the individual's OT/PT status is reviewed and plans updated as indicated by a change in the person's status, transition (change in setting), or as dictated by monitoring results</u>: Occupational/Physical Therapy</td><td></td></tr>
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#	Provision	Assessment of Status	Compliance
	and/or other adaptive equipment; and, for individuals who have regressed, interventions to minimize further regression.	Services Policy (#014), Section IV on Monitoring documented: "The State Center shall implement a system to monitor and address: 1) The status of individuals with identified occupational and therapy needs; 2) the condition, availability, and appropriateness of physical supports and assistive equipment; 3) the effectiveness of treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of each individual; and 4) the implementation of programs carried out by direct support staff." The reviewer requested Therapy Progress Notes for OT/PT for October, November, December 2009, but progress notes were not submitted for: Individual #26, Individual #29, Individual #53, Individual #54, Individual #57, Individual #61, Individual #62, Individual #65, Individual #79, Individual #87, Individual #106, Individual #107, Individual #108, Individual #109, Individual #110, Individual #111, Individual #112, Individual #113, Individual #114, Individual #115, Individual #116, Individual #117, Individual #118, Individual #119, Individual #120, and Individual #121.	
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.	During the next monitoring visit, this provision will receive further review.	
P4	Commencing within six months of the Effective Date hereof and with full implementation within two years, the Facility shall develop and implement a system to monitor and address: the status of individuals with identified occupational and physical therapy needs; the condition, availability, and effectiveness of physical supports and adaptive equipment; the treatment interventions that address the occupational therapy, physical therapy, and physical and nutritional management needs of	Occupational/Physical Therapy Services (#014), Section IV on Monitoring states: 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, and physical and nutritional management needs of each individual; and ▪ The implementation of programs carried out by direct support staff. OT/PT Update recommendations for multiple individuals reviewed stated "continue with OT/PT Level III, Tracking." Competency-based training/monitoring for person-specific positioning plans was not formalized. This provision will receive further review at the next onsite visit.	

#	Provision	Assessment of Status	Compliance
	each individual; and the implementation by direct care staff of these interventions.		

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

- Occupational/Physical Therapy assessments should include an analysis of findings that provide a rationale for recommendation(s) and intervention strategies.
- Functional outcomes need to be identified clearly, and monthly documentation needs to be utilized to justify initiation, continuation of or discontinuation of OT/life skill supports recommendations.
- There should be review of monthly documentation of the provision of indirect supports, and a process for implementing change in a individual's supports when progress is made or a lack of progress is detected. Timeframes for re-evaluation should be identified clearly.

<table>
<tr><th>SECTION Q: Dental Services</th><th></th></tr>
<tr><td></td><td>Steps Taken to Assess Compliance: The following activities occurred to assess compliance:
▪ Review of Following Documents:
o Dental notes for the following individuals: Individual #57, Individual #58, Individual #59, Individual #60, Individual #61, and Individual #62;
o List of individuals who had pre-sedation for dental appointments;
o CCSSLC's Dental Manual;
o Information regarding Total Intravenous Anesthesia (TIVA);
o List of individuals who have had TIVA (23); and
o Physician orders and Sedation Care Plans for the following individuals: Individual #54, Individual #56, Individual #59, Individual #77, Individual #78, Individual #108, Individual #118, Individual #138, Individual #139, Individual #140, Individual #141, Individual #142, Individual #143, Individual #144, Individual #145, and Individual #146
▪ Interviews with:
o Enrique D. Venegas, DDS, Director;
o Kathy Y. Roach, RDH;
o Josie Delaney, DADS Staff Attorney; and
o Colleen M. Gonzales, BSHS, Chief Nurse Executive</td></tr>
<tr><td></td><td>Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.</td></tr>
<tr><td></td><td>Summary of Monitor's Assessment: From the records reviewed, it appears that individuals generally are seen by dental every six (6) months. However, there were a number of "no shows" documented in the dental progress notes that is an indication that there may be problematic issues at the unit level in ensuring that individuals attend their scheduled appointments. At the time of this review, there was no formal system in place that monitored and tracked refusals or missed dental appointments.

In addition, problems with regard to the provision of dental care included missing documentation regarding: 1) obtaining or attempts at obtaining dental x-rays; 2) a documented review of the individuals' medication and allergies; and 3) comprehensive treatment plans indicating what dental work the individual actually needed regarding restorations and preventative care.

There is no system in place to ensure that individuals are being properly monitored when receiving pre-sedation. Nursing needs to collaborate with dental to develop a monitoring system to ensure that individuals are appropriately monitored when receiving pre-sedation for medical/dental procedures.</td></tr>
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#	Summary of Provision	Assessment of Status	Compliance
Q1	Commencing within six months of the Effective Date hereof and with	The Dental Department at CCSSLC currently has one (1) full-time dentist, one (1) Dental Assistant, one (1) Dental Hygienist and one (1) Dental Technician. The Facility maintains	

#	Summary of Provision	Assessment of Status	Compliance
	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.	two (2) contract dentists, including an oral surgeon and an endodontist. The Facility has two (2) open positions in the dentistry department, including for a dentist and a hygienist. At the time of this review, the Facility had contracted with a dentist in September 2009 to provide general anesthesia at the Facility to those individuals who require such sedation to tolerate dental care. However, from discussions with the Facility's administration and State's attorneys, a number of issues had not been adequately addressed to ensure that this procedure was within the scope of the licensure of the Facility. During the review week, the Facility decided to suspend the procedure until all unresolved issues have been adequately addressed. If the practice was going to be continued, then all required documentation such as policies, procedures and protocols were to be developed and implemented that adequately addressed roles and responsibilities and ensured safe practice. A review was conducted of six (6) individuals' dental progress notes, including Individual #57, Individual #58, Individual #59, Individual #60, Individual #61, and Individual #62. All were seen and provided dental care basically every six (6) months. The dental notes clearly indicated the individual's oral hygiene status and condition of the teeth. In addition, the notes included the individual's response to the examination, and included the medication, dose and route of any pre-sedation given prior to the appointment. In addition, there was evidence of communication between the dentist and the individual's primary care physician in situations where the dentist had questions about the individual's medical issues. However, there were a number of items missing in the documentation including: ▪ Obtaining or attempts at obtaining dental x-rays; ▪ A documented review of the individuals' medication and allergies; and ▪ A comprehensive treatment plan indicating what dental work the individual actually needed regarding restorations and preventative care. According to the interview with the Dentist, there are currently no monitoring systems in place to ensure that dental notes and practices are being implemented in alignment with generally accepted standards of practice. In addition, the Dental Department needs to review all of its policies and procedures to ensure that they are in alignment with current practices, the SA and Health Care Guidelines. In addition, there were a number of "no shows" documented in the dental progress notes that is an indication that there may be problematic issues at the unit level in ensuring that individuals attend their scheduled appointments. At the time of this review, there was no formal system in place that monitored and tracked refusals or missed dental appointments.	

#	Summary of Provision	Assessment of Status	Compliance
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.	Review was completed of the Sedation Care Plans for 16 individuals, including plans for: Individual #54, Individual #56, Individual #59, Individual #77, Individual #78, Individual #108, Individual #118, Individual #138, Individual #139, Individual #140, Individual #141, Individual #142, Individual #143, Individual #144, Individual #145, and Individual #146. Of the 16, 13 did not include all the relevant clinical information as required by the form. There were a number of missing vital signs post sedation, missing times for administration of the pre-sedating medication, missing indications of whether the individual was to have nothing by mouth (NPO), missing or inconsistent information regarding the individual's level of consciousness, missing signatures indicating that instructions were received by the direct care professionals and the RN initiating the care plan. Clearly, there is no system in place to ensure that individuals are being properly monitored when receiving pre-sedation. Nursing needs to collaborate with dental and develop a monitoring system to ensure that individuals are appropriately monitored when receiving pre-sedation for medical/dental procedures. As noted above, the Dental Department needs to review all of its policies, procedures and protocols to ensure that they are in alignment with current practices and the requirements of the SA and Health Care Guidelines. In addition, a monitoring system needs to be developed and implemented to ensure that these policies are consistently being implemented. The Dental Department needs to collaborate with other disciplines such as nursing and psychology, regarding the monitoring of certain policies/procedures since other disciplines have shared responsibilities addressing certain issues such as missed and refused appointments. At the time of the review, psychology had just started collaborating with dental in developing a draft of a desensitization program/strategies to assist in decreasing the use of pre-sedation for dental appointments. This collaboration needs to continue and be expanded. During future visits, the Monitoring Team will review these revised policies, procedures and practices as they are implemented.	

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

- Dental policies, procedures and protocols should be revised to ensure that they are in alignment with current practices, and the requirements of the SA and Health Care Guidelines.
- Monitoring systems should be developed and implemented to ensure that dental notes and practices are in alignment with generally accepted standards of practice and the requirements of the SA and Health Care Guidelines.
- A formal system should be developed and implemented to monitor and track refusals or missed dental appointments so that the PSTs can develop strategies to help the individual tolerate dental care.
- Dentistry should continue to collaborate with other disciplines such as nursing and psychology, regarding the implementation of certain policies/procedures that have shared responsibilities regarding dental issues, such as the development of plans to reduce the need for pre-sedation medications.
- Dentistry should collaborate with nursing regarding the development and implementation of a monitoring system to ensure that individuals are appropriately monitored when receiving pre-sedation medication for medical/dental procedures.

<table>
<tr><th>SECTION R: Communication</th><th></th></tr>
<tr><td rowspan="3">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:</td><td>Steps Taken to Assess Compliance: The following activities occurred to assess compliance:
▪ Review of Following Documents:
o List of individuals currently using alternative or augmentative communication systems;
o Communication Services Policy (#016); and
o Record reviews, including assessments, PSPs, and PNMPs, of the following individuals: Individual #26, Individual #29, Individual #53, Individual #57, Individual #61, Individual #62, Individual #65, Individual #79, Individual #87, Individual #106, Individual #107, Individual #108, Individual #109, Individual #110, Individual #111, Individual #112, Individual #113, Individual #114, Individual #115, Individual #116, Individual #117, Individual #118, Individual #119, and Individual #120
▪ Interviews with:
o Angela Roberts, Au.D., CCC-A, F-AA, Audiologist; and
o Speech and Language Pathologists</td></tr>
<tr><td>Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.</td></tr>
<tr><td>Summary of Monitor's Assessment: Given the needs of the individuals living at CCSSLC, staffing for speech and language does not appear to be sufficient to adequately provide for the needs of the individuals served.

The Facility Audiologist has developed an Audiology Standards Manual to provide a foundation for the implementation of audiology services that supports the implementation of functional communication. An audiology database had been developed to track the status of audiology assessments and related adaptive equipment.

It appears that a number of individuals who do not currently have access to alternative and augmentative communication systems might benefit from such systems. However, they have not been properly assessed and/or plans developed to address their needs.

For the individuals reviewed, the three (3) prominent communication strategies that were integrated into their PSPs were for staff to utilize parallel talk, allowing choices, and to provide sensory stimulation activities. Picture boards were observed on the walls in common areas. Additional individualization of communication strategies should occur.</td></tr>
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#	Summary of Provision	Assessment of Status	Compliance
R1	Commencing within six months of the Effective Date hereof and with	The facility provides an adequate number of speech language pathologists or other professionals with specialized training or experience: According to the submitted Survey	

#	Summary of Provision	Assessment of Status	Compliance
	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.	Staffing for ICF-MR Facilities, there are two (2) full-time speech language pathologists, one (1) with a Bachelor degree and one (1) with a Master's degree; one (1) part-time contract speech language pathologist, with a Master's Degree; and two (2) speech assistants to support 310 residents at Corpus Christi State Supported Living Center. Given the needs of the individuals living at CCSSLC, this staffing does not appear to be sufficient to adequately provide for the needs of the individuals served. A job description was submitted for a Speech Therapy Director, but no job description was submitted for a staff Speech Therapist(s). Supports are provided to individuals based on need and not staff availability: Thirty-two (32) people out of a current census of 310 individuals are working with alternative and augmentative systems per submitted documentation, that is approximately 10 percent of the current population at Corpus Christi. As is discussed in further detail below, it appears that other individuals at CCSSLC would benefit from alternative or augmentative communication systems. Of note, the Facility Audiologist has developed an Audiology Standards Manual to provide a foundation for the implementation of audiology services that supports the implementation of functional communication. An audiology database had been developed which included the following fields: last name, first name, case number, dorm, Master Patient Identification (MPI) number, date tested, test due date, hearing aid use (FM systems or plugs), and comments. The database is used to track the status of audiology assessments and related adaptive equipment.	
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.	All people have received a communication screening. If newly admitted, this occurred within 30 days of admission: Communication Services Policy (#016), Section II on Assessments states: "Individuals will be screened for communication needs, including augmentative communication needs, within 30 days of admission." Since July 2009, there have been no new admissions to CCSSLC. This indicator will be further reviewed during the next onsite visit. Policy exists that outlines assessment schedule and staff responsibilities: Communication Services Policy (#016) documents the following: "Comprehensive communication assessments will be completed according to the schedule set forth in the Communication Master Plan, or as indicated by need." All people identified with therapy needs have received a comprehensive communication assessment within 30 days of identification that addresses both verbal and nonverbal skills, expansion of current abilities, and development of new skills: Communication Services Policy (#016), Section II on Assessments indicates the following:	

#	Summary of Provision	Assessment of Status	Compliance
		▪ Comprehensive communication assessment will be completed according to the schedule set forth in the Communication Master Plan, or as indicated by need; ▪ Assessment will include evaluation of need for augmentative and alternative communication, as appropriate; ▪ Assessment will consider behavioral issues and provide recommendations, including recommendations regarding communication systems involving behavioral supports or interventions, as indicated; and ▪ Information contained in assessments will be analyzed and interpreted in a clinically justified manner to identify individuals who would benefit from alternative or augmentative communication. The following individuals had an identified communication need through a screening, but did not receive a comprehensive communication assessment: ▪ Individual #62's Speech and Language Screening, dated 12/09/09, recommended the use of parallel talk with staff instructions, allowing choices during routine activities throughout the course of the day with staff instructions, and to have Individual #62 use a simple voice output communication device, with intent, to alert staff that she wants to get out of bed. Individual #62 did not have a comprehensive communication assessment. ▪ Individual #115's Speech and Language Screening, dated 06/30/09, identified communication needs, but he has not received a comprehensive communication assessment. ▪ Individual #116's Speech and Language Screening, dated 04/14/09, documented "adaptations are available in the home and classrooms. [Individual #116] sometimes shows an interest in them. She sometimes shows an interest in simple voice output systems in the home and classrooms and can use them when appropriately placed and she is not experiencing pain." A comprehensive communication assessment had not been completed to identify person-specific functional communication strategies for Individual #116. ▪ Individual #110's Speech and Language Screening, dated 01/30/09, recommended: "use parallel talk with staff instructions, allow choices during routine activities throughout the day with staff instructions, encourage use of communication board and contact Speech when changes are made, and provide sensory activities as per [Individual #110's] needs/interests." Individual #110 did not have a comprehensive communication assessment. ▪ Individual #118's Speech and Language Evaluation, dated 09/15/09, included recommendations to use parallel talk with staff instructions, allow choices during routine activities throughout the course of the day with staff instructions, provide sensory stimulation exercises as per Individual #118's needs and interests, encourage the use of the voice output communication systems in a	

#	Summary of Provision	Assessment of Status	Compliance
		meaningful and purposeful way during routine activities, and encourage functional use of the Environmental Control Units to promote independence and to assist with cause and effect. Individual #118 did not have a comprehensive communication assessment. ▪ Individual #111's Speech and Language Update, dated 12/18/09, recommended no speech therapy, but that staff should provide environmental sensory stimuli. The update documented that "[Individual #111] communicates non-verbally with body language and facial expression. He uses vocalization with intent, uses dorm adaptations, and moan and groans when he is in discomfort." Individual #111 did not have a comprehensive communication assessment. ▪ Individual #106 received a Speech and Language Screening on 03/09/09, which was a checklist for the areas of Receptive Language and Expressive Language. The screening identified functional communication needs, but a comprehensive communication assessment had not been completed. ▪ Individual #109 received a Speech and Language Update on 01/05/10, with the recommendations to use parallel talk, allow choices during routine activities throughout the course of the day, and provide sensory activities according to Individual #109's interests or needs. The update did not address an expansion of her current abilities, and/or the development of new functional communication skills. ▪ Individual #107's Speech and Language Update on 01/27/09, identified the following recommendations: use parallel talk with Individual #107 with staff instructions, and allow choices during routine activities throughout the course of the day with staff instructions. The update did not address the expansion of current abilities and the development of new skills. ▪ Individual #114's Speech and Language Update, dated 01/04/10, identified the following recommendations: use parallel talk with Individual #114 with examples for staff, and allow choices during routine activities throughout the course of the day with staff instructions. The update did not address the expansion of current abilities, and the development of new skills. ▪ Individual #119's Speech and Language Screening, dated 09/15/08, had the following recommendation: "provide [Individual #119] with different sensory stimuli to find preferences." A comprehensive communication assessment had not been completed. ▪ Individual #115's Speech and Language Screening, dated 06/30/09, included recommendations to use "parallel talk throughout his daily activities and provide choice making activities. Place choices in front of him and see which he looks at." A comprehensive communication assessment has not been completed. ▪ Individual #57's Speech and Language Screening, dated 03/17/09, recommended use of parallel talk with staff instructions, allowing choices during routine activities throughout the day with staff instructions, and providing	

#	Summary of Provision	Assessment of Status	Compliance
		sensory activities as per Individual #57's needs/interests. Individual #57's PNMP did not incorporate these recommendations. Individual #57 had not received a comprehensive communication assessment. Her Audiological Evaluation, dated 02/04/09, recommended "[Individual #57] has abnormal middle ear function at the right ear which will not be relieved unless she has a PE tube placed." Individual #57's PSP documented that "[Individual #57's] sister and legal guardian has decided against tube placement", and a Nursing Assessment, dated 04/17/09, documented "ENT consult (04/24/08) and PE tubes-family not agreeable, not done." ▪ Individual #61's Speech and Language Screening, dated 08/07/08, did not include recommendations, but there were identified communication potentials documented in the screening. Individual #61 did not have a comprehensive communication assessment. ▪ Individual #26's Speech and Language Update, on12/18 and 12/23/2008, included recommendations to use parallel talk with staff instructions, allow choices during routine activities throughout the course of the day, and no speech therapy is recommended due to past progress. Individual #26 did not have a comprehensive communication assessment. ▪ Individual #79's Speech and Language Screening, dated 08/03/09, included recommendations to use parallel talk with staff instructions, allow choices during routine activities throughout the day with staff instructions and provide sensory stimulation exercises as per Individual #79's needs and interests. Individual #79 did not have a comprehensive communication assessment. ▪ Individual #65's Speech and Language Update, dated 12/18/09, recommended no speech therapy at this time, parallel talk should be used throughout the day with activities of daily living, and staff should make their presence known by touching him and talking to him. The update documented that: "[Individual #65] is nonverbal. He communicates with facial expressions and sometime uses vocalizations without intent. He does not use gestures or initiate communication." Individual #71 did not have a comprehensive communication assessment. ▪ Individual #121's Speech and Language Update, dated 01/11/10, indicated that: speech therapy is not recommended as he has not appeared to benefit from it in the past, staff should continue to encourage Individual #121 to use his communication board to clarify messages that are not understood, continue to attend classes appropriate to his needs, encourage him to participate in groups and activities that promote appropriate social interactions with others, and use of his communication board will be monitored by the Speech Department, and managed accordingly. Individual #121 did not have a comprehensive communication assessment. ▪ Individual #54's Speech and Language Screening, dated 08/03/09, included	

#	Summary of Provision	Assessment of Status	Compliance
		recommendations to use parallel talk with staff instructions, allow choices during routine activities as per Individual #54's needs and interests and provide sensory stimulation exercises as per his needs and interests. Individual #54 did not have a comprehensive communication assessment. ▪ Individual #113's Speech and Language Screening, dated 04/03/09, included recommendations for parallel talk with staff instructions, allowing choices during routine activities throughout the course of the day with staff instructions, introduction of a variety of items/activities to expand Individual #113's interests with staff instructions, and provide sensory stimulation exercises. A comprehensive communication assessment has not been completed to identify person-specific functional communication strategies for Individual #113. <u>For persons receiving behavioral supports or interventions, the Facility has a screening and assessment process designed to identify who would benefit from Alternative of Augmentative Communication (AAC). Note: This may be included in PBSP</u>: This indicator will further reviewed during the next onsite review.	
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.	<u>Rationales and descriptions of interventions regarding use and benefit from AAC are clearly integrated into the PSP</u>: The following example illustrates how communication interventions are not currently integrated into an individual's PSP and/or PNMP: ▪ Individual #106's Speech and Language Screening, dated 03/09/09, stated: "Although AAC is available, [Individual #106] does not show an interest in various systems." There is no further discussion in the screening or the PSP, dated 04/02/09, addressing the use of an AAC system for Individual #106. Individual #106's PSP, dated 04/02/09, documented speech recommendations, including staff should continue to use "parallel talk" during daily routines and activities, provide choices throughout the day, and encourage use of environmental control units to help with independence, but these recommendations were not integrated in Individual #106's PNMP. For the individuals reviewed, the three (3) prominent communication strategies that were integrated into their PSPs were for staff to utilize parallel talk, allowing choices, and to provide sensory stimulation activities. Picture boards were observed on the walls in common areas. Additional individualization of communication strategies should occur. Further evaluation of indicators for this provision will be reviewed during the next monitoring visit.	
R4	Commencing within six months of the Effective Date hereof and with	Communication Services Policy (#016), Section V on Monitoring documented the monitoring process as follows:	

#	Summary of Provision	Assessment of Status	Compliance
	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.	▪ The status of individuals with identified therapy needs; ▪ The condition, availability, and appropriateness of physical supports or assistive equipment; ▪ The effectiveness of treatment interventions, including whether the intervention addresses the individual's communication needs in a manner that is functional and adaptable to a variety of settings and that the identified communication systems are readily available to the individual; and ▪ The implementation of communication program carried out by direct support staff. However, there was no evidence that monitoring was occurring as described in the policy.	

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

- A speech language/communication supports screening instrument should be developed and implemented to identify people who need a comprehensive communication assessment.
- Screening results also should be analyzed to determine required SLP/communication human resource needs.
- A SLP/communication support service delivery system needs to include: a) comprehensive assessment of domain areas; b) analyses of assessment findings to provide a rationale for recommendations and intervention strategies; c) integration of recommendations into the individual's PNMP and PSP; d) monthly documentation of progress and/or lack of progress; e) rationale for continuation and/or discontinuation of assessment recommendations; f) quarterly documentation for provision of indirect supports; g) a process for implementing change in a individual's support plan when progress is made or there is a lack or progress; and h) timeframe(s) for re-evaluation.

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 Brief on-site individual chart reviews were conducted on the following individuals: Individual #41 (on 1/5/10), Individual #7 (on 01/06/10), Individual #40 (on 01/06/10), Individual #42 (on 01/06/10), Individual #43 (on 01/07/10), and Individual #44 (on 01/07/10). Items targeted for the chart reviews included PBSPs, safety plans, PSPs, and/or skill acquisition/maintenance programs (i.e., SAOs, SPOs, and SSOs). In addition, review of current and past behavior and/or skill acquisition/maintenance was completed, if available. Often during these visits, direct observations of and/or discussions with staff members were completed as well; and o Off-site documentation reviews, including examination of the items listed above, were completed on a sample of requested documents for the following individuals: Individual #2, Individual #7, Individual #8, Individual #12, Individual #14, Individual #22, Individual #40, Individual #41, Individual #42, Individual #44, Individual #48, Individual #49, Individual #50, Individual #51, and Individual #52 ▪ **Interviews with**: o Dr. Robert Cramer, Director of Behavioral Service and Chief Psychologist, on 01/07/10 and 01/08/10; o Bruce Boswell, Director of Active Treatment, on 01/07/10; o Large group interview with 12 of the 14 current Associate Psychologists, including Lloyd Halliburton, Amy Flores, Samantha Mendoza, Marie Rangel-Gomez, Sandra Vera, Dorothy Montelongo, Gina Hawkins, Debbie Taylor, Everett Bush, John Guerra, Daniel Rivera, and Rochella Thomas, and all seven of the current Psychologist Assistants, Tiffany Carranza, Christina Martinez, Erica Pedraza, Patricia Sprencel, Melissa Perez, Laura Maldonado, and Erin Tetreault; and o A large group interview with 11 of the current residential QMRPs ▪ **Observations of**: o An initial tour of the facility conducted on 01/04/10, including the following sites: Coral Sea Unit (Seahorse and Sand Dollar residences), Pacific Unit (Ribbonfish 3), Tropical Unit (Angelfish and Pompano residences), Habilitative Therapies Building, Vocational Building, Adult Life Skills Building, Gym, Hurricane Ally, and the Atlantic Unit (Starbright and Kingfish residences); o Personal Support Team (PST) meeting held for Individual #6 on 01/05/10; and o Site visits to residential programs, including direct observation, chart reviews, data reviews, and/or discussions with psychologists, direct care professionals (DCP), active treatment specialists, and/or site QMRPs were conducted at the following sites: Coral Sea and Angelfish (on 01/05/10), Pompano (on 01/06/10), Kingfish #1 and #4 (on 01/06/10), Adult Life Skills (on 01/06/10), Habilitation/Annex Building (on 01/06/10),

	and Ribbonfish #4 (on 01/07/10).
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: Although many appear to be individualized, many skill acquisition programs appear to be inadequate. Several critical components necessary for learning and skill development appear lacking. In addition, skill acquisition programs seldom appear to be implemented in community settings for the majority of individuals. It was evident that plans contained information detailing a schedule of implementation, the staff responsible for implementation, materials needed, teaching conditions and instructions, including an initial instruction, and information on data collection. In addition, plans typically included behavioral objectives and information on the use of reinforcement. However, plans do not appear to be based on task analyses, and did not include readily evident and comprehensive operational definitions of replacement behaviors. Also, although the delivery of positive reinforcement was prescribed in the objectives reviewed, the use of differential reinforcement (e.g., lavish reinforcement only after correct responding) during teaching trials was not evident. Lastly, the potential for progress on these plans appears restricted by the limited number of teaching trials that are offered per month. Engagement levels appeared to be quite high when visiting Facility work sites. More specifically, individuals at these sites were engaged in various work activities (i.e., paper cleaning and shredding paper, can crushing, sorting hangers, folding wash clothes, pic-pac assembly, etc.). Individuals at these sites appeared happily engaged and many reported great satisfaction in their work. Efforts are being made to identify additional off-campus vocational options and employment for individuals. However, the vocational assessment format being utilized does not adequately address individuals' strengths, needs and preferences. It does not create a vocational profile based on, for example, objective data, situational assessments, and/or a thorough work history or interest inventory. According to discussions with QMRPs and DCPs, most individuals do not have opportunities to engage in skill acquisition programs in community settings. This corresponds to the lack of SAOs or SPOs identified as requiring a community setting for implementation.

#	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	According to the information obtained through discussions with behavioral services staff and QMRPs, there appear to be two (2) types of skill acquisition or maintenance programs currently implemented, these include Skill Acquisition Objectives that are outlined in PBSPs, and Specific Performance Objectives which are displayed in separate documents and referenced in individuals PSPs. It was reported that SPOs might be utilized as skill acquisition as well as maintenance programs. There is a third objective,	

#	Summary of Provision	Assessment of Status	Compliance
	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.	entitled a Staff Service Objective that were described as ongoing prompts to staff members as reminders to offer individuals various activities, and were not considered formal teaching programs. The SAOs appear to be the most formal teaching program, and are developed and implemented by the Associate Psychologists in an attempt to train staff how to teach replacement behaviors as part of an individual's PBSP. It appears that the QMRPs are responsible for developing SPOs and SSOs. It is currently unclear if individuals without PBSPs have SAOs in addition to SPOs. In addition, in conversation with various staff members, there appears to be some confusion regarding who is ultimately responsible for the implementation and monitoring of SPOs. Following onsite and offsite review of requested SAOs and SPOs, it was evident that plans contained information detailing a schedule of implementation, the staff responsible for implementation, materials needed, teaching conditions and instructions, including an initial instruction, and information on data collection. In addition, plans typically included behavioral objectives and information on the use of reinforcement. However, plans do not appear to be based on task analyses, and did not include readily evident and comprehensive operational definitions of replacement behaviors. Also, although the delivery of positive reinforcement was prescribed in the objectives reviewed, the use of differential reinforcement (e.g., lavish reinforcement only after correct responding) during teaching trials was not evident. Lastly, the potential for progress on these plans appears restricted by the limited number of teaching trials that are offered per month. In general, there seemed to be a consensus among the QMRPs that they require more intensive training in the area of skill acquisition; that is, developing, implementing and monitoring teaching programs. They voiced that, although some within the group had educational backgrounds, many did not and they felt that they could benefit greatly from more intensive training in writing teaching programs. Staff within behavioral services division endorsed this sentiment as well. Also, many QMRPs reported that the diversity and nature of the individuals served presented unique challenges to effective assessment and individualized intervention as well as successful participation, integration and placement within the community. The group voiced agreement in pursuing more staff training that targets topics relevant to the population currently served (e.g., Autism). With regard to engagement at the residential programs, there appeared to be efforts to schedule recreation, leisure and other activities, including opportunities for community outings. This is evidenced by monthly schedules posted in the residential programs as well as documentation related to completed community outings. More information regarding observed engagement is found below (see Section S.3).	

#	Summary of Provision	Assessment of Status	Compliance
		With regard to day and vocational habilitation, the sheltered work programs on campus appear to offer individuals opportunities for consistent work. Many of the individuals served by CCSSLC expressed great pride in the work that they do each day. In addition, the Facility appears to be offering some opportunities for individuals to work on and off campus in enclave or supported employment positions. However, during this initial review, concerns were noted with regard to: 1) the goals and objectives that individuals' PSPs include with regard to day and/or vocational activities; and 2) the provision of day program options for people with more complex needs. The Vocational Assessment process is discussed in further detail in the section below that addresses Section S.2 of the SA. However, the issues related to the vocational assessment process appear to impact the types of goals and objectives that are developed for individuals. Many of them were not measurable, and/or did not address functional activities. In addition, goals and objectives should assist staff by providing structure with regard to an activity schedule that can be implemented so that meaningful learning and activities occur throughout the day. As is discussed in further detail below, this did not appear to be the case as individuals had very few objectives, and the expectation appeared to be for a limited number of trials to be conducted each day. For many individuals served by CCSSLC, one (1) trial per day likely will not result in mastery of the goal/objective within a reasonable time. Some examples of vocational/day program goals that were of concern include: ▪ Individual #2 has a goal to "attend work on time and stay until completed." Although these are important work skills, this goal does not appear to be based on a thorough evaluation of her preferences, strengths and needs. Without a thorough evaluation, it is difficult for the PST to identify a list of vocational needs and preferences, prioritize them, and develop goals around them. ▪ Individual #40 had goals to continue in the pic-pack sheltered workshop, and attend SRB classes. The Facility also has recognized that a number of individuals do not leave their residential building during the day to attend a day program elsewhere on campus. For many individuals, this did not appear to be as a result of medical restrictions. Efforts were underway to develop a day program in the rehabilitation building on campus. When members of the Monitoring Team returned during the week of January 25th, some individuals had begun to attend day program in the newly designed area. It was clear that significant efforts had been made to ensure that numerous activities were available for the individuals. These efforts should continue, and in addition, PSPs should include goals and objectives that will assist staff in the day program to engage individuals in functional and meaningful activities. The following provide some examples of limited expectations for individuals with regard	

#	Summary of Provision	Assessment of Status	Compliance
		to ongoing habilitative services: ▪ Individual #8's PSP includes a desired outcome to "stimulate interest in her surroundings, nature walk" and describes a strategy as "[Individual #8] will be taken out of dorm at least twice a week by one or both shifts and documentation will be made at that time." Individual #8's PSP does not identify any specific medical concerns that prevent her from leaving the unit on a daily basis. ▪ Individual #12's 11/19/09 PSP identifies his vocational goal as attending work for a minimum of two (2) days per week. The vocational assessment dated 10/11/09, in the section on progress on current SPO, indicates that: "[Individual #12] has made no progress on his SPO because he has not been assigned a SPO from the QMRP." The assessment also indicates that Individual #12 had been working on shredding/cleaning paper, but he only works on this task for 10 to 15 minutes at a time because he "has voiced several times that he does not want to work shredding or cleaning paper because it makes his hands hurt." According to the assessment, he had only been to work 12 times in 11 months. As is discussed in further detail below, a comprehensive vocational assessment might assist Individual #12's team in identifying his vocational aptitudes and preferences, and allow the team to develop appropriate vocational goals and objectives for him.	
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.	Verbal reports from the QMRPs indicated that the "Personal Focus Worksheet: Individualized Assessment Screening Tool" is discussed annually at team meetings for each individual served at the Facility. As described, the PFW is completed in an attempt to identify important individual goals, interests, likes/dislikes, achievements and lifestyle preferences to assist with the PSP planning process. It also appeared to function as the primary screening device that would assist with the identification of additional necessary assessments. Upon offsite review of the documents requested of the randomly sampled individuals, only three (3) PFWs were available for review. All three (3) of the assessments completed for Individual #22, dated 10/29/09, Individual #44, dated 12/15/09, and Individual #48, dated 12/15/09, were completed within the last year. However, the report for Individual #44 was significantly less comprehensive than the other two. It is currently unclear if the PFW was completed within the past year for the rest of the sample. In addition, discussions with QMRPs indicated the Positive Adaptive Living Skills (PALS) assessment is also completed for each individual served. This assessment evaluates a substantial number of skill areas and would offer additional information on individuals' preferences, strengths, skills, needs and barriers to community integration. Of the individuals sampled, seven (7) of the 10 individuals had a completed PALS assessment. For one (1) individual, Individual #44, an "Assessment of Living Skills" had been completed. Of those completed, most were completed in the last year. However, three	

#	Summary of Provision	Assessment of Status	Compliance
		(3) assessments were not dated and/or appeared incomplete, specifically the PALS for Individual #43, Individual #52, and Individual #22. According to verbal reports from QMPRPs and others, a new PSP process was just initiated in December 2009. At the time of the review, many of the QMRPs had not had substantial opportunities to become familiar with the new format. This is an area that will be reviewed in further detail in future reviews. As presented earlier with regard to Sections K.5 and K.6 of the SA, ICAP assessments are typically reviewed or re-assessed for each individual served on an annual basis. Currently, the criteria for assessments completed by behavioral services staff have changed to include a re-evaluation utilizing the ICAP at least once every three (3) years. Current review of requested documentation indicated that ICAPs had been completed for each sampled individual within the last three (3) years. It should be noted that reviewed PBSPs typically had information regarding the preferences of each individual described within the text of the plan. This information was included to assist staff in identifying potential reinforcers. The vocational assessment format being utilized does not adequately address individuals' strengths, needs and preferences. The current "Vocational Annual Evaluation" form consists of a brief (one-page) questionnaire that includes information related to an individual's work history for the past year, strengths, problems, preferences, response to program, vocational recommendations, salary cap recommendations (if a person is not able to manage his/her entire paycheck, some of it is put into a bank account), and vocational SPO recommendation. It is unclear what training is provided to staff responsible for completing vocational assessments, but the form lends itself to a rather subjective and surface review of an individual's vocational history, preferences, and potential. It does not create a vocational profile based on, for example, objective data, situational assessments, and/or a thorough work history or interest inventory. For example: ▪ Individual #2's assessment completed on 11/6/09, lists as her strengths: "[Individual #2] is independent, she can count and sort hangers and also bundled rags. She can spread. She tolerated working from 8 a.m. to 11:30 a.m." Her needs were listed as: "She would be argumentative with peers she disliked or would not use closed shoes. She would get upset when redirected, but usually would calm down." Her preferences were listed as: "She preferred to take her smoke break at 10 a.m. and would like to be reinforced with $5 Campus Bucks and Diet Dr. Pepper." The assessor recommended that she continue to work at bed making which she had started the month prior. In terms of a goal, the assessor recommended that Individual #2 work on attending work on time on a	

#	Summary of Provision	Assessment of Status	Compliance
		daily basis. In addition to the fact that the goal did not appear to relate to one of Individual #2's need areas, the assessment of her strengths and needs did not appear to be comprehensive, nor did it provide the team with information about what direction Individual #2 may wish to go from a vocational perspective. The assessment only commented on her skills related to some of the jobs that currently are available at the Facility, not the breadth of jobs that might be available in the larger community. ▪ Individual #40's assessment, dated 7/8/09, identifies her strengths as: "works independently, accepts redirection, completes her work with little verbal prompts", and her problems as "needs to attend work; be on time; cannot stand or walk for long periods; gets into conflicts with others." Her preference is listed as "stay where she is". The assessor recommended that Individual #40 work on the following goals: "to be able to attend work schedule everyday, be on time, and to focus on her task." Again, this assessment does not provide an in-depth evaluation of Individual #40's vocational abilities, aptitudes and preferences. It does not address the reasons why she may not be attending work daily, and coming to work on time. The information in it is not sufficient to assist Individual #40 and her team in setting a vocational path for her.	
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	As previously presented, SAOs are developed to target replacement behaviors through strategies outlined in PBSPs. Previously, these plans were based on psychological assessments or behavioral services evaluations. Review of randomly sampled individuals with PBSPs indicated that corresponding psychological assessments identified the need to address specific target behaviors. These assessments appeared to be individualized and contained recommendations that were addressed through subsequent behavioral programming. However, few psychological assessments identified specific replacement behaviors to be targeted through SAOs; that is, even though all PSBS contain one or more SAO. This past December, a new format, entitled Structural and Functional Behavior Assessment, has been implemented and will be the basis for strategies in PBSPs. Future reviews will need to assess how well this new assessment process determines targeted goals and, subsequently, how they correspond to target behaviors for increase and decrease within PBSPs.	

#	Summary of Provision	Assessment of Status	Compliance
		Discussions with DCPs and direct observation during on-site visits provided mixed findings in relation to the implementation integrity of written skill acquisition plans. More specifically, some staff reported accurate information regarding skill training programs, correctly identifying replacement behaviors and strategies to promote these responses, and others were unsure of the objectives and related teaching strategies. During on-site visits at residential programs over the course of the week, little formal or incidental teaching was observed. The efforts of DCPs and other staff members to encourage active engagement in leisure or recreation activities (e.g., puzzles, Wii, craft activities, sensory activities, watching television, playing musical instruments, etc.) was frequently observed during site visits. Indeed, many leisure and/or recreation items and activities appeared to be readily available. However, observed levels of engagement were mixed. That it, in some settings, staff vigorously encouraged individuals to participate in ongoing activities, and were likely to offer multiple choice opportunities and praise for active involvement. In other settings, engagement appeared to primarily involve passive engagement (e.g., listening to music), and seemed limited by the availability of staffing. On-site visits to the Annex and Adult Life Skills provided observations of classes promoting didactic and role-playing strategies (e.g., to teach anger management and problem solving skills) as well as more passive participation in multi-sensory activities. Review of provided documentation as well as interviews with staff indicated that individuals with dual diagnoses and/or alleged offenses attend structured classes, referred to as "Socially Responsible Behaviors" programs, where they are exposed to curriculums targeting, in addition to ones previously identified, for example, sex offender training, alcohol/substance abuse, sex education, social skills, health and nutrition, and culinary arts. In addition, engagement levels appeared to be quite high when visiting Facility work sites. More specifically, individuals at these sites were engaged in various work activities (i.e., paper cleaning and shredding paper, can crushing, sorting hangers, folding wash clothes, pic-pac assembly, etc.). Individuals at these sites appeared happily engaged and many reported great satisfaction in their work. Upon review of SAOs and SPOs of randomly sampled individuals, it is clear that strategies are outlined to prompt appropriate responding and reinforce participation. However, specific evidenced-based teaching strategies, including task analysis, chaining procedures, error correction procedures, and/or prompting hierarchies, were not generally apparent. In addition, differential reinforcement procedures, as related to individual accuracy or performance, were not typically described. In addition, most SAOs only prescribed a limited number of trials per day. In fact, some behavioral objectives for replacement behaviors only require a small [less than five (5)] number of trials per month. Lastly, data associated with skill acquisition programs is seldom graphed. As	

#	Summary of Provision	Assessment of Status	Compliance
		noted above, the graphing of challenging behaviors as well as replacement behaviors is a new expectation of behavioral services staff, and has begun in earnest in December 2009. It is currently unclear if data from other skill acquisition programs (e.g., SPOs) will be graphed as well. As previously described above with regard to Sections K.5 and K.6 of the SA, some replacement behaviors, as identified in SAOs, did not appear to be appropriate (i.e., functionally equivalent) based on hypotheses regarding behavioral function identified by the psychological assessment. In addition, based on direct observation, some SPOs did not match those identified by individual's PSP.	
	(b) Include to the degree practicable training opportunities in community settings.	According to discussions with QMRPs and DCPs, most individuals do not have opportunities to engage in skill acquisition programs in community settings. This corresponds to the lack of SAOs or SPOs identified as requiring a community setting for implementation. Some individuals do work offsite at community-based locations performing a variety of janitorial duties as well as lawn services for state and private business and residences. However, it is a rather limited number [seven (7) to12] of individuals that hold supported employment positions at these community-based sites. Based on discussions with staff, one of the challenges that the Facility faces in this regard is the limited availability of transportation. The Facility has a fleet of vehicles, including vans that are assigned to each residential building. These vans are limited in number and are designed to transport larger numbers of people than passenger cars. As more individuals have goals and objectives that require community participation, care will need to be taken to ensure that transportation is available, and that such transportation does not encourage large group outings all or most of the time. The Facility is making laudable efforts to work with the public transportation system in Corpus Christi to increase the availability of public transportation options to the individuals served. These and other such creative options should continue to be explored.	

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

- Initial intensive and on-going training on the development, implementation, and monitoring of skill acquisition plans should be provided to behavioral services staff, including Associate Psychologists and Psychology Assistants, QMRPs, Active Treatment Coordinators and others that are likely to develop, implement, and/or monitor these teaching plans (SAOs and SPOs). Training should address writing operational definitions and behavioral goals as well as evidenced-based teaching strategies, including task analysis, chaining procedures, error correction procedures, differential reinforcement, and/or prompting hierarchies and fading.
- Consideration should be given to highlighting (or modifying) the recent cultural change within behavioral services by emphasizing the view that Associate Psychologists and Psychology Assistants are "teachers" and can offer considerable competencies in developing, implementing, and monitoring skill acquisition programs, in addition to their currently perceived primary role as professionals targeting the suppression of

challenging behaviors.

- Efforts to expand meaningful day and vocational programs should continue. The teams of individuals currently not attending a day or vocational program away from their residential unit should identify what the barriers are for participation in an off-unit program. Unless there is clinical justification for an individual remaining on the unit, individuals should attend off-unit day and vocational programs.
- If already not in place, a grid, similar to the Behavior Services Monthly Tracking Log, should be developed, and the last date of completed assessments (e.g., PALS, PFW, etc.) typically utilized within the PSP process should be recorded. Such a grid would facilitate efficient status monitoring of required and/or optional assessments as well as help ensure their timely completion.
- There appears to be some overlap and inconsistencies in the assessments currently being completed. Consideration should be given to evaluating if all assessments are needed, or if the required assessments could be reduced to those that provide the most meaningful and useful information.
- Although the integration of skill training strategies within PBSPs is critical, consideration should be given to creating a separate document developed solely to outline specific teaching strategies for identified skills. This change may reduce the amount of information contained with the PBSP as well as allow for more comprehensive information in each skill acquisition program. More general strategies related to prompting and reinforcing replacement behaviors would then be included in the PBSP.
- Consideration should be given to surveying staff members, including behavioral services staff as well as QMRPs, and identifying potential areas for further staff training. For example, it appears that staff members are likely to benefit from additional training on autism, including evidenced-based assessment and intervention strategies.
- Alternatives to the current vocational assessment tool should be considered.
- Consideration should be given to graphing progress on skill acquisition programs in addition to challenging behaviors. This process should include monthly summary and graphing of data as well as review by an Associate Psychologist.
- During PSP meetings, attempts should be made to identify community settings in which SAOs and/or SPOs could be implemented to enhance the goal's meaning and function.
- Creative efforts should continue to increase the availability of transportation to facilitate individuals' participation in community skill acquisition programs as well as community integration in general. Every effort should be made to ensure that such activities occur individually or with small groups of individuals and staff, and in a normalized fashion.

SECTION T: Serving Institutionalized Persons in the Most Integrated Setting Appropriate to Their Needs	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents:** o List of Individuals Assessed for Placement since 7/1/09; o List of Individuals Recommended by His/Her Team for Community Placement since 7/1/09; o List of Individuals Referred for Placement since 7/1/09; o List of Individuals who Have Requested Placement since 7/1/09; o List of Individuals with Discharge Planning between 7/1/09 and 12/11/09; o List of Individuals who Have Been Transferred to a Community Setting since 7/1/09; o List of Individuals who Have Been Transferred pursuant to an Alternative Discharge since 7/1/09; o DADS Policy Number 018, entitled "Most Integrated Setting Practices", dated 10/30/09; o CCSSLC Policy, Section G.7, entitled "Community Referral", dated 3/16/09; o CCSSLC Policy, Section G.8, entitled "Community Placement, dated 3/16/09; o CCSSLC Policy, Section G.9, entitled "Discharge", dated 3/16/09; o CCSSLC Policy, Section C.1, entitled Ensuring Individuals Rights, dated 3/12/08; o CCSSLC Policies from Section F, related to Person Supported Planning and Active Treatment, including: • Section F.41, entitled Participating in the PSP Monthly Review, dated 8/18/09; and • Section F.45, entitled Ensuring Community Integration, dated 1/12/09; o Living Options Discussion Record Template; o Identified Obstacles to Individual Movement form; o Community Living Discharge Plan format; o CCSSLC Tour Activity information; o Community Living Options Process (CLOIP) information; o Texas Money Follows the Person Demonstration Project, Informed Consent for Participation form; o Information on the Money Follows the Person Demonstration Project; o Email from Donnie Wilson to Dora Flores regarding MRA responsibilities with regard to the CLOIP; o Contract Amendment, Attachment I, describing MAR responsibilities with regard to the CLOIP; o Post-Move Monitoring Checklist form; o PSPs, including related assessments for: Individual #2, Individual #12, Individual #40, Individual #91, Individual #106, Individual #147; Individual #148, Individual #149, Individual #150, Individual #151, Individual #152, and Individual #153

	- Post-move monitoring documentation for Individual #20 and Individual #154; and - Community Living Discharge Plans for: Individual #18, Individual #149, and Individual #154 ▪ **Interviews with:** - Dora Flores, Admissions/Placement Coordinator (APC); - Daniel Dickson, Quality Enhancement Director; - Polly Ramirez, Settlement Agreement Coordinator; - Group interview with QMRPs; - Individual #45, Individual Served; - Individual #87, Individual Served; - Individual #95, Individual Served; - Individual #99, Individual Served; - Individual #112, Individual Served; - Individual #106, Individual Served; - Individual #147, Individual Served; and - Individual #153, Individual Served ▪ **Observations of:** - PSP Staffing meeting for Individual #26
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: Individuals' PSPs do not consistently identify all of the protections, services and supports that need to be provided to ensure safety and the provision of adequate habilitation. It is essential as teams plan for individuals to move to community settings that PSPs provide a comprehensive description of individuals' preferences and strengths as well as their needs for protections, supports and services. A new format for the PSP had been developed, and its use began in mid-November 2009. One of the new sections of the plan reportedly includes documentation of the team's discussion with regard to obstacles to movement to the most integrated setting appropriate to the individual's needs and preferences, as well as strategies to overcome such obstacles. With regard to the timeliness of the Community Living Discharge Plans (CLDPs), it appears that many are developed only a few weeks prior to the individual's discharge, making adequate transition planning difficult. The CLDPs reviewed included a number of action steps related to the transition of the individuals to the community. However, many of them did not clearly identify the specific steps that the Facility would take to ensure a smooth and safe transition, and were not sufficiently detailed or measurable. The CLDPs reviewed included essential and non-essential supports. However, it appears that the Facility is at the beginning stages of refining this process. Teams did not consistently identify all the essential supports that the individual needed to transition safely to the community, nor did teams adequately define

	the essential supports in measurable ways. Moreover, the plans did not consistently identify preferences of the individuals that might affect the success of the transition. This makes it difficult for thorough and meaningful monitoring to occur prior to and after the individual's transfer to the community. Post-move monitoring had been completed for some, but not all of the individuals who had transitioned to the community. With regard to the content of the checklists, the checklists all utilized the format attached to the SA as Appendix C. Each of the items on the checklists had been addressed. It would be helpful, however, if additional information was provided with regard to the methodology used to conduct the reviews and the information gathered with regard to each indicator. The post-move monitoring identified some issues with regard to the provision of services at the community sites. It would be helpful if the reviewers identified more specific action items describing the Facility's best efforts to ensure the supports are implemented. Such items might include but not be limited to notifying the provider agency's management team of the issues identified, attempting to reach agreement with the agency on persons responsible and timeframes for the completion of needed actions, and notifying the community case manager of the need for follow-up.

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T1	**Planning for Movement, Transition, and Discharge**		
T1a	Subject to the limitations of court-ordered confinements for individuals determined incompetent to stand trial in a criminal court proceeding or unfit to proceed in a juvenile court proceeding, the State shall take action to encourage and assist individuals to move to the most integrated settings consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, that the transfer is consistent with the individual's ISP, and the placement can be reasonably accommodated, taking into account the statutory authority of	On 10/30/09, DADS issued a policy entitled "Most Integrated Setting Practices." This State policy accurately reflects the provisions contained in Section T of the Settlement Agreement. The policy's stated purpose is to "prescribe procedures for encouraging and assisting individuals to move to the most integrated setting in accordance with the Americans with Disabilities Act and the Untied States Supreme Court's decision in Olmstead v. L.C.; identification of needed supports and services to ensure successful transition in the new living environment; identification of obstacles for movement to a more integrated setting; and, post-move monitoring." The policy includes components to ensure that any move of an individual to the most integrated setting is consistent with the determinations of professionals that community placement is appropriate, that the transfer is not opposed by the individual or the individual's LAR, and that the transfer is consistent with the individual's PSP. During future reviews, the Monitoring Team will continue to evaluate the State and the Facility's implementation of this policy.	

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	the State, the resources available to the State, and the needs of others with developmental disabilities.		
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:	CCSSLC provided a copy of the DADS policy on Most Integrated Setting Practices when asked for the Facility policy. Staff indicated that CCSSLC was adopting the DADS policy as the Facility policy. However, it appears that the CCSSLC Policy Manual had not yet been updated to reflect this. The Facility policy manual contained a number of policies related to the community placement process. Specifically, the Facility Policy Manual includes policies on: 1) Community Referral; 2) Community Placement; and 3) Discharge. Although these policies provide some valuable guidance with regard to the community placement and discharge processes, they do not address all of the provisions of the SA. Some of the items that are missing, include: ▪ The PST's role in the identification of obstacles to the individual's movement to the community, and an action plan to overcome such obstacles; ▪ Provision of education to individuals and their LARs to assist them in making informed choices; ▪ A detailed description of the Community Living Discharge Plan development process; ▪ A description of the post-move monitoring process; and ▪ A description of the discharge process to be used for individuals for whom alternate discharges are implemented. The Facility provided a list of individuals who have requested placement. However, it is unclear how this list is developed. As the reviewer talked with individuals who reside at CCSSLC, questions were asked such as "What are you working toward?" or "What are staff helping you with?" or "What are your goals?" In some cases, individuals responded that they wanted to move to a group home or live closer to their families. In some cases, individuals who clearly stated they wanted to move were on the list of individuals who had requested placement, including, for example, Individual #147 and Individual #106. However, other individuals were not on the list. For example: ▪ When the reviewer introduced herself to Individual #112, Individual #112's response was that she wanted to move to a group home. She stated that it was her "number one goal." When asked if she had talked about this with staff, Individual #112 said she had, and that she had told them she wanted to visit group homes during one of the Friday trips. As is discussed below, the Facility has been scheduling trips to community settings on Fridays. Individual #112 was not on the list provided to the reviewer of individuals who had requested community transition. It could be that her interest is more recent. ▪ Individual #95 clearly stated that he is going to and wants to move to a group home. Individual #95 had been on a trip to a group home, and drew a picture of	

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		the house he had visited. Although he is listed on the community referral list, he was not listed on the list of individuals who had requested placement. ▪ Individual #2's 12/2/09 PSP indicates that what is most important to her is "going to a group home/or half way house in Dallas." However, she was not included on the list of individuals who have requested community placement. (The list was inclusive of those who had made such requests through 12/11/09.) Her PSP indicates that she had not been referred at that time. There is a difference, though, between a person requesting placement and the team recommending it, and making a referral.	
	1. The IDT will identify in each individual's ISP the protections, services, and supports that need to be provided to ensure safety and the provision of adequate habilitation in the most integrated appropriate setting based on the individual's needs. The IDT will identify the major obstacles to the individual's movement to the most integrated setting consistent with the individual's needs and preferences at least annually, and shall identify, and implement, strategies intended to overcome such obstacles.	As is discussed in a number of places throughout this report, individuals' PSPs do not consistently identify all of the protections, services and supports that need to be provided to ensure safety and the provision of adequate habilitation. Some of these issues relate to thorough and adequate assessments not being completed (e.g., nursing, psychiatry, physical and nutritional management, and communication), services and supports not being adequately integrated with one another (e.g., psychology and psychiatry, psychology and dental/medical, and occupational and physical therapy), and/or adequate plans not being developed to address individuals' preferences, strengths and needs (e.g., nursing, psychiatry, psychology and habilitation, physical and nutritional supports, and communication). It is essential as teams plan for individuals to move to community settings that PSPs provide a comprehensive description of individuals' preferences and strengths, as well as their needs for protections, supports and services. This is important for two (2) reasons, including: 1) as individuals and their guardians are considering different options in the community, it is important for them as well as potential providers to have a clear idea about what protections, supports and services the individual needs to ensure that perspective provider agencies are able to support the individual appropriately; and 2) as the progress progresses, the PSP will be the key document that is used to ensure that essential supports are identified and in place prior to an individual's move. If all of the necessary protections, supports and services are not outlined in the PSP, it will be much more difficult to ensure the individual's safe transition. In a meeting that members of the Monitoring Team held with many of CCSSLC's QMRPs, the QMRPs explained that a new format for the PSP had been developed, and its use began in mid-November 2009. One of the new sections of the plan reportedly includes documentation of the team's discussion with regard to obstacles to movement to the most integrated setting appropriate to the individual's needs and preferences, as well as strategies to overcome such obstacles. The older format PSP, which is what was available for review, did not include these sections. The Monitoring Team looks forward to reviewing PSPs that includes this information during upcoming monitoring visits.	

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	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.	CCSSLC has 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. This has taken a number of forms, including: ▪ On November 19, 2009, a provider fair was held. It appeared from the sign-in sheets that it was well-attended by providers, individuals, their families, and Facility staff. According to the Admissions/Placement Coordinator (APC), approximately 25 providers were in attendance. These providers offer services in a variety of counties; ▪ Visits to community group homes and day programs occur on Fridays, and are open to individuals, families/guardians, or staff who want to attend. Such visits offer 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. This is important as illustrated by interviews with individuals currently served at CCSSLC. For example, one individual, Individual #87, who had not been on visits to community homes, but expressed an interest, reported that he lived with his mother until moving to CCSSLC. When asked what he knew about group homes in the community, he said he thought they were "boarding houses," but was not able to provide a description beyond that. On the other hand, Individual #95, who had been on a visit to a group home, was able to describe in some detail what the home looked like, and what he liked about it. According to the APC, more formal tracking has begun to occur with regard to who attends these visits, particularly with regard to staff attendance. CCSSLC is encouraged to continue offering regular visits to community homes and day programs. ▪ In some cases, individual teams appear to be tailoring educational activities to meet the needs of the particular families and individuals. For example, Individual #95's guardian reportedly was originally reluctant to consider community placement. The guardian also was not able to attend the visit to community programs with Individual #95. However, the QMRP took pictures of the community settings that were visited, and sent them to the guardian along with information about the provider(s). Individual #95 was recently referred for community placement. ▪ Individuals and their guardians also are provided information through the Mental Retardation Authority (MRA) Community Living Options Information Plan (CLOIP) process. This occurs regularly as part of the individual planning process. In addition, it was reported that the MRAs also have met with PST members in meetings designed specifically to provide information about services and supports that are available in the community.	

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		▪ CCSSLC is fortunate to have a number of staff, including the Admissions/Placement Coordinator who have experience working in the community system. This allows the APC, for example, to assist in answering questions about the community that individuals, families/LARs, or other staff may have. Efforts are being made to ensure that Facility staff have current knowledge of supports and services that are available in the community. For example, within three (3) months of any new staff member starting work at CCSSLC, they are required to go visit a group home and day program in the community. The Facility is encouraged to continue offering a variety of educational options to individuals and families, and to expand these options to creatively meet the needs of various individuals and guardians. The Monitor briefly discussed with the Admissions/Placement Coordinator activities that have been successful in other jurisdictions. For example, as individuals successfully transition to community settings, with their and their guardians' permission, newsletter articles could highlight such success stories. At times, it might be helpful to match individuals and/or guardians who have gone through the process with individuals and/or guardians who are considering a placement referral. This allows someone with first-hand knowledge about the process, including the challenges as well as the successes to share information and provide support.	
	3. Within eighteen months of the Effective Date, each Facility shall assess at least fifty percent (50%) of individuals for placement pursuant to its new or revised policies, procedures, and practices related to transition and discharge processes. Within two years of the Effective Date, each Facility shall assess all remaining individuals for placement pursuant to such policies, procedures, and practices.	The SA anticipated that the Facility would require 18 months to complete this activity. However, to gain a baseline assessment of the Facility's progress, the Monitoring Team requested as part of its initial document request a list of individuals who had been assessed for placement since July 1, 2009, pursuant to the new or revised policies, procedures, and practices related to transition and discharge practices. CCSSLC provided a list that contained 19 individuals' names out of approximately 310 individuals that the Facility serves, or six (6) percent. During upcoming monitoring visits, the Monitoring Team will continue to review the Facility's progress in this regard, including the process being used by team to assess individuals for placement.	
T1c	When the IDT identifies a more integrated community setting to meet an individual's needs and the	Community Living Discharge Plans were reviewed for three (3) individuals. This sample was drawn from the list of 11 individuals whom the Facility identified as having had a CLDP developed since July 1, 2009.	

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	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:	With regard to the timeliness of the Community Living Discharge Plans, it appears that many are developed only a few weeks prior to the individual's discharge, making adequate transition planning difficult. For example: ▪ For Individual #155, his CLDP was dated 10/13/09. Although the documentation is not completely clear, it appears that the team made the referral for community placement following a 5/6/09 PSP meeting, his mother who is his guardian selected a provider, and pre-placement visits were set up and occurred on 7/16/09 through 7/19/09. His CLDP indicated that the provider did not report any concerns, and stated they would be able to accommodate Individual #155 in the home. The original discharge date was scheduled for 10/19/09. This was modified to 11/9/09, due to a medical issue that arose slightly prior to the original discharge date. However, it is unclear why three (3) months elapsed from the time the provider was selected and Individual #155 was accepted for placement, and the meeting was held to develop the transition plan. Although it appears there were issues during this time related to funding availability for community placement, it would have been beneficial for Individual #155 and his team to begin transition planning as early as possible. Further comments regarding the content of Individual #155's CLDP are provided below. ▪ Likewise, for Individual #18, her CLDP was developed on 11/18/09, and her discharge date was set for 12/1/09. She was referred for community placement on 2/23/09. It is somewhat unclear from the documentation on what date a placement was agreed upon, but there are notations that Individual #18 was affected by a delay in Home and Community-Based Services (HCS) enrollments. However, earlier development of a CLDP likely would have been beneficial to ensure that all essential supports were identified, and in place in Individual #18's new community placement. As is discussed in further detail below, it does not appear that her team identified all of what was necessary for her safe transition. ▪ Individual #149 was referred for community placement on 10/30/08. His CLDP was not developed until 6/23/09, and his discharge date was approximately one week later on 7/1/09. However, it appeared that other CLDPs had been developed in the interim, each time a potential provider was identified, but at least one provider, indicated that it had decided after an overnight visit that it could not effectively serve him.	
	1. Specify the actions that need to be taken by the Facility, including requesting assistance as necessary to	The Community Living Discharge Plans reviewed included a number of action steps related to the transition of the individuals to the community. However, many of them did not clearly identify the specific steps that the Facility would take to ensure a smooth and safe transition, and were not sufficiently detailed or measurable. In addition, although	

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	implement the community living discharge plan and coordinating the community living discharge plan with provider staff.	monitoring activities were identified in the CLDPs, they largely described the role of the MRA. Some did, while others did not, detail the role of Facility staff in the post-move monitoring and follow-up process. As is described in further detail in the section of this report that addresses Section T.1.e of the SA, the CLDPs also did not consistently identify the essential supports required by the individuals. The following provide examples of some of the concerns noted with regard to the CLDPs reviewed with respect to defining the role of the Facility staff in the transition process: ▪ According to his CLDP dated 10/13/09, Individual #155 "needs continued assistance in addressing his disruptive behaviors of physical aggression and being uncooperative by means of a Positive Behavior Support Plan and psychoactive medication." However, the CLDP did not identify the PBSP as an essential or non-essential support, and it provides no indication of Facility staff's role in coordinating with the community provider's psychology staff to share information with regard to the behavior plan or its implementation. Likewise, Individual #155 was being prescribed psychoactive medication, but the team did not identify the need for oversight by a psychiatrist as an essential or non-essential support. The team identified a general essential support as "Appointments to be set up with needed Dr.'s within 30 days of move." In order to ensure that needed appointments occur, the specific physicians and specialists that the individual needs to see, and the frequency should be clearly stated. It is unclear as well if the team considered the possible need for the Facility psychiatrist to share information with the community psychiatrist to ensure continuity of care. ▪ Likewise, Individual #18's CLDP did not identify ways in which Facility Staff could assist in her transition. For example, she has a PBSP that was not mentioned at all in the essential support section of her CDLP, as well as a dining plan. CCSSLC could assist by providing training to the new provider staff on the implementation of these plans. However, this is not contemplated in the CLDP. Individual #18's CLDP did define the role of Facility staff in completing post-move monitoring visits.	
	2. Specify the Facility staff responsible for these actions, and the timeframes in which such actions are to be completed.	Based on the sample reviewed, Teams generally identified target dates for the completion of actions steps included in CLDPs. However, teams did not consistently identify the persons responsible for action steps included in CLDPs for which Facility staff or others were responsible. Some examples include: ▪ Individual #155's CLDP identified "30 days of medication" as an essential support and the responsible person was listed as "CCSSCL" as opposed to a particular person. For the majority of the action items in Individual #155's CLDP, the team identified the provider agency or HCS case manager as the responsible party without stating a specific name.	

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		▪ Individual #18's CLDP only identified names of persons responsible with regard to some of the financial pieces, for example, closing the CCSSLC trust fund. For other essential and non-essential supports, it identified just the agency or Facility as responsible. ▪ Individual #149's plan did not identify due dates or persons responsible for the provision of essential, non-essential supports, or what the team referred to as "Aftercare Provisions."	
	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.	From the sign-in sheets provided with the CLDPs that were reviewed, it appears that teams consistently reviewed CLDPs with the individuals and their guardians prior to discharge. Community provider staff also participated in the meetings. At times, teleconferencing was used to facilitate the participation of appropriate team members.	
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.	It is unclear what process is in place to ensure that written updates to assessments are completed within 45 days prior to the individual's leaving the Facility. As is illustrated below, although it appears assessments are reviewed, documentation could not be found that any changes are memorialized in writing, or if there are no changes that this is committed to writing by each staff person responsible for the particular assessment. The following are examples: ▪ Individual #155's CLDP indicated that an updated profile was completed on 10/13/09, in preparation for his transition to the community on 11/9/09. Many of the assessments were conducted between May and early August 2009. The CLDP included a statement that the team met on 10/13/09 "to review all assessments and report changes to programming." However, it did not appear that all assessments had been reviewed by relevant staff, and amended as needed. For example, as is discussed above, Individual #155 was hospitalized shortly before he was discharged. It is unclear if his comprehensive nursing and medical assessments were updated to include this information, including recommendations for follow-up, and/or how this information was provided/communicated to the new provider. ▪ Likewise, it appeared that assessments for Individual #18 had been completed at different times, and it was not clear that they all had been updated prior to her discharge date of 12/1/09. For example, the date of the medical evaluation was 10/2/09, 60 days prior to her discharge. Other examples of older assessments included nursing that was completed on 6/15/09, and a nutritional evaluation that was completed on 7/28/09. Her PNMP had been updated on 11/18/09. Dental had provided an update on 12/9/09, that appears to be after Individual #18's discharge date.	

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T1e	Each Facility shall verify, through the MRA or by other means, that the supports identified in the comprehensive assessment that are determined by professional judgment to be essential to the individual's health and safety shall be in place at the transitioning individual's new home before the individual's departure from the Facility. The absence of those supports identified as non-essential to health and safety shall not be a barrier to transition, but a plan setting forth the implementation date of such supports shall be obtained by the Facility before the individual's departure from the Facility.	The CLDPs reviewed included essential and non-essential supports. However, it appears that the Facility is at the beginning stages of refining this process. Teams did not consistently identify all the essential supports that the individual needed to transition safely to the community, nor did teams adequately define the essential supports in measurable ways. Moreover, the plans did not consistently identify preferences of the individuals that might affect the success of the transition. This makes it difficult for thorough and meaningful monitoring to occur prior to and after the individual's transfer to the community. Likewise, teams did not consistently identify non-essential supports or do so in measurable ways. The following provide examples of issues identified with regard to the identification of measurable essential and non-essential supports:
		▪ Individual #155's 10/13/09 CLDP did not appear to address some supports that would appear to be essential to his health and safety, including, for example:
		    o As noted above, his team noted in the narrative summary that Individual #155 "needs continued assistance in addressing his disruptive behaviors of physical aggression and being uncooperative by means of a Positive Behavior Support Plan and psychoactive medication." However, the CLDP did not identify the PBSP as an essential or non-essential support nor was staff competency in the implementation of the BSP listed as an essential (or non-essential) support;
		    o In its assessments, Individual #155's team identified allergies to fish and shrimp, and other diet restrictions, as well as the need for him to sit up for at least one (1) hour after eating or drinking due to gastroesophageal reflux disease (GERD) as important. However, ensuring that these precautions were in place at the time of his discharge were not identified as essential supports.
		    o As previously noted, Individual #155's CLDP identified that doctor appointments needed to be set up within 30 days, but did not specify which appointments needed to be scheduled with what frequency. As noted above, Individual #155 received psychoactive medications at the time of his discharge, so follow-up with a community psychiatric provider should have been identified as an essential support. Likewise, shortly before his discharge he was admitted to the hospital due to possible gastrointestinal (GI) bleeding. The recommendations for follow-up included a GI consultation once he moved to his new home. However, this was not included as an essential support.
		▪ Individual #18's CLDP did not identify a number of essential supports that would have the potential to impact her safety, including, for example:
		    o Individual #18 requires a number of different pieces of adaptive equipment, including, a wheelchair with solid padded seat and back, removable arm rests, and flip up foot rests; head rest on wheelchair to	

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		protect head during vehicle transport; a rolling hospital walker; a posey bed alarm; a bed that allows her head to be elevated to 30 degrees; soft shell helmet; gait belt; right elbow pad; kneepads; padding sown into the knees of her pants; plastic plate guard; and a dycem mat. None of these are listed as essential supports. Presumably, she also requires a wheelchair accessible van, and supports from Occupational and Physical Therapy, but these are not listed as essential (or non-essential) supports. o Individual #18 has a dining plan with a number of requirements that are needed "to prevent choking". For example, staff are supposed to encourage her to chew and swallow each bite, are to soften her food with au jus or milk, and to serve all serve her half portions of all of her food in individual bowls. Her dining plan and/or staff's competence in implementing it are not listed as essential supports. There is a broad reference under essential supports to "staff in-servicing on PSP, Likes/Dislikes, diet; special considerations, treatments." Moreover, there is no reference in either essential or non-essential supports for the need for her dining plan to be monitored, and regularly reviewed by a team with expertise in physical and nutritional supports. o While at CCSSLC, Individual #18 had a PBSP that addressed aggression toward self and others. Her BSP is not listed as an essential support. At the time of her discharge she also was prescribed a number of psychotropic medications. However, regular review by a psychiatrist is not listed as an essential or non-essential support, nor is regular coordination between psychology/behavior staff and the psychiatrist. o It appears that Individual #18 was placed at CCSSLC in part due to involvement with illegal drugs and alcohol. Her plan indicates that "she verbalizes she strongly desires" to access these again. Although her team documented discussion regarding which town/city she should live in to try to prevent her return to these activities, there is no documentation to show that planning occurred with the new provider agency to ensure that supports and services were in place to assist Individual #18 to successfully return to the community without relapsing to drug and alcohol abuse. ▪ The narrative of Individual #149's plan identifies a number of his preferences such as solitude and privacy, friends who are quiet and mature, and being allowed to take his time. It also states that he can be mistrusting until he gets to know someone. None of these appear to have been incorporated into the essential or non-essential supports, or the transition plan. For example, it is not clear if the team incorporated time for Individual #149 to get to know staff at his new setting prior to his transition.	

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		With regard to Monitoring by the MRA or other means to ensure essential supports are in place prior to an individual's transition, this appeared from the records reviewed to be a general safety assessment as opposed to an individualized assessment based on the essential supports identified by the team. For example: ▪ On 10/5/09, a staff member from the MRA sent a letter regarding the home to which Individual #155 was scheduled to move. In it she indicated that she had visited the home and found it to be clean, adapted to accommodate individuals who were non-ambulatory (which is not a concern for Individual #155), and in compliance with the "Life Safety Code". In recommending the placement, the MRA staff person stated, "The setting assures the individual's health, safety, and welfare and effectively addresses the outcomes important to the consumer." The MRA staff person did not address any of the specific essential supports identified for Individual #155. ▪ Individual #18's documentation included a different form called "Continuity of Care Pre-Move Site Review Instrument for the CLDP" that was completed on 11/18/09. A section of this form asked for confirmation that the reviewer had checked the DADS Quality Reporting System website to ensure that the contractor was in good standing with DADS. It also asked if during the site review any environmental concerns that would impact the individual's needs were noted. Both of these indicators appeared to be acceptable to the reviewer. Another section asked the following: "The site Administrator/Manager had a copy of the consumer's draft Community Living Discharge Plan and knew of the outcomes important to the consumer or LAR?" The reviewer checked "no" in response. Likewise, the reviewer checked "no" to the following question: "The site Administrator/Manager verified services and supports could be provided that were necessary to assist the consumer in achieving the outcomes?" Despite negative responses to both of these questions, the reviewer summarized that the setting did meet the criteria and recommended IDT approval of the placement. In addition to the fact that "no" responses to these indicators should have resulted in a recommendation not to move ahead with placement, the indicators are too general to ensure that all essential supports are in place.	
T1f	Each Facility shall develop and implement quality assurance processes to ensure that the community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible, consistent with the	Facility staff reported honestly that they have not yet developed quality assurance processes to ensure that community living discharge plans are developed, and that the Facility implements the portions of the plans for which the Facility is responsible. Staff indicated that in developing such processes, Quality Enhancement staff at CCSSLC are collaborating with other SSCLs, some of whom reportedly have some of these processes in place. The Monitor appreciates staff's frank assessment of the status of the Facility's progress with regard to this provision of the SA. The Monitoring Team looks forward to reviewing such quality assurance processes during future reviews.	

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	provisions of this Section T.		
T1g	Each Facility shall gather and analyze information related to identified obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. On an annual basis, the Facility shall use such information to produce a comprehensive assessment of obstacles and provide this information to DADS and other appropriate agencies. Based on the Facility's comprehensive assessment, DADS will take appropriate steps to overcome or reduce identified obstacles to serving individuals in the most integrated setting appropriate to their needs, subject to the statutory authority of the State, the resources available to the State, and the needs of others with developmental disabilities. To the extent that DADS determines it to be necessary, appropriate, and feasible, DADS will seek assistance from other agencies or the legislature.	The SA contemplated that it would take six (6) months for policies to be developed and/or revised and implemented related to transition and discharge of individuals to more integrated settings, consistent with their needs and preferences. As noted above, based on policy and procedure changes at the State level related to the individual planning process as well as the most integrated setting, at the time of the baseline review, CCSSLC had begun just recently to identify specific obstacles to individuals' movement to more integrated settings, consistent with their needs and preferences. Such changes began to be implemented for PSP meetings occurring in approximately mid-November 2009. As a result, the Facility had not yet had the opportunity to collect sufficient data for analysis and submission of a report to the State. The Monitoring Team looks forward to reviewing such reports as part of future reviews. In March 2010, the Monitoring Panel will be meeting with DADS staff responsible for oversight of movement of individuals to the most integrated settings, consistent with their needs and preferences. The Monitoring Panel anticipates that separate reports may be issued periodically that address the components of Section T of the SA for which the State and DADS has responsibility.	
T1h	Commencing six months from the Effective Date and at six-month intervals thereafter for the life of this Agreement, each Facility shall issue to the Monitor and DOJ a Community Placement Report listing: those individuals whose IDTs have determined, through the ISP process, that they can be appropriately placed in the community and receive	As part of CCSSLC's response to the document request from the Monitor dated 11/25/09, the Facility submitted to the Monitor a Community Living Placement Report. The report listed individuals who had been referred by their teams for community placement between 5/1/2009 and 11/30/2009, including the individual's name, the date of referral, and, if applicable, the date the referral had been rescinded, and the reason the referral was rescinded. This list included the names of 16 individuals, including one person for whom the team had rescinded the referral due to "IDT – medical". Discrepancies noted between the Community Living Placement Report and individuals' PSPs, included: ▪ Individual #147 was not included on the list of individuals who had been referred for placement. However, her PSP dated 11/18/09, specifically the	

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	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.	Living Options Discussion Record indicated, "[Individual #147] has a HCS slot and is hoping to move in the near future. The team has been in touch with Dallas Metrocare and is hoping for placement in December… The PST agrees with the proper supports [Individual #147] could function in a group home setting…" During future reviews, the Monitoring Team will review a larger sample of individuals' PSPs to determine whether individuals identified by their teams as appropriate for placement in the community are listed in the Facility's Placement Report. The report also included a list of individuals for whom community transition had occurred, including the individuals' names and the dates on which they were transitioned to community settings. This list included the names of 12 individuals who had transitioned to community settings between May and October 2009.	
T2	**Serving Persons Who Have Moved From the Facility to More Integrated Settings Appropriate to Their Needs**		
T2a	Commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility, or its designee, shall conduct post-move monitoring visits, within each of three intervals of seven, 45, and 90 days, respectively, following the individual's move to the community, to assess whether supports called for in the individual's community living discharge plan are in place, using a standard assessment tool,	<u>Timeliness of Checklists</u>: The SA anticipated that post-move monitoring would commence by December 26, 2009, for individuals transferred to community settings. To obtain a baseline measurement with regard to this activity, the Monitoring Team requested a sample of the post-move monitoring checklists for four (4) out of the 11 individuals that the Facility identified as having moved to community settings since July 1, 2009. Review of these documents revealed that for one (1) out of the four (4) individuals (25%), all of the required post-move monitoring had been completed. The following provides specific information for each: ▪ Individual #149 moved to a community setting on 7/1/09. Facility staff reported that they began conducting post-move monitoring visits in August 2009, so no post-move documentation was available for Individual #149. ▪ Individual #154 moved to a community setting on 11/9/09. Two (2) monitoring checklists were provided for this individual. One indicated it was the "1-7 days" checklist, and the other indicated it was the "8-45 days" checklist.	

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	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.	However, neither was dated. ▪ Individual #20 moved to a community setting on 11/11/09. Documentation was provided of the seven (7)-day monitoring visit that occurred on 11/18/09. However, no documentation was provided of a 45-day monitoring visit. ▪ Individual #156 moved to a community setting on 12/7/09. Facility staff reported that Individual #156 moved to the Houston area. As a result, the post-move monitoring responsibilities rested with the Admissions and Placement Coordinator of one of the other SSLCs that is located close to Houston. However, the seven (7)-day visit had not been completed. Staff explained that positions were in the process of being filled at each Facility that would include specific responsibilities related to post-move monitoring. This is a positive step that should assist the State in ensuring that adequate monitoring and follow-up occurs as individuals transition to community settings. Content of Checklists: With regard to the content of the checklists, the checklists all utilized the format attached to the SA as Appendix C. Each of the items on the checklists completed for Individual #20 and Individual #154 had been addressed. It would be helpful, however, if additional information was provided with regard to the methodology used to conduct the reviews and the information gathered with regard to each indicator. For example, it was unclear from the monitoring checklists if onsite visits were conducted, which documents were reviewed, and if staff and/or the individual was interviewed. Other than a "yes" or "no" response, no additional information was provided to substantiate that essential and non-essential supports were in place. For example, no detail was provided with regard to Individual #154's day program assessment, community integration activities, or medical appointments, all of which were identified as non-essential supports. Although the reviewer indicated that these were in place, there was no documentation provided to substantiate these conclusions. The same was true for Individual #20. The reviewer indicated that her non-essential supports such as enhanced level of supervision at night due to challenging behavior, attending church services of her choice, medical appointments and treatments, and following her special diet were all in place. However, there was no indication of what information was reviewed to draw these conclusions. In order to substantiate findings and maintain a complete record of the monitoring conducted, it would be helpful to include detailed information on the post-move monitoring checklists. The primary reasons for conducting post-move monitoring are to identify if any protections, supports or services that the individual requires are not in place, and, if any issues are identified, to take action to correct them. The monitoring checklists for both Individual #154 and Individual #20 identified some concerns with regard to the provision of what had been identified by their teams as "non-essential" supports. Specifically, all of the post-move monitoring checklists provided for Individual #20 and	

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		Individual #154 indicated that the community providers had not provided their staff with training on the individuals' medical needs, dietary/nutritional needs, personal hygiene needs, mobility needs, behavioral considerations and/or psychiatric needs/symptoms, communication needs, and/or adaptive aids. As is discussed in further detail above with regard to Section T.1.e, it is unclear why the individuals' teams had not identified training on many of the items listed as missing on the monitoring checklist as essential supports that needed to have been in place at the time of the individual's transfer to a community setting from the SSLC. Also of note, for both Individual #154 and Individual #20, one of the essential supports that the post-move monitors identified on the monitoring checklists as having been in place was in-service training on the individuals' PSPs. It is unclear how if this was found to be present that training on the areas identified above could have been found not to have occurred. An individual's PSP should be comprehensive and should include all of the items listed, as applicable to the individual. That being said, it is positive that the reviewers identified the missing training, and identified the need for further follow-up in the action plan sections of the monitoring tools. Other issues identified included the BSP for Individual #20 not being updated, a community checking account not being set up for Individual #154, and the 30-day meetings for each individual not being scheduled. The reviewers for both Individual #20 and Individual #154 indicated that the action that they would take to address the issues identified would be to follow-up at the next visit. The reviewer for Individual #154 also requested training documentation from the provider. It would be helpful if the reviewers identified more specific action items describing the Facility's best efforts to ensure the supports are implemented. Such items might include but not be limited to notifying the provider agency's management team of the issues identified, attempting to reach agreement with the agency on persons responsible and timeframes for the completion of needed actions, and notifying the community case manager of the need for follow-up.	
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	This could not be assessed as no post-move monitoring visits were scheduled during the week of the review.	

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	accuracy of the Facility's monitoring and shall occur before the 90th day following the move date.		
T3	**Alleged Offenders -** The provisions of this Section T do not apply to individuals admitted to a Facility for court-ordered evaluations: 1) for a maximum period of 180 days, to determine competency to stand trial in a criminal court proceeding, or 2) for a maximum period of 90 days, to determine fitness to proceed in a juvenile court proceeding. The provisions of this Section T do apply to individuals committed to the Facility following the court-ordered evaluations.		
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	This Monitoring Team did not evaluate this provision, as CCSSLC had not had any alternate discharges since July 1, 2009.	

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	timeframe; (d) individuals receiving respite services at the Facility for a maximum period of 60 days; (e) individuals discharged based on a determination subsequent to admission that the individual is not to be eligible for admission; (f) individuals discharged pursuant to a court order vacating the commitment order.		

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

- CCSSLC should modify its Facility-level policy and procedure manual to reflect the DADS policy on Most Integrated Setting Practices. Consideration should be given to customizing the policy to ensure its usefulness to Facility staff. For example, the current Facility policies provide lists of items that should be sent with the person on the date of discharge as well as records that should be transferred. This is valuable information that the Facility may want to consider continuing to use as it revises its policies to be consistent with the DADS policy.
- The Facility is encouraged to continue to offer a variety of educational opportunities with regard to community options to ensure that individuals and their guardians make informed decisions regarding movement to the community. CCSSLC also should continue to add creative and individualized educational activities to meet the needs of various individuals and families/guardians. Consideration should be given to developing a written plan that identifies the actions that will be taken, persons responsible and timeframes for completion.
- CCSSLC should ensure that an adequate system is in place to identify individuals whose teams have determined that they can be placed appropriately in the community, and that such individuals' names are included on the Community Placement Report required by Section T.1.h of the SA.
- Consideration should be given to beginning the process of developing the CLDP much sooner in the process to ensure that a comprehensive plan is developed, and that there is time to implement an adequate transition process.
- Essential and non-essential supports need to be better defined in Community Living Discharge Plans. Likewise, the role of the Facility staff in the transition and discharge process needs to be better defined.
- As the positions for staff responsible for Post-Move Monitoring are filled, clear expectations should be established with regard to the frequency and types of visits that need to be completed, the process that needs to be used for monitoring, and the documentation that needs to be maintained.
- Post-Move Monitoring Checklists should include: 1) a description of the monitoring methodology (e.g., documents reviewed, people interviewed, observations made); and 2) information to substantiate conclusions that essential and non-essential supports are in place and/or steps being taken by the provider agency to ensure that such supports and services are provided.
- The action plans that are part of Post-Move Monitoring checklists should be more focused on resolving the issues identified.
- Staff responsible for the completion of post-move monitoring activities should complete competency based training on the completion of monitoring reviews, including the methodology, proper documentation, and the development and implementation of action plans to address issues identified.

SECTION U: Consent	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents:** o List of individuals residing at Corpus Christi SSLC without a Legally Authorized Representative (LAR); 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; 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; o Corpus Christi Policies and Procedures, including: • C.1 – Ensuring Individuals' Rights; • C.3 - Identifying Need and Requesting Personal Advocate; • C.7 – Obtaining Guardian Consent Prior to Non Routine Medical Appointments; • C.8 – Completing Guardian Document Verification Form; • C.9 – Obtaining Consent for Medication for Behavior Management; • Personal Support Plans, including assessments for the following individuals: Individual #2, Individual #8, Individual #12, Individual #40, Individual #91, Individual #106, Individual #147; Individual #148, Individual #149, Individual #150, Individual #151, Individual #152, and Individual #153 ▪ **Interviews with:** o Daniel Dickson, Quality Enhancement Director; o Dora Flores, Admissions/Placement Coordinator; o Lorri Haden, Attorney for DADS; and o Individual #147, Individual Served
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: Although Corpus Christi SSLC has some of the preliminary processes in place to identify the need for individuals to pursue the guardianship process, the Facility has not met the requirements of this provision of the Settlement Agreement. Facility staff were extremely honest about the fact that this is an area in which they need to make additional efforts. Staff also indicated that DADS Central

	Office was still in the process of developing a policy on guardianship and consent that is expected to provide guidance to the Facilities with regard to the implementation of this SA requirement. Some of the concerns related to the current process include the following: 1) in at least one (1) instance, there were inconsistencies with regard to an individual's guardianship status; 2) the process that teams currently are using to determine an individual's ability to provide informed consent is vague and does not appear to be based on specific assessment tools; and 3) identification of concerns related to an individual's ability to make informed decisions does not result consistently in recommendations for either supports and services to increase the individual's decision-making capacity or to pursue guardianship.

#	Summary of Provision	Assessment of Status	Compliance
U1	Commencing within six months of the Effective Date hereof and with full implementation within one year, each Facility shall maintain, and update semiannually, a list of individuals lacking both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision ("individuals lacking LARs") and prioritize such individuals by factors including: those determined to be least able to express their own wishes or make determinations regarding their health or welfare; those with comparatively frequent need for decisions requiring consent; those with the comparatively most restrictive programming, such as those receiving psychotropic medications; and those with potential guardianship resources.	Although Corpus Christi SSLC has some of the preliminary processes in place to identify the need for individuals to pursue the guardianship process, the Facility has not met the requirements of this provision of the Settlement Agreement. Facility staff were extremely honest about the fact that this is an area in which they need to make additional efforts. Staff also indicated that DADS Central Office was still in the process of developing a policy on guardianship and consent that is expected to provide guidance to the Facilities with regard to the implementation of this SA requirement. The Monitoring Team appreciated this frank assessment by the Facility of its status with regard to these requirements. Specifically, Corpus Christi SSLC provided the Monitoring Team with a list of individuals who do not currently have LARs. Staff explained, however, that they have not yet begun to prioritize a list of individuals who lack both functional capacity to render a decision regarding the individual's health or welfare and an LAR to render such a decision, as required by the SA. As part of the annual individualized planning process, individual teams at Corpus Christi identify whether an individual has a Legally Authorized Representative or not. It appears that individual teams also review the Rights Assessment that is completed prior to each individual's annual Personal Support Plan meeting, and make some basic determinations regarding whether an individual is able to make informed decisions, and/or if supports are necessary to ensure that the individual's rights are maintained with respect to decision-making. Some of the concerns related to the current process include the following: 1) in at least one (1) instance, there were inconsistencies with regard to an individual's guardianship status; 2) the process that teams currently are using to determine an individual's ability to provide informed consent is vague and does not appear to be based on specific assessment tools; and 3) identification of concerns related to an individual's ability to	

#	Summary of Provision	Assessment of Status	Compliance
		make informed decisions does not result consistently in recommendations for either supports and services to increase the individual's decision-making capacity or to pursue guardianship. Each of these concerns is discussed in further detail below: <u>Inconsistencies with regard to guardianship status</u>: The PSP format includes a section on the first page that addresses whether the individual has an LAR and/or an Advocate. The Rights Assessment that is prepared by the QMRP for review by the interdisciplinary team at the annual PSP meeting also has a section that identifies the individual's "Legal Status", specifically their guardianship status. Corpus Christi SSLC also maintains a database that tracks guardianship status. For one (1) individual inconsistencies were found with regard to guardianship information maintained. It is not clear at this point, if this is an isolated instance, or if it is an issue for other individuals as well. Specifically: ▪ Individual #147's PSP dated 11/18/09 indicated that she had a guardian, specifically her mother. However, the Rights Assessment appears to have been completed after the PSP meeting on 12/12/09 indicated that Individual #147 is an "Adult, No Guardian." Individual #147's name is included on the list provided by CCSSLC identifying "Individuals without Legally Authorized Representative." Given this conflicting information, it is unclear if she has a guardian or not. <u>Process Used to Determine Individuals' Capacity to Make Informed Decisions:</u> Section J of the "Rights Assessment" discusses the ability of the individual to give or withdraw informed consent. For each individual, "[b]ased on assessments and the annual review process, the PST [determines] that he/she in **unable** to give informed consent in the areas noted below." Areas that may be identified by the team include medical, programmatic, financial, restrictive/intrusive practices, media/photo, and release of records. It is unclear which formal assessments, if any, teams utilize to reach conclusions regarding individuals' ability to provide informed consent in the various areas identified in the "Rights Assessment" document. The following are examples that illustrate this concern: ▪ Individual #147's "Rights Assessment" dated 12/12/09 indicated that her team determined that she is unable to provide informed consent with regard to medical, programmatic, financial, restrictive/intrusive practices, and release of records. The only area in which her team indicated she could provide informed consent was with regard to media/photos. Her PSP dated 11/18/09 has a section on her achievements and abilities. Among her strengths, the team listed: "[Individual #147] understands essentially all incoming information, including complex verbal directions, questions and conversation. She also is able to read basic written material… [Individual #147] communicates well using complete and complex sentences that are pertinent to the current topic. Spontaneous speech is fully intelligible to the average listener. Vocabulary is [Individual #147's] greatest weakness, but functional for her needs." These statements	

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		appear to have been taken from her speech and language screening dated 10/5/09. Her behavioral services evaluation dated 11/2/09, reflects similar information related to Individual #147's ability to communicate, and comments on her ability to understand the general value of money, but not the actual value of paper money. In reviewing the assessments used for planning purposes, none were found that provided specific information related to Individual #147's capacity to make decisions in the areas outlined in the "Rights Assessment." ▪ For Individual #8 who's PSP was completed on 11/24/09, no "Rights Assessment" was found. Her psychological evaluation did not include any specific information related to her ability to make informed decisions. It indicated that the last psychological testing was completed in April 1991. The first page of Individual #8's PSP indicated that she did not have an LAR. She is described as not being able to communicate verbally, and it appears to be difficult to determine what she is communicating. For example, the CLOIP document indicated that her interest in community placement could not be determined as she nodded her head when shown pictures of possible community placements, but had done this throughout the CLOIP process. Recommendations to Increase Decision-Making Capacity or Pursue Guardianship: Even when teams identify concerns with regard to an individual's ability to provide informed consent, there does not appear to be an expectation that this will result in a plan to either provide supports to increase the person's capacity, or to pursue guardianship as an alternative. For example, some individuals may be able to give or withdraw informed consent with additional education or when information is provided in alternative formats. The following provide some examples of individuals whose teams identified concerns with regard to their ability to give or withdraw informed consent: ▪ Individual #147's team indicated on the "Rights Assessment" dated 12/12/09, that she was unable to give or withdraw informed consent with regard to five (5) out of the six (6) areas identified, including medical, programmatic, financial, restrictive/intrusive processes, and release of records. Although there is inconsistent information in various documents related to her guardianship status, the "Rights Assessment" indicates she is her own guardian. Her team made no comments or recommendations regarding actions that would be taken to either assist Individual #147 to be able to increase her decision-making capacity and/or to pursue guardianship. ▪ Individual #8's team did not make any recommendations with regard to pursuit of a guardian. As described above, it appears that she has limited ability to express informed consent. Individual #8 has a sister who lives out of state, and appears to have limited contact. Her sister did not participate in the PSP meeting. ▪ Individual #40 is identified as an adult with no guardian. Her Rights Assessment	

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		dated 8/12/09, indicates that her team had determined that she is not able to make informed decisions in the following areas: financial, restrictive/intrusive practices, media/photo and release of records. However, no plan was found to either increase her ability to make decisions, or to pursue guardianship. Facility staff interviewed recognized guardianship as a restrictive procedure that, at times, is necessary to protect an individual who has limited ability to make informed decisions. Likewise, the Texas Guardianship Statute recognizes guardianship as a restrictive procedure that requires due process. The statute also offers limited guardianship as a less restrictive option to full guardianship. Therefore, it is important for assessments of an individual's capacity to provide informed consent to detail the areas in which they are able to make informed decisions as well as those areas in which they cannot make such decisions. Further, it is important for such assessments to identify if there are supports or resources that could enable a person to make informed decisions, or increase their capacity to make such decisions.	
U2	Commencing within six months of the Effective Date hereof and with full implementation within two years, starting with those individuals determined by the Facility to have the greatest prioritized need, the Facility shall make reasonable efforts to obtain LARs for individuals lacking LARs, through means such as soliciting and providing guidance on the process of becoming an LAR to: the primary correspondent for individuals lacking LARs, families of individuals lacking LARs, current LARs of other individuals, advocacy organizations, and other entities seeking to advance the rights of persons with disabilities.	The Texas Guardianship Statute identifies a number of pieces of information that the court may consider in making its decision regarding the need for guardianship and, if needed, the type of guardianship that will be ordered (i.e., full or limited guardianship). For example, guardian ad litems, attorney ad litems, and/or investigators may be appointed to assist the court in evaluating the need for guardianship as well as the type of guardianship needed. In addition, it appears that it is possible for other interested parties to be involved in guardianship proceedings. For example, people who must be noticed regarding guardianship proceedings include family members as well as the facility director of the facility currently supporting the individual. Given the knowledge that individuals' teams have regarding their strengths, needs and preferences, teams could potentially provide valuable information both in terms of written reports as well as verbal information regarding individuals who become the subject of guardianship proceedings. A meeting has been scheduled for March 2010 with the Monitoring Panel and the State to further discuss the guardianship process. However, at this juncture, it is unclear what, if any, role the State views Facility staff as having with regard to guardianship proceedings.	

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

- The State should finalize the state policy on guardianship and consent, and implement it as soon as possible. In doing so, it should consider including in the policy the following:

- 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;
- An assessment process that identifies potential supports or resources that would either allow an individual to make informed decisions or increase his/her ability to make informed decisions over time (e.g., education, information provided in alternative formats, etc.); and
- 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.

- Once the State policy is finalized, the State should provide key Facility staff with training on its implementation.

SECTION V: Recordkeeping and General Plan Implementation	
	Steps Taken to Assess Compliance: The following activities occurred to assess compliance: ▪ **Review of Following Documents**: o Tables of Contents of Records; and o DADS policy #020 entitled "Recordkeeping", dated 9/28/09; ▪ **Interviews with**: o Polly Ramirez, Settlement Agreement Coordinator; and o Records Management staff
	Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.
	Summary of Monitor's Assessment: The State is in the process of revising the Table of Contents for the unified record, and has asked the Monitoring Panel for input regarding the new format before it is finalized. During future reviews, the Monitoring Team will review records that are in the new format.

#	Summary of 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.	The State is in the process of revising the Table of Contents for the unified record, and has asked the Monitoring Panel for input regarding the new format before it is finalized. During future reviews, the Monitoring Team will review records that are in the new format.	
V2	Except as otherwise specified in this Agreement, commencing within six months of the Effective Date hereof and with full implementation within two years, each Facility shall develop, review and/or revise, as appropriate, and implement, all policies, protocols, and procedures as necessary to implement Part II of this Agreement.	As is discussed throughout this report, policies and procedures necessary to implement the SA are in various stages of development.	
V3	Commencing within six months of the Effective Date hereof and with full implementation within three years, each Facility shall implement	Facility staff reported honestly that they have not yet fully developed quality assurance processes to ensure that the Facility maintains a unified record for each individual consistent with the guidelines in Appendix D, including random review of at least five (5) individuals per month. Staff indicated that in developing such processes, Quality	

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	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.	Enhancement staff at CCSSLC are collaborating with other SSCLs, some of whom reportedly have some of these processes in place. Again, the Monitor appreciates staff's frank assessment of the status of the Facility's progress with regard to this provision of the SA. The Monitoring Team looks forward to reviewing such quality assurance processes during future reviews.	
V4	Commencing within six months of the Effective Date hereof and with full implementation within four years, each Facility shall routinely utilize such records in making care, medical treatment and training decisions.	An issue that was identified in the review of medical records related to the timely filing of information. Specifically, in reviewing medical records, it was noted that a number of documents had to be obtained from the units since they were not timely filed in the charts. This appeared to be a significant issue throughout the review when looking for specific documents. The Facility needs to ensure that documents are filed in a timely manner in the medical records so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services.	

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

- The State and Facility should move forward with implementing the new record Table of Contents.
- 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.
- Quality Enhancement monitoring tools and procedures should be finalized and implemented to allow regular review of records, analysis of data, and action steps/plans to address individual as well as systemic issues as they are identified.
- Documents should be filed in a timely manner in the medical records so that pertinent clinical information is readily available to clinicians needing this information when making decisions regarding treatments and health care services.

Health Care Guidelines

SECTION I: Documentation	
Steps Taken to Assess Compliance: Please see sections above that address Sections J, L, and M of the Settlement Agreement.	
Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.	
Summary of Monitor's Assessment: Please see sections above that address Sections J, L, and M of the Settlement Agreement.	

Recommendations: No additional specific recommendations are offered at this time.

SECTION II: Seizure Management	

Steps Taken to Assess Compliance: The following activities occurred to assess compliance:

- **Review of Following Documents**:
  - Individual medical records for the following individuals: Individual #13, Individual #27, Individual #28, Individual #29, Individual #31, Individual #32, Individual #33, and Individual #35
- **Interviews with**:
  - Dr. Sandra Rodrigues, Medical Director

Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.

Summary of Monitor's Assessment: The following is based on a very small sample of records. Additional review will need to be conducted during upcoming monitoring visits. However, preliminary review shows the following:

- As noted previously, a consultant neurologist is available. For at least a couple individuals reviewed who have active seizure disorders, documentation could not be found that there had been annual review by a neurologist.
- There appears to be a mechanism for administration of Diastat (diazepam rectal gel) for prolonged seizures or status epilepticus. However, a policy and/or procedure defining the operational criteria for this were not found.
- There is evidence of attention to unnecessary drugs and occasionally to cessation of drugs after a substantial seizure-free period, as described in the HCG. However, consistent documentation of the justification for polypharmacy and systematic review was not always evident.
- With regard to diagnostic workups, Electroencephalograms (EEGs) were often recorded, but there were few instances of brain scans. The Facility would benefit from an overall policy on diagnostic workups (for example, an algorithm), including thresholds for neurological consultations, and how individuals are scheduled for blood levels of antiepileptic medications (AEMs) when indicated.
- There were several instances of vagus nerve stimulators (VNS) units having been installed for intractable seizures, but no assessment was found in individuals' records of how these devices were working and the degree to which they were able to replace one or more AEMs.

The following provide some examples of individuals reviewed:

- According to Individual #27's Health Management Plan developed on 1/15/09, he had 21 seizures, with two (2) requiring Diastat, over past year. On 9/25/91, an EEG showed severe cortical depression. AEMs included Pregabalin, 300 mg, twice a day (BID); and phenytoin, 100 mg,

BID, both indicated for seizures. Phenytoin blood levels were high (therapeutic range of 10-20) on 4/4/08 (21.7) and on 2/17/09 (30.8). Phenytoin blood levels should be checked more frequently and abnormal levels followed up. There does not appear to be neurologist involvement for this individual with an active seizure disorder.

- Individual #28's diagnoses include unspecified seizures with occasional myoclonic jerks on Axis III. She was seen by a neurologist on 4/25/08, and 5/8/09. AEMs include Keppra, 1500 mg, BID; Klonopin 0.5 mg, BID; and Neurontin, 300 mg, three times a day (TID). There was a drug regimen review completed, which showed no drug-drug interactions, but the presence of polypharmacy. All three (3) levels of seizure records were present. This is a complex regimen, which should have neurologist's review due to polypharmacy.
- Individual #29's diagnoses include seizures (unspecified) on Axis III. EEG reports were from 2003 and 2004. There was a neurological consultation on 9/25/08 as well as older ones, but one was not found for 2009. There is a detailed description of seizures, which are characterized as "intractable." Reasons for medication changes were noted. There was an attempt not to use more than two (2) concurrent AEMs. Although it appears that the neurology consultant has evaluated Individual #29, the HCG require annual review for an individual with an active seizure disorder

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

- Annual reviews by a neurologist should be completed for each individual with an active seizure disorder.
- Policies and procedures related to the management of seizure disorders should be included in the health care policies and procedures being developed by the State and Facility. Included in these documents should be policies on diagnostic workups or evaluations that should be completed, and the general timeframes for completion of such testing, and the use of Diastat.
- A format should be developed and implemented to ensure that written justification is provided when polypharmacy is used to treat seizure disorders, and that there is a process for regularly reviewing its use and making changes as appropriate.
- When Vagus Nerve Stimulators are used, an analysis should be documented of their efficacy.

SECTION III: Psychotropics/Positive Behavior Support	
Steps Taken to Assess Compliance: Please see the portions of the report that address Psychiatric Care and Services (Section J), and Psychological Care and Services (Section K).	
Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.	
Summary of Monitor's Assessment: Please see the portions of the report that address Psychiatric Care and Services (Section J), and Psychological Care and Services (Section K) for information related to the use of psychotropic medication and Positive Behavioral Support Plans.	

Recommendations: Please see the recommendations for Section J and Section K of the Settlement Agreement.

SECTION IV: Management of Acute Illness and Injury	
Steps Taken to Assess Compliance: Please see sections above that address Sections L and M of the Settlement Agreement.	
Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.	
Summary of Monitor's Assessment: Please see sections above that address Sections L and M of the Settlement Agreement.	

Recommendations: No additional specific recommendations are offered at this time.

SECTION V: Prevention	
Steps Taken to Assess Compliance: Please see sections above that address Sections L and M of the Settlement Agreement.	
Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.	
Summary of Monitor's Assessment: Please see sections above that address Sections L and M of the Settlement Agreement.	

Recommendations: No additional specific recommendations are offered at this time.

SECTION VI: Nutritional Management Planning	
Steps Taken to Assess Compliance: Please see sections above that address Section O of the Settlement Agreement.	
Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.	
Summary of Monitor's Assessment: Please see sections above that address Section O of the Settlement Agreement.	

Recommendations: No additional specific recommendations are offered at this time.

SECTION VII: Management of Chronic Conditions	
Steps Taken to Assess Compliance: Please see sections above that address Sections L and M of the Settlement Agreement.	
Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.	
Summary of Monitor's Assessment: Please see sections above that address Sections L and M of the Settlement Agreement.	

Recommendations: No additional specific recommendations are offered at this time.

SECTION VIII: Physical Management	
Steps Taken to Assess Compliance: Please see sections above that address Sections O and P of the Settlement Agreement.	
Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.	
Summary of Monitor's Assessment: Please see sections above that address Sections O and P of the Settlement Agreement.	

Recommendations: No additional specific recommendations are offered at this time.

SECTION IX: Pain Management	
Steps Taken to Assess Compliance: Please see sections above that address Sections L and M of the Settlement Agreement.	
Facility Self-Assessment: This is not applicable during the baseline reviews. It will be assessed in future reports.	
Summary of Monitor's Assessment: Please see sections above that address Sections L and M of the Settlement Agreement.	

Recommendations: No additional specific recommendations are offered at this time.

List of Acronyms Used in This Report

Acronym	Meaning
AAC	Alternative or Augmentative Communication
ABA	Applied Behavior Analysis
AED	Antiepileptic Drugs
AEM	Antiepileptic medication
A/N/E	Abuse/Neglect/Exploitation
AP	Alleged Perpetrator
APC	Admissions/Placement Coordinator
APS	Adult Protective Services
ARNP	Advanced Registered Nurse Practitioner
ATS	Active Treatment Specialist
BCBA	Board Certified Behavior Analyst
BSC	Behavior Support Committee
BID	Twice a Day
BSP	Behavior Support Plan
CANRS	Client Abuse and Neglect Reporting System
CCSSLC	Corpus Christi State Supported Living Center
CD	Compact Disc
C-Diff	Clostridium difficile
CDC	Centers for Disease Control
CLDP	Community Living Discharge Plan
CLOIP	Community Living Options Information Process
COTA	Certified Occupational Therapy Aide
CRIPA	Civil Rights of Institutionalized Persons Act
DADS	Texas Department of Aging and Disability Services
DCP	Direct Care Professional
DFPS	Department of Family and Protective Services
DISCUS	Dyskinesia Identification System: Condensed User Scale
DOJ	United States Department of Justice
DRR	Drug Regimen Reviews
DSM	Diagnostic and Statistical Manual
DUE	Drug Utilization Evaluation
EEG	Electroencephalogram
EGDs	Esophagogaastroduodenoscopies
ENT	Ear, Nose and Throat
ER	Emergency Room
FBI	Federal Bureau of Investigation
FIR	Final Investigation Report
FTE	Full-time Equivalent
GERD	Gastroesophageal Reflux Disease

GI	Gastrointestinal
HCG	Health Care Guidelines
HCS	Home and Community-Based Services
HgbA1c	Glycated hemoglobin
HIV	Human Immunodeficiency Virus
HRC	Human Rights Committee
IBW(R)	Ideal Body Weight (Range)
IC	Infection Control
ICAP	Inventory for Client and Agency Planning
ICF/MR	Intermediate Care Facilities for persons with Mental Retardation
ID	Identification
IDT	Interdisciplinary Team
IMC	Incident Management Coordinator
IMRT	Incident Management Review Team
IQ	Intelligence Quotient
ISP	Individual Service Plan
LAR	Legally Authorized Representative
LVN	Licensed Vocational Nurse
MAR	Medication Administration Record
MBSS	Modified Barium Swallow Study
MD	Medical Doctor
MOSES	Monitoring of Side Effects Scale
MPI	Master Patient Identification
MR	Mental Retardation
MRA	Mental Retardation Authority
MRSA	Methicillin-resistant Staphylococcus aureus
NM	Nutritional Management
NMT	Nutritional Management Team
NP	Nurse Practitioner
NPO	Nothing by Mouth
OCD	Obsessive Compulsive Disorder
ORIF	Open reduction internal fixation
OT(R)	Occupational Therapist
PA	Physician Assistant
PALS	Positive Adaptive Living Skills
PBSP	Positive Behavior Support Plan
PNMT	Physical Nutritional Management Team
PNM	Physical and Nutritional Management
PNMP	Physical and Nutritional Management Plan
PO	By mouth
PPD	Purified Protein Derivative
PRN	Pro re nata (as needed)

PROM	Passive Range of Motion
PSP	Personal Support Plan
PSPA	Personal Support Plan Addendum
PST	Personal Support Team
PT	Physical Therapist
PTA	Physical Therapist Aide
PTSD	Post Traumatic Stress Disorder
PFW	Personal Focus Worksheet
RBO	Replacement Behavior Objective
RD	Registered Dietician
RNP	Registered Nurse Practitioner
ROM	Range of Motion
QA	Quality Assurance
QE	Quality Enhancement
QMRP	Qualified Mental Retardation Professional
RN	Registered Nurse
SA	Settlement Agreement in U.S. v. Texas
SAO	Skill Acquisition Objective
SFBA	Structural and Functional Behavior Assessment
SGA	Second-generation Antipsychotic
SIB	Self-Injurious Behavior
SLP	Speech and Language Pathologist
SPCI	Safety Plans for Crisis Intervention
SPO	Specific Program Objective
SSLC	State Supported Living Center
SSO	Staff Service Objective
STD	Sexually-transmitted disease
TID	Three times a day
TIMA	Texas Implementation of Medical Algorithms
TIVA	Total Intravenous Anesthesia
TMAP	Texas Medical Algorithm Project
TSH	Thyroid Stimulating Hormone
TST	Tuberculin Skin Test
UTI	Urinary Tract Infection
VNS	Vagus Nerve Stimulators
VRI	Viral Respiratory Infection